1980

A Study of Alcohol Prevention Grants in the State of Nebraska, 1973-1979

Center for Public Affairs Research (CPAR)
University of Nebraska at Omaha

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Center for Applied Urban Research

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INTRODUCTION

In the early 1970's as the enormous pressure of drug related problems was abating, the attention of mental health professionals, school personnel, and the criminal justice system was refocused on the problems that come with alcohol. A new phenomenon seemed to be following the drug "scene", the increased alcohol usage among teen-agers and even children. The message was clear: an effort had to be made to prevent alcohol abuse before problem drinking became more widespread.

Most prevention efforts until the 1960's stemmed from the same roots as the Prohibition Amendment to the Constitution, the moral precepts of the major Protestant denominations. These early precepts asserted that the cause of alcoholism was in the alcohol, and prevention efforts should be directed at removing the substance from individuals. Post-prohibitionists maintained that addiction was inherent in the individual who was predisposed to alcoholism. In both cases, alcoholism was bound to the concepts of sin and/or weakness, and prevention efforts took on an evangelistic quality.

In 1972, the state of Nebraska began receiving prevention money through the Division on Alcoholism (DOA) of the Department of Public Institutions. A prevention coordinator ran a program, part of which was to fund prevention programs around the state. Since 1973 the DOA has granted $504,972 for alcohol prevention. Over the years, the department recognized the need for an integrated, focused, and shared approach. To this end they granted funds to found a Nebraska Center for Alcohol Abuse and Alcohol Prevention.

One of the first tasks of the new Center was to evaluate the impact of the state's previous programs. Previous programs were to be assessed on the basis of 1) target population served, 2) their styles and philosophies, and 3) their impacts on the target populations. This report is directed toward this assessment of previous programs and is presented in 5 sections: 1) a logical typology of alcohol prevention theories and techniques, 2) a description of the methodology used in this study, 3) a discussion of the results of the evaluation, 4) implications of the findings, and 5) a brief set of general recommendations for the new Center's prevention programs indicated by the assessment of past prevention programs in the state.

REVIEW OF THE LITERATURE

Prevention Models: Logical Bases and Program Strategies

Prevention strategies have been gaining increased support and attention as a means of either preventing alcoholism and alcohol abuse or at least reducing these problems. Prevention activities assume that knowledge of the causes of alcoholism and its mechanisms of action may serve as a basis for strategies to help individuals alter their behavior to prevent a reliance on alcohol.

During the 1960's, distinctions between different levels of prevention of alcohol abuse and alcoholism were posited. Often they were couched in epidemiological terms which were based on a disease conception of alcoholism. Prevention was seen as part of a public health model and took on three aspects:

> Primary prevention consists of removing or preventing the causes of a disorder or of increasing the number of those who are immune or resistant in the population. Secondary prevention is the arresting of a disorder through early treatment before it becomes fully developed. Tertiary prevention signifies treatment of the full-blown condition in order to prevent chronic or permanent disability or to effect cure (Cumming, 1963).

A discussion of tertiary models and techniques will not be included in this report since they are usually considered under treatment models.

A more specific design is needed in the area of primary prevention in the state of Nebraska. As one of the foremost authorities in the field of education and prevention of alcoholism states,

> The principal classes of techniques or prevention of alcohol problems include information and education of the public at large, including advertising; education through the school system; manipulation of substance, person, and environmental factors affecting consumption patterns; and singling out for special attention subpopulations having characteristics which make them especially suitable targets for preventive work (Blane, 1976).

A survey of alcohol prevention programs currently in vogue provides four major theoretical perspectives or models of alcoholism. In most prevention programs, the causal theory is implied from the nature and content of the program activities.

Two of the models focus prevention efforts on the level of some social group or aggregate, and two models focus prevention efforts on individuals. Figure 1 summarizes the models.

FIGURE 1

SUMMARY OF PREVENTION MODELS

Model	Focus	Cause	Goals
Socio-cultural	Social group	Problems occur because of lack of norms of responsible drinking, ambivalent values, sanctions, or integrating into other activities.	Establish strong norms of responsible drinking within the society.
Distribution of consumption	Social-political group	Problem occurs because of easy access to alcohol.	Raise the relative cost per unit of alcohol, thus lowering consumption.
Socialization/educational	Individuals	Problems occur because people don't understand implications of too much alcohol. If they knew they would choose the best pattern.	
[a] Responsible choice content			Educate people to choose responsible drinking behavior
[b] Proscriptive content			Educate people to choose abstinence.
Mental health	Individuals	Alcoholism is a symptom of other psycho-social problems.	Make people aware of psycho-social problems and resolve them.

The Socio-Cultural Prevention Model

The socio-cultural model is based on the results of alcohol research by social and behavioral scientists. The basic premises are that problem drinking and/or alcohol abuse is a result of a lack of clear social values, norms, and sanctions concerning the drinking behavior of a social group. Programs based on this model are aimed at the social group. The mixed messages from the culture cause guilt, ambivalence, and anxiety about alcohol usage. A further instance of socially dysfunctional drinking norms is that the actual use of alcohol and even drunkenness become the goals of drinking rather than the accompaniment to other activities in society.

The scientific evidence to support this model stems from demographic data from various sub-cultures summarized by Bacon and Jones (1968) and Plaut (1967). The research generally indicates that in those cultures in which alcohol use is integrated into the normative activity of the family, a lower incidence of alcoholism occurs. For instance, Jews and Italians both use wine at ceremonial meals and occasions to which children are exposed at an early age and have low alcoholism rates.

Cultures which prohibit drinking such as Mormons and Southern Baptists and cultures with ambivalent norms of drinking such as the Irish have a higher relative incidence of alcohol abuse. In the latter cultures, drinking becomes a way of rebelling against authority.

The ultimate prevention goal of this model is to lower the incidence of problem drinking of a social group. This goal is implicit in this model but is rarely measured. The immediate goal of a program based on this model is to change some law, norm, custom, punishment, value,or attitude toward drinking of a specific social group.

Program strategies to achieve the goal are directed toward manipulating the drinking environment of a society or to develop integrated and consistent norms on how to drink and on what occasions. They include developing negative attitudes and social sanctions against over-drinking and drunkenness; changing both formal (laws) and informal (customs, practices) norms of drinking; changing the laws to allow families to serve wine to children in restaurants; or developing codes against advertising alcohol in non-natural situations.

Specific program activities based on this model are determined by the specific target population, the area, current laws, major norms currently operating, the present norms concerning over-drinking, and present formal and informal negative sanctions concerning alcohol abuse.

Several problems with using this model arise. First, the evidence is primarily ex post facto and based on ecological correlation. No programs have been developed which actually test, over time, whether more integrated social norms affect drinking behavior. Second, to develop such a program would be expensive with results too distant. Third, manipulating social norms and values may be quite dangerous as some non-planned side effects may result. Finally, in a complex society the vested interests and the value positions are too variant to enjoy normative consensus, let alone agreement on a definition of "excessive" drinking.

The Distribution of Consumption Prevention Model

The distribution of the consumption model is based on research from a Canadian group, the Addictive Research Foundation (ARF). Its prevention thrust is to prevent the consumption of alcohol by manipulating the cost of alcoholic substances. The model is based on demographic correlation with cause imputed to an uncontrolled correlation between cost and cirrhosis mortality rates and cost and consumption.

The scientific evidence seems strong because of the correlations. However, because intervening causal variables have not been controlled, the model is functional only for social aggregates with political boundaries. The ARF group found that consumption of alcohol varies across populations with the relative cost of alcohol. Relative cost is the per unit cost of alcohol in proportion to annual disposable income. In addition in countries that have taken many measures to control alcohol consumption, only raising the relative price has been significantly related to decrease in both alcohol consumption and cirrhosis mortality rates.

The ultimate prevention goal of this model is to lower the alcohol consumption of a social aggregate or geographical area. The immediate goal of programs based on this model is to gain public approval to develop public policies which would raise the cost of alcohol.

Program strategies are aimed at manipulating the cost of the substance. They may include changing the laws so that the cost per ounce of alcohol in all types of beverages is the same, increasing the price of alcohol gradually, decreasing the size of containers for the same price, levying higher taxes, etc.

Specific program activities are aimed at gaining public support for changing legislation.

There are many problems with this model as a prevention model as discussed in Blane (1976). First, it tends to define alcoholism only in physical terms and completely ignores psycho-social factors. Second, it does not consider the possible "side effects" likely to occur, such as an increase of illegal alcohol, or an increase of "explosive" drinking, attaching an aura of clandestine thrill with drinking, etc. Finally, the data on which the model is based do not control for other variables such as economic status, urban versus rural locations, etc.

The Socialization/Educational Model

The basic premise of this model is that members of society are socialized to perform their roles in society. The model's focus is on the individual. Socialization is the process by which the individual learns the attitudes and activities to perform these roles. Formal education is usually a more advanced form of learning roles. Implied in this context is the notion that the use of alcohol is learned behavior. A prevention program would socialize individuals into responsible adult roles with regard to drinking. This model is the most widely used in primary alcohol prevention programs. It is the model behind most mass media and public education efforts, most formal programs, workshops, etc., in the schools and elsewhere. Whether or not it is conscious, socialization/education is the process by which very young children form attitudes that will affect their life long drinking behaviors. A major assumption of this model is the belief in man as a rational animal whose social behavior will change given proper learning opportunities.

The scientific evidence for this approach is mixed. On the one hand faith in training children in the home and educating children in the schools to new knowledge and activities is well supported. On the other hand, the belief that education or knowledge can solve social problems is not necessarily supported and needs further study.

The ultimate prevention goal of this model is to affect individuals' drinking behaviors so that over their lifetimes they refrain from problem drinking. This ultimate goal is defined differently by those with a socio-cultural perspective and those with a proscriptive perspective. For the latter, any alcoholic consumption is problem drinking. For the former, responsible drinking patterns can be developed. The immediate goals of this model are to develop or change knowledge or attitudes about drinking alcohol, its physical effects, its emotional effects, etc.

Program strategies are developed to use any agents or institutions which affect education or socialization. These include the family, the church, the school, voluntary organizations, work organizations, mass media, etc. The programs can be aimed at a specific target population in either very large or very small groups. Since the most lasting socialization or learning occurs in young children, the family should be the primary focus for alcohol socialization.

Specific program activities depend on the target group and the institution. A program for 10 year olds developed by a school would differ from a program directed toward workers in an insurance company. Most specific education-socialization programs are alcohol-specific. That is, the content of the learning is on alcohol, usually with the purpose of enabling individuals to develop their own responsible drinking patterns.

In the proscriptive model, the facts are presented, but they are presented in a way that will help individuals choose the "correct" behavior, which is defined as abstinence.

The major problem in using educational teachings is that they are often used with the blind faith that if it is educational, it must be effective. If people understand the risks, they will not drink, or they will drink responsibly. In fact, much evidence to the contrary has been found. Blane (1976, p. 538) reports several reviews of the research on the effects of mass communications on drinking behavior. Several studies show some immediate change in attitude with a rapid fall-off but no behavioral change.

The same is true of the research on the effect of socialization or alcohol education in the junior high and high schools. The evidence points to a much earlier learning of drinking attitudes. Perhaps educational programs aimed at the family will have more long term effect. At any rate more research and evaluation are needed to determine both the immediate and long term impact of socialization/educational programs.

The Mental Health Model

Plaut (1972) reports the development of a non-specific model based on the rationale that alcoholism is not a disease but a symptom of personal or social problems. Problem drinking is merely a way that some people handle these problems. Both prevention and treatment are directed toward these underlying problems. Hence it is a non-specific approach meaning that the content of programs does not concentrate on alcohol and its usage.

Scientific evidence for this model comes from a wealth of social and psychological research on treatment. The research on high risk populations such as delinquents indicates that they tend to have a high alcohol usage along with other acting out behavior.

The ultimate goals of the mental health model are to improve the quality of family life, help people to cope with crises, and improve the quality of interpersonal relations. On a societal level, goals are to reduce poverty,

deprivation, injustice, alienation, etc. Specific program goals include increasing coping, communication, and problem solving skills in a target group.

Program strategies include group discussion, one-to-one counseling sessions, peer-counseling, small support groups, etc.

Specific program activities include focusing programs on feelings about the self in relationship to others; discussing sex, drugs, authority, friends, alcohol in relationship to making decisions about life; clarifying individual values about drugs, alcohol, and the cause of their usage, etc.

The major problem with this approach is the increased effort necessary to implement programs. Training teachers or program personnel is much more complicated than with the educational approach because they must first deal with their own ambivalence about alcohol, sex, drugs, authority, etc. The mental health model is also more expensive to implement because individuals or a small group is the most effective program unit.

Delivery Systems in Nebraska

Alcohol prevention programs are delivered in a number of ways. They vary from programs to deal specifically with the prevention and treatment of alcoholism to programs in which alcohol prevention or alcohol treatment is a part of a large program system. The programs are delivered on a local, regional, state, or national level.

Few of the prevention grants were given to support only one activity or program. Most had multiple programs with multiple target audiences. Several used more than one of the models previously described.

In Nebraska, local delivery of prevention programs was through several different systems. The majority were through the schools, regional mental health centers, quasi-public agencies, and non-profit organizations especially alcohol specific local coordinating bodies.

Delivery of prevention through educational systems was mostly attempted by non-school agencies who received the prevention grant. In those cases, the model used in the prevention program was dependent upon the perspectives of the agency with the grant. In the case of one large grant, five schools combined to get the grant. In that case, the schools had impact on the selected models, their contents, and on the delivery procedures.

Regional mental health centers are agencies which deliver a variety of mental health programs in each region. Many of the programs are funded by the state and Federal sources.

Quasi-public organizations are those such as the Macy Industries, Winnebago Alcohol Services Center, and Santee Sioux Alcohol Services Center. In some cases local government or one of its committees got the grant and formed the basis of the board of directors who hired personnel to run the program.

The non-profit organizations were primarily coordinating councils, some with affiliation to the National Council on Alcoholism. Some of these councils were also quasi-governmental in that additional support came from the city or county board. Other non-profit agencies were established by churches and non-profit agencies for the purpose of administering alcohol related programs.

The multiple approach with different models illustrates the lack of consistent prevention policy or approach in Nebraska. A more detailed description of prevention programs is needed in order to determine the relative impact of different types of programs.

Finally, in Nebraska, as in much of the alcohol treatment and prevention field, basic philosophical and often political tensions occur over 1) who is qualified to work with alcoholics - ex-alcoholics or mental health/education/religious professionals; 2) the content of educational messages - responsible drinking or absolute abstinence; and 3) organizational location of drinking programs within a total context of the school, the mental health center, or separate, "alcohol-specific" organizations. These issues will be discussed within the section on implications following the research.

METHODOLOGY

The purpose of this research was to determine the impact in Nebraska of alcohol prevention programs funded by the Division on Alcoholism. Because of the ex post facto nature of the research, a descriptive methodology was used. The focus of the description is on the program operations. The assessment of impact is from the nature of the operations and the informed assessment from program directors.

The population under study was all organizations or units which received DOA prevention grants from 1973 through 1979. Any programs still in operation were not included. Since the total number was only 43, sampling was not used.

Data Gathering Method

Data were gathered using two methods: analysis of program records and interviews with key informants from each grantee agency.

Program Records. Much can be learned about a program's operation, efficiency, professionalism, and clients by analysis of program proposals and on-going reporting systems or record keeping systems. The original plan was to obtain data from the following records.

1. Program proposals--to determine program philosophy, intended target groups and geographical areas, and specific program activities.
2. Regular quarterly reports to granting agency--to determine numbers and types of persons served, contacts made, and activities accomplished.
3. Final report to granting agency--to determine total persons served, nature of services, assessed impact, problems and successes, etc.
4. Evaluation reports by program--evaluation results, required of each program, were to be included as part of the impact.

In reality only the program proposals could be located by staff of the DOA. Many of the agencies that received grants retained none of the other records.

Interviews with Key Persons. The interviews were focused, open-ended interviews and were administered with the purpose of determining the problems,

successes,and assessments of the impact of programs by those persons who knew them best, the program administrators. A questionnaire was sent to each administrator two weeks prior to the interview. A covering letter explained the project, stating that someone would call for an appointment. Interviews were held between January 7 and January 19, 1980.

The interviews proved difficult to administer because some of the programs had closed, and some of the agencies were no longer in operation. Previous administrators had moved away, and agencies often could not remember which of their numerous ongoing or previous programs a particular grant had supported.

Numerous phone calls were made to determine the current status of each of the grants. A total of 18 interviews covering 34 grants was finally conducted. Sixteen were personal interviews, and two were by telephone. Four agencies mailed back their questionnaires. Data were not obtainable for the remaining five grants. Agencies receiving three of these five grants were no longer operating. Data from a total of 38 grants were finally gathered.

Data Analysis

Data were analyzed in two ways: content analysis and frequency distribution of interview responses. A content analysis of program proposals was made to determine models of prevention, program activities and goals, target populations, etc. In addition, an attempt was made to categorize the program by region and by program type.

FINDINGS

TABLE A

EXPENDITURE OF PREVENTION MONEY RECEIVED PER REGION THROUGH 1979*

	Total Allocation of Prevention Money	Region's Percent of Total Expenditure	Population (1970 Census)	Region's Percent of Total Population
Region I	$ 31,667	6	94,818	6
Region II	21,175	4	97,034	7
Region III	64,542	13	217,044	15
Region IV	77,712	15	214,289	14
Region V	203,209**	40	340,989	23
Region VI	116,667	23	519,319	35
Total	$510,972	101	1,483,493	100

*Analysis based on budget figures stated in the proposal.

**This figure includes $50,000 that was not evaluated because it was Federal money from NIAAA granted to the State of Nebraska. This report evaluated only money granted to individual programs by the State of Nebraska.

TABLE A

The proportion of prevention money received by Regions I, III, and IV was fairly close to the proportion of the population. Region V received more money in proportion to the population. Both Region II and Region VI received less money in proportion to their population.

TABLE B

NUMBER AND PERCENT OF TYPE OF PROGRAM ELEMENTS BY REGION*

	Total Number Grants By Region	Mental Health				Education/Socialization								
		Counseling/Therapy/ Decision Making/ Communication Skills		Information and Referral		Mass Media		Education/Knowledge/Attitudes				Coordination Planning		Total Program Elements
								Schools		Other				
		No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	
Region I	2	1	50	2	100	1	50	2	100	0	0	2	100	8
Region II	5	3	60	4	80	1	20	0	0	0	0	2	40	10
Region III	7	1	14	3	43	3	43	2	29	3	43	3	43	15
Region IV	9	4	44	6	67	3	33	3	33	2	22	6	67	24
Region V	12	4**	33	0	0	8	66	1	8	4	33	4	33	21
Region VI	8	1	13	7	88	6	75	2	25	6	75	6	75	28
Totals	43	14	33	22	51	22	51	10	23	15	35	23	53	106

*Total equals more than the number of grant programs because most used more than one program element.
**Two were treatment services.

TABLE B

Five major types of program elements were identified as being utilized by the agencies in carrying out their prevention plans as stated in their proposals. Program elements included: 1) counseling/therapy/decision-making/communication skills, or the mental health model; 2) information and referral; 3) mass media; 4) education/knowledge/attitudes; and 5) coordination and planning.

The mental health model focused on the use of such methods as group counseling, peer group counseling, or individual counseling sessions where emphasis was on improving self-image, decision-making, or problem-solving skills. Generally, these types of techniques were found with the school system or an agency which offered counseling as an already established part of their services.

Information/referral techniques were spoken of conjointly but represented several different but related types of activities or methods. Information might have involved the dissemination of written materials in brochures or newspaper articles, the development of a media library, and the use of a speakers' bureau or a telephone service. Referral as a type of education

prevention technique indicated that individuals were sent or directed to direct services agencies for further treatment or services. A client referral might be the result of the individual having been the recipient of alcohol information.

Mass media techniques included public service campaigns conducted over television or radio, sometimes in newspapers or by means of pamphlets. The contents of the messages sponsored by various groups were not examined.

Education/knowledge/attitude techniques were defined as those methods which provided information in such a way that the intended audience gained knowledge and/or insight which might affect attitudes and thus perhaps change behavior. Two categories were identified: 1) programs delivered in the schools and 2) programs delivered to others. Others were defined as professionals already working in the area of alcoholism prevention. For example, this category might include law enforcement personnel, clergy, or community groups. Workshops, presentations, films, and discussion groups were the methods initiated to carry out this type of technique. One agency developed a puppet show to educate children about alcohol.

Coordination/planning techniques could be described as those efforts initiated for the purpose of organizing existing agencies into a common effort of providing comprehensive alcohol services. Coordinating and planning activities were performed through committee work or consultation. Technical assistance with planning school curriculums and establishing training workshops for teachers were also a part of these activities.

Many different techniques were used by each region in carrying out their particular prevention programs. For instance, within the 43 grants, 106 program elements were found or an average of two and a half program elements per grant. The majority of these programs seemed to have no clear-cut philosophy statement in their proposals. Goals tended to be broad and general; e.g., make the public aware of the problems of alcoholics, educate the community, overcome the stigma of alcoholism.

Region I received two grants. Information/referral, education/knowledge/attitudes in the schools, and coordination/planning were the program elements used most often by both grant programs. One of the two grants used the mental health techniques, and one used the mass media in their prevention plan.

Region II received five grants. Information/referral was the most frequently used technique in Region II (80 percent) followed by mental health

techniques (60 percent), coordination/planning techniques (40 percent), and mass media techniques (20 percent).

Region III received seven grants. Four of the techniques (information/referral, mass media, education programs provided to professionals, and coordination/planning) were each used by 43 percent. Education programs delivered through the schools were used by 29 percent, and 14 percent used mental health techniques to carry out the prevention plans in Region III.

Region IV received nine grants. Information/referral and coordination/planning were the most frequently used techniques in Region IV with 67 percent or six of the nine grants using these program elements. Another 44 percent used mental health techniques, followed by mass media and educational programs delivered in the schools with 33 percent each. Educational programs provided for professionals were used by only 22 percent.

Region V received 12 grants. Mass media was the most frequently used program element (66 percent). Utilization was evenly distributed among three of the program elements with 33 percent each for mental health techniques, educational programs provided for professionals, and coordination/planning. Educational programs delivered through the schools comprised eight percent of the program elements. None of the prevention grants was used for information and referral programs.

Region VI received eight grants. The most frequently used program element was information and referral in 88 percent of the programs. Mass media, educational programs provided to professionals, and coordination/planning program elements (techniques) were used by 75 percent. Mental health techniques were used by only one of the programs, representing 13 percent.

Of the 43 grants in all regions, 23 (53 percent) of the grants used coordination/planning techniques. Twenty-two (51 percent) of the grants involved mass media. Another 22 (51 percent) used information/referral. Fourteen (33 percent) used mental health techniques. Fifteen (35 percent) used educational programs provided for professionals. Ten (23 percent) of the 43 grants used educational programs delivered through the schools.

TABLE C

GRANT PROGRAMS WITH EVALUATIONS

	Number of Grants Received	Availability of Evaluation			Reason Not Available			
		Completed and Available	Completed but Not Available	Not Available	Unable [a] to Locate Evaluation	Evaluations Not Provided	No Longer [b] Operating	Did Not [c] Complete An Evaluation
Region I	2	1	1		1			
Region II	5		5		3	2		
Region III	7	4	3		3			
Region IV	9	3	3	3	3		3	
Region V	12	5	2	5	1	1	1	4
Region VI	8	8						
Totals	43	21 (49%)	14 (33%)	8 (19%)	11 (50%)	3 (14%)	4 (18%)	4 (18%)

[a] Records could not be located because a) after 5 years they had been thrown away, or b) present agency personnel had no knowledge of the grant nor the records, or c) personnel from grant period were no longer with the agency.

[b] Two others discontinued their programs yet provided evaluation information on them. Four were no longer in operation and records were not located.

[c] Because of poor response to the program, evaluation effects were not undertaken for three programs. An evaluation was never proposed for the fourth.

TABLE C

Of the total prevention grants awarded between 1973 and 1979, 49 percent of the evaluations were available. Another 33 percent of the evaluations had been completed but were not available. Evaluations were not available for 22 of the grant programs for several reasons. Fifty percent of the evaluations could not be located because a) records had been thrown away when they were five years old, b) present agency personnel had no knowledge of the grant or the records, or c) personnel from the grant period were no longer with the agency. Evaluations were not provided by 14 percent of the agencies. Eighteen percent of the evaluations were not available because the programs were no longer operating. Another 18 percent of the evaluations were not completed because of poor response to the program. An evaluation was never proposed for one program. Most of the evaluations were poorly conceived. Most of the data were in the form of monthly, quarterly, final, or annual reports rather than by actual formal evaluations of outcomes.

TABLE D

TARGET POPULATIONS

	Number of Grants	Youth	General Public	Minorities Women Elderly	Professionals School Personnel (minister law enforcement)	Populations at Risk		Adolescents Referred By Juvenile Authorities
						Indians	Alcoholics and/or Families	
Region I	2	1	1		1			
Region II	5	1	3					
Region III	7	3	2		1		1	
Region IV	9	1	2		1	5	1	
Region V	12	4	4	2	2		1	
Region VI	8	2	7		2			2
Total	43	12 (28%)	19 (44%)	2 (5%)	7 (16%)	5 (12%)	3 (7%)	2 (5%)

*Totals equal more than total number of grant programs because some worked with more than one target population.

TABLE D

The majority of the grants (44 percent) named the general public as their target population. Twelve of the grants (28 percent) named youth as their target population, and seven (16 percent) named professionals. Another five grants (12 percent) named Indians as the target population. Three of the grants (seven percent) named alcoholics and/or their families. Minorities, women, the elderly, and adolescents referred by juvenile authorities were each selected by two grants (five percent each) as target populations.

TABLE E

TYPES OF PROBLEMS ENCOUNTERED*

Reported Problems	Number Mentioning	Comments
Financial		
1. Funding shortages	12	Not enough money was available to meet needs; i.e., staff salaries, or to follow through with program goals. Teachers often were not compensated for their extra time.
2. Funding uncertain	3	Budget cuts caused difficulty with meeting program goals and keeping staff members.
Programming		
1. Administration	12	Several lacked experience in running a program of this type. Others felt their evaluation plans were poorly devised. Several programs were started late into the grant period. Some found their approach was too general and/or impractical. Some experienced problems coordinating and devising a uniform prevention effort.
2. Other limitations	7	Project demands were greater than the staff could meet. Some projects tried to do too much and so ran out of time. Some programs had problems with attracting and/or keeping clients.
Political		
1. Relationships	8	The board had no function and was a figurehead only. Problems occurred among agencies over who was going to do what in alcohol prevention. Bureaucrats were constantly changing their emphasis making continuity difficult.
2. Difficulties with schools	9	Alcohol prevention was not an administrative or teacher priority. Participation was voluntary or by request only which greatly influenced participation in the alcohol prevention effort. Program development depended on faculty members. Cooperation and support were lacking from school administrators.
Staff		
1. Finding qualified people	7	Too many people called themselves alcohol "experts"; i.e., recovered alcoholics, people who had taken a crash course only, or "qualified" help were not "effective." Convincing workers that alcohol prevention/education is serious business was difficult.
2. Staff turnover	5	Turnover in key personnel caused problems with consistency in programming.

*Four administrators said they encountered no problems.
*Five administrators did not respond.

TABLE E

Administrators reported encountering several types of problems while carrying out their prevention programs. Four major areas were identified: 1) financial, 2) programming, 3) political, and 4) staff.

1) Financial difficulties were among those problems most frequently mentioned. Several program administrators reported that funding was inadequate to follow through with program goals or to enable programs to reach their full potentials.

For example, funding shortages caused difficulties in covering staff salaries. Uncertainties about continued funding caused some staff members to seek other employment.

2) Programming problems were also among those most frequently mentioned. For example, several administrators felt they lacked experience in running a prevention program. Some administrators reported their approaches were either too general or too impractical. Devising and coordinating a uniform prevention effort was also found to be a problem. Other limitations existed as well. Some programs seemed to have difficulties getting clients. For example, one program had problems attracting the clients they had targeted to serve (i.e., women). Another program administrator felt that parents resisted their children's involvement in therapy groups. Some felt their projects tried to do too much and simply ran out of time.

3) Political problems were reported by several administrators in the form of relationship problems with either boards, other agencies, or the "bureaucrats" themselves. For example, administrators complained that their boards had no real function. Also territoriality among agencies emerged as an issue that often hindered goal achievement. Several administrators noted areas of discontent with the funding agency. They either offered no directions as to the areas of interest to pursue, they were constantly changing their emphasis, making continuity difficult, or they offered no consistent, articulated definition of prevention.

Difficulties with the schools also emerged as a major concern among administrators. For example, some felt that alcohol prevention was often not a priority of either teachers or school administrators. Where success or continuation of the program depended on school support, cooperation or voluntary participation programs were often jeopardized. In one case a

program was forced to close down due to a lack of cooperation from the school system.

4) Staff problems were also mentioned as a particularly difficult area. For example, administrators expressed difficulty with finding qualified people to work with the program. Several reasons emerged: 1) too many people were calling themselves alcohol "experts", 2) "qualified" workers were not "effective", or 3) workers did not view alcohol prevention/education as serious business. Another example of staff problems involved staff turnover. Several administrators felt that turnover in key personnel caused problems with consistency in programming.

TABLE F

PROGRAM STRENGTHS*

Reported Strengths	Number Mentioning	Comments
Support/cooperation	10	Several programs received support and cooperation from the community, professional groups, schools and other agencies.
Need	5	The fact that the program met a need by providing a necessary service was felt to be a major strength.
Staff	5	Several felt that the major strength of their programs was the staff and that a program is only as good as the people running it.
Local ownership	3	Local ownership of the project made the program more successful.
Program was a catalyst	2	The project served as a catalyst for development of intervention into schools. The project had a catalytic effect in that it forced three mental health centers to deal with problems of territoriality.
Other	6	They made "correct" information available to the Nebraska residents. Most activities were accomplished by volunteers. Target population was exposed to systematic alcohol education. Program emphasis was on early prevention. The agency developed a very efficient management/administration system of responding to information requests.

*Five administrators reported no strengths.
*Seven administrators did not respond to the question.

TABLE F

Administrators reported several different types of program strengths. Six major areas were identified: 1) support/cooperation, 2) need, 3) staff, 4) local ownership, 5) program as a catalyst, and 6) other.

The most frequently mentioned program strength was support and/or cooperation. Several program administrators felt that the support and cooperation their alcohol prevention programs received from the community, professional groups, schools, and other agencies proved to be the major strength of the program overall.

Several administrators felt the major strength of the program was that it met a real need in the community. For example, administrators felt that the program provided a necessary service, especially since very little was being done in the area of alcohol prevention/education.

The quality and dedication of their staffs was considered a major asset to the program by several administrators. For example, several commented that a program is only as good as the people running it.

Local "ownership" was also seen as a major strength by a few administrators. They felt that initiation and support within the community served to increase participation, making the program more workable.

The program served as a catalyst in other activities, according to a few administrators. For example, a project led to development of programs in the school, and, in another case, the project forced confrontation and resolution of, as one administrator put it, "turf" or territoriality problems among three community mental health centers.

The "other" category contains specific comments about an administrator's particular program. For example, one administrator felt that the major strength of his program was that most activities were accomplished by volunteers. Another said that the target population had been exposed to systematic alcohol education.

TABLE G

ADMINISTRATORS' ASSESSMENTS OF IMPACT OF PROGRAMS ON COMMUNITIES

Impact for	Number Mentioning	Comments
Existing alcohol services of the grantees	14	Expanded community awareness of problem and sources for help led to greater utilization of current services.
Other community agencies (new prevention programs)	6	Got the programs accepted by other agencies in town, and they are now supporting the activity. Provided a chance to try a new program.
General community	2	Gained community support and help for alcohol education.
Target population (new prevention programs)	5	Had little or no impact on target populations. Had very valuable impact on a few people demonstrated a need to the community.

TABLE G

Administrators felt their prevention programs impacted upon four general areas: 1) existing alcohol services of the grantees, 2) other community agencies (new prevention programs), 3) general community, and 4) target populations (new prevention programs).

Impact was felt to be greatest on existing alcohol services of the grantees and was experienced through increased utilization of existing services. This was due to expanded awareness of the kinds of resources available to help those with alcohol related problems.

Other community agencies felt the impact through greater acceptance of their programs by other agencies in town, according to administrators. Impact occurred in terms of expanded community awareness and support for alcohol education for the general community and for new prevention programs.

Several administrators felt, however, that their prevention programs actually had little or no impact on the target population.

TABLE H

ADMINISTRATORS ASSESSMENTS OF NEEDED PROGRAM CHANGES

Area of Needed Change	Number Mentioning	Comments
Administration (delivery system)	7	condense training time start organizing earlier in grant period do training locally and condense sessions buy less equipment get better long term funding
Program planning	7	define goals/activities more specifically develop priority areas do long term planning keep better records do some evaluation
Political/community support	3	build a community base build better inter-organizational relationship deal with state bureauracy

TABLE H

When asked what they would do differently if they were to do their programs over, administrators identified several areas of needed change: 1) administration (delivery system), 2) program planning, and 3) political/ community support.

Comments concerning administration involved organizational changes ranged from earlier planning in terms of the overall program to training participants locally or reducing training time. Securing long term funding was felt to be vital if program goals were to be met or programs continued.

Comments concerning program planning involved changes which could benefit the program efforts through redefinition and re-establishment of priority areas, goals, and objectives. More long term planning was felt to be a real need in terms of resource allocation, locating funding sources, and determining priority areas. Documentation through better record keeping and formalized evaluations were mentioned as changes that should be initiated to assist with other program planning activities.

Comments related to political/community support varied. For example, building a power base from within the community and perhaps legislating to deal with administrators at the state level were seen as needed changes.

IMPLICATIONS OF FINDINGS

The need for prevention is a relatively new trend, and the state system had to gear up to develop an adequate philosophy and procedures.

Five issues that can offer guidance for the future can be inferred from the preceding data. These issues are 1) the level of support, 2) the commitment to prevention, 3) prevention policy, 4) program quality, and 5) community support.

The first inference is that the level of support per region per year was insufficient for any but the most minimal effort toward prevention. The sum of only $504,972 allocated over an entire state for seven years was inadequate to develop and continue any kind of on-going prevention. Many programs were allocated barely enough to hire part-time staff or to fund part of an on-going staff person's time, instead of allocating enough to fund a full-time person.

Second, a lack of commitment to prevention was evident. Not all of the funds that were allocated, especially for primary prevention, were used for prevention efforts. Programs that included information and referral elements could be classified as secondary or tertiary prevention since "referral" generally means referral of problem drinkers to some treatment. Two program elements in Region V to fund coordinating councils could be considered treatment since they coordinated alcohol services, primarily treatment services. Many respondents were unable to identify the programs supported by prevention funds since the funds went into the larger budget to support on-going programs--many of them treatment programs.

The variety of programs to which funds were allocated indicated the lack of a clear prevention policy in the state. This is not unusual with new programs but does indicate a need for clarification of policy. Even with a single grant proposal, lack of a clear prevention model was often apparent. For instance, an agency would propose educational activities with no attention to the reason for the activities or the content of the proposed education.

The models used varied, sometimes contradicting each other within the same city or region. No programs appeared to be aimed at changing social mores or drinking patterns on a community or state-wide basis or to changing legal systems or even enforcing of existing laws more strictly.

The funded programs varied dramatically in quality. This fact was clear from the enumeration of the types of problems encountered by program administrators. The large number who listed finding qualified staff (7), turnover in key staff (5), and lack of administrative expertise (7) was indicative of quality problems. Many of these problems were due to the nature of funding. Programs funded for only one year have difficulty attracting and keeping professional personnel. One year funding also prevents a program from learning from mistakes and revising program activities to reach goals more successfully. In addition, several program administrators indicated conflicts between professionals and para-professionals (usually ex-alcoholics) adversely affected their prevention programs.

Another indication of varying quality was the unrealistic program goals in relationship to funds allocated. With $504,972 spent on 43 program activities, an average of $11,743 per program was allocated. Many programs reported a variety of program activities with different goals and models. This means that funds were often spread thin with very little successful prevention possible.

A third indication of variation in program quality was the lack of emphasis on evaluating programs to correct or modify problems. Very few of the 43 grants provided any evaluation results that attempted to measure outcomes. A few provided program records that indicated an accountability for the way the funds were dispersed. The remainder may have had such records, but neither the program nor DOA could locate them.

Finally, the interview responses by administrators about impact of the programs, program problems, and what they would do differently indicate that interagency relationships could either expand state allocated funds or diminish the effects of state funds. Expansion of funds is illustrated by the fact that six of the programs got their programs accepted by the schools or other agencies on an on-going basis, and 14 grantees found an increased usage of programs already operating as the community became more aware of alcoholism as a problem.

As an example of how the impact of state funds was diminished, two

program administrators said they would not apply for funds again because of interagency problems. Two other administrators mentioned building a supportive community base as what they would do differently. Eight programs mentioned lack of interagency or interorganizational cooperation as problems, and eight programs mentioned community cooperation as a strength.

PROGRAM RECOMMENDATIONS

Future program activities to be funded are dependent on a wide variety of factors. Therefore, specific recommendations are not logically feasible at this time. However, some suggestions based on the experience of the past seven years can be made. These suggestions will be listed with only explanatory discussion.

1. Target specific population groups. Unless a far greater amount of money is allocated, the state should develop programs for the population group that can most effectively benefit from primary prevention efforts. A needs assessment using survey and demographic procedures could determine possible cost benefits. Populations could be targeted by age, occupation, socio-economic status, ethnic group, sex, urban-rural designation, region, etc.

2. Allocate funds to activities that increase the effect per dollar. Some of the activities that should be encouraged are training professionals in other fields for prevention activities, developing general community expertise, changing the local enforcement policies, and changing local drinking norms especially among youth. Activities that are antithetical to cooperation among agencies should be discouraged.

3. Develop a state prevention plan. This should include prevention philosophy, a long term plan, and specific, achievable, measurable goals. It should also include an administrative plan with staffing needs related to the program goals and details of delivery of prevention services on the local level.

4. Develop an evaluation plan. This should include an outcome evaluation plan. A plan to evaluate the process of the program or the delivery system should also be developed to guide the program administrators as they refine the delivery process.

5. Require a yearly assessment. Both the programs' goal related activites and administrative/process activities should be assessed to assure that minor problems do not become major barriers to state alcohol prevention efforts.

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APPENDIX

APPENDIX I

LIST OF ALCOHOL PREVENTION GRANTS, 1973-79

REGION I

Agency	Location	Amount	Grant Period
Panhandle Community Action Agency	Gering	$15,000	11/1/73-11/1/74
Panhandle Region I Mental Health, Alcohol, and Drug Services	Scottsbluff	16,667	1/1/78-12/31/78
Total		$31,667	

REGION II

Alcohol Information and Referral Center Now called Alcohol-Court-Education Service	Gothenburg Lexington	$ 8,500 4,000	7/1/75-6/30/76 4/1/75-6/30/75
Touch	Ogallala	2,760 4,300	1/1/76-12/31/76 7/1/76-6/30/77
Great Plains MHC	North Platte	1,615	1/6/76-6/30/76
Total		$21,175	

REGION III

South Central Adams County ASAP Alcohol Services	Hastings	$ 8,260	11/15/75-6/30/76
Central Nebraska Council on Alcoholism	Grand Island	13,079 14,810 15,393	7/1/74-6/30/75 7/1/76-6/30/77 7/1/77-6/30/78
South Central CMHC	Kearney	3,500 6,500	12/1/75-6/30/76 11/1/75-6/30/76
Pioneer Mental H. C.	Broken Bow	3,000	12/1/75-6/30/76
Total		$64,542	

REGION IV

Macy Industries	Macy	$ 1,500 8,809	6/1/73-6/30/73 10/1/75-9/30/76
Niobrara Area Neighborhood Service Center	Niobrara	15,000 5,872	11/1/74-10/31/75 1/1/76-12/30/76
Northern Nebraska Comprehensive MHC	Norfolk	15,659	7/1/75-6/30/76
Santee Sioux Alcohol Services	Niobrara	3,000	7/1/77-6/30/78
Winnebago Alcohol Services Center	Winnebago	5,872	7/1/76-6/30/77
Columbus Alcohol Information Service	Columbus	5,000 17,000	7/1/77-6/30/78 8/1/78-7/31/79
Total		$77,712	

REGION V

Lincoln Council on Alcoholism and Drugs	Lincoln	$ 20,991 20,000	9/1/77-9/1/78 7/1/78-6/30/79
Lincoln-Lancaster County Health Dept.	Lincoln	17,236	1/1/78-12/31/78

REGION V - Continued

Agency	Location	Amount	Grant Period
Pioneer MHC	Seward	12,000 9,000	4/1/76-3/31/77 4/1/77-3/31/78
Nebraska Safety Council	Lincoln	2,166	2/1/76-6/30/76
Nebraska Task Force on Women, Alcohol and Drugs	Lincoln	10,000	3/1/76-2/28/79
Media Center (Part of Lincoln Council on Alcohol and Drugs)	Lincoln	4,016	4/1/76-3/31/77
Nebraska Alcohol Information Clearing House	Lincoln	30,000	7/1/78-6/30/79
Campus Alcohol Education Project	Lincoln	2,800	9/29/78-6/30/79
Independence Center Radius Project	Lincoln	15,000	9/1/78-8/31/79
Nebraska Alcoholism Foundation	Lincoln	10,000	11/1/78-10/31/79
Department of Public Institution	Lincoln	50,000*	7/1/74-6/30/76
Total		$203,209	

REGION VI

Omaha Area Council on Alcoholism	Omaha	$ 15,000	1/1/74-12/31/74
"	"	15,000	1/1/75-6/30/75
"	"	5,000	7/1/75-12/31/75
"	"	10,000	1/1/76-6/30/76
"	"	5,000	7/1/76-12/1/76
"	"	16,667	7/1/77-6/30/76
"	"	20,000	7/1/78-6/30/79
Creighton Prep High School	"	30,000	7/1/78-6/30/79
Total		$116,667	

*This $50,000 was not evaluated because it was Federal money from NIAAA granted to the State of Nebraska. This report evaluated only money granted to individual programs by the State of Nebraska.

LOCATION OF ALCOHOL PREVENTION PROGRAMS IN NEBRASKA