

# **State Epidemiological Outcome Workgroups (SEOW)**

## ***Request for Proposal***

January 9, 2006

Issued By:

Synectics for Management Decisions Inc.  
1901 N. Moore St., Suite 900  
Arlington, VA 22209  
703.528.2772

## **Important Request for Proposal (RFP) Information and Timelines**

Release of RFP	<i>January 9, 2006</i>
Questions Due Regarding RFP	<i>January 12, 2006</i>
Responses to Questions	<i>January 17, 2006</i>
Request for Proposals (RFP) Due	<i>January 27, 2006</i>
Proposal Review Process	<i>January 28—February 9, 2006</i>
Notice of Subcontract Awards	<i>By February 10, 2006</i>

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# **Request for Proposal (RFP)**

## **State Epidemiological Outcomes Workgroups (SEOWs) Program**

### **I. Introduction**

#### **1. Purpose of the SEOWs**

The purpose of this procurement is to establish State Epidemiological Outcomes Workgroups (SEOWs) who will be responsible for the collection, analysis, and reporting of substance use incidence, prevalence and related data and National Outcome Measures (NOMs). These data will, in turn, be used by States and communities for planning, monitoring, and evaluation purposes.

#### **2. Background**

The National Outcome Measures are a set of domains and measures which SAMHSA will use to meet all its reporting requirements, including GPRA and PART, thus reducing burden and redundancy for its grantees. All service activities will be monitored in each of SAMHSA's three Centers. Given the differing components of SAMHSA, the actual measures are slightly different across mental health, prevention, and treatment. To see the actual measures for each center, you should refer to the SAMHSA web site ([www.samhsa.gov](http://www.samhsa.gov)) for more information on the SAMHSA NOMs.

Substance abuse and mental health NOMs are drawn from many types of data: substance use and mental illness incidence and prevalence, related consequence data, and program process and output data. The use and reporting of NOMs data represents a significant change in the way SAMHSA will coordinate with State and Territory prevention agencies. The SEOWs are a critical component to enable States to report on NOMs and to address the Strategic Prevention Framework (SPF) that is being implemented by the Substance Abuse and Mental Health Services Administration (SAMHSA)'s Center for Substance Abuse Prevention (CSAP). The SPF guides States and Territories in developing comprehensive plans to prevent substance abuse and and reduce problems associated with substance abuse and mental illness. As a data-driven planning process, the SPF is organized around five major steps:

- Needs and resource assessment
- Capacity building
- Community planning for outcomes
- Implementation of evidence-based interventions
- Evaluation and performance monitoring

Synectics will serve as the contractor for this effort and will be responsible for managing all aspects of the subcontract process, from applicant solicitation, review, selection, and award, to program monitoring, follow-up, and reporting. Under separate contracts, technical assistance will be provided, as well as data processing.

## **II. Eligibility**

Synectics, through a contract with CSAP, will provide funding of up to \$200,000 per year to up to 33 States and Territories that are not currently SPF State Incentive Grantees. These subcontract awards will be made for one base year, and two option years. States and Territories that meet the requirements for establishing and maintaining SEOWs and reporting NOMs will receive up to \$200,000 per year for up to three years.

States receiving SEOW awards shall have no financial overlap between the SEOW and SPF SIG programs. States or Territories that receive SEOW funding and subsequently win a SPF SIG grant will be expected to maintain the SEOW with SPF-SIG grant funds and will no longer receive funding from this subcontract.

## **III. Task Requirements**

### **1. Overview of Tasks**

Participating States and Territories shall establish a State Epidemiological Outcomes Workgroup to examine alcohol, tobacco and other drug-related archival data, including NOMs, and to determine the scope and extent of substance abuse and substance abuse related problems in States and communities. The SEOWs are also responsible for collecting the NOMs data for the State.

These SEOWs may be established around a previously-existing epidemiological workgroup. SAMHSA expects that these data collection efforts will support ongoing monitoring and evaluation throughout the life of the program. SEOWs will be expected to consider data defined in the State Epidemiological Data System (SEDS, <http://www.epidcc.samhsa.gov>) and to add other data as deemed important and available in the States.

Pursuant to these goals, the SEOWs and the Substance Use Epidemiologist must conduct periodic, statewide/community assessments, which will include but will not be limited to the following:

- assessment of the prevalence of substance use, abuse, and dependence and related problems within specific populations and across the life span;
- determination of the nature, magnitude, and problems associated with substance abuse and mental illness;

- establishment and management of all relevant data systems, including systems used to conduct archival, evaluative, ethnographic, and prospective studies as well as those that are designed to serve as an early warning network;
- development of State profiles of need—patterns of consumption and consequences of substance use;
- employment of systematic, analytical thinking to better understand the causes and consequences of the use of alcohol, tobacco, and other drugs;
- coordination with appropriate decision-making entities within the State or Territory to provide data in formats that will be useful in guiding effective and efficient use of prevention resources; and
- promotion of ongoing, in-depth exchange of data and learning among the SEOW and State or Territory and community leaders who have in-depth understanding of local substance abuse problems.

Using SEOW funding, States and Territories should through contractual agreements, employment, interagency agreements or other means acquire the services of an SEOW epidemiologist with an understanding of substance abuse who will participate in the work of the SEOW and work collaboratively with the Single State Agency or NPNs in addition to public health and other related agencies in the operation of the SEOW. In so doing, the SEOW and the epidemiologist will help facilitate data driven decision-making across state and community organizations helping to assure the effective and efficient use of resources.

In addition to the SEOW epidemiologist, SAMHSA, in conjunction with Synectics, recommends that SEOW membership be composed of appropriate representatives from State or Territory public health agencies; drug enforcement, law enforcement, and criminal justice agencies; education agencies; behavioral health organizations; universities; social science research/statistics organizations; community groups; youth groups; and other involved service providers.

In general, the organization of the SEOW shall demonstrate an appropriate combination of needed capabilities, knowledge, and skills, including:

- the ability to access relevant data on substance use;
- the ability to analyze and interpret these data;
- knowledge of State or Territory context;
- access to appropriate State or Territory decision-makers; and
- knowledge of health communications, including skills in information dissemination and knowledge transfer.

SAMHSA recommends that the SEOWs should be organized according to a basic set of operating principles. These include:

- establishing and documenting a clear purpose and set of goals and objectives, such as through a formal charter;
- establishing and keeping regular working meetings and work plans;

- identifying specific workgroup products, schedules, and milestones;
- establishing and maintaining regular contacts with an appropriate State advisory group and/or key State or Territory decision-makers; and
- ensuring an ongoing and meaningful exchange of data and information between the SOEW, State or Territory leaders and staff, and SAMHSA.

## 2. SEOW Task Deliverables

### **Task 1: Progress Reporting**

SEOWs shall provide monthly progress reports to the SEOW program administrator for at least the first six months after award. After the first six months, SEOWs shall provide quarterly progress reports. The SEOW program administrator may require a SEOW to resume the provision of monthly reports at any time after the first six months as circumstances warrant.

Progress reports must include:

- a summary of accomplishments for the period;
- planned activities for the next period;
- problems encountered, and their resolution;
- any anticipated issues or problems, with a proposed approach to their resolution;
- any T/TA requirements that are anticipated; and
- finance reports, including (but not limited to) analyses of projected expenditures against proposed budget.

Progress reports should be submitted within fifteen days of the close of the reporting period. Progress reports may be submitted by mail or electronically to the SEOW program administrator.

### **Task 2: State or Territory Epidemiological Profile**

SEOWs shall produce an “Epidemiological Profile” that summarizes and characterizes consumption patterns and consequences of the abuse of alcohol, tobacco, marijuana, heroin, cocaine, methamphetamines, inhalants, prescription drugs, or other substances as appropriate. The Epidemiological Profile should identify the sources of data on consumption patterns (e.g., NSDUH), as well as the indicators used to identify consequences (e.g., morbidity and mortality data). The Epidemiological Profile should provide a concise, clear picture of the burden of substance abuse in the State using tables, graphs, and words as appropriate to communicate this burden to a wide range of stakeholders.

A sample epidemiological profile is included as Appendix A.

A draft Epidemiological Profile shall be submitted to the SEOW program administrator by the end of the 9<sup>th</sup> month following award. The SEOW program administrator will provide comments on the draft Profile by the end of the 10<sup>th</sup> month from award. The SEOW shall provide a final, edited Epidemiological Profile by the end of the 12<sup>th</sup> month after award.

### **Task 3: Submit Data Used for Epidemiological Profile**

The SEOW shall provide the SAMHSA Data Coordination and Consolidation Center (DCCC) with copies of, or references to the sources of, data and indicators used in the Epidemiological Profile.

The SEOW program administrator, the SEOW Epidemiologist, and the DCCC shall coordinate the methods and timing for the provision of data and references.

SEOWs shall provide data and references by the end of the 11<sup>th</sup> month following award. The deliverable shall consist of data files, methodology, codebooks, and programs used to generate all data values in the Epidemiological Profile. Final formats have not been determined, but will be made available as soon as possible. Assume that, at a minimum, Excel, SAS, and Access files will be acceptable data formats and Word, RTF, PDF, and TXT files will be acceptable for methodologies, codebooks, and programs.

### **Task 4: Work Plan and Goal Statement**

The SEOW shall produce a charter that describes its principles, functions, and organization. The charter must state the goals and purpose of the SEOW, and include a work plan that identifies:

- an appropriate mission statement for the group;
- the date of the group's creation and expiration (if applicable);
- chairperson/main point of contact for said group;
- specific activities that will be undertaken;
- proposed individual and organizational participants, and their roles and responsibilities;
- sources and forms of data that will be employed;
- SEOW agreement deliverables; and
- methods that the SEOW proposes to employ in measuring and monitoring its progress and accomplishments.

A draft SEOW charter shall be submitted to the SEOW program administrator by the end of the 3<sup>rd</sup> month following award. The SEOW program administrator will provide comments on the draft charter by the end of the 7<sup>th</sup> month from award. The SEOW shall provide a final SEOW charter by the end of the 12<sup>th</sup> month after award.

**Task 5: NOMs Data and Performance Measurement**

The specific requirements for reporting on NOMs have been approved by the Office of Management and Budget. SAMHSA/CSAP will provide a final set of measures to SEOW awardees. States will provide a description of their methods to collect the NOMs 11 months after receiving the final list of measures, data collection tools, and approved methodologies from SAMHSA. Applicants for the SEOWs program must propose a State approach to collecting and reporting data on the NOMs measures in their proposal. The target date for full reporting of the NOMs is FY2007. The current version of the prevention NOMs is shown below in table 1.

Table 1. Prevention National Outcome Measures

Desired Outcome/Domain	Performance Measure
Abstinence from Drug Use/Alcohol Abuse	30-day substance use (non-use/reduction in use)
	Age of first use
	Perceived Risk/Harm of Use
	Perception of Disapproval/Attitude
Increased/Retained Employment or Return to/Stay in School	School attendance and enrollment
	ATOD-related suspensions/expulsions
	Perception of Workplace Policy
	Workplace AOD Use
Decreased Criminal Justice Involvement	Alcohol and Drug-related crime
	Alcohol Related Car Crashes and Injuries
Increased Access to Services (Service Capacity)	Number of persons served by age, gender, race, and ethnicity
Increased Social Supports/Social Connectedness	Family Communication Around Drug Use
Cost Effectiveness	Services provided within cost bands
Use of Evidence-Based Practices	Total number of evidence-based programs and strategies

**Task 6: Option Years 2 and 3**

The schedule and all deliverables shall remain the same as the base year, with the exception of the progress reports, which will be due quarterly unless monthly reporting requirements are reinstated.

3. Delivery Schedule

This subcontract will be for a one-year base period with two one-year option periods. The tasks to be performed in years 2 and 3 will be essentially the same as the tasks and reports required for the first year of the subcontract performance period, except for the progress reports, which will be expected quarterly in years 2 and 3.

Table 2. SEOW Deliverables Summary

Deliverable	Due Date
Progress reports	Monthly for the first six months following award, quarterly thereafter (unless monthly reporting requirements are reinstated by SEOW program administrator)
Draft SEOW Charter	End of 3 <sup>rd</sup> month following award
Draft Epidemiological Profile	End of 9 <sup>th</sup> month following award
Copies and/or references to data supporting Epidemiological Profile	Delivered by the end of the 11 <sup>th</sup> month following award
NOMs Data Collection Plan, methodology, and data	End of 11 <sup>th</sup> month following final list of measures
Final Epidemiological Profile	End of 12 <sup>th</sup> month following award (based on receipt of comments on draft Profile by end of 10 <sup>th</sup> month from award)
Final SEOW Charter	End of 12 <sup>th</sup> month following award (based on receipt of comments on draft Profile by end of 7 <sup>th</sup> month from award)

#### IV. Proposal and Submission Information

##### 1. Content and Form of Response

Proposals must comply with the following basic requirements:

- Proposals must be typewritten on 8.5-inch by 11-inch paper.
- The Proposal Narrative will be limited to 10 pages containing twelve (12) point Times New Roman font and minimum one (1) inch margins on all sides.
- All pages must be numbered sequentially with the exception of the cover page, abstract, table of contents page, and appendices.
- Programs must submit 3 copies of the proposal, if sending via mail.
- Proposals should not be bound or stapled. Please use paper or binder clips if mailing.

The closing date for the receipt of all proposals will be 5:00 p.m., on January 27, 2006. Programs should allow sufficient time for delivery by the U.S. Postal Service. If you find that you do not believe you can meet this deadline please contact the SEOW Program Managers. Proposals may be mailed, e-mailed, sent by Federal Express, UPS, or hand delivered to the following address:

Synectics for Management Decisions, Inc.  
 Attn: SEOW Program Administration  
 1901 North Moore Street, Suite 900  
 Arlington, VA 22209  
 seowadmin@smdi.com  
 (703) 528-2772 (Alisa Male, *program administrator* or Marc Lauterbach, *program assistant*)

States and Territories should provide a narrative describing the proposed approach and timeline for implementing the SEOW, preparing the Epidemiological Profile, and submitting required reports, data, and documentation. In addition, responses should present a credible plan for reporting all defined NOMs and a timeline for reporting that identifies when the State or Territory expects to begin reporting each NOM.

The implementation plan should include a description of any potential barriers to establishing and operating a SEOW, or to full reporting of the required reports and deliverables, including the NOMs, and a description of the scope and kind of technical assistance that may be required to overcome these barriers by the end of FY 2006. Technical assistance to SEOWs will be provided under a separate SAMHSA central services contract.

### **Proposal Content**

Your proposal should be organized as follows:

#### *Cover Page/Sheet*

- Indicate primary agency/organization name, address, phone, fax number, and e-mail address.
- Provide contact name, title, phone, fax number, and e-mail address.

#### *Proposal Abstract*

- Provide an abstract of your proposal, not to exceed 500 words. (If you become a subcontract awardee, the summary may be used for informational or reporting purposes.)

#### *Table of Contents*

- Include page numbers for each of the major sections and subsections of the Proposal Narrative.

#### *Proposal Narrative (10 pages, maximum)*

1. Program/Agency Description
  - A. Background
  - B. Goals and Objectives
2. SEOW Staffing Plan
3. Reporting and Data Requirements
  - A. Data Work Plan
  - B. Epidemiological Profile Plan
4. Staff Capabilities and Project Management
  - A. Staff Qualifications and Commitment
  - B. Project Management

*Letter of Support*

- Include letter from state health department or equivalent state public health agency.

2. Submission Date and Time

Proposals must be received no later than close of business **FRIDAY January 27, 2006**. If you find that you do not believe you can meet this deadline please contact the SEOW Program Managers.

3. Other Submission Requirements

The SEOW Agreement Administrator (Synectics for Management Decisions, Inc.) will execute written subcontracts with each State or Territory that receives an award under this program. The subcontract agreement shall be signed by an official authorized to bind the State or Territory in such matters, and returned to the Agreement Administrator.

**V. Proposal Review Information**

The following criteria will be applied in evaluating proposal submissions for the SEOW Program.

States and Territories responding to the RFP shall be evaluated according to their apparent ability to meet SEOW program requirements and to initiate regular reporting of NOMs and other available data. The information gleaned during this review will enable Synectics to recommend potential TA needs of the applicants.

All States and Territories that demonstrate the ability and willingness to meet SEOW program requirements shall receive awards.

Your proposal will be reviewed and scored against the requirements listed below for developing the Proposal Narrative. **The Proposal Narrative must not exceed 10 pages.** It is structured into four (4) major sections. Your proposal will be scored according to how well you address the requirements for each section. Appendices A through C will be considered by reviewers in assessing your response, along with the material in the Proposal Narrative.

The number of points after each heading below is the maximum number of points the reviewers may assign that section of the Proposal Narrative. The specific evaluation criterion for each section is also listed. The statements below direct reviewers to important areas within each section. These evaluation criteria will allow us to evaluate your proposal with a focus on the ultimate goals of the program which are the collection of State NOMs and the development of an Epidemiological Profile.

**Total Points: 100**

**Section 1: Program Description**

**(15 Points)**

*Evaluation Criterion: Structure of Agency and Communication*

Background

Provide a description of the host agency and its history with collaborating with other agencies in addressing public health problems at the State level. In addition describe how the SEOW host State agency will communicate and share information with other State agencies and how the agencies will interact regarding the epidemiological data and their use.

Goals and Objectives

The goals, objectives, and expected outcomes of the SEOW.

**Section 2: Approach to Reporting and Data Requirements**

**(30 Points)**

*Evaluation Criterion: Viability and Organization of Data and Profile Plans*

Data Work Plan

Describe plans to collect and report on NOMs.  
Describe plans to collect, analyze and report on substance abuse/use and problems related to substance use/abuse.

Epidemiological Profile Plan

Describe the goals, objectives, and expected outcomes of the Epidemiological Profile report.

**Section 3: SEOW Staffing and Staff Capabilities**

**(30 points)**

*Evaluation Criterion: Ability to Recruit and Plans for Recruiting Members for the Workgroup*

Resources Available

Demonstrate plans for creating and maintaining the SEOW, Identify proposed workgroup membership, and document epidemiological expertise of staff and their involvement and how these particular staff members will assist with the analysis and reporting of data on substance use.

Staff Experience, Qualifications, and Commitment

Identify a project director and describe the role of the SEOW epidemiologist in the SEOW. Identification of internal and external staff assigned to implement the proposed plans, including roles and responsibilities, and their commitment to the success of the project. Include the relevant expertise, qualifications, and skills of internal and external staff. Attach, as **Appendix A**, resumes and letters of commitment for all key staff to be assigned to the project.

#### **Section 4: Project Management**

**(15 points)**

*Evaluation Criterion: Management Plan*

##### **Project Management**

Description of how the SEOW will be managed and interact with other agencies within the State or Community on the development of the epidemiological profiles and NOMS reporting. Attach, as **Appendix B**, a schedule of milestones or tasks to achieve the requirements during the 12-month project period.

##### **Budget**

**(10 Points)**

*Evaluation Criterion: Reasonableness of the Budget*

Provide a detailed one (1)-page budget, with narrative, supporting and explaining your budget request. Attach, as **Appendix C**, your budget request and narrative for the proposed SEOW, data plan development, and reporting requirements.

**Appendices** (Attach appendices A-C)

##### **Review and Selection Process**

Reviewers will conduct an evaluation of proposals focusing on the overall quality and responsiveness of the proposals to the above review criteria. The reviews will be used to identify strengths and weaknesses to be addressed both pre- and post- award.

Strengths and weaknesses of the proposal in describing:

- the program's readiness to implement the SEOW;
- efficacy of the proposed data plan and epidemiological profile plan;
- qualifications and experience of proposed staff; and
- budget feasibility.

## VI. Subcontract Award Administration and Information

### 1. Subcontract Funding

Participating States and Territories are eligible to receive up to \$600,000, if all option years are exercised, based on successfully meeting data quality, completeness, and timeliness reporting standards for each of the full agreement periods. States and Territories will be paid 50% of the annual award total following the first 6 months of the agreement year, based on the satisfactory submission of all deliverables for the first 6 months of the year. States and Territories will be paid the remaining 50% of the award amount following the final 6 months of the agreement year, based on the satisfactory submission of all deliverables for the entire year.

### 2. Relationship to SPF-SIG Grants

States receiving SEOW awards shall have no financial overlap between the SEOW and SPF-SIG programs. States or Territories that receive SEOW funding and subsequently win a SPF-SIG grant will be expected to maintain the SEOW with SPF-SIG grant funds and will no longer receive funding from this subcontract.

### 3. Funding Mechanism

Payments to States and Territories will be made twice yearly: within 4 months following the first 6 months of the year and 4 months following the end of the agreement year, based on receipt and acceptance of satisfactory quarterly reporting of NOMs and other data. Payments will be made by check or electronic transfer.

### 4. Funding Subcontract Administrator

Synectics for Management Decisions, Inc.  
Attn: SEOW Program Administration  
1901 North Moore Street, Suite 900  
Arlington, VA 22209  
seowadmin@smdi.com  
(703) 528-2772 (Alisa Male, *program administrator* or Marc Lauterbach, *program assistant*)

### 5. Agency Sponsor

Center for Substance Abuse Prevention  
Substance Abuse and Mental Health Services Administration  
1 Choke Cherry Road  
Rockville, MD 20857  
(240) 276-2422 (Dr. Pam Roddy)  
(240) 276-2487 (Nancy Kennedy)

# Appendix A: Sample State Epidemiological Profile

## Alcohol

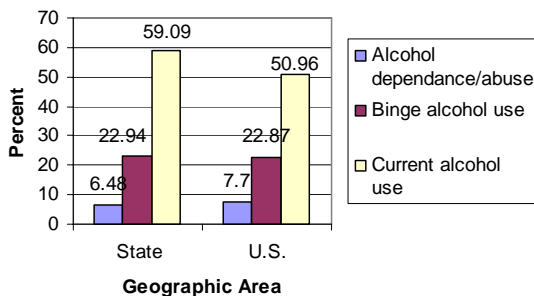
### Consumption

Alcohol is the most commonly abused substance nationally and statewide. According to the 2002 National Household Survey of Drug Use and Health (NSDUH), 56% of people age 12 or older in [State] (an estimated 1,636, 932 persons) were current users of alcohol. The State's rate was 16% higher than the national average (51%). While data from the 2003 [State] Adult Household Survey showed the use of alcohol had decreased slightly since 1995, 16% of adults would be classified as risky drinkers.

According to the NSDUH, young adults aged 18-25 in [State] had the highest rate of post-month use (69%) as well as the highest prevalence of binge drinking (45%) and alcohol abuse and dependence (18%). Data from a survey conducted on [State] college campuses in 2004 had comparable findings: 72% of college students reported that they were current drinkers and 46% had been binge drinking within the past two weeks. Thirty percent of students said that they had driven a car while under the influence of alcohol or other substance use.

Most adults begin using alcohol in adolescence. A 2000 student survey found that 24% of 7<sup>th</sup>-8<sup>th</sup> grade and 46% of 9<sup>th</sup>-10<sup>th</sup> grade students were past-month alcohol users. [State] students were drinking at higher rates than their peers nationwide (e.g., 29% of [State] 8<sup>th</sup> graders were current alcohol users compared to 22% nationwide). The average age of first alcohol use was 11 among the State's 8<sup>th</sup> grade drinkers.

**Alcohol Use, Ages 12 and older, State and United States, 2002**



State Estimates of Use from the 2002 National Survey on Drug Use and Health

### Consequences

- Approximately 100,000 deaths each year in the U.S. are attributed to alcohol misuse.
- In [State], underage drinking cost the state and estimated \$600M in 2001. Nationwide during the same year, the costs of alcohol use were \$101.9 billion.
- Binge drinking, as indicated by consumption of five drinks or more within a short time span, is strongly associated with injuries, motor vehicle crashes, violence, fetal alcohol syndrome, chronic liver disease, and other chronic and acute conditions.
- Initiation of alcohol use at young ages has been linked to more problematic levels of use in adolescence and adulthood. Young people who drink are more likely than adults to be binge drinkers.
- Heavy drinkers are at increased risk for alcohol abuse and dependence. People who begin drinking before the age of 15 are four times more likely to develop alcohol dependence than those who wait until age 21. Each additional year of delayed drinking onset reduces the probability of alcohol dependence by 14 percent.
- Studies have shown that long-term alcohol abuse produces serious, harmful effects on a variety of the body's organ systems, especially the liver and the immune, cardiovascular and skeletal systems.
- Immediate adverse effects of alcohol can include: impaired judgment, reduced reaction time, slurred speech, and unsteady gate. When consumed rapidly and in large amounts, alcohol can result in coma and death.
- Excessive drinking, including binge and heavy drinking, has numerous chronic and acute health effects. Chronic health

## Appendix A: Sample State Epidemiological Profile

consequences include: liver cirrhosis, pancreatitis, various cancers, including cancer of the liver, mouth throat, larynx, and esophagus, high blood pressure, and psychological disorders. Acute health consequences of excessive drinking can include motor vehicle injuries, falls, domestic violence, rape, and child abuse.

### **Selected Indicators**

- DWI Arrests via DMV license Suspensions\*
- Adult DUI Arrests\*
- Alcohol-Related Fatal Motor Vehicle Crashes\*
- Alcohol-Related Vehicle Death Rate\*
- Alcohol-Involved Drivers of All Drivers in Fatal Crashes\*
- Liquor Law Violations\*
- Violent Crime Rate
- Alcohol Treatment Admissions\*
- Alcohol-related School Suspensions/Expulsions\*
- Ethanol sales per capita
- Suicide death rate
- Homicide death rate
- Chronic Liver Disease
- Alcohol Abuse or Dependence

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\* SEOW Recommended Indicator for Consideration

# Appendix A: Sample State Epidemiological Profile

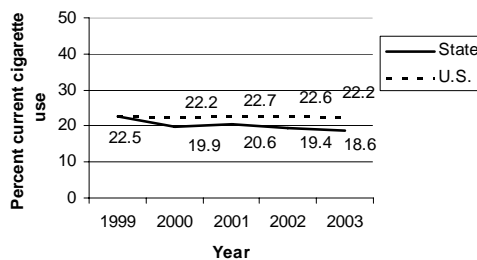
## Tobacco

### Consumption

The 2003 [State] Adult Household survey found that 21% of the State's population age as using tobacco (more that 500,000 people), including 10% who were heavy smokers. The highest rates of smoking were found among men (25%); adults aged 18-34 (33%) and Blacks (25%). The 2003 National Survey of Drug Use and Health (NSDUH) reported a slightly lower prevalence of cigarette smoking in [State] compared to the nation (15.6% vs. 22.2%). Data over time from the NSDUH shows that cigarette smoking in [State] has been falling since 1999.

In a 2000 student survey, 12% of 7<sup>th</sup>-8<sup>th</sup> graders and 22% of 9<sup>th</sup>-10<sup>th</sup> graders were current cigarette smokers. These rates were significantly lower than those found by the 1997 statewide student survey. For the first time in a decade, current cigarette smoking among [State's] 8<sup>th</sup> graders had fallen to match the national rate (15%). A 2002 youth tobacco survey found that the overall prevalence of cigarette smoking continued to decrease among the State's middle and high school students across all gender and race/ethnic groups. This survey found that approximately 10% of middle and 27% of high school students are currently using some type of tobacco product with cigarettes, cigars, and biddies, respectively being the most prevalent. This tobacco survey showed the highest rates of recent cigarette smoking among high school males and White and Hispanic students.

Current Use, Ages 18 and Older, State and United States, 1999-2003



CDC (1999-2003) Behavioral Risk Factor System Survey Data.

### Consequences

- More than 400,000 deaths in the U.S. each year are attributed to cigarette smoking, making it the leading preventable cause of death. In [State], more than 5,400 people annually die from smoking-related diseases.
- Smoking increases the risk of heart disease, cancer, stroke, and chronic lung disease. Heart disease is the leading cause of death in the US and [State], and the leading cause of heart disease is smoking.
- Approximately 80% of chronic obstructive pulmonary (COPD) and emphysema deaths are attributable to smoking.
- Lung cancer results from long-term tobacco use and it is the most common form of cancer mortality in the U.S., accounting for 80-90% of all cancer deaths. [State's] lung cancer death rate was 53.8 per 100,000 population in 2001.
- Environmental tobacco smoke increases the risk for heart disease and lung cancer among nonsmokers.
- Careless smoking is the leading cause of fatal fires in the U.S.
- The social costs per year of tobacco use in the United States were estimated to be \$177.2 billion in 2001, including those attributed to lost productivity and medical expenditures.

## Appendix A: Sample State Epidemiological Profile

### **Selected Indicators**

- Synar non-compliance rate\*
- Wholesale number of cigarettes taxed\*
- Lung cancer deaths
- Lung disease deaths
- Chronic Obstructive Pulmonary Disease deaths
- Cardiovascular Disease deaths

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\* SEOW Recommended Indicator for Consideration

# Appendix A: Sample State Epidemiological Profile

## Marijuana

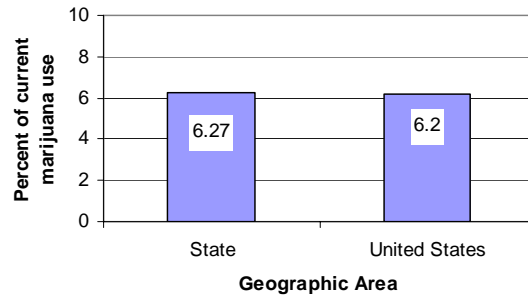
### Consumption

Marijuana is the Nation's most commonly used illicit drug and is the illicit drug of choice in [State]. Trend data from the National Survey of Drug Use and Health (NSDUH) showed that the prevalence of current marijuana use has increased in [State] from 5.2% in 1999 to 6.2% in 2002. A 2003 [State] adult household survey found that 39% of adults 18 or older had ever used marijuana and 7.3% had used it in the past year and also documented an increase in marijuana use over the past decade. The highest rates of past-month use were among men (7%), young adults 18-25 (17%) and Blacks (7%).

Marijuana use is widespread among young adults and adolescents. A 2004 survey of [State] college students showed that 35% of students admitted using marijuana in the past year and 21% had used in the past month. These rates were slightly higher than the national rate for college students.

After an increase in marijuana use throughout the 1990s, a student survey found that use of marijuana among middle and high school students had decreased. In 2000, 7% of 7<sup>th</sup>-8<sup>th</sup> grade and 22% of 9<sup>th</sup>-10<sup>th</sup> grade students reported using marijuana in the past month. Marijuana use among [State] students, however, has been consistently higher than the national average (e.g., 26% vs. 20% for 10<sup>th</sup> graders in 2000). Marijuana accounts for the majority of adolescent substance abuse treatment admissions.

**Marijuana Use, Ages 12 and older,  
State and United States, 2002**



State Estimates of Substance Use from the 2002 National Survey on Drug Use and Health

### Consequences

- Smoking marijuana frequently has been associated with increased reporting of health problems and more days of missed employment than nonsmokers.
- In the short-term, Marijuana use may cause adverse physical, mental, emotional, and behavioral changes such as problems with memory and learning, distorted perceptions, difficulty in thinking and problem solving, loss of coordination, and increased heart rate.
- Longer term adverse health effects include respiratory illnesses, memory impairment, and weakening of the immune system. Long-term marijuana use causes changes in the brain similar to those seen after long-term use of other major drugs.
- Marijuana has been shown to compromise the ability to learn and remember information, often leading to deficits in accumulating intellectual, job or social skills.
- Depression, anxiety, and personality disturbances have been associated with marijuana use.

## Appendix A: Sample State Epidemiological Profile

- Babies born to women who used marijuana during their pregnancies display altered responses to visual stimuli, increased tremulousness, and potential neurological problems.
- Risk of heat attack more than quadruples in the first hour after smoking marijuana.
- Initiation of marijuana use at younger ages has been linked to higher and more severe patterns of use of marijuana and other substances in adolescence and adulthood.
- The number of marijuana-related treatment admissions to publicly funded facilities in [State] has increased annually since 1994. In 1999, [State] ranked 19th in the nation for the rate of marijuana-related treatment admissions (134 per 100,000 population).
- Although marijuana abusers generally do not commit violent crimes, the distribution of marijuana has been associated with violent crime in [State], usually involving rival criminal groups and gangs.
- The social costs of marijuana use were estimated at \$9.1 billion in 2001.

### **Selected Indicators**

- Drug-related arrests\*
- Marijuana Abuse Treatment Admissions\*
- Drug-related school suspensions and expulsions\*
- School Drop-out Rate\*
- Illicit Drug use Death Rate

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\* SEOW Recommended Indicator for consideration

## Appendix A: Sample State Epidemiological Profile

### Heroin Use

#### Consumption

After a declining prevalence since the 1970's, heroin use began to increase beginning in the mid 1990s. From 1995 to 2002, nationally the lifetime use rate among adolescents rose from 0.1% to 0.4% and among 18-25 year olds it rose 0.8% to 1.6%. According to the 2003 National Survey on Drug Use and Health (NSDUH), which may actually underestimate illicit opiate use, an estimated 3.7 million people had used heroin at some time in their lives, and over 119,000 of them reported using it within the month preceding the survey. In 2003, 57% of past year heroin users were classified as dependant on or abusing heroin and an estimated 281,000 persons were in treatment for their heroin addiction. Combined 1995-1996 National Survey of Drug Abuse data show that males, young adults, Blacks, college students, and the unemployed had the highest rates of heroin use.

Demand for heron increased dramatically in [State] in the last decade. It is now easily accessible, of high purity (an average of 70-80% purity according to the D.E.A.) and selling at remarkably low prices. Data from [State's] adult housing survey show that lifetime prevalence of reported heroin use among adults 18 and older rose from 1.7% in 1995 to 2.2% (more than 56,000 persons) in 2003. [State's] rate of heroin use among adults exceeds the national rate. A survey administered to university students in 2003 found that 1.8% of 9<sup>th</sup>-10<sup>th</sup> graders reported ever using heroin.

#### Consequences

Heroin is a highly addictive drug and its abuse has repercussions that extend far beyond the individual user. The medical and social consequences of drug abuse- HIV/AIDS, tuberculosis, fetal effects, crime, violence, and disruptions in family, workplace, and educational environments- have a devastating impact on society and

cost billions of dollars each year. In the United States, the cost of heroin addiction including the cost to treat, economic and social costs like loss of productivity had been estimated to be \$26.4 billion.

- Chronic heroin use can lead to serious medical consequences such as fatal overdose, scarred and/or collapsed veins, bacterial infections of the blood vessels and heart valves, abscesses and other soft-tissue infections, and liver or kidney disease. Poor health conditions and depressed respiration from heroin use can cause lung complications, including various types of pneumonia and tuberculosis.
- Addiction is the most detrimental long-term effect of heroin use because it is a chronic, relapsing disease characterized by compulsive drug seeking and use.
- Long-term effects of heroin use also can include arthritis and other rheumatologic problems and infection of blood-borne pathogens such as HIV/AIDS and hepatitis B and C (which are contracted by sharing and reusing syringes and other injection paraphernalia). It is estimated that injection drug use had been a factor in one third of all HIV and more than half of all hepatitis C cases in the United States.
- Heroin use by a pregnant woman can result in a miscarriage or premature delivery. Heroin exposure in

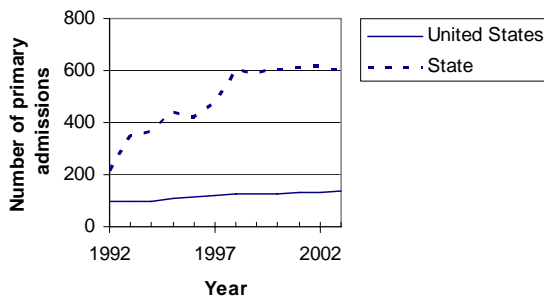
## Appendix A: Sample State Epidemiological Profile

utero can increase a newborn's risk of sudden infant death syndrome (SIDS)

- Heroin and other opiates lead all others in drug-involved deaths in 2001. Data from the [State] Office of Chief Medical Examiner indicate that heroin was a factor in 107 of the 451 deaths involving drugs.
- In 2002, half (49%) of law enforcement officials in [State] responding to the National Drug Threat Survey reported that heroin was a high threat in their jurisdiction.
- In [State], the rate of primary heroin admissions per 100,000 population age 12 and older increased 156% between 1992 and 2003. In 2002, 6% of all heroin admissions nationwide occurred in [State].

- Illicit Drug Use Death Rate\*
- Drug Arrests
- DEA Information on Purity, Seizures, etc.

**Heroin Treatment Admission Rate per 100,000 Persons Age 12 and Older, State and United State, 1992-2003**



Office of Applied Studies, SAMHSA, Treatment Episode Data Set (TEDS)

### Selected Indicators

- Heroin Treatment Admissions\*
- HIV, Hepatitis, and STI Rates\*
- Property Crimes\*

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\* SEOW Recommended Indicator for Consideration

# Appendix A: Sample State Epidemiological Profile

## Prescription Drugs

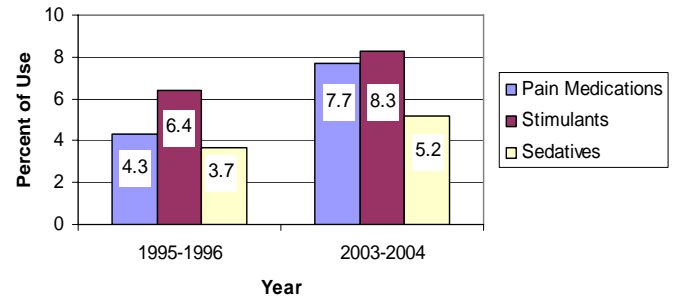
### Consumption

Between 1992 and 2003, the number of people abusing controlled prescription drugs jumped 94% - twice the increase in the number of people abusing marijuana, five times the increase in the number abusing cocaine, and 60 times the increase in the number abusing heroin. From 1990 to 1998, the number of new users of pain relievers increased by 181%; the number of individuals who initiated tranquilizer use increased by 132%; the number of new sedative users increased by 90%; and the number of people initiating stimulant use increased by 165%. The 1999 National Survey of Drug Use and Health (NSDUH) found that almost 2% of the U.S. population aged 12 and older were currently using prescription drugs non-medically, including pain relievers (2.6 million users), sedatives and tranquilizers (1.3 million users), and stimulants (0.9 million users). Controlled prescription drugs like OxyContin, Ritalin and Valium are now the fourth most abused substances in America behind marijuana, alcohol, and tobacco.

Misuse of prescription drugs may be the most common form of drug abuse among the elderly who use prescription medications approximately three times as frequently as the general population and have been found to have the poorest rates of compliance with directions for taking medication. Young adults are also the fastest growing segment of the population abusing prescription and over the counter drugs.

A 2003 [State] adult household survey found lifetime rates for non-medical use of prescription drugs exceeded those for heroin and methamphetamines, including 8.3% for stimulants, 7.7% for pain medications, 6.0% for tranquilizers and 5.2% for sedatives. Males, young adults, and Whites were especially at risk for misuse of prescription drugs. Data from a 2003 survey of college students found rates of sedative use ranging from 8.9% to 14.3% compared to 8.0% nationally.

Lifetime Use of Prescription Drugs, Ages 18 and Older, State



Data from [State's] substance abuse treatment system show that there were 1,076 primary prescription drug abuse treatment admissions in 2003, representing 2.3% of all treatment admissions statewide. From 2001 to 2003, there was a 45% increase in synthetic opiate drug admissions.

### Consequences

- Negative health consequences include potential for developing tolerance to the drug, physical dependence.
- Severe Respiratory depression, cardiovascular failure, seizure or death can follow a large single dose of a prescription drug.
- Abuse of controlled prescription drugs is implicated in at least 23% of drug-related emergency department admission and 20% of all single drug-related emergency department deaths. Between 1994 and 2002, there was a 79% increase in the total number of controlled prescription drug visits, with prescription opioids demonstrating the sharpest increase (168%) over this period.

## Appendix A: Sample State Epidemiological Profile

- Prescription opioids accounted for more drug abusers report experiencing emotional or mental health problems caused or worsened by their abuse of drugs.
- Twelve percent of adult prescription drug abusers and 15% of teenage prescription drug abusers meet DSM-IV diagnostic criteria for abuse or addiction to these drugs.
- In [State] during the period 1992 (0.7%) to 2003 (2.7%), there has been a 285% increase in the percentage of other opiate (non-heroin) drug primary substance abuse treatment admissions.
- It has been estimated that the cost of opioid analgesic abuse in the U.S. in 2001 was \$9.2 billion.

### **Selected Indicators**

- Other Opiates Substance Abuse Treatment Admissions \*
- Emergency Room Mentions

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\* SEOW Recommended Indicator for Consideration

# Appendix A: Sample State Epidemiological Profile

## Cocaine

### Consumption

In 2002, an estimated 2.0 million persons (0.9%) nationwide were current cocaine users, 567,000 of whom used crack. Trend data from the National Survey of Drug Use and Health (NSDUH) indicated that cocaine use was higher among young adults and was on the rise. The percentage of youth aged 12 to 17 who had ever used cocaine increased slightly from, 2001 to 2002 (2.3 to 2.7%) and among young adults aged 18 to 25, the rate increased from 14.9% to 15.4%. Age-specific incidence rates generally have mirrored the overall incidence trends, with the highest rates of initiation among those aged 18 or older and males. The average age of cocaine initiation was 21 years in 2001.

According to the National Office of Drug Control Policy, cocaine, including both powdered and crack, is the second highest illicit drug threat after heroin. Based on data from the 1999-2001 NSDUH, it was estimated that 1.8% of [State] residents used cocaine during the past year. Past year cocaine use was highest among the State's 18-25 year olds (4.8%) and 12-17 year olds (1.5%), although both rates were below those found nationally. However, the rate of cocaine use among adults 26 and older in [State] was 25% higher than the nationwide rate. Among 9<sup>th</sup>-10<sup>th</sup> graders, the rate of current cocaine use increased slightly from 1.4% in 1997 to 1.7% in 2000.

A recent [State] adult household survey found that lifetime rates for cocaine use had increased from 8.6% in 1995 to 14.6% in 2003. Males and Caucasians had the highest rates of lifetime cocaine use. In contrast, data from the 2001 and 2003 survey of college students found that the prevalence of current cocaine use decreased from 2.7% to 2.3% in 2003.

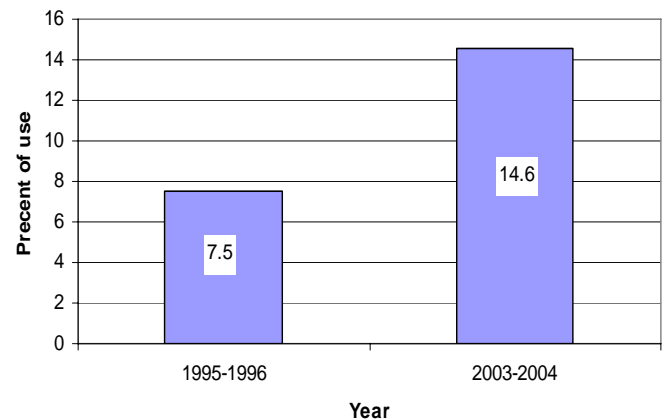
### Consequences

There are significant physical, mental and social problems associated with cocaine use, abuse, and addiction. In 2001, the social cost of

cocaine consumption was estimated to be \$62.6 billion- the third largest for any drug after tobacco and alcohol.

- Negative Physical consequences include: cardiovascular disease, including hypertension, arrhythmia, cardiomyopathy, myocarditis, myocardial ischemia, myocardial infarction, erosion of dental enamel, rhinitis, perforation of the nasal septum, seizures, lung damage, pneumonia, chronic cough, acute renal failure, sexual dysfunction, spontaneous abortion in pregnant women, and infections (HIV, hepatitis B or C, tetanus) from sharing needles.

Lifetime Cocaine Use, Ages 18 and older, State, 1995 and 2003



[State] Household Survey.

- Psychological consequences include: anxiety, depression, suicidal feelings and behaviors, insomnia, emotional instability, irritability, aggressive behavior, and psychotic symptoms. Symptoms of psychiatric disorders such as schizophrenia, panic disorder,

## Appendix A: Sample State Epidemiological Profile

depression, or mania can be triggered or exacerbated by cocaine use or withdrawal.

- Cocaine use is associated with damaged family and social relationships, child abuse and neglect, lost jobs, accidents, prostitution, spread of infections, criminal behaviors, violence, and homicide.
- In 2001, data from the [State] Office of the Chief Medical Examiner indicated that cocaine was a factor in 16.6% of all deaths statewide involving drugs.
- Data from [State's] substance abuse treatment system show that there were 5,754 primary cocaine abuse treatment admissions in 2003, representing 12.6% of all treatment admissions statewide. The number of cocaine-related treatment admissions remained higher than the number of treatment admissions for any other illicit drug except heroin.

### **Selected Indicators**

- Cocaine Abuse Treatment Admissions\*
- Violent Crimes\*
- Drug Arrests
- Illicit Drug Use Death Rate
- Homicide Rate
- Child abuse/neglect rate.

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\* SEOW Recommended Indicator for Consideration