

Strategic Prevention Plan 2013-2018



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Department of Health
and Human Services

*Maine People Living
Safe, Healthy and Productive Lives*

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Office of Substance Abuse
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Prevention Team Vision

A public untouched by substance abuse.

Mission Statement

To prevent and reduce substance abuse and related problems by providing leadership, education and support to communities and institutions throughout Maine.

Foreword

In 2010, the Maine Office of Substance Abuse Prevention Team undertook a strategic planning process that resulted in the Strategic Prevention Plan 2010-2013. In 2012, the plan was updated through a State Prevention Enhancement grant planning process and resulted in this Strategic Prevention Plan 2013-2018. This document includes the initial three-year plan that has been amended and updated to reflect current events and that has been expanded to result in a five-year plan.

A close review of the table of contents is recommended to gain a greater understanding of this document; there is a purposeful design and flow, very much like the building of a house. The following pages will guide the reader through the foundational building blocks of substance abuse prevention services of the Maine Office of Substance Abuse (OSA). This document provides definitions from “substance abuse prevention” to “evidence based strategies and programs” to the guiding principles and best practices that the OSA staff uses every day and which have been incorporated over the years so that it is “just the way we do our work.” The History section gives a snapshot of how the Prevention Services have grown, developed, and sustained over the years through collaborative efforts with OSA’s local, state, and national partners and stakeholders. The section on OSA Strategic Planning Process and Overview describes the process that resulted in the three-year strategic plan and the further planning that resulted in this five-year plan. There is also a description of how data collection and research is conducted and used in decision-making, or a commonly used term in OSA, “data driven decision making.” The compilation of this information leads to the Goals and Objectives. Additional supporting information is in the appendixes as marked. Finally, it is important to acknowledge that the work that the Office of Substance Abuse conducts on behalf of the citizens of Maine could not be done without the contributors mentioned in this document and the many others who support this work.

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Executive Summary

The Maine Office of Substance Abuse (OSA) is the single state administrative authority responsible for the planning, development, implementation, regulation, and evaluation of substance abuse services. OSA provides leadership in substance abuse prevention, intervention, treatment, and recovery. Its goal is to enhance the health and safety of Maine citizens through the reduction of the overall impact of substance use, abuse, and dependency.

The OSA Prevention Team developed this Strategic Prevention Plan 2013-2018 in conjunction with input from the OSA Prevention Advisory Board and with funding from a State Prevention Enhancement (SPE) grant from the Substance Abuse and Mental Health Services Administration. This five-year plan builds on the Strategic Prevention Plan 2010-2013, providing continuity with past work and planning for future successes.

Collaboration

The OSA Prevention Team works in partnership with many state agencies, and the SPE planning process provided opportunities to discuss current activities and possibilities for future collaboration. OSA partners with the Maine Attorney General's Office and divisions within the Departments of Education, Labor, Public Safety, Corrections, and Health and Human Services. The OSA Prevention Team relies on federal and state funds to implement its strategic plan and works primarily through the public health infrastructure's Healthy Maine Partnerships to implement strategies at the local level.

Funding

Considerable expansion of the prevention infrastructure at the state and local levels began in 2002 with funding from the US Center for Substance Abuse Prevention's State Incentive Grant, followed by the State Strategic Prevention Framework State Incentive Grant (SPF SIG) in 2004. Ongoing support from the Substance Abuse Prevention and Treatment Block Grant allows for continued implementation of strategies beyond the SPF SIG funding, which ended in 2010. Funds from the Enforcing Underage Drinking Laws grant support work with law enforcement as well. The OSA Prevention Team seeks other sources of funding that align with the priorities and goals identified in this plan.

Strategies

OSA understands that substance abuse exists within the context of a larger environment and must be addressed using evidence-based strategies that address policy, enforcement, access and availability. OSA's focus on environmental prevention strategies benefits and complements other, more traditional substance abuse prevention strategies. Environmental strategies include policy, enforcement, education, communications and collaboration strategies.

Priorities

OSA's prevention work is data driven, and OSA uses key data sources such as the Maine Youth Drug and Alcohol Use Survey, the Maine Integrated Youth Health Survey, Community

Epidemiology Surveillance Network, the Treatment Data System, the Higher Education Alcohol Prevention Partnership, National Survey on Drug Use and Health, Behavioral Risk Factor Surveillance System, and the Youth Risk Behavior Surveillance System. OSA selects evidence-based interventions, and uses its resources efficiently to implement a limited number of interventions statewide to provide consistency across the state.

Based on data analyses and an evaluation of the SPF SIG process, OSA has identified the underage population and the population of 18 to 25 year olds as the priority populations for prevention interventions. More specifically,

- For the underage population the areas of focus will include: any underage alcohol use, binge drinking, high-risk alcohol use, marijuana use, prescription drug misuse, and inhalant abuse.
- For the 18 to 25 year old population, the areas of focus will include: binge and/or high-risk alcohol use, prescription drug misuse, and marijuana use. This will include focusing on both the college and workplace environments.

Goals

The goals in this plan are based on recommendations resulting from the evaluation of Maine's SPF SIG process and focus on the priority populations and on two broad themes: infrastructure, and workforce development/technical assistance.

In the area of infrastructure development, this plan includes goals which follow naturally from the SPF SIG process:

- Increase OSA's capacity to support implementation of quality evidence based programming and best practices by stakeholders and implementers across Maine.
- Increase collaboration with special populations, other state agencies/offices, and local stakeholders.
- Promote awareness to key stakeholders and communities about the impact of substance abuse in Maine and OSA's work to prevent and reduce substance abuse and related problems.
- Improve, enhance, and expand OSA's capacity to make data-driven decisions and quality improvement.

Recognizing the substance use patterns among youth and young adults, goals that specifically target the priority populations are:

- Reduce use of marijuana among Mainers, with emphasis on teens and young adults.
- Reduce use of prescription drugs among Mainers, with emphasis on teens and young adults.
- Reduce underage drinking and binge drinking among Mainers, with emphasis on teens and young adults.

OSA recognizes the importance of embedding cultural competency throughout the agency and its programs, and understands the need to increase capacity in Maine in this area. OSA's goal around cultural competency is:

- Develop ways to incorporate cultural competency into substance abuse prevention programming.

Accomplishing OSA's workforce development goals is critical to the success of prevention in Maine. Building a Certified Prevention Specialist program will expand interest in the field of prevention by building a career path in prevention; enhance skills and performance among prevention providers across the state; and expand prevention initiatives into other professions. This will be another opportunity for professionals across disciplines to take advantage of opportunities for cross training. Workforce development goals are:

- Develop a workforce that is proficient in effective substance abuse prevention.
- Implement a statewide prevention certification system for Maine based on International Certification and Reciprocity Consortium standards.
- Ensure prevention providers statewide have access to credible training on evidence based programs, policies and practices, understand the need to use data and understand the value of evaluation.

In the area of technical assistance, OSA has identified the following goals:

- Improve data quality, accessibility and usefulness for process measures.
- Disseminate outcomes.
- Meet all data reporting requirements
- Include cost and benefit analyses routinely in performance measurement and evaluation
- Link process measures to outcomes to gauge program effectiveness.
- Expand capacity to engage in evaluation at the state and local levels.

Gaps

The Prevention Team identified the need for consistent and adequate funding through the HMP infrastructure, and the need to support primary prevention in schools. Funding for both of these areas has been significantly reduced in recent years. In addition, OSA recognizes the need for consistent education and messaging statewide that increases the perception of harm and the knowledge of the costs associated with alcohol and drug use.

Summary

This plan provides a road map for substance abuse prevention in Maine. Environmental policies are the primary strategies that will be used along the way to prevent and reduce substance abuse, particularly among youth and young adults. In addition, education and raising awareness about behavioral health and the stigma associated with substance abuse and treatment are keys to creating and sustaining future successes.

Office of Substance Abuse Structure

The Maine Office of Substance Abuse (OSA) is the single state administrative authority responsible for the planning, development, implementation, regulation, and evaluation of substance abuse services. The Office provides leadership in substance abuse prevention, intervention, treatment, and recovery. Its goal is to enhance the health and safety of Maine citizens through the reduction of the overall impact of substance use, abuse, and dependency. The Prevention Team is one of four teams within OSA. Other teams that complete the Office are Intervention Services, Treatment and Recovery Services, and Data and Research. Each team consists of a manager and staff who implement various projects based on data, research, requirements of funders and legislative directives. The organization chart for OSA is in Appendix A and a list of acronyms and definitions that may be useful to the reader is in Appendix B.

Prevention Revenue

State legislative designation, awards won by competitive bid, and population based formula grants at the federal level fund Maine state prevention services. Existing funders of prevention initiatives include:

- State of Maine General Fund
- State of Maine Fund for a Healthy Maine
- Substance Abuse Mental Health Services Administration's (SAMHSA) Substance Abuse Prevention and Treatment Block Grant (SAPTBG)
- U.S. Department of Education (via Memorandum of Understanding with Maine Department of Education)
- Building State Capacities Grant
- State Epidemiological Outcomes Workgroup grant
- Office of Juvenile Justice and Delinquency Prevention (OJJDP), Enforcing Underage Drinking Laws (EUDL) – Block Grant and Discretionary Grant

The Prevention Team diligently seeks additional resources and opportunities to fund initiatives identified in the strategic plan.

Contracts and Expenditures

Through the Strategic Prevention Framework State Incentive Grant (SPF SIG), a substance abuse prevention platform was established in the newly emerging statewide public health infrastructure. From this platform prevention contracts can be issued to community coalitions across the state, thereby making the most of an administrative cost savings at the local and state levels. OSA contracts with additional community-based prevention providers for services targeting specific populations. Independent sub-contractors are retained to support prevention initiatives with services such as media campaigns, evaluation, and data collection.

Funding is disseminated by a pre-identified proposal or application process. OSA uses an outcome-based funding model for grantee contracts in which contracted agencies are required to demonstrate progress toward achievement of proposed outcomes. All contracts are monitored through required quarterly progress narrative and fiscal reports.

History

In 1989, the Maine Substance Abuse Prevention and Treatment Act established the Office of Substance Abuse, which was in the Executive Department and directly responsible to the Governor. Its mandate included the adoption of an integrated and comprehensive approach to substance abuse and the establishment of a single administrative unit within state government (5 MRSA, 2004). In the fall of 1991, OSA was given increased responsibility for training, the Driver Education and Evaluation Program (DEEP), and the Maine Alcohol and Drug Abuse Clearinghouse from the Department of Human Services. OSA coordinated Clearinghouse activities with the Resource Center that was located in the Department of Education (5 MRSA, Ch 521). In 1993, the Legislature gave OSA responsibility to administer all state substance abuse programs, including those previously run by the Departments of Education, Corrections, and Mental Health/Mental Retardation. In 1994, all substance abuse programs were consolidated within the Office of Substance Abuse. The Division of Alcohol and Drug Education within the Department of Education (DOE) was moved to OSA. OSA created the Prevention and Education Division. Drug Free Schools and Communities Act personnel and programs were moved to OSA (under a Memorandum of Understanding with DOE). The Clearinghouse and Resource Center became the Information and Resource Center. OSA was given responsibility to prevent youth access to tobacco products through federal regulation.

In 1995, OSA was moved from the Executive Branch of state government into the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS). OSA was created as a distinct unit within the DMHMRSAS and as the sole agency responsible for administering the “Maine Substance Abuse Prevention and Treatment Act” (5 MRSA, 2004). In 2000, OSA received \$5.7 million by legislative designation from the Tobacco Settlement funds, also known as the Fund for a Healthy Maine.

In October 2000, First Lady Mary Herman led a Town Hall Meeting in Gardiner to kick off the Governor's Spouse's initiative “Leadership to Keep Children Alcohol Free.” At this same event, the Maine Underage Drinking Task Force released its report and recommendations. In January 2001, OSA received a \$400,000 Underage Drinking Discretionary Grant from the Office of Juvenile Justice and Delinquency Prevention (OJJDP) to fund nine community coalitions in their efforts to increase the effectiveness of enforcement, decrease underage access to alcohol, and change community norms that encourage or support underage drinking. In 2002 OJJDP awarded OSA another \$400,000 discretionary grant, this time to establish a two-year Higher Education Alcohol Prevention Project (HEAPP). HEAPP consists of both a statewide initiative that is open to participation by all Institutions of higher education in Maine and a sub-grant

program that provides funding to six Maine colleges for development of effective strategies to reduce and prevent underage and high-risk drinking.

Also in 2002, the US Center for Substance Abuse Prevention awarded Maine a \$9 million, three-year State Incentive Grant for prevention. Eighty-five percent of the money was awarded to community nonprofit organizations to implement evidence based prevention programming. This grant focused on the selection of programming that had been evaluated for effectiveness when implemented with fidelity.

In 2004 Maine was awarded a \$15 million, five-year Strategic Prevention Framework State Incentive Grant (SPF SIG) to build Maine's prevention infrastructure and implement environmental strategies based on data. The SPF SIG required a five-step process of assessment, capacity building, planning, implementation, and evaluation.

In January 2006, Substance Abuse Prevention and Treatment Block Grant dollars were granted to prevention programs around the state and for the first time OSA required that each grantee implement at least one environmental strategy.

In the fall of 2007, implementation of the SPF SIG began. These environmental strategy dollars were braided with funds from the Maine Center for Disease Control and Prevention (MCDC) and the Maine DOE into the Healthy Maine Partnership Request for Proposals. The funds were kept distinct to track outcomes associated with each funding source.

In February 2009 a portion of Substance Abuse Prevention and Treatment Block Grant (SAPTBG) prevention dollars were put out to bid for two projects, the Youth Substance Abuse Prevention Program (YSAPP) and the Student Intervention and Reintegration Program (SIRP). YSAPP applicants were given a choice of evidence-based programming to select for implementation. Programs funded through the YSAPP were CAST (Coping and Support Training), LifeSkills Training, Lions Quest, Project Alert, and Project Success. Funding for these projects ended in June 2012.

Current Grants and Programs

Healthy Maine Partnerships

At the State level, the Healthy Maine Partnerships (HMPs) are a collaboration of partners from MCDC, OSA and DOE working together to promote health throughout Maine. These statewide partners support 27 local HMPs with training, technical assistance, evaluation, program development, and media help in order to reach the communities at the local level.

SPF SIG funds for HMP grantees began September 1, 2007 and ended July 30, 2010. As of that date, OSA funds only environmental strategies through the local HMPs.

In an ongoing effort to support the new public health infrastructure and to sustain and further the work of substance abuse prevention in Maine, OSA provides HMPs the opportunity to apply for additional funds to enhance work on OSA's HMP Minimum Common Program (OSA HMP MCP) Objectives. OSA allocated \$640,000 annually from the SAPT Block Grant to support this HMP work. This allocation was divided equally among the eight Public Health Districts (\$80,000 annually per district). Each district's allocation was then divided equally among local HMPs.

OSA contracted with the HMPs for additional work on specific strategies through June 30, 2010. This contract funded HMPs to:

- Expand implementation of predetermined substance abuse objectives and strategies to more communities in their local services area, and/or
- Accomplish more outputs within the towns they are currently working with on specific strategies; and/or
- Reach the "monitor and evaluate" process step in all towns within their local service area for a specific objective through the work of selected strategies.

Safe and Drug-free Schools and Communities Act grantees

For school year 2008-09, Safe and Drug-free Schools and Communities Act (SDFSCA) grants funded 25 different model prevention programs in Maine. Additionally, in the past few years many districts have started to use their own local funds to implement substance abuse and violence prevention model programs.

Effective July 1, 2010 Congress de-funded Title IV-A (the SDFSCA Program) of the Elementary & Secondary Education Act. OSA's Prevention Staff will continue to look for ways to maintain, if not build the relationships with the schools across Maine; continue and strengthen the relationship with the Maine DOE; and continue to support substance abuse prevention in schools by providing education, resources, and technical assistance.

Enforcing Underage Drinking Laws Grant

Maine's strategy for reducing underage drinking has focused much energy in recent years on increasing the effectiveness of enforcement of the underage drinking laws and on reducing both retail and social access to alcohol by minors. OSA has taken both a localized and statewide approach, combining grants from the Enforcing Underage Drinking Laws (EUDL) Grant to community coalitions, colleges, and county sheriff's departments with statewide strategies such as undercover compliance checks, the Card ME Program, and Project Sticker Shock. The results demonstrate a substantial increase in enforcement efforts where grant funds have been available at the local level. In addition, data show a decrease statewide in how easy youth perceive it to be to obtain alcohol (50.7% of 6-12th graders who took the Maine Youth Drug and Alcohol Use Survey in 2008 said it was "very easy" or "sort of easy" compared to 52.7% in 2002).

Compliance Checks

OSA works closely with Department of Public Safety to ensure a cost effective means of assuring holders of liquor licenses comply with underage access laws. The Bureau of Liquor Licensing within the State Police was established when the Bureau of Liquor Enforcement was abolished, but it lacked the resources to conduct compliance inspections. OSA provides EUDL funding through a contract with the Maine Sheriff's Association to perform these services, as well as mini grants to local law enforcement agencies.

Drug-Free Workplace Program

The Drug-Free Workplace Program works collaboratively with the Department of Labor, MCDC and other key stakeholders to address the effects of substance abuse in the workplace. The goals of the program are:

- To reduce workplace accidents, death, injury, disability and health care costs due to substance abuse;
- To reduce employee substance use and stress; and
- To improve responsible attitudes towards drinking and social support for drinking reduction; increase employee knowledge and use of healthier stress reduction techniques; and enhance help-seeking behaviors by encouraging the use of employee assistance programs or community service providers.

Products of this program include WorkAlert, an online resource for employers wishing to develop a drug-free workplace policy and Healthy Maine Works (HMW). HMW is a web-based wellness tool that uses evidence based strategies and resources to address targeted health risk factors. Resistance to address substance abuse is reduced by including substance abuse prevention in a wellness model.

Youth Substance Abuse Prevention Program

The Youth Substance Abuse Prevention Program funds 10 organizations to implement evidence-based model programs in schools or through youth-serving organizations across the state. Model programs selected for this initiative are: Lions Quest, CAST (Coping and Support Training), LifeSkills Training, Project SUCCESS, and Project Alert. Funding for this initiative ended June 30, 2012.

Student Intervention and Reintegration Program

SIRP is an evidence based youth diversion program which is being implemented in five organizations across the state.

Prescription Monitoring Program Promotion

Each public health district was funded to promote the Prescription Monitoring Program. Participants met regularly to develop promotional materials and strategize about how promotion would be delivered. This initiative ended June 30, 2012.

Maine Youth Action Network

OSA contracts with the Maine Youth Action Network to develop strategies and supports oriented toward substance abuse prevention among youth.

Alcoholscreening.org

OSA contracts with Boston University to provide a Maine specific online screening tool which refers participants to assessment and treatment.

Maine Alliance for Prevention of Substance Abuse

The mission of the Maine Alliance to Prevent Substance Abuse (MAPSA) is to build a unified statewide voice for substance abuse prevention. MAPSA members are a diverse group of prevention specialists, service providers, community coalition members and individuals with an interest in and a commitment to substance abuse prevention.

MAPSA works with members, allies and key stakeholders to assess and strengthen Maine's infrastructure for substance abuse prevention by:

- Sharing information on the need for and benefit of consistent funding for substance abuse prevention;
- Supporting a climate where Maine communities are empowered to address substance abuse issues;
- Demonstrating that substance abuse prevention should be a statewide public health priority;
- Providing a network for members to identify and take action on common issues;
- Sharing current research, best practices, publications and resources; and
- Identifying opportunities for state and federal resources.

AdCare

AdCare Educational Institute of Maine, Inc. is a private, non-profit organization located in Augusta. The agency works to enhance both service system development and workforce development. It provides services through funding from OSA and other funders in the areas of prevention, intervention, treatment and recovery for the substance abuse field and other allied public health fields. The Institute accomplishes its mission by providing education, training, consultation, and technical assistance to organizations and individuals on public health issues related to substance abuse. AdCare staff has expertise in a wide range of areas, including policy development, program planning, and delivery of clinical services.

Synar

SAMHSA's Synar amendment program is a federal and state partnership aimed at ending illegal tobacco sales to minors. It requires states and U.S. jurisdictions to have laws and enforcement programs for prohibiting the sale and distribution of tobacco to persons under 18.

In Maine, OSA, MCDC and the Office of the Attorney General collaborate to perform statewide tobacco vendor inspections for purposes of Synar. The MCDC contracts with law enforcement

personnel to conduct inspections of 100% of all licensed retailers open and available to youth. States and U.S. jurisdictions must report annually to SAMHSA on their retailer violation rates, which represent the percentage of inspected retail outlets that sold tobacco products to a customer under the age of 18. OSA contributes SAPT Block Grant Funding as a requirement of the Block Grant. Maine continues to keep its non-compliance rate at under 10%.

Definition of Prevention

The Maine Office of Substance Abuse has adopted the definition of prevention established by the Maine Coordinated School Health Program. “Prevention is the active, assertive process of creating conditions that promote well-being.” Substance abuse prevention means keeping the many problems related to the use and abuse of substances from occurring.

OSA’s approach to substance abuse prevention is constructed upon research-based concepts, tools, skills, and strategies that reduce the risk of alcohol and other drug related problems.

Substance abuse is not solely an individual problem to be addressed with strategies targeting individuals. Rather substance abuse exists within the context of a larger environment and must be addressed by evidence based strategies of policy, enforcement, access and availability. Examining community norms that are favorable to substance abuse and changing those norms is critical to the success of prevention work. OSA’s environmental prevention strategies benefit and complement other, more traditional, substance abuse prevention strategies.

Prevention Categories

Prevention initiatives implemented by OSA staff and through OSA grantees align with the Institute of Medicine’s categorical definitions listed below.

Universal

These interventions are targeted and are beneficial to the general public or a general population. Two subcategories further define universal interventions:

- *Universal Indirect* provides information to a whole population who has not been identified as at risk of having or developing problems. Interventions include media activities, community policy development, posters, pamphlets, and internet activities. Interventions in this category are commonly referred to as environmental strategies.
- *Universal Direct* interventions target a group within the general public who has not been identified as having an increased risk for behavioral health issues and share a common connection to an identifiable group. Interventions include health education for all students, after school programming, staff training, parenting class, and community workshops.

Selective

This category of prevention interventions targets individuals or a population subgroup whose risk of developing mental or substance abuse disorders is significantly higher than average (prior to the diagnosis of the disorder). Examples of interventions include group counseling and social/emotional skills training for youth in low-income housing developments, and a clinician-facilitated group discussion that provides education and support to families with parental depression.

Indicated

These interventions target individuals at high risk who have minimal but detectable signs or symptoms of mental illness or substance abuse problems (prior to a DSM IV diagnosis¹). Examples include programs for high school students who are experiencing problem behaviors such as truancy, failing academic grades, juvenile depression, suicidal ideation, and early signs of substance abuse.

Types of Environmental Strategies

OSA utilizes effective environmental strategies delivered in multiple domains and at multiple dosages for a comprehensive prevention approach.

Policy Strategies

Perhaps the most potent strategies for preventing, reducing, or eliminating substance abuse are the creation, promotion and enforcement of policies and norms designed to change the environments in which people live and work. Policies include laws, rules, and regulations that serve to control availability and abuse of alcohol, tobacco, and other drugs through 1) pricing; 2) deterrence for using or incentives for not using; 3) restrictions on availability; and 4) restrictions on use. Policies also codify norms about substance use and specify sanctions for violations. Governments (municipal, state, and federal levels), public agencies (e.g., police departments, school systems), and private organizations and businesses (e.g., Health Maintenance Organizations, hospitality establishments, convenience stores) are all institutions which can impact people's decisions about using substances.

Enforcement Strategies

Consistent enforcement and reinforcement are needed to enhance the effectiveness of existing policies as well as new policies regarding substance abuse. Police officers, in particular, are important to enforcement and should be represented on community advisory boards, health task forces, or school and community coalitions. Police, however, are not the only key; community members are critical to the enforcement of policies and norms in a community. Parental enforcement of clear guidelines regarding expected behavior strengthens prevention efforts for their children. Young people, parents, school personnel, and other community

¹ American Psychiatric Association. (2000). *Diagnostic and Statistical Manual of Mental Disorders*. 4th ed., text rev. Washington, DC.

members play an important role in combination with police and others in the law enforcement and judicial fields.

Education Strategies

Instructional approaches that combine social and thinking skills are effective ways of enhancing individual abilities, attitudes, and behaviors around substance abuse and other kinds of delinquent behavior. These methods tend to be far more effective at changing behavior than educational programs that focus simply on imparting knowledge about substances and the adverse effects of substance abuse, or on programs that focus on bolstering self-esteem. Instructional programs are typically found in schools and in some after-school programs, but may also be found in worksites; they may educate a group about a new policy or create awareness about an issue. Some instructional programs have been important, necessary, and effective at imparting knowledge, developing skills, and changing some behaviors; however, most are insufficient to produce far reaching and long lasting change if they are the only strategy employed.

Communications Strategies

Communications strategies may influence community norms as well as increase public awareness about specific issues and problems related to substance abuse, attract community support for other program efforts, reinforce other program components, and keep the public informed about program progress. Communications strategies include: public education; social marketing campaigns that apply marketing principles to the design and implementation of communication campaigns; media advocacy approaches that encourage various media outlets to change the way they portray substance use issues in order to influence policy changes; and media literacy programs that educate people to be critical of what they see and read in the media.

Collaboration Strategies

While not directly affecting the use of tobacco, alcohol, and other drugs, collaborative efforts have been shown to be effective in raising awareness about substance abuse. This is especially true for community coalition building and interagency collaboration. Coordination of prevention and treatment services stretch resources for a broader prevention impact and cost savings.

OSA acknowledges that policy, enforcement and education must go hand-in-hand to be effective, and OSA directs grantees to adhere to this model.

Evidence-Based Programs, Practices and Strategies

Evidence-based (or science-based) substance abuse prevention programs are those programs that have positive evaluation results and have been reviewed by experts in the field. Science-based programs have sound research methodology and have proven that program effects were clearly linked to the program itself and not to some other causal factor. The Center for

Substance Abuse Prevention maintains a registry of evidence based prevention programs that can be found at www.nrepp.samhsa.gov.

OSA turns to the US Department of Education's Principles of Effectiveness found in Appendix C, and utilizes SAMHSA's definition of evidence-based strategies to help guide which initiatives will be funded in Maine. The definition, criteria, and process for approval of strategies can be found in Appendix D. The document is also available on the OSA website at: http://www.maine.gov/dhhs/osa/prevention/community/spfsig/documents/StrategyApprovalPacket_RevisedFinal_11-13-07.pdf

Guiding Principles of Substance Abuse Prevention

1. Effective substance abuse prevention is comprehensive and incorporates multiple strategies in multiple domains over extended periods of time. The domains refer to areas where prevention work occurs. These include peer/individual, family, school, work place, community and society settings.
2. A combination of Universal Indirect, Universal Direct, Selective, and Indicated interventions provides a comprehensive approach
3. Prevention specialists must possess a set of core competencies and a commitment to lifelong learning, and they must stay current with the rapidly evolving knowledge and skill base in this field.
4. Substance abuse prevention shares many elements with other fields of prevention and health promotion (e.g., juvenile delinquency prevention; adolescent suicide prevention; tobacco prevention; and mental, emotional and behavioral health promotion). Collaboration and cross training across the prevention spectrum maximizes human and material resources.
5. Substance abuse prevention is an active contributing partner supporting Maine's public health infrastructure.
6. A continuum of services that encompasses substance abuse prevention, intervention, treatment, and recovery must be available.
7. All sectors of the community, including parents and youth, are needed in successful prevention work. Members of the education, law enforcement, public health, and health care communities are critical partners in promoting mental and emotional health and preventing behavior disorders.
8. Prevention efforts must be grounded in needs assessment data, backed by current research, and evaluated for effectiveness.
9. Prevention strategies must address all people across the life span and must be relevant for each new generation.
10. Maine's substance abuse prevention framework utilizes the risk and protective factor framework developed by Hawkins and Catalano. The youth developmental assets and resiliency research contribute to the knowledge base of the field. These disciplines are implemented through the five-step process of the Strategic Prevention Framework:
 - a. Assess prevention needs based on epidemiological data;

- b. Build prevention capacity;
 - c. Develop a strategic plan;
 - d. Implement effective prevention programs, policies and practices; and
 - e. Evaluate outcomes.
11. Programs and initiatives should be executed with cultural competence and inclusivity when working with populations of diverse cultures and identities.

Costs of Substance Abuse

Substance abuse is implicated in most of society's ills. Drug abuse and addiction have negative consequences for individuals and for society. The costs of substance abuse include loss of productivity and health, crime, family disintegration, loss of employment, failure in school, domestic violence, and child abuse. Substance abuse is a factor in the four leading causes of death for youth: accidents (including motor vehicle fatalities), suicide, homicide, and unintentional injuries.

The cost of substance use compounds the burden on society when it results in treatment and special considerations needed for children who were drug exposed during pregnancy. The total cost of substance abuse to Maine people is staggering; investing in prevention can reduce the burden that society must bear. The National Institutes on Drug Abuse estimate that for every dollar spent in prevention, four to five dollars is saved in costs for drug abuse treatment and counseling². SAMHSA's *Substance Abuse Prevention Dollars and Cents: A Cost-Benefit Analysis* showed that effective school-based programs pay for themselves and more.³ For every dollar spent on these programs, an average of \$18 dollars per student would be saved over their lifetime of the student.

OSA Strategic Planning Process Overview

The Maine Office of Substance Abuse Prevention Team developed this Strategic Prevention Plan to contribute to meeting the overall mission of OSA as well as specific outcomes in the prevention arena. The prevention planning process is inclusive of community and state level stakeholders and takes into consideration the many needs and issues relating to equity, capacity and gaps in service throughout the state. The Prevention Team developed a three-year strategic plan, that was revised and enhanced in 2012 and resulted in a five-year strategic plan and that provides a road map to lead substance abuse prevention towards set goals and focuses statewide prevention efforts on data-driven priorities. Evidence-based strategies were

² National Institutes on Drug Abuse, National Institutes of Health, *Preventing Drug Use Among Children and Adolescents: A Research-Based Guide*, NIH Publication No 97-4212, March 1997.

³ Miller T. & Hendrie, D. (2008). *Substance Abuse Prevention Dollars and Cents: A Cost-Benefit Analysis*. DHHS Pub. No. (SMA) 07-4298. Rockville, MD: Center for Substance Abuse Prevention, Substance Abuse and Mental Health Services Administration.

selected to meet goals and objectives and will be implemented by the State and by community coalitions. Given that resources (financial, staff, and other) are limited, careful thought, based on data and research, must be given to the allocation of these resources. The plan will align primary stakeholder groups' prevention efforts and resources with the identified priority areas and will guide prevention decision-making and policy development at the state, public health district, and coalition levels.

The Strategic Prevention Plan 2011-2013 was developed with the help of an outside facilitator through a series of planning days. A comprehensive group of stakeholders was provided data and research and were engaged in discussion and an analysis of Strengths, Weaknesses, Opportunities and Threats (SWOT) to help determine the direction of the plan. The list of stakeholders who participated in the face-to-face meetings is in Appendix E and the SWOT analysis in its entirety is in Appendix F. The Prevention Team draws from the expertise of the Community Epidemiology Surveillance Network (CESN), the State Epidemiology Outcomes Workgroup (SEOW), as well as on data from other state agencies to guide prevention programming and ensure integration and inclusion in the prevention of compounding conditions. The Prevention Team continued to review data to make informed decisions about substance priorities, including age ranges, and target populations. A draft of the plan was then disseminated to the key stakeholders for their feedback and input.

The Prevention Team developed the Strategic Prevention Plan 2013-2018 in conjunction with input from the OSA Prevention Advisory Board and with funding from a State Prevention Enhancement (SPE) grant from SAMHSA. This five-year plan focused specifically on developing four "mini plans" which in turn formed the basis for the following assessments:

- Coordination of Services (Appendix G)
- Training and Technical Assistance (Appendix H)
- Data Collection, Analysis and Reporting (Appendix I)
- Performance Measurement and Evaluation (Appendix J).

Recommendations in the "mini plans" were incorporated into the final goals, objectives and milestones in the Strategic Prevention Plan 2013-2018.

The SPE grants support States in strengthening and enhancing their current prevention infrastructure. In Maine, OSA developed SPE planning objectives based on recommendations resulting from the evaluation of Maine's SPF SIG process.⁴ Those objectives focus on two broad themes: infrastructure, and workforce development/technical assistance. The Prevention Team convened the OSA Prevention Advisory Board, which provided valuable input into the planning process. Advisory Board members participated in development and review of the mini plans, and served on work groups that developed the recommendations and objectives below.

⁴ Hornby Zeller Associates, Inc. (2010). *Evaluation of Maine's Strategic Prevention Framework: Final Report 2005-2010*. Available at <http://www.maine.gov/dhhs/osa/prevention/community/spfsig/documents/FinalReport%202005-2010.pdf>

Data Analysis

Data resources used for the analysis and development of the strategic plan include: the Maine Youth Drug and Alcohol Use Survey (MYDAUS), Maine Integrated Youth Health Survey (MIYHS), Community Epidemiology Surveillance Network (CESN), Treatment Data System (TDS), HEAPP Data, National Survey on Drug Use and Health (NSDUH), Behavioral Risk Factor Surveillance System (BRFSS), Youth Risk Behavior Surveillance System (YRBSS) and the SPF-SIG Evaluation. A more in-depth analysis of the data than is provided here is available in the latest CESN report online at <http://www.maineosa.org/data/index.htm>.

According to YRBSS data, alcohol is the drug of choice for both youth and adults across the country and in Maine. YRBSS data cannot be compared to MIYHS data, so in order to compare Maine to the nation, OSA uses the YRBSS. Table 1 shows Maine data compared to national data. In 2011, 38.7% of high school students across the nation had at least one drink in the 30 days prior to the survey compared to 28.7% of Maine high school students. As for binge drinking, 21.9% of high school students in the nation consumed five or more drinks of alcohol in a row within a couple of hours on at least one day during the past 30 days, this was compared to 16.2% for Maine high school students. The percentage of high school students having used marijuana in the 30 days prior to the survey is very similar at 23.1% nationally and 21.2% in Maine.

Table 1

YRBSS Grades 9-12	Maine (2011)	National (2011)
30 Day Alcohol Use	28.7%	38.7%
30 Day Binge Drinking	16.2%	21.9%
30 Day Marijuana Use	21.2%	23.1%

BRFSS data shown in Table 2 from 2010 show that Maine is close to the national average when it comes to 30 day alcohol use for adults ages 18 to 24 at 48.7% and 48.3%, respectively. Maine also has a similar rate of binge drinking (males having five or more drinks on one occasion, females having four or more drinks on one occasion) as the nation, 21.9% versus 22.1%. The same holds true for heavy drinking (adult men having more than two drinks per day and adult women having more than one drink per day) with Maine's percentage of 18 to 24 year olds at 4.7% and the United States at 5.2%. This is a vast improvement over the 2009 rates, when Maine's rates were much higher than the nation's.

Table 2

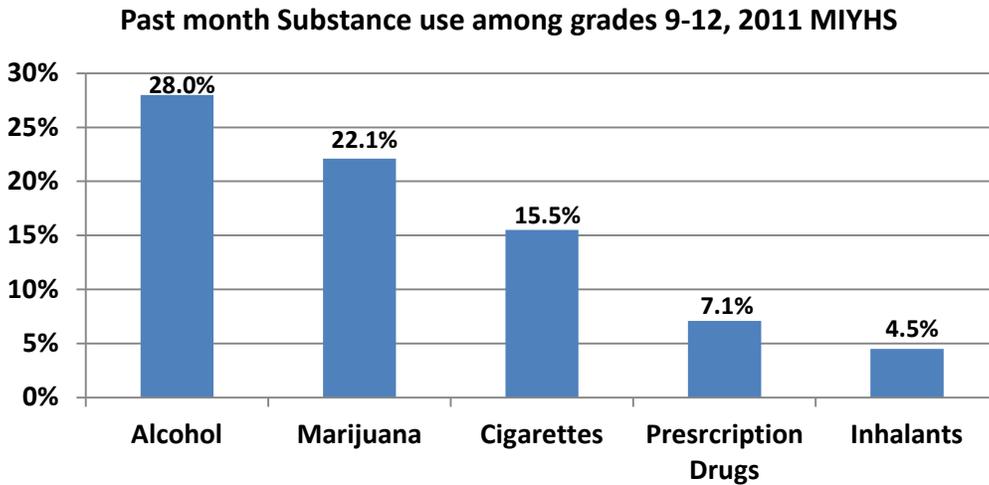
2010 BRFSS Ages 18-24	Maine	National
30 Day Alcohol Use	48.7%	48.3%
Binge Drinking (Alcohol)	21.9%	22.1%
Heavy Use (Alcohol)	4.7%	5.2%

Local situation and trends

As stated above, alcohol is the drug of choice in Maine. As Chart 1 below demonstrates, the 2011 MIYHS survey results show that 28% of Maine high school students had used alcohol in the 30 days prior to the survey. This is followed by 22.1% having used marijuana in the past 30 days.

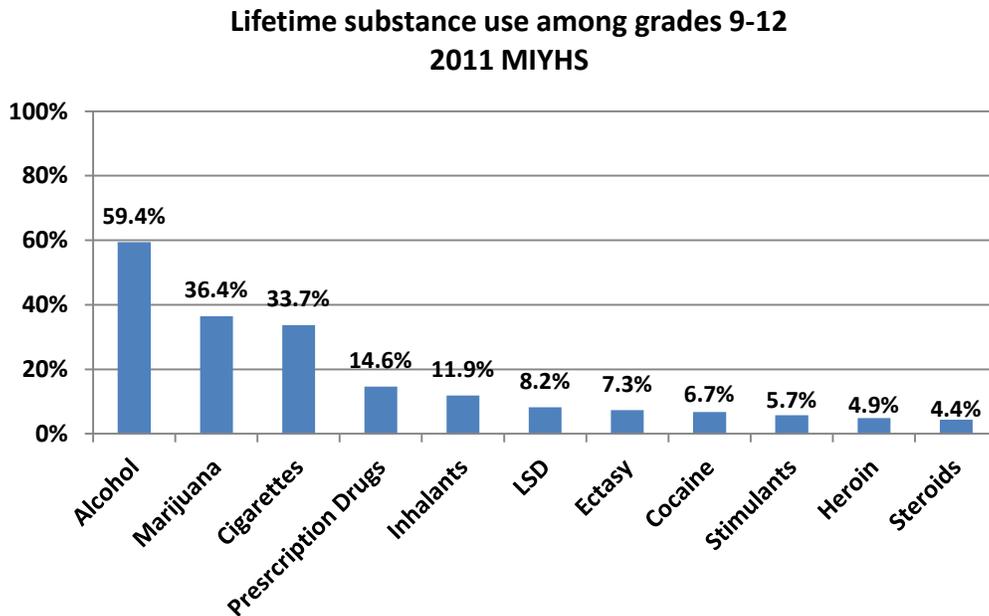
Chart 2 shows lifetime alcohol use rates of 59.4% for high school students. Lifetime rates for other drugs are 36.4% for marijuana, 33.7% for cigarettes and 14.6% for prescription drugs.

Chart 1



Source: MIYHS, 2011.

Chart 2

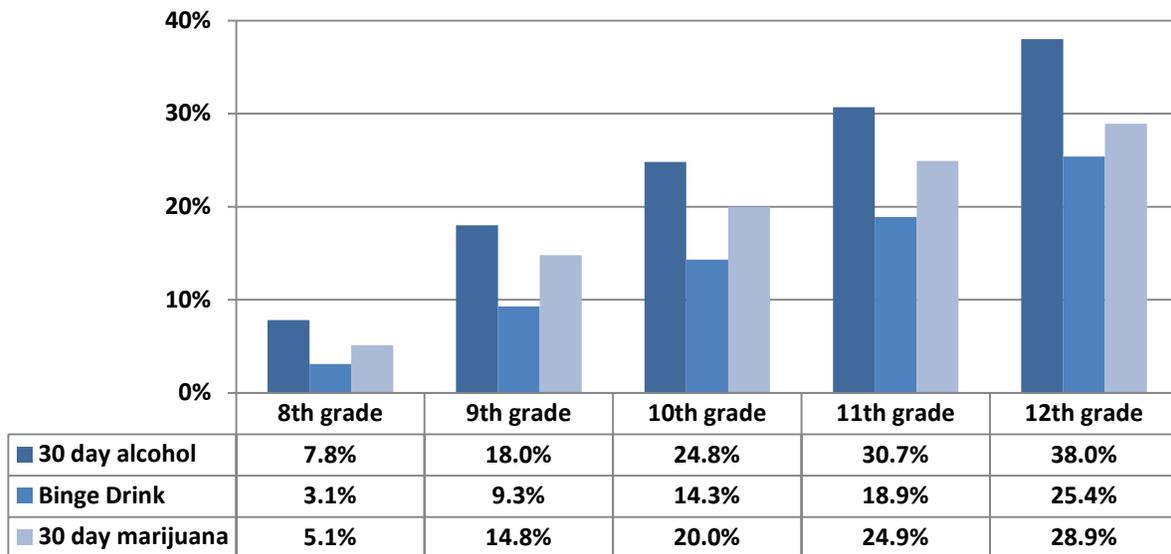


Source: MIYHS, 2011.

The 2011 MIYHS data shown in Chart 3 below reveal that substance use rates tend to have the largest increases between eighth and ninth grades. There are also large increases in binge drinking and 30-day marijuana use when students move from 11th to 12th and from 10th to 11th grade. A deeper analysis of the data shows that beginning in ninth grade about half (46%) of the students who reported having drunk in the past 30 days also report having binge drank. Approximately 55% of tenth graders, 60% of eleventh graders, and 66% of twelfth graders who reported having consumed alcohol in the past 30 days also reported binge drinking.

Chart 3

Substance use by grade (8-12), MIYHS 2011

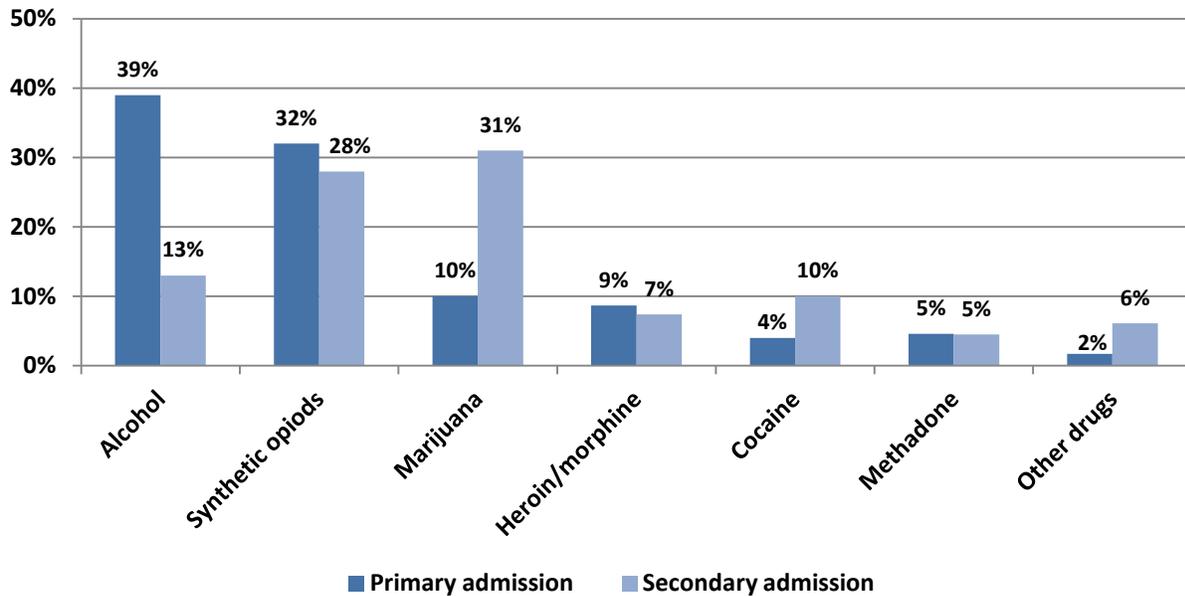


Source: MIYHS, 2011.

According to the 2010 BRFSS survey, 57% of adults in Maine consumed at least one alcoholic drink in the past 30 days, 14.5% binge drank (five drinks in one occasion), and 6.9% used alcohol heavily (more than one or two alcoholic drinks per day). Adults between the ages of 21 to 29 have the highest rates of binge drinking, at 29%.

The Treatment Data System (TDS) collects data regarding admissions and discharges for substance abuse treatment. Chart 4 below shows that TDS data from 2011 indicate that the most common substance for which primary treatment was sought was alcohol (39%), followed by synthetic opioids (32%). Marijuana was the leading substance for which secondary treatment was sought, followed by synthetic opiates.

Chart 4
Percentage of primary and secondary admissions by substance,
TDS 2011



Source: TDS, 2011.

Needs and Gaps

While existing funding has been used to address many needs, Maine’s prevention infrastructure is still in its infancy and many issues in equity, capacity, and gaps in services still need to be addressed. A map that illustrates the public health infrastructure and the 27 Healthy Maine Partnerships funded by the state can be found at www.healthymainepartnerships.org.

The Prevention Team identified the following needs and gaps:

- **Need:** consistent and adequate funding via the HMP infrastructure
 - **Gap:** SPF SIG funding for HMPs ended in 2010
- **Need:** consistent messaging statewide
- **Need:** support of primary prevention in the schools
 - **Gap:** loss of SDFS funding and minimal other funding
- **Need:** clear education/messaging that increases the perception of harm and costs associated with use.

Proposed Future of Prevention, Targeted Initiatives, Programming, and Funding Needs

Based on the data analysis and identification of needs and gaps in 2010, the Prevention Team identified the areas below for future programming and funding needs. The SPE planning process then built on these, and developed additional recommendations and objectives. The targeted initiatives, programming and funding needs and the related priorities, goals and objectives from the 2010 planning process are presented below, followed by additional recommendations and objectives from the 2011-2012 planning process.

Workforce Development

While a prior workforce development assessment showed a semi stable prevention workforce with many years of experience, the need for prevention specialists to gather and analyze data and to conduct evaluation emerged as areas where professional development is needed. The infusion of SPF SIG funding statewide revealed that filling positions with knowledgeable Prevention Specialists has been difficult in several areas of the state (particularly more rural areas). In addition, a career ladder for people wishing to make a lifelong commitment to prevention needs to be created to help retain knowledgeable and competent Prevention Specialists. Working towards a certification program for Prevention Specialists will be important to help move Maine in a positive direction.

The identification of core competencies for prevention workers and cross training with other related disciplines would allow for the most efficient use of training dollars. Creating linkages with the community college system and universities would further legitimize the field and provide a structured training mechanism. In addition, university linkages could provide the necessary evaluation expertise needed to document the effectiveness of prevention programming.

School personnel need to be provided opportunities to learn about substance abuse and its effect on school climate and academic performance. As new people enter the field, “substance abuse 101” needs to be available and seen as valuable. Providing teachers with a basic understanding of the signs, symptoms, and risk factors of substance use is a necessary component to catch substance use early. Teachers and other school staff are most often the first people to notice the signs that a student may be in difficulty, and increasing their familiarity with the signs and symptoms of abuse would allow for earlier intervention. Other ideas include utilizing Screening and Brief Intervention as a Universal or Selected prevention strategy, and pre-service training for teachers, health professionals, social workers, and other professionals in understanding substance use, abuse, and dependence.

Policies

- Underage drinking policies need to be examined and recommendations for strengthening enforcement and/or creating new laws should be explored.
- The voices of youth and parents should be an integral part of prevention planning.
- Examination of best practices in price and promotion strategies needs to continue.

Prevention data

- Data system should be refined to meet needs of prevention providers, State, and Federal funders.
- Needs, as shown by the CESN report and workgroup utilizing MIYHS, BRFSS, and other data, should continue to be the basis for funding decisions and program strategies.

Interdepartmental and intergovernmental initiatives

- Collaborative efforts that maximize resources (e.g. Maine Youth Suicide Prevention Program, underage drinking prevention efforts, coordination with Healthy Maine Partnerships, MIYHS survey, substance abuse prevention in the workplace, Coordinated School Health Program) should continue.
- Other possibilities for interdepartmental collaboration should be explored.
- Collaborative efforts with the Native American Indian Tribes located in Maine to further prevention efforts in their communities should be continued.
- Possibilities for cross state and regional collaboration efforts should be explored.

Outreach to schools

- OSA should work with school health coordinators to ensure that substance abuse prevention is addressed in comprehensive school health education programs.
- OSA should serve as a resource on such topics as model policies and procedures, model programs, and working with parents.
- The Information and Resource Center's collection of materials for school audiences should be expanded.
- OSA should continue to develop relationships with alternative education programs and work with the Maine DOE Truancy, Dropout, Alternative and Homeless Education Coordinator.
- Pre-service training should be provided for teachers, health professionals, social workers and other professionals on substance use, abuse, and dependence.

Funding for continuation of the following priorities:

- The Higher Education Alcohol Prevention Project
- Public education, including OSA prevention media campaigns
- Healthy Maine Partnerships
- KIT Prevention System
- Continued development of state infrastructure
- Statewide compliance checks
- Mini-grants to law enforcement agencies

Funding for the development of the following:

- Evaluation of promising Maine programs for designation as NREPP program.
- District/local prevention specialists; coordinators to work with coalitions, schools, and other groups to better understand substance abuse prevention, their local data and how to plan and evaluate their efforts.
- Development and dissemination of Maine specific resource materials.
- Effective RBS system, including the Card ME Program.
- Statewide screening and brief intervention program.

Priorities

The priority populations that are to be targeted include the underage population and the population of 18 to 25 year olds.

For the underage population the areas of focus will include: any underage alcohol use, binge drinking, high-risk alcohol use, marijuana use, prescription drug misuse, and inhalant abuse.

For the 18 to 25 year old population, the areas of focus will include: binge and/or high-risk alcohol use, prescription drug misuse, and marijuana use. This will include focusing on both the college and workplace environments.

Goals and Objectives

Program Initiatives

Goal: Increase OSA's capacity to support implementation of quality evidence based programming and best practices by stakeholders and implementers across Maine.

Objectives:

1. Promote and enhance utilization of evidence based interventions (i.e., SBIRT) in appropriate settings (healthcare, courts/judicial).
2. Increase the number of evidence based/best practices available to substance abuse preventionists across the state, that take into account risk and protective factors that cut across related mental, emotional, and behavioral disorders.
3. Create and implement a comprehensive Drug Free Workplace Program.
 - i. Across all workplaces in Maine
 - ii. Emphasis for the 18 to 25-year old workforce
4. Sustain effective evidenced based law enforcement practices (i.e., party patrols and compliance checks) to reduce underage drinking.
5. Improve school climate through the implementation of evidence-based programming on substance abuse prevention to impact student health, wellness, safety and success.

Collaboration

Goal: Increase collaboration with special populations, other state agencies/offices, and local stakeholders.

Objectives:

1. Enhance programs by identifying and collaborating with key stakeholders who share common interests (i.e., law enforcement, DOE, courts).
2. Partner with agencies/offices or stakeholders on grant applications.
3. Collaborate with behavioral health, including substance abuse, other state offices, mental health providers and primary care providers to create cross-training opportunities.
4. Participate on state-level boards and committees where substance abuse issues are relevant.
5. Partner with representatives from various special populations to explore potential program initiatives and to provide consultation on substance abuse prevention (tribes, military, behavioral health entities, etc.)

Public Awareness

Goal: Promote awareness to key stakeholders and communities about the impact of substance abuse in Maine and OSA's work to prevent and reduce substance abuse and related problems.

Objectives:

1. Create media campaigns to raise awareness about alcohol and drugs
 - i. Counter-advertising and social norming messages;
 - ii. Increase information about Maine laws to the public.
2. Create and disseminate information about how substance abuse affects everyone in Maine – both cost and impact.
3. Promote the work of OSA as well as the resources available.
4. To increase outside agencies' awareness and understanding of substance abuse-related initiatives or issues.
5. Promote underage drinking as a public health issue with the same urgency as any other health condition.

Data and Evaluation

Goal: Improve, enhance, and expand OSA's capacity to make data-driven decisions and quality improvement.

Objectives:

1. Train key stakeholders (i.e. , coalitions, schools, worksites, law enforcement, etc.) to use data to increase buy-in, create action, and evaluate progress.
2. Increase the number of programs evaluated.

3. Increase accountability for prevention and early identification activities through uniform reporting:
 - i. Utilize KIT to track progress of OSA grantees.
4. Increase access to data sources relevant to Maine people (i.e., behavioral health, military, tribal).

Workforce Development

Goal: Develop a workforce that is proficient in effective substance abuse prevention.

Objectives:

1. Implement a system of prevention credentialing opportunities in Maine.
2. Improve availability and accessibility of education and training opportunities for evidence based programming for stakeholders (including primary care physicians, ER docs, and mental health providers).
3. Work with Professional Development Workgroups to coordinate and provide training and education for prevention providers around core competencies.
4. Increase the number of cross-training opportunities available for prevention providers and mental health workers across a variety of disciplines.
5. Increase training opportunities for teachers on behavioral health as a student health, safety, and success issue.
6. Develop and provide training on risk/protective factors, risk-reduction and intervention programs for a variety of groups. (Substance Abuse and Mental Health for groups such as: parents, young adults in transition, LGBTQ, drop-outs, elderly, military).

Marijuana Use

Goal 1: Reduce use of marijuana among Mainers, with emphasis on teens and young adults.

Sub goal: Reduce the availability of illicit marijuana and related products which support production or use.

Objectives:

1. Increase public's readiness to recognize and to reduce the visibility of products, symbols, and terms which are pro-marijuana.
2. Increase communities' readiness to implement retail control strategies to address sales of marijuana related products.
3. Educate the public about how to use nuisance abatement strategies to decrease illegal marijuana activity in communities.

Sub-goal: Inform the public about the risks and harm of marijuana use.

Objectives:

1. Educate parents about the effects of marijuana use on teens and young adults.
2. Increase education opportunities for teachers and counselors about marijuana research findings, including the risk of early onset of marijuana use.
3. Educate the public about the laws (state and federal) relating to marijuana.

Prescription Drug Use/Abuse

Goal 1: Reduce use of prescription drugs among Mainers, with emphasis on teens and young adults.

Sub goal: Reduce the retail availability of prescriptions drugs (over prescribing, doctor shopping).

Objectives:

1. Increase training opportunities around the Prescription Monitoring Program (PMP) for prescribers/dispensers.
2. Increase awareness among prevention providers and other partners around the PMP and prescription drug abuse.
3. Increase the number of prescribers/dispensers registered to use the PMP.

Sub goal: Improve awareness around safe storage and disposal of prescription medication.

Objective:

1. Increase the public's awareness around safe storage and safe disposal of prescription medication.

Sub goal: Reduce the number of prescription drugs diverted in the State of Maine.

Objectives:

1. Increase law enforcement's and other prevention providers' awareness around prescription drug diversion and signs of impairment.
2. Increase the public's awareness around prescription drug use/risks and diversion through the expansion of the Parent Media Campaign.
3. Increase the number of schools who review and update their school policy to ensure the prescription drug misuse/abuse is being addressed.

Sub goal: Increase people's perceived risk of prescription drug use.

Objective:

1. Increase the public's awareness around the dangers of prescription drug misuse.

Sub goal: Improve awareness around individual/family factors that impact prescription drug use.

Objective:

1. Increase parental awareness about the dangers of prescription drug misuse.

Alcohol use/abuse: Underage and Binge Drinking

Goal 1: Reduce underage drinking and binge drinking among Mainers, with emphasis on teens and young adults.

Sub goal: Reduce the retail availability of alcohol for underage and binge drinking.

Objectives:

1. Improve liquor licensees' knowledge and skill around responsible beverage sales/service (RBS) practices.
2. Enhance capacity to monitor and educate stakeholders about how alcohol outlet setting and quantity may impact underage and binge drinking behaviors.
3. Reduce people under 21 years of age's possession and use of fraudulent IDs (fake IDs) to gain access to alcohol for underage drinking.

Sub goal: Reduce the economic availability of alcohol for underage and binge drinking.

Objective:

1. Enhance public awareness of how low alcohol pricing can influence behaviors of price sensitive underage and binge drinkers.

Sub goal: Reduce underage and binge drinkers' access to alcohol from social sources such as peers, family, and community members.

Objectives:

1. Reduce underage drinkers' ability to access alcohol from older siblings/peers who are of legal drinking age.
2. Reduce people's willingness to allow illegal consumption (both underage and consumption by visibly intoxicated persons) to occur at places under their control. (such as: homes, land, camps, vehicles, etc.).
3. Reduce youth access to alcohol from people they do not have a relationship with.

Sub goal: Increase the effective enforcement of Maine's liquor laws and the utilization of clear and consistent consequences so as to deter underage and binge drinking.

Objectives:

1. Increase the existence of clear and consistent consequences for underage drinking violations or visible intoxication in systems which interact with youth and young adults (such as family, school, community, courts).
2. Enhance law enforcement's capacity & readiness to enforce Maine liquor laws related to underage and binge drinking.

Sub goal: Reduce marketing and media messages which promote underage and binge drinking.

Objectives:

1. Improve awareness of and capacity to address marketing and media messages which promote underage and binge drinking.
2. Increase awareness of regulations/ laws related to limiting alcohol promotions which impact underage and binge drinking.

Sub goal: Reduce norms which perpetuate underage and binge drinking as behaviors which are normal, safe, and acceptable.

Objectives:

1. Reduce perception that drinking illegally and/or excessively is a rite of passage that is "part of growing up."
2. Reduce adults' perceptions that young people are going to drink (and drink to excess) anyway, so they are powerless to try to stop it.
3. Decrease public misperception that "Everyone is drinking" and/or "Everyone is drinking to excess frequently."
4. Reduce parents/families who model binge or illegal alcohol use.
5. Reduce cultural messages and practices which encourage high-risk drinking when there are events or triggers (holidays, celebrations, athletic events, hard day/week).
6. Reduce parents who say that they are ok with teens drinking at a home because it is safer than them drinking elsewhere.

Sub goal: Increase people's perceived risk of underage and binge drinking so as to reduce their likelihood of engaging in the behavior.

Objectives:

1. Increase public perception of getting caught for violating Maine liquor laws related to underage and binge drinking.
2. Increase public awareness of consequences of underage and binge drinking beyond drunk driving (e.g. physical harm, sexual assault.)

Sub goal: Improve public awareness around individual/family factors that impact underage and binge drinking and related risks.

Objectives:

1. Increase public knowledge of predisposition to alcohol issues (i.e. those with adverse childhood experiences, co-occurring, and genetics) so as to inform drinking choices.
2. Increase public knowledge of basic alcohol information (such as: knowledge of how alcohol interacts with body, risk reduction strategies, BAC, standard drink, genetic factors, etc.).

State Prevention Enhancement

In 2012, OSA completed a planning process to strengthen and enhance Maine's current prevention infrastructure to support more strategic, comprehensive systems of community-oriented care. OSA staff led the planning process, with valuable input and guidance from the multi-sector OSA Prevention Advisory Board. At the direction of the Advisory Board, the planning process was informed by the Institute of Medicine's developmental framework for prevention and health promotion.⁵

The Prevention Team consulted with Advisory Board members individually, in work groups designed to utilize resources and time efficiently, and at five board meetings where the planning process and draft documents were discussed in detail. Advisory Board members provided input at meetings, via phone and email, and through an online survey, all with the aim of gaining an understanding of ways in which OSA prevention planning could enhance other planning processes, further coordination across agencies and utilize scarce resources most efficiently.

This strategic planning process and resulting plan align with other strategic planning activities in Maine, which presents opportunities to support and expand efforts to utilize resources efficiently.

- **Healthy Maine 2020:** The resulting goals and objectives align with *Healthy Maine 2020* objectives to reduce past-year non-medical use of prescription drugs, to increase the proportion of adolescents never using substances, and to reduce the proportion of persons engaging in binge drinking of alcoholic beverages.
- **Youth suicide prevention.** OSA's strategic plan aligns with the *Maine Youth Suicide Prevention Program Plan* goals to develop and implement strategies to reduce the stigma associated with being a consumer of behavioral health services for families and youth and increase help-seeking behaviors; and to improve access to and community linkages with mental health, substance abuse and suicide prevention services.⁶

⁵ National Research Council and Institute of Medicine. (2009). *Preventing Mental, Emotional, and Behavioral Disorders Among young People: Progress and Possibilities*. Washington DC: The National Academies Press.

⁶ This plan is available at <http://www.maine.gov/dhhs/mh/blockgrant/attachment-j-2.pdf>.

- **Education.** OSA’s strategic plan aligns with DOE’s *Education Evolving: Maine’s Plan for Putting Learners First* by supporting coordinated health and wellness programs and a commitment to community and family engagement. In addition, OSA workforce development initiatives to strengthen Maine’s prevention workforce may include educators and other professionals who engage youth in schools and the community.⁷ There is considerable overlap in *Preventing Substance Abuse and Violence in Schools: A Strategic Plan for Maine* as well.
- **Enforcing underage drinking laws.** The planning process related to enforcing underage drinking laws resulted in *Maine’s Enforcing the Underage Drinking Laws System Assessment, Strategic Planning, and Implementation Initiative: Strategic Action Plan*. This planning process intersects with OSA’s strategic prevention planning in numerous areas, including supporting implementation of evidence based strategies and engaging HMPs and Drug Free Communities coalitions to implement enforcement strategies consistently across the state at the local level.⁸
- **Workforce development.** OSA’s plan to develop a statewide certification system for prevention professionals dovetails with initiatives in Maine to ensure fidelity of program implementation and the creation of a career ladder for professionals in early care and education.⁹
- **Cultural Competency.** OSA’s ongoing commitment to embedding cultural competency throughout the agency and its programs intersects with Office of Minority Health initiatives, including in particular the development of a Toolbox of Resources on cultural competency. With the Office of Minority Health in the lead, there are numerous opportunities for training across disciplines and State agencies.¹⁰
- **Problem Gambling.** OSA’s *2011-2014 Problem Gambling Services Strategic Plan* recognizes that problem gambling prevention, treatment and recovery share many elements with other fields of prevention, health promotion and treatment and recognizes the importance of cross training across the prevention and treatment spectrum to maximize human and material resources.
- **Teen Driver Safety.** The *Strategic Workplan of the Maine Teen Driver Safety Committee* includes an objective to decrease teen driving related crashes, injuries and fatalities due to alcohol and other drugs. The strategies identified align with OSA’s prevention initiatives related to enforcing underage drinking laws and include youth and teens as target audiences for messages related to enforcing these laws.
- **Violence in Schools.** *Preventing Substance Abuse and Violence in Schools: A Strategic Plan for Maine* was completed by a multi-agency workgroup in 2011. Many of the

⁷ The plan is available at <http://www.maine.gov/doe/plan/evolving.pdf>

⁸ A summary of recommendations is available at http://www.maine.gov/dhhs/osa/prevention/lawenforcement/EUDL%20Grantees%20Web/EUDL%20Assessment%20Visit%20Recommendations%205_25_11.pdf

⁹ More information on Maine’s Early Care and Education Career Development Center is available at <http://muskie.usm.maine.edu/maineroads/>

¹⁰ More information on the Office of Minority Health initiatives is available at <http://www.maine.gov/dhhs/mecdc/minority-health/>

objectives in this plan overlap considerably with OSA's prevention initiatives, particularly as they pertain to improving coordination of resources across state-level partners, seeking joint funding with state level collaborators and expanding training opportunities across disciplines and agencies.

The goals and objectives below embed coordination of public and private services, particularly as they relate to educating professionals (including primary care providers) and the general public about the integration of substance abuse and mental health into a behavioral health concept, and as they relate to education about the stigma associated with having a substance use problem and seeking treatment for it. This upstream approach to prevention is critical to the success of other evidence based prevention interventions identified in the goals and objectives above. Further, overall coordination of services is addressed in other goals and objectives regarding cultural competency training, and regarding the development of a Prevention Specialist Certification program that will be available to individuals across professions.

Education and raising awareness about behavioral health and the stigma associated with substance abuse and treatment are also keys to sustaining Maine's prevention efforts. As our colleagues in State government and in the private sector understand that their work—in education, social services, juvenile justice, highway safety and other areas—forms a part of preventing behavioral health problems across the life span, opportunities will arise to work together to increase funding opportunities and to use existing resources more efficiently.

The objectives and milestones below are provided as an action plan for the next five years, to be accomplished within existing OSA resources, by OSA staff, and with assistance from partners and their existing resources. Where funding at the sub-state level will take place, funding will be distributed equally to Maine's Public Health Districts. Sustainability occurs in the context of considerable budget constraints and the uncertainties of health care reform, and consists of:

1. Expanding OSA's base of prevention partners and linking their work with substance abuse prevention initiatives;
2. Educating prevention partners about behavioral health integration and the stigma associated with substance use and seeking treatment;
3. Providing and taking advantage of opportunities for cross-training;
4. Building a Prevention Specialist Certification program that will expand interest in the field of prevention by building a career path in prevention, enhance skills and performance among prevention providers across the state, and expand prevention initiatives into other professions (e.g. education professionals);
5. Building capacity in the area of grant writing; and
6. Utilizing existing and emerging technologies effectively.

Cultural Competence

Goal: Develop ways to incorporate cultural competency into substance abuse prevention programming

Objectives and Milestones:

1. Using aggregated information on state and federal level definitions of cultural competency, establish a working definition to use as OSA develops a self-assessment. (Incorporate elements from definitions used by SAMHSA, Agency for Toxic Substance & Disease Registry, and the National Center for Cultural Competency at Georgetown University.)
2. Develop standards for cultural competency trainings and identify opportunities to partner with other public health stakeholders.

Year 1

- Definition of cultural competency created.
- Outside resources (e.g., NCCC) used to develop agency self-assessment process to determine compliance with definition.
- Components essential to comprehensive cultural competency training identified.
- “OSA Standard” for cultural competency trainings developed.

Year 2

- Agency self-assessment to determine cultural competency completed: “Walk the walk.”
- Resources that provide trainings that incorporate the essential components identified in year 1 promoted (e.g., putting training opportunities on the prevention calendar).

Year 3

- Cultural competency integrated into contracts, policies, regulations and rules.
- Plan to assess and evaluate resources and training developed and implemented.

Years 4-5

- Ongoing self-assessment plan implemented; adjustments made based on identified strengths and challenges.
- Ongoing identification, assessment, evaluation and dissemination of trainings.

Prevention Specialist Certification

Goal: A statewide prevention certification system is implemented for Maine based on International Certification and Reciprocity Consortium (IC&RC) standards.

Objectives and Milestones:

1. Convene a Credentialing Committee dedicated to creating a certification process, establishing a certification board and implementing IC&RC certification in Maine.
2. Establish certification requirements and training capacity/opportunities necessary to support and sustain Prevention Certification in Maine to meet the IC&RC standard.

3. Establish a credentialing board to meet IC&RC standard.
4. Implement a Prevention Certification process in Maine using the IC&RC standard.
5. Create a long-term sustainability plan for prevention credentialing.

Year 1

- Credentialing Committee formed and meets at least monthly. Membership includes OSA (convener), Training/Workforce Development (including higher education), and Prevention workforce from the field (including non-supporters of certification and non-OSA funded professionals). Majority are representatives of the prevention workforce.
- Assessment results and recommendations submitted to the Office of Substance Abuse.
- Core competencies identified.
- Initial training offered and existing training that meets competencies identified.

Year 2

- Independent Certification Board that meets IC&RC standards authorized/sanctioned in Maine.
- Additional training/trainer capacity identified.
- Training and trainer workforce competencies identified.
- Credentialing Committee oversees, enhances and sustains the credentialing process.

Year 3

- Certification process finalized.
- Training and trainer workforce capacity fully developed.
- Independent Certification Board application approved.
- Certification process begins (applications accepted and reviewed).
- Sustainability planning begins.
- Credentialing Committee oversees, enhances and sustains the credentialing process.

Year 4

- Prevention field moving towards universal certification.
- Recertification process begins.

Year 5

- Prevention field moving towards universal certification.
- Sustainability plan completed.
- Credentialing Committee oversees, enhances and sustains the credentialing process.

Training, Technical Assistance and Sustainability

Goal: Ensure prevention providers statewide have access to credible training on evidence based programs, policies and practices, understand the need to use data and understand the value of evaluation.

Objectives and Milestones:

1. Provide information to prevention partners and the general public on the concepts of behavioral health as the integration of substance abuse and mental health, and behavioral health as a public health issue.
2. Develop materials for prevention partners that address the stigma associated with substance abuse and mental health.
3. Develop training for prevention partners that address stigma associated with substance abuse and mental health.
4. Incorporate sustainability and grant writing competencies as a requirement for grantees.

Year 1

- Materials developed (e.g., talking points and fact sheets) and disseminated to grantees, prevention partners, the general public and higher education partners.
- Resource list of training opportunities developed and disseminated to grantees.
- Sustainability and grant writing competencies incorporated into OSA contracts.
- Current technology opportunities assessed and incorporated appropriately into practice, based on resources available.

Year 2

- Trainings on behavioral health integration assessed.
- Training in grant writing and sustainability assessed and developed.
- Current technology opportunities assessed and incorporated appropriately into practice, based on resources available.

Year 3

- Ongoing dissemination of information.
- Ongoing training.
- Current technology opportunities assessed and incorporated appropriately into practice based on resources available.

Year 4

- Materials and training are assessed to determine further needs.
- Current technology opportunities assessed and incorporated appropriately into practice, based on resources available.

Year 5

- Continued training incorporated into the next strategic plan.
- Current technology opportunities assessed and incorporated appropriately into practice, based on resources available.

Data Collection, Analysis and Reporting

Goal: Improve data quality, accessibility and usefulness for process measures.

Objectives and Milestones:

1. Improve KIT reporting system.

Year 1

- Data currently collected through KIT assessed and edited.
- Determination of what is necessary to collect (add/remove counts) completed.
- Exploration of who else would report into KIT completed.

Year 2

- Improvements of what is already collected in KIT completed.
- Determination of how KIT can be used to capture cost and staff counts completed.
- Ways to expand users/groups required to report to the system developed.

Year 3

- Changes and improvements identified in previous years implemented.
- Partnering with other agencies (e.g., CDC, other grantees) so they report in KIT/data that would work with KIT begins.
- Collection of staff and financial information begins.

Year 4

- KIT's use as a tool for users expanded.
- Evaluation protocol developed.
- Reporting mechanisms developed that would aid in local-level evaluation. (See below.)

Year 5

- Assessment and refining reporting processes continues.

2. Establish Continuous Quality Improvement (CQI) process.

Year 1

- Assessment and inventory of current CQI process for OSA prevention grantees completed.

Year 2

- Best practices in CQI to use while KIT process reporting system is being expanded/improved as outlined above identified.

Year 3

- Grantees encouraged to engage in best practice CQI processes.

Year 4

- Use of KIT as part of CQI process expanded.
- Procedures to use KIT data to link local counts to program improvement developed.
- Project officers trained in CQI.
- Local grantees trained in CQI.

Year 5

- CQI process implemented.

3. Explore implications of Performance-Based Contracting on data collection/reporting.

Year 1

- List counts recorded as part of performance-based contracting compiled.
- Assessment of how these counts can be used completed.
- Gaps in data collected identified.

Year 2

- Data collected for individual strategies identified.
- Determination of how OSA can collect data for individual strategies not currently collected completed.

Year 3

- Participation in calls/training in use of data required in all OSA contracts.

Years 4-5

- Additional needs surrounding local capacity to collect/use data identified.

4. Improve TA/Training data

Year 1

- Review of data collection for TA/Training to determine areas for improvement completed.

Year 2

- Development of standard counts for TA/Training that will be routinely collected and reported completed.

Year 3-5

- TA/Training data to identify strengths and challenges collected and analyzed regularly.

Goal 2: Disseminate outcomes.

Objectives and Milestones:

1. Determine where objectives of strategic plan overlap with SEOW.

Year 1

- Determination of where objectives of strategic plan overlap with SEOW completed.

Year 2

- Development of ways to effectively communicate/collaborate to encourage efficient use of funds/staff completed.

Years 3-5

- Continue above.

2. Develop interactive data dashboard of relevant outcomes measures at state/local levels for trending, sub-state analysis.

Year 1

- Assessment of options for interactive data platform completed.
- Data added to current public health dashboard.
- Exploration of how services and strategies counts from KIT could be incorporated into current DHHS dashboard completed.
- Guide to using outcomes data updated.

Year 2

- Determination of which type of data dashboard OSA will use (its own, coordination with other public health entities) completed.

Year 3

- Partnerships established (e.g., with public health if that avenue is chosen, with IT if own will be developed).

Year 4

- Counts/measures will be available and which reports the dashboard will generate identified.

Year 5

- Dashboard complete.

3. Assess current data available for adult and subpopulations and explore new partnerships to obtain additional data.

Year 1

- Current data assessed.
- Data identified that are already collected for special populations.
- Efforts increased to analyze existing data for special populations.
- Purchase of questions around prescription drugs and marijuana continues.

Year 2

- Populations identified for which data are limited.
- Data increased collection from under-analyzed populations or substances.
- Adding questions to BRFSS that are asked of cell phone sample explored.
- Other survey options explored.

Year 3

- Partnerships established to obtain data not collected at state level. For example, for the military.
- Collaboration with National Guard or VA to determine data sources available and what can be used begins.
- Question added to MIYHS to determine if respondent is part of an active military family.
- Work begins with Thrive to get aggregate military family data.

Year 4

- Additional partnerships established based on data gaps identified through Year 1 assessment.

Year 5

- Continue above.

Performance Measurement and Evaluation

Goal: Meet all data reporting requirements.

Objectives and Milestones:

1. Collect all required SAMHSA measures (GPRA; NOMs)

Year 1

- Inventory of current and potential GPRA/NOMs completed.
- Funding opportunities explored to determine priority measures.

Year 2

- Capacity to comply with collecting required measures ensured.

Years 3-5

- Continue above.

Goal: Include cost and benefit analyses routinely in performance measurement and evaluation

Objectives and Milestones:

1. Inventory and assess currently used cost savings procedures and data to develop OSA prevention cost savings methodologies.

Year 1

- Cost savings indicators identified.
- “Shoveling Up” report updated.¹¹
- National figures identified that could be translated into cost savings (e.g., x% of violent crime related to alcohol—how much does this crime cost and what would reduction save?).
- Cost data prioritized (e.g., DOL wages lost, DOC incarceration costs).
- CDC’s PRISM system explored to see how they incorporate cost benefit or cost effectiveness analyses.

Year 2

- Methodology developed for cost savings calculations.

Year 3

- Capacity to collect or identify necessary data ensured.

Year 4

- Mechanism developed for collecting missing data.

Year 5

- Cost savings procedures incorporated as a regular part of evaluation.

2. Explore partnerships with other agencies (e.g., CDC, MHDO) for data and evaluation purposes.

Year 1

- Partnering with Maine Health Data Organization to get healthcare cost data (get data through DHHS agreement with MeCDC) begins.

¹¹ The National Center on Addiction and Substance Abuse at Columbia University. (2009). *Shoveling Up II: The Impact of Substance Abuse on Federal, State and Local Budgets*. Available at www.casacolumbia.org/su2report

Year 2

- Insurance and Medical data reporters/coders trained to ensure correct use of eCodes that indicate alcohol/drug related injuries or medical conditions.

Year 3

- Health care/medical data analyzed to determine utility in evaluating substance abuse prevention programs.

Years 4-5

- New data sources incorporated into evaluation and cost savings reporting.

Goal: Link process measures to outcomes to gauge program effectiveness.

Objectives and Milestones:

1. Develop standard evaluation procedures and guidelines.

Year 1

- Logic Model for Prevention across funding sources/programs using the social-ecological framework articulated.
- Determination of which outcomes each program should consider when evaluating its own effectiveness completed.
- Relevant process measures, quality and source(s) identified.
- Critical outcomes measures that can be analyzed and tracked regularly identified.
- Supplemental qualitative measures identified.

Year 2

- Methodology developed to gauge the impact of prevention efforts on observed outcomes.

Year 3

- Qualitative data utilized to aid in determining the links between process measures and outcomes. Gaps filled in where counts and numbers fail to reveal a connection.
- Interviews conducted.
- Focus groups conducted.
- Fidelity assessments conducted.

Years 4-5

- Refining and implementing procedures developed during previous years continues.

Goal: Expand capacity to engage in evaluation at the state and local levels.

Objectives and Milestones:

1. Develop evaluation plan and requirements.

Years 1-5

- Funding sought for evaluation.
- Importance of data/evaluation promoted at the state level.
- OSA's access to evaluation expertise expanded and sustained.
- Local grantees trained in evaluation.

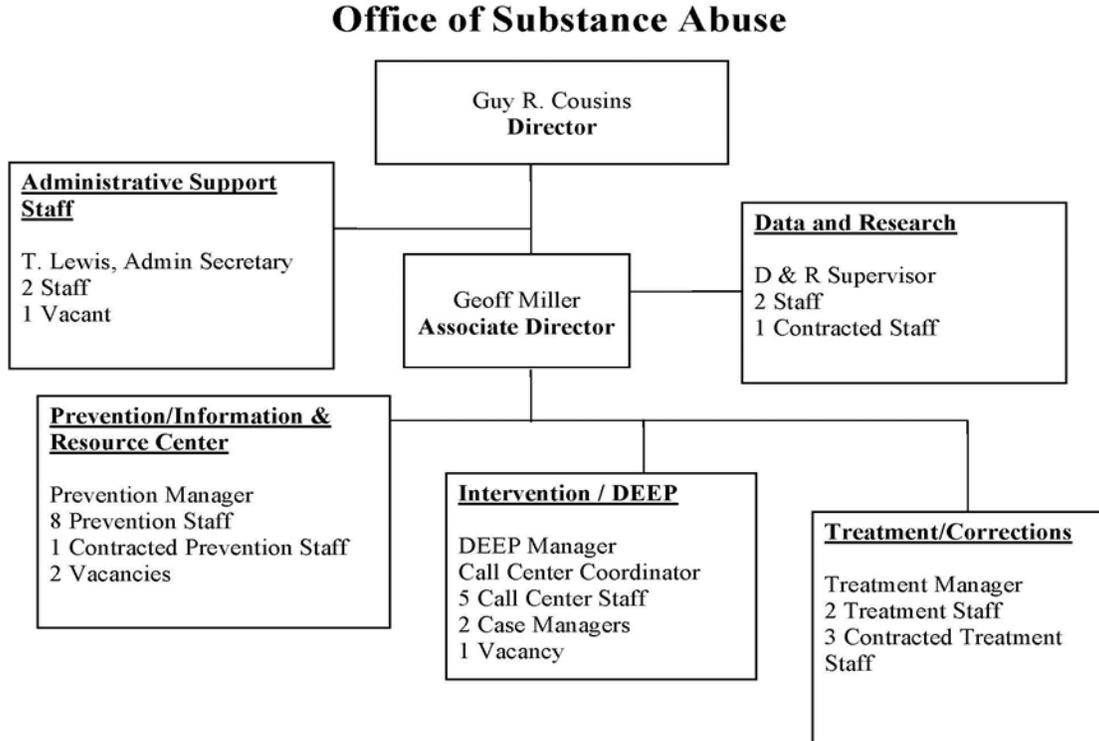
Strategic Plan Monitoring and Review

Benchmarks for the strategic plan will be set and monitored through one-year work plans created by Prevention Team members.

Prevention team staff, led by the Prevention Team Manager, will create one year work plans that will provide guidance to staff on strategies that will be focused on in order to work towards meeting the goals set in the plan. The plans will be reviewed monthly to track progress towards objectives for the year. Work plans will be updated yearly based on data and the latest research available. The Prevention Team will review and revise the strategic plan every five years.

Appendix A

Office of Substance Abuse Organization Chart



Appendix B

Acronyms and Definitions

Acronyms

- BHS: Bureau of Highway Safety
- BRFSS: Behavior and Risk Factor Surveillance System
- C4CY: Communities for Children and Youth
- CDC: Centers for Disease Control and Prevention
- CESN: Community Epidemiology Surveillance Network
- CSAP: Center for Substance Abuse Prevention
- CSHP: Coordinated School Health Program
- CSHE: Coordinated School Health Education
- DCC: District Coordinating Council
- DDR: Drug Demand Reduction program (National Guard)
- DFC: Drug Free Communities
- DHHS: Department of Health and Human Services
- DOE: Department of Education
- DOL: Department of Labor
- EUDL: Enforcing the Underage Drinking Laws
- GLESN: Gay, Lesbian and Straight Education Network
- HMP: Healthy Maine Partnership
- HEAPP: Higher Education Alcohol Prevention Partnership
- IRC: Information Resource Center, Office of Substance Abuse
- JJAG: Juvenile Justice Advisory Group
- JMG: Jobs for Maine Graduates
- MAPSA: Maine Alliance to Prevent Substance Abuse
- MASAP: Maine Association of Substance Abuse Programs
- MCDC: Maine Center for Disease Control and Prevention
- MOU: Memorandum of Understanding
- MYAN: Maine Youth Action Network
- MYDAUS: Maine Youth Drug and Alcohol Use Survey
- MIYHS: Maine Integrated Youth Health Survey
- NCCC: National Center for Cultural Competency
- NE CAPT: North East Center for Application of Prevention Technologies
- NREPP: National Registry of Evidence Based Programs and Practices
- NE RET: Northeast Regional Expert Team
- OAS: Office of Applied Studies
- OJJDP: Office of Juvenile Justice and Delinquency Prevention
- OSA: Office of Substance Abuse

- ONDCP: Office of National Drug Control Policy
- RBS Training: Responsible Beverage Server/Seller Training
- RSPM: Restorative School Practices of Maine
- SAMHSA: Substance Abuse and Mental Health Services Administration
- SBHC: School Based Health Center
- SCC: State Coordinating Council
- SETU: Staff Education Training Unit
- SIRP: Student Intervention and Reintegration Program
- SPF SIG: Strategic Prevention Framework State Incentive Grant
- SYVC: Shared Youth Vision Council
- UDETF: Underage Drinking Enforcement Task Force
- YEPP: Youth Empowerment Policy Project
- YRBSS: Youth Risk Behavior Surveillance System

Definitions

Behavioral Health (broader than mental health): The term “behavioral health” is used in this document as a general term to encompass the promotion of emotional health; the prevention of mental illnesses and substance use disorders; and treatments and services for substance abuse, addiction, substance use disorders, mental illnesses, and/or mental disorders.

http://www.samhsa.gov/about/sidocs/SAMHSA_SI_paper.pdf

Cultural Competence: Cultural competence is the capacity to work effectively with people from a variety of ethnic, cultural, political, economic, and religious backgrounds. It is being aware and respectful of the values, beliefs, traditions, customs, and parenting styles of those we serve, while understanding that there is often as wide a range of differences within groups (e.g., Native Americans) as between them. It is being aware of how our own culture influences how we view others. Cultural competency is about developing skills. This includes improving your ability to control or change your own false beliefs, assumptions, and stereotypes; to think flexibly; to find sources of information about those who are different from you; and to recognize that your own thinking is not the only way. (Reference pending.)

- o (2nd definition option) Understanding and appreciating the differences in individuals, families, and communities, which can include: thoughts, speech, actions, customary beliefs, social forms and material traits of a racial, religious or social group. It also affects age, national origin, gender, sexual orientation or physical disability.

<http://systemsofcare.samhsa.gov/ResourceGuide/glossary.html>

Emerging Practices: Emerging Practices includes practices that practitioners have tried and feel are effective and new practices or programs that have not yet been researched. These include practices that are not based on research or theory and on which original data have not been collected, but for which anecdotal evidence and professional wisdom exists.

http://www.k8accesscenter.org/training_resources/researchapproach.asp

Evidence-based practice: From SAMHSA's Center For Substance Abuse Prevention evidence-based interventions are defined in the SPF SIG Program by inclusion in one or more of the three categories: Included in Federal registries of evidence-based interventions; reported (with positive effects on the primary targeted outcome); in peer-reviewed journals; or documented effectiveness supported by other sources of information and the consensus judgment of informed experts. <http://prevention.samhsa.gov/>

Fidelity: Fidelity refers to adherence to the key elements of an evidence-based practice shown to be critical to achieving the positive results found in a controlled trial. Studies indicate that the quality of implementation strongly influences outcomes.
<http://systemsofcare.samhsa.gov/ResourceGuide/glossary.html>

Institute of Medicine: Categories for Strategies and Interventions: The three categories are widely used to classify target populations, intervention strategies, and specific interventions.
http://www.ca-cpi.org/Document_Archives/IOMArticle3-14-07fs.pdf

1. Universal preventive interventions: Addresses general public or a segment of the entire population with average probability of developing a disorder, risk, or condition.
2. Selective preventive interventions: Serves specific sub-populations whose risk of a disorder is significantly higher than average, either imminently or over a lifetime.
3. Indicated preventive interventions: Addresses identified individuals who have minimal but detectable signs or symptoms suggesting a disorder.

Intervention: Intervention refers to a spectrum of responses to reduce or ameliorate the problem behaviors under consideration. Among the least intrusive but often effective interventions are conversations between an adolescent and a concerned parent, teacher, physician, or friend. More formalized interventions include prevention programs (aimed at preventing drug use onset), early intervention programs (aimed at intervening before the substance use becomes problematic), and intensive treatment programs (typically directed at stopping current use and maintaining abstinence).
<http://www.ncbi.nlm.nih.gov/bookshelf/br.fcgi?book=hssamhsatip&part=A55129>

Prevention: Prevention means the use of methods or activities that seek to reduce or deter specific or predictable problems, protect the current state of well-being, or promote desired outcomes or behaviors.
<http://www.childwelfare.gov/preventing/overview/whatisap.cfm>

- o (2nd definition option) Prevention is the active, assertive process of creating conditions that promote well-being. www.maineeshp.com/aboutus.html

Promising Practice: These practices have been tested but the results are not as clear as those results in the evidenced-based research category above. Practices that fall in this category are based on some type of research – whether it is theoretical, qualitative, or quantitative – but data have yet to be collected on effectiveness. Promising practices may have been tested under different conditions and, therefore, may have a research foundation. However, the practices themselves have not been tested using the most rigorous research designs, or were tested in

different educational contexts.

http://www.k8accesscenter.org/training_resources/researchapproach.asp

- o (2nd definition option) Promising Programs have the appropriate components for successful prevention, but have not yet been supported by rigorous evaluations. They are made up of strategies that have been found effective in previous research.
<http://www.unf.edu/dept/fie/sdfs/strategies/>
- o (3rd definition option) Clinical practices for which there is considerable evidence or expert consensus and which show promise in improving client outcomes, but which are not yet proven by the highest or strongest scientific evidence.
<http://systemsofcare.samhsa.gov/ResourceGuide/glossary.html>

Restorative Justice: Restorative justice is a new way of looking at criminal justice that focuses on repairing the harm done by people and relationships rather than on punishing offenders. Restorative justice includes communities of care as well; with victims' and offenders' families and friends participating in collaborative processes called "conference" or "circles."
McCold, P. & Wachtel, T. (2003). In Pursuit of Paradigm: A Theory of Restorative Justice; International Institute For Restorative Practices.

Safe and Drug Free Schools: The Safe and Drug Free Schools funding is used to prevent violence in and around schools and to strengthen programs that prevent the illegal use of alcohol, tobacco and other drugs. <http://www.maine.gov/dhhs/osa/sdfsca/about.html>

Substance Abuse Prevention: OSA's approach to substance abuse prevention uses research-based concepts, tools, skills, and strategies which reduce the risk of alcohol and other drug related problems. Substance abuse prevention means keeping the many problems related to the use and abuse of these substances from occurring.
<http://www.maine.gov/dhhs/osa/pubs/prev/2004/preventionplan1004.doc>

Sustainability: Sustainability refers to the process through which a prevention system becomes a norm and is integrated into ongoing operations, ensuring that prevention values and processes are firmly established, that partnerships are strengthened, and that financial and other resources are secured over the long term
<http://prevention.samhsa.gov/sustainability/default.aspx>

Violence Prevention: Violence Prevention is an effort to reduce risk factors and promote protective factors in relation to violence. It addresses all levels that influence violence: the individual, the relationship, the community, and society. Violence Prevention also promotes awareness about violence and helps to foster the commitment to social change.
<http://www.cdc.gov/ncipc/dvp/YVP/YVP-prvt-strat.htm>

Youth (Positive) Development: Positive Youth Development (PYD) is a comprehensive way of thinking about the development of children and youth and the factors that facilitate or impede their individual growth and their achievement of key developmental states. The concepts of

PYD suggest that most young people can develop and flourish if they are connected to the right mix of social resources. The PYD perspective recognizes that some youth grow up in circumstances that do not equip them for the transition from childhood to adulthood. It also recognizes that some youth behave in ways that cause serious problems for themselves and their communities. Jeff Butts, Chapin Hall Center for Children: Issue Brief #105

- o (2nd definition option): Positive youth development (PYD) is a comprehensive framework outlining the supports young people need in order to be successful. PYD emphasizes the importance of focusing on youths' strengths instead of their risk factors to ensure that all youth grow up to become contributing adults.

<http://www.ncsl.org/?tabid=16375>

Youth Engagement: Youth Engagement is the meaningful participation and sustained involvement of a young person in an activity with a focus outside of him or herself; specifically on the growth and well-being of other youth. www.engagementcentre.ca/

Appendix C

Principles of Effectiveness

In 1998, the United States Department of Education adopted the Principles of Effectiveness and expanded their list in 2002. These principles identify a scientifically defensible process for selecting and implementing a science based prevention program.

IN GENERAL – For a program or activity to meet the Principles of Effectiveness, such program or activity shall:

- (1) Be based on an assessment of objective data regarding the incidence of violence and illegal drug use in the elementary schools and secondary schools and communities to be served, including an objective analysis of the current conditions and consequences regarding violence and illegal drug use, including delinquency and serious discipline problems, among students who attend such schools (including private school students who participate in the drug and violence prevention program) that is based on ongoing local assessment or evaluation activities;
- (2) Be based on an established set of performance measures aimed at ensuring that the elementary schools and secondary schools and communities to be served by the program have a safe, orderly, and drug free learning environment;
- (3) Be based on scientifically based research that provides evidence that the program or strategy to be used will reduce violence and illegal drug use;
- (4) Be based on an analysis of the data reasonably available at the time, of the prevalence of risk factors, including high or increasing rates of reported cases of child abuse and domestic violence; protective factors, buffers, assets; or other variables in schools and communities in the State identified through scientifically based research;
- (5) Include meaningful and ongoing consultation with and input from parents in the development of the application and administration of the program or activity; and
- (6) Undergo a periodic evaluation to assess its progress toward reducing violence and illegal drug use in schools to be served based on performance measures. Use of results: The results shall be used to refine, improve, and strengthen the program, and to refine the performance measures, and shall also be made available to the public upon request, with public notice of such availability provided.

Appendix D

Identifying and Selecting Evidence-based Interventions

Revised Guidance Document for the Strategic Prevention Framework State Incentive Grant Program

SPF Definitions of Evidence-based

The SPF SIG Program specifically requires implementation of evidence-based interventions. Evidence-based interventions are defined in the SPF SIG Program by inclusion in one or more of the three categories below:

- A.** Included in Federal registries of evidence-based interventions;
- B.** Reported (with positive effects on the primary targeted outcome) in peer-reviewed journals; or Identifying and Selecting Evidence-based Interventions ;
- C.** Documented effectiveness supported by other sources of information and the consensus judgment of informed experts (as specified in the Guidelines that follow).

Each of the three definitions helps identify interventions appropriate to targeted needs and each has its own advantages and challenges. Prevention planners and practitioners must be prepared to consider the relative adequacy of evidence when deciding to select a particular prevention intervention to include in their comprehensive community plan.

A. Using Federal Registries

Federal registries are readily accessible and easy-to-use public resources for identifying interventions that reduce substance use risk factors and consequences or increase protective factors thought to be associated with reduced potential for substance abuse. Many registries use predetermined criteria and a formalized rating process to assess the effectiveness of interventions reviewed. Some registries apply quality scores to the intervention. These quality scores are indications of the strength of evidence according to the ratings applied. Thus, inclusion of an intervention in a registry can be viewed as providing some evidence of effectiveness. However, the level of evidence required by registries varies considerably. When choosing among interventions that have been reviewed by registries, we generally recommend selecting the one with the highest average score, provided that it demonstrates positive effects on the outcomes targeted for the population identified. Ultimately, while selecting interventions from registries may seem easier in some respects, it still requires planners and practitioners to think critically and make reasoned judgments about intervention selection, taking into account the degree of congruence with the particular cultural context and local circumstances.

Advantages

Federal Registries—

Provide concise descriptions of the interventions.

Provide documented ratings of the strength of evidence measured against defined and accepted standards for scientific research.

Present a variety of practical information, formatted and categorized for easy access and potentially useful to implementers.

Offer “one-stop” convenience for those seeking quick information on the interventions included.

Challenges

Federal Registries—

Include a limited number of interventions depending on how they are selected.

Include interventions most easily evaluated using traditional scientific methods. Consequently, registries include predominantly school- and family-based interventions and relatively few community, environmental, or policy interventions.

May be confusing to consumers seeking to compare the relative strength of evidence for similar programs included on different registries since the criteria and rating procedures may vary from one registry to another.

Federal registries include:

SAMHSA National Registry of Evidence based Programs and Practices (NREPP)

<http://www.nrepp.samhsa.gov> Provides descriptions of and rates evidence for various interventions related to substance use and abuse and mental health problems.

OJJDP Model Programs Guide http://www.dsgonline.com/mpg2.5/mpg_index.htm

Provides descriptions of and rates evidence for youth-oriented interventions, many of which are relevant to the prevention of substance use and abuse.

Exemplary and Promising Safe, Disciplined and Drug-Free Schools Programs Sponsored by the U.S. Department of Education

<http://www.ed.gov/admins/lead/safety/exemplary01/exemplary01.pdf> Provides descriptions of and rates evidence for educational programs related to substance use.

Guide to Clinical Preventive Services Sponsored by the Agency for Healthcare Research and Quality [AHRQ] <http://www.ahrq.gov/clinic/cps3dix.htm>

Provides recommendations regarding screening and counseling in clinical settings to prevent the use of tobacco, alcohol, and other substances.

Guide to Community Preventive Services Sponsored by the Centers for Disease Control and Prevention [CDC] <http://www.thecommunityguide.org> Provides recommendations regarding generic programs and policies to prevent and reduce tobacco use and alcohol-impaired driving.

A list of other registries may be found at SAMHSA'S website:
<http://www.samhsa.gov/ebpWebguide/appendixB.asp>.

B. Using Peer-Reviewed Journals

The research literature constitutes another primary resource for identifying evidence-based prevention interventions, including those not listed in Federal registries. When the literature is used to determine strength of evidence, all articles relevant to the specific intervention should be considered. In other words, it is not sufficient to garner support for an intervention from a single document selected from a larger body of work. We recommend careful review of all documents that have been published on a particular intervention to ensure that the outcomes reported comprise a consistent pattern of positive effects on the target outcomes.

Unfortunately, using the primary literature is not easy and can be very time-consuming and resource-intensive, particularly for practitioners without ready access to university libraries or electronic copies of journal articles. Additionally, a healthy degree of skepticism and considerable technical expertise is required to review articles and interpret results, as the quality of the study reported depends on many factors such as the conceptual model or theory on which the intervention is based, the measurement and design strategies used to evaluate it, and the findings that are presented.

Assessing Elements of Evidence Reported in Peer-Reviewed Journals

Listed below are key elements addressed in most peer-reviewed journal articles, along with some questions to consider.

A defined conceptual model that includes definitions and measures of intermediate and long-term outcomes. Does the article describe the theory or provide a conceptual model of the intervention and link the theory or model to expectations about the way the program should work? Does the article describe the connection of the theory or the conceptual model to the intervention approach, activities, and expected outcomes in sufficient detail to guide your decision?

Background on the intervention evaluated. How closely does the problem targeted by the intervention match the identified needs of your community? Does the article adequately describe the proposed mechanism of change of the intervention? Are the structure and content of the intervention described in enough detail? Is the context or setting of the intervention described to an extent that allows you to make an informed decision concerning how well it might work in the communities targeted?

A well-described study population that includes baseline or "pre-intervention" measurement of the study population and comparison or control groups included in the

study. Does the article describe in detail the characteristics of the study population and the comparison or control groups used? How well does the study population match your local target group?

Overall quality of study design and data collection methods. Does the article describe how the study design rules out competing explanations for the findings? Are issues related to missing data and attrition addressed and satisfactorily resolved? Did the study methodology use a combination of strategies to measure the same outcome using different sources (e.g., child, parent, teacher, archival)?

Analytical plan and presentation of the findings. Does the article specify how the analytical plan addresses the main questions posed in the study? Do the analyses take into account the key characteristics of the study's methodology? Does the article report and clearly describe findings and outcomes? Are the findings consistent with the theory or conceptual model and the study's hypotheses? Are findings reported for all outcomes specified?

A summary and discussion of the findings. Does the discussion draw inferences and conclusions that are clearly related to the data and findings reported?

Advantages

Peer-Reviewed Journals—

Typically present detailed findings and analyses that document whether or not the program, practice, or policy has an adequate level of evidence that the intervention works.

Provide authors' contact information that facilitates further discussion about the appropriateness of the intervention to the target need.

In some cases, report and summarize meta-analyses and other types of complex analyses (e.g., core components) that examine effectiveness across interventions or intervention components. These types of analyses are potentially very useful to prevention planners.

Challenges

Peer-Reviewed Journals—

Leave it to the reader to interpret results and assess the strength of the evidence presented and its relevance and applicability to a particular population, culture, or community context.

Describe in limited detail the activities and practical implementation issues pertinent to the use of the intervention.

C. Using Other Sources for Documenting Effectiveness

When no existing evidence based interventions are available in registries or the research literature to address the problem, then empirical support for other interventions may be found in unpublished reports (e.g., doctoral theses) or published, non-peer-reviewed sources (e.g., book chapters, evaluation reports, and Federal reviews). We recommend caution when relying on these other sources of support because they usually have not been subjected to the methodological scrutiny provided by registries and peer-reviewed journals. Ultimately, the “burden of proof” for documented effectiveness lies with the program planners and practitioners making the selection decision.

Under what conditions is it appropriate to select an intervention that is not included in an established Federal list of evidence-based programs or reported with positive effects in the peer-reviewed journal literature? When no appropriate interventions are available through these primary resources on evidence based interventions, then prevention planners may need to rely on other, weaker sources of information to identify an intervention that is appropriate for the assessed community need, the population served, and the cultural and community context in which it will be implemented.

When selecting interventions based on other sources of supporting information, ***all four of the following guidelines should be met:***

Guideline 1: The intervention is based on a theory of change that is documented in a clear logic or conceptual model;

Guideline 2: The intervention is similar in content and structure to interventions that appear in registries and/or the peer-reviewed literature;

Guideline 3: The intervention is supported by documentation that it has been effectively implemented in the past, and multiple times, in a manner attentive to scientific standards of evidence and with results that show a consistent pattern of credible and positive effects; and

Guideline 4: The intervention is reviewed and deemed appropriate by a panel of informed prevention experts that includes: well-qualified prevention researchers who are experienced in evaluating prevention interventions similar to those under review, local prevention practitioners, and key community leaders as appropriate (e.g., officials from law enforcement and education sectors or elders within indigenous cultures).

These guidelines are intended to assist prevention planners by expanding the array of interventions available to them. In a comprehensive prevention plan, these interventions should be considered supplements, not replacements, for traditional scientific standards used in Federal registry systems or peer-reviewed journals.

Advantages

Other Sources for Documenting Effectiveness —

Enable State and community planners to consider interventions that do not currently appear on a Federal list or in the peer-reviewed literature but which have the potential to address the problem targeted.

Provide opportunities for State and community planners to use locally developed or adapted interventions, provided they are supported by adequate documentation of effectiveness.

Challenges

Other Sources for Documenting Effectiveness —

Place substantial responsibility on prevention planners and practitioners for intervention selection decisions.

Require prevention planners and practitioners to develop and implement decision-making and documentation processes.

Require prevention planners and practitioners to assemble additional documentation and assess its adequacy to support using a particular intervention as part of the larger comprehensive community prevention plan.

Appendix E

Stakeholders

Survey Monkey Survey:
August 2, 2010 – 46 Responses.

Facilitated Focus Group discussion, August 23, 2010:

Ronni Katz
Joanne Joy
Dalene Dutton
Shawn Yardley
Rene Page

Facilitated Planning Days with state-level stakeholders, August 24-25, 2010:

Jo McCaslin	OSA - Prevention Manager
Anne Rogers	OSA - Prevention Team
Jacinda Goodwin	OSA - Prevention Team
Cheryl Cichowski	OSA - Prevention Team
Maryann Harakall	OSA - Prevention Team
Peter Brough	OSA - Prevention Team
Leanne Morin	OSA - Prevention Team
Melissa Boyd	MAPSA
Frank Lyons	UDETf rep
Kathryn McGloin	DOC
Susan Berry	DOE/SAVPS
Claudia Bepko	Adult Mental Health
Claire Harrison	Adult Mental Health
Sarah Goan	HZA
Becky Ireland	HEAPP/SASC
Melanie Lanctot	OSA D&R
Jeff Austin	Liquor Licensing
Michelle Ross	MCDC/PTM

Appendix F

SWOT Analysis

Strengths

- **Strong leadership (7)**
- **Dedicated / committed staff (6)**
- **Data & research driven (5)**
- **Collaboration / systems thinking (5)**
- Media campaigns (4)
- Customer service / response (2)
- Training / evidence based practices/keeping up w/field (2)
- Committed to high quality (2)
- Thinking outside the box / thinking creatively (2)
- Staff diversity / Broad based knowledge (2)

Weaknesses/Challenges

- **Data collection –specific to law enforcement-consistent and sustainable-not always reliable (7)**
- **Relationships/integration w/other state agencies (7)**
- **Communicating and promoting who we are and what we do (6)**
- **Lack OSA presence in many DHHS initiatives / functions due to lack of staff / lack of presence in regional offices (4)**
- Sometimes acting in reactive mode instead of proactive / hard to prioritize(2)
- Working w/legislature, re-educating new legislators (2)
- Too specific unreliable data collection / data gaps (2)

Opportunities

- **Legislature / new elections (13)**
- **To work with other programs (10)**
- **Behavioral health: Partnership and blending of substance abuse & mental health / MeHAF (6)**
- **Building /improving infrastructure & workforce (6)**
- **Relationships: Building relationships (w/MDEA, Congressional, organizations and initiatives) (4)**
- Promote OSA's mission & accomplishments (2)
- Community partners (2)
- Broader depth of understanding of OSA programs (1)
- Health care reform and SBIRT potential funding / Health homes and primary care (2)

Threats

- **Laws & policies that work against (weaken) prevention (11)**
- **Lack of stable funding & workforce (10)**
- **Social norms & media promote use / abuse (medical marijuana/alcohol) (7)**
- **Legislature / new election /political change(6)**
- Federal funding bypassing state to communities-the formula hurts state overall and creates a lack of coordination because no connection (3)
- Keeping substance abuse prevention a priority in light of national priority changes/ culture of substance abuse into behavioral health. (3)
- Apathy (2)

Appendix G

State Prevention Enhancement Assessment of Coordination of Services

Contents

- I. Introduction
- II. Assessment of Coordination of Services for Substance Abuse Prevention
- III. Summary of Coordination of Services

Attachment 1: OSA Prevention Advisory Board Members

Introduction

The Maine Office of Substance Abuse (OSA) is the single state administrative authority responsible for the planning, development, implementation, regulation, and evaluation of substance abuse services. OSA is an office within the Department of Health and Human Services (DHHS), and provides leadership in substance abuse prevention, intervention, and treatment. ***OSA's goal is to enhance the health and safety of Maine citizens through the reduction of the overall impact of substance use, abuse, and dependency.*** Since 2006, coordination of substance abuse prevention services and resources has taken place at OSA, and at state, regional and local levels within Maine's emerging public health infrastructure.

This document describes the coordination of substance abuse prevention services currently taking place in Maine as of July 2012. In accordance with the Institute of Medicine's 2009 *Preventing Mental, Emotional and Behavioral Disorders Among Young People: Progress and Possibilities*, in the coming five years OSA seeks to align prevention efforts across the developmental stages and across the lifespan. Further, OSA seeks to integrate all behavioral health prevention initiatives. This will entail conducting research into evidence-based interventions and building relationships in order to integrate OSA prevention efforts with other health promotion, wellness and prevention efforts throughout the state.

Specific definitions and acronyms used in this report are in Appendix B of the Strategic Prevention Plan 2013-2018.

I. Assessment of Coordination of Services for Substance Abuse Prevention

This assessment describes the current status of the coordination of services in Maine and identifies gaps, challenges and items to consider in developing a strategic plan.

Current Coordination of Services within OSA

OSA's current prevention work builds on the planning and capacity building process that began in 2004 and was funded through a Strategic Prevention Framework State Incentive Grant (SPF SIG). That process allowed for the creation and support of a statewide prevention/health promotion infrastructure that remains in place after SPF SIG funding ended in 2010. The public health infrastructure includes other health topics such as tobacco, healthy weight, physical activity, nutrition, and cardiovascular disease. These topics are funded by other sources outside of OSA.

OSA also organized the Community Epidemiology Surveillance Network (CESN) in 2006. CESN is a multi-agency work group, which studies the spread, growth and development of drug abuse in Maine and its communities. Network members contribute information they routinely collect. Also, qualitative data is collected from a variety of key informants to identify emerging trends. CESN meets twice a year to assess information from the multiple sources comprising the network and to draw conclusions about drug abuse.

Although CESN provides data for the entire office, the OSA Prevention Team utilizes the data to prioritize prevention service needs and then seeks opportunities to implement identified needs. The Team creates goals, objectives and activities based on data and evidence-based strategies. The assessment process for 2011 prevention planning identified two priorities for prevention. OSA's prevention efforts will address the specific characteristics and needs of these populations:

1. Underage youth: alcohol use, marijuana use, prescription drug misuse and inhalant abuse.
2. 18-25 year old: binge/high risk alcohol use, prescription drug misuse, and marijuana use.

OSA will concentrate prevention efforts on environmental strategies statewide, primarily through grants to Healthy Maine Partnerships (HMPS) and local Underage Drinking Task Forces, and with limited funds going to curriculum based prevention services. Prevention targets are community settings for universal, selective and indicated interventions, including hard-to-reach communities and communities that have been slow to take up implementation of prevention strategies. Because the current level of resources for individual prevention strategies is limited, prevention targets in this realm will be limited. Limited funds are also available for evidence-based prevention strategies in schools and local social service agencies.

Funding streams for OSA prevention work currently include:

- The State of Maine General Fund,
- The Fund for Healthy Maine,
- SAMHSA's Substance Abuse Prevention and Treatment Block Grant,
- Strategic Planning Enhancement grant
- The State Epidemiological Outcomes Workgroup grant, and
- The Office of Juvenile Justice and Delinquency Prevention, Enforcing Underage Drinking Laws Block Grant and Discretionary Grant.

Strengths of Current Coordination of Services within OSA

Each Prevention Team member has different responsibilities (e.g., workplace, law enforcement, schools, health care, tribal, and media) and works together to meet prevention needs around the state. The Team has a range of experience and skills, and coordinates work well within OSA. The Team meets regularly to ensure that programming and funding are coordinated and align with the OSA Prevention Plan.

OSA Managers for the Prevention, Intervention, Treatment, and Data programs meet regularly to ensure that programming and funding are coordinated and align with the overall OSA and DHHS plans. For example, when considering a block grant application, the managers conduct a mini assessment, capacity, and planning exercise in order to align needs with resources available through the block grant.

Challenges of Current Coordination of Services within OSA

While OSA Prevention Team members have a mix of experience and skills, they do not have the same basic education and training in prevention (e.g., Certified Prevention Specialist training). Additional training and expertise are needed in the areas of marijuana and prescription drug abuse prevention; prevention strategies to address emerging issues (e.g., bath salts); and linking substance abuse prevention strategies with mental health prevention strategies.

Current Coordination of Services with Other State Agencies

Maine has made significant progress in aligning the current substance abuse prevention infrastructure with that of other state agencies, most notably the three state agencies with a significant prevention presence: OSA within DHHS, the Maine Centers for Disease Control (MCDC) within another arm of DHHS, and the Maine Department of Education (DOE) which in partnership with MCDC oversees the Coordinated School Health program that has been operationalized through the HMP initiative. The infrastructure is further aligned through Maine's nine Public Health Districts and its statewide system of comprehensive community health coalitions, the 27 Healthy Maine Partnerships.

Since 2006, the primary way these three agencies have coordinated prevention services is through "braided" funding and the issuance of integrated Requests for Proposals (RFPs) to the HMPs. There is potential for cost savings when one HMP can accept and administer multiple funding sources, conduct several types of prevention services, and staff multiple programs. This is the same concept that guides the Coordinated School Health program, which is designed to

address multiple programmatic areas including physical activity, nutrition, tobacco use and alcohol use.

The Prevention Team has a strong partnership with the Department of Corrections and the Department of Public Safety, as well as local law enforcement agencies statewide, to work on the Enforcing Underage Drinking Laws grant from the Office of Juvenile Justice and Delinquency Prevention. OSA is currently working on a statewide strategic plan with partners as a result of a three-year discretionary award. This planning process and resulting implementation steps will strengthen these partnerships and build new ones. Part of this planning process is identifying ways to increase OSA's collaboration with Maine's judicial system.

OSA has been the administrator of the US DOE's Safe and Drug-Free Schools and Communities Act funding since its inception, and this has provided opportunities for collaboration with Maine DOE. In 2011, OSA and Maine DOE administered the Building State Capacities grant, which brought together state partners to plan future support of substance abuse and violence prevention in schools. OSA also has a strong working relationship with the Coordinated School Health Program, and has integrated work on substance abuse prevention and policy in schools into HMP work plans. Though the US DOE's Safe and Drug-Free Schools funding has ended, OSA will continue to seek opportunities with its partners in Maine DOE and other departments to find future funding for prevention services within schools.

The Maine Suicide Prevention Program is a collaborative initiative among several state agencies. OSA serves as the clearinghouse for this program's materials. The Maine Suicide Prevention Program is represented on OSA's Advisory Board to coordinate services and initiatives to ensure substance abuse prevention; intervention, treatment and recovery services are integrated when appropriate.

The Office of Substance Abuse and the Office of Adult Mental Health Services are starting an integration process. The process is in its very beginning stages with management staff just starting discussions on how to proceed. This pending integration will have an impact on all services provided by OSA and OAMHS; however the founding principles of our work will remain and will help guide and build the new structure. These principles include using data to drive decision-making; use of evidence-based strategies and programs; use of performance-based contracts with measurable outcomes; continuous evaluation; and use of process improvement to improve systems and services.

Collaboration and coordination among sectors of substance abuse prevention services at the state level occurs primarily through the Prevention Advisory Board (Attachment 1 provides a list of members). When SPF-SIG funding was available, the Advisory Board was actively engaged in the planning process and was able to build coordination capacity at the state level, and this role is valued and will continue.

Examples of coordination of services at the state level include:

- *The Community Epidemiology Surveillance Network*. CESN serves as Maine's State Epidemiological Outcomes Workgroup (SEOW) and is a multi-agency work group that

studies the spread, growth and development of substance use in Maine and its communities. The CESN/SEOW meets bi-annually to assess information from the multiple sources comprising the network, draws conclusions about drug abuse and provides updated trend reports twice a year.

- *Coordinated data collection.* OSA, MCDC and DOE together fund the administration and data analysis of the common statewide school survey, the Maine Integrated Youth Health Survey. Localized program data are collected at the community level through the utilization of the web-based KIT Performance Based Prevention System.
- *Teen Driver Safety Committee.* OSA serves on the committee with other state agencies to implement teen driver safety initiatives. One initiative is working with the Bureau of Highway Safety (BHS), Department of Public Safety, to conduct Teen Driver Awareness trainings. This is a training conducted by BHS, and because the two agencies have been working together on other public safety projects, BHS has requested OSA to provide a presentation on underage drinking at those trainings. This expands OSA connections and effectiveness statewide through new trainees. Similarly, through this partnership with BHS, OSA is forming connections with the Maine State Police and other law enforcement agencies in the state.
- *Fetal Alcohol Spectrum Disorder Coordinator.* The DHHS Office of Child and Family Services has contracted with OSA to provide a Fetal Alcohol Spectrum Disorder state system coordinator. The \$275,972 contract will pay for office space and supervision of the coordinator at OSA for four years, ending in 2015.
- *Worksite wellness.* MCDC and individual HMPs look to OSA for substance abuse prevention strategies to incorporate into worksite wellness programs such as Healthy Maine Works and community wellness initiatives such as Keep Me Well. Additionally, OSA is working with the Maine Department of Labor (DOL) to develop tools such as an online drug testing policy builder for employers and provide technical assistance that help employers implement comprehensive Drug-Free Workplace Programs. OSA also works with DOL and employers on Healthy Maine Works and Work Alert.
- *Professional development.* OSA and its state agency partners regularly participate in professional development opportunities. Through the Staff Education Training Unit (SETU), OSA is also able to offer a variety of substance abuse trainings needed at the state level at little to no cost.
- *Working with Youth.* OSA and MCDC contract with the Maine Youth Action Network (MYAN) to integrate youth involvement into substance abuse prevention strategies. MYAN provides trainings statewide for youth and adults as well as hosts a statewide conference each fall.
- *Shared Youth Vision Council.* This group serves as the Children's Cabinet's advisory collaborative-stakeholder body, through which program efficiencies, improvements, coordination, communication, and collaboration among youth-serving agencies and providers at the state, regional, and local levels are examined. OSA participates in the Shared Youth Vision Council and in the planning of the Positive Youth Development Institute where OSA is able to offer substance abuse prevention training to a variety of youth, local, and state level stakeholders.
- *Juvenile Justice Advisory Group.* OSA serves on the Maine Juvenile Justice Advisory Group (JJAG) that oversees the state's participation in the federal juvenile justice

initiative. The purpose of the initiative is to help states craft effective responses to the problems of juvenile crime and violence. As part of this initiative, Maine receives funds to improve its juvenile justice system, which JJAG oversees and disburses.

OSA also coordinates prevention efforts with the Office of Child and Family Services (child abuse prevention and neglect) and the Office of Elder Services (long term care programs and protective services).

The following represents a list of statewide initiatives that have missions which align with substance abuse and violence prevention in schools. Many are active in schools and communities across the state:

- *Communities for Children and Youth (C4CY)*. This initiative of the Governor's Children's Cabinet aims to measurably improve the well-being of children in every Maine community and to increase educational attainment and achievement levels of all Maine children. This has occurred by supporting 72 communities over the past twelve years. C4CY currently works with fifteen communities and supports three grant projects: Diversion to Assets, College-Community Mentoring Project and Assets Getting to Outcomes for Maine.
- *Gay, Lesbian & Straight Education Network (GLSEN)*. GLSEN is a national education organization making schools safer for all students, regardless of sexual orientation or gender identity/expression. There are two GLSEN chapters in Maine: Downeast GLSEN (based in Ellsworth) and GLSEN-Southern Maine (based in Portland). Members of both chapters consult with school staff and provide resources and support for over 50 Gay Straight Alliances in Maine's secondary schools.
- *Jobs for Maine Graduates (JMG)* is a private, non-profit organization that provides drop-out prevention and school-to-work transition services for at-risk youth. The high school program is delivered as a for-credit course in conjunction with the student's regular course load. Project Reach is a project-oriented and adventure-based program designed to address the challenges of middle school. JMG also supports a number of other initiatives such as the Maine Mentoring Partnership; the Maine Municipal Literacy initiative; programs specifically for incarcerated youth; and Opportunity Passport, a financial literacy and matched savings program.
- *Keeping Maine's Children Connected* is an initiative of the Maine Children's Cabinet that takes an integrated approach to help children and youth who experience school disruption due to homelessness, foster care placement, correctional facility placement and/or in-patient psychiatric care. The intent is to simplify the transitions to and from school so that these children and youth can stay connected or re-connect to their educational program as soon as possible. It is a collaborative effort among the Departments of Corrections, Education, Labor, Justice, and Health and Human Services.
- *Maine After School Network* has as its purpose to enable every child to have access to quality, inclusive, affordable after school programming that meets the needs of the child, the family and the community. The network is a collaboration of individual and organizational partners across the state that works to foster communication among

policymakers and providers, assist in securing resources to develop and/or sustain programs, and assist with training and technical assistance.

- *Maine Coalition to End Domestic Violence* aims to create and encourage a social, political, and economic environment in which domestic violence no longer exists, and to ensure that all people affected by domestic abuse and violence are supported and that batterers are held accountable. The coalition mobilizes and coordinates community action through a statewide network of domestic violence projects.
- *Maine Families Home Visiting Program* is administered by the Early Childhood Division of the Maine DHHS and provides grants to community agencies which maintain local sites within each of Maine's sixteen counties. Through home-based appointments, home visitors help first-time parents and parents-to-be to access information and resources that can support the physical and emotional health of their baby and entire family.
- *Maine Mentoring Partnership* was established in 2001 by the Maine Children's Cabinet and is a statewide public-private partnership of mentoring program providers and supporters. Its primary role is to increase the number of formal mentoring relationships available to Maine's children and youth. The partnership came under the Jobs for Maine Graduates umbrella in 2006 and is a formal partner of Communities for Children and Youth.
- *Maine Youth Action Network (MYAN)*. The goal of MYAN is to empower and prepare youth and adults to partner for positive change by offering them training, networking and leadership opportunities. MYAN's work is grounded in the models and philosophies of positive youth development. Annual events include the Peer Leadership Conference.
- *Restorative School Practices Collaborative of Maine (RSPM)*. In 2006, the Restorative Justice Project of Midcoast Maine began to apply the principles and practices of restorative justice in the area of education, known as Restorative School Practices. In partnership with the University of Maine Peace & Reconciliation Studies Program and the Maine Law and Civics Education Program at University of Southern Maine, RJP formed RSPM, which is a coalition of trainers that assist and support Maine educators in understanding and implementing restorative practices, values and skills, including restorative discipline, in schools throughout Maine.
- *School-Based Health Centers (SBHC)* are administered by the Family Health Division of the Maine DHHS and provide grants to partnerships between a school and a medical provider/agency in order to keep students healthy and in school. Currently Maine funds seventeen SBHCs that have over 7,000 students enrolled. SBHCs provide primary and preventive health care with mental health and oral health services integrated into most of the centers. Students are seen in a youth-friendly environment by providers experienced in serving adolescents. They are assessed for health risks such as alcohol and tobacco use, physical activity, nutrition, unintentional injuries and intentional injuries. Treatment is provided or referrals are made to community providers, as appropriate. SBHC staff receive additional training in suicide prevention and dating violence and work with their schools in developing appropriate policies and providing support to school personnel, students and their families.
- *Youth Empowerment and Policy Project (YEPP)* is an active, diverse group of students from around the state of Maine trained in public speaking, facilitation, and policy issues.

YEPP was established in 2001 with the primary goal of involving Maine's youth in the effort to decrease underage drinking. The philosophy of the project is that, because underage drinking is a problem affecting the youth population, the most effective way to analyze and improve the environment is to involve youth directly in the discussion. YEPP is coordinated by AdCare Educational Institute of Maine, Inc., a private, non-profit organization based in Augusta.

Strengths of Coordination of Services with Other State Agencies

Braiding of funds has created important administrative efficiencies at the local and state levels. Since there is one contract that includes multiple funding streams and deliverables with each HMP, less state agency staff time is necessary to draft and monitor the contracts. This approach also makes possible the use of other (non-OSA) funds in the contract to leverage staffing positions that cover multiple services/activities. OSA has been able to leverage more focused strategies and activities, and the result is that prevention services are consistent across the state and are strategically aligned. In addition, OSA funds are available through RFP on a non-competitive basis; and HMPs are more willing to work together on substance abuse prevention strategies and activities because they are no longer competing for these funds.

The Advisory Board has been re-activated to guide the SPE planning process. The upcoming merging of OSA and the Office of Adult Mental Health Services presents opportunities to follow federal level examples of efficiencies to address simultaneously the interrelation of mental health and substance abuse, and to prevent their negative consequences.

Challenges of Coordination of Services with Other State Agencies

The mechanism for braiding funds is evolving, and improvements continue to be made. Because there is one contract for all the programs, contract monitoring has been spread among all the participating programs. Coordination of this many entities can be challenging.

The Advisory Board is still in the “forming” stage of group development. The Advisory Board is working to learn more about what each of the diverse members brings to the table as well as identifying and recruiting new members. Members are also not currently focused on addressing behavioral health prevention strategies. This is due primarily to lack of a common understanding of the definition of behavioral health prevention strategies, and how that definition affects each member’s work.

Capacity does not yet exist at the state level for coordinating substance abuse and mental health prevention services as “behavioral health prevention services.”

Coordination of Services with Other Partners

OSA also coordinates with, and builds upon the strengths of, existing healthcare and education systems, non-profit organizations, and other regional and local entities.

Primary care providers (PCPs) engage in some primary substance abuse prevention, however there is little coordination of these services. Some PCPs work to raise awareness and provide

information to parents and teens about substance abuse (including information provided by OSA), and some PCPs conduct screenings (including the screening tool made available by OSA) and brief interventions (motivational interviewing). Many PCPs across the state are developing ways to integrate behavioral health and primary care services; however to date substance abuse prevention has not been a priority in integration initiatives.

HMPs have interfaced with health care providers (e.g., PCPs, emergency physicians, dentists) by providing information on high-risk drinking and prescription drug abuse, and by promoting the Prescription Monitoring Program.

The OSA prevention team has struggled to build meaningful relationships within the judicial system. For purposes of this document the judicial system is defined as the system of law courts that administer justice and constitute the judicial branch of government, including the juvenile community corrections officers. This also includes drug courts. There are pockets within the state where law enforcement agencies have forged effective relationships in reducing and effectively adjudicating underage drinking, but nothing has been formally developed at the state level.

Maine's Higher Education Alcohol Prevention Partnership (HEAPP), an OSA-funded project, has built relationships with the majority of Maine's colleges and universities over the past 11 years. HEAPP has increased capacity and readiness among institutions of higher education for evidence-based underage and high-risk drinking prevention and intervention strategies, as well as for effective prevention practices such as data-driven needs assessments, strategic planning, and project evaluation.

The National Guard has a significant prevention presence in Maine through its Drug Demand Reduction program (DDR). The Guard's Prevention Coordinator dedicates one day/week to work with OSA at the OSA offices and serves on the OSA Prevention Advisory Board. Recognizing that service members and their families live and work in Maine communities, the Maine Guard has recently launched an initiative to work collaboratively with coalitions in the state through the Guard's eleven Intel Analysts. Currently four of these Analysts dedicate one day/month to assist HMPs in ways the HMPs identify as helpful. The Guard's DDR program also provides evidence-based programs in middle schools (Stay on Track) throughout the state, and a ropes course that teaches life skills as a general prevention strategy. The Guard also trains its members in Team Readiness (an adaptation of Team Awareness), which includes modules on drug use, prevention and general coping skills.

OSA has over the past eighteen months worked to build a relationship with the five tribal communities in Maine. Recently, legislation was passed creating a ninth Public Health District, the Tribal Public Health District, which includes all five tribal communities and provides additional support to ongoing relationship building and work between state government and the tribes. OSA and the tribes are working together in a variety of ways: the Tribal Public Health District received PMP Promotion Project funds, the tribes are working to finalize the OSA-HMP work plan, and the OSA Advisory Board includes a tribal representative. OSA is often invited to

participate in quarterly Tribal Health Directors meetings and, as a result of this partnership, OSA has begun to work more with the Office of Minority Health.

Strengths of Coordination of Services with Other Partners

There is a growing awareness of the role health care and especially PCPs can play in preventing the onset of substance abuse, high risk drinking and prescription drug abuse. Initiatives throughout the state to integrate primary care and behavioral health services represent an opportunity to engage PCPs around substance abuse prevention. In addition, PCPs are interested in supporting their communities, which includes raising awareness and providing information and anticipatory guidance to parents about substance abuse.

OSA's new relationship with the tribes will create numerous opportunities to coordinate prevention services in tribal communities. Capacity now exists to develop policies and interventions that are tailored to the particular circumstances and interests of each tribe. The tribes have expressed an interest in expanding their partnerships as well, to align prevention services with the functions of the Indian Health Service.

OSA's growing relationship with the National Guard presents an opportunity for increased collaboration. The Guard's commitment to share resources and staff time is an important contribution to prevention at the state, regional and community levels.

OSA has a very strong relationship with the Maine Sheriffs' Association as well as the Maine Chiefs of Police Association. Both associations take underage drinking enforcement seriously and are committed to the cause. The Maine Sheriffs' Association is also contracted to conduct both the tobacco and alcohol compliance checks and is represented on the Underage Drinking Enforcement Task Force which strengthens the relationship with OSA.

Challenges of Coordination of Services with Other Partners

Health care providers have very little time to devote to substance abuse prevention. Substance abuse resources (staff time, trainings, and reimbursements for services) in the health care field are primarily devoted to secondary and tertiary prevention. OSA staff do not always know exactly what the PCPs need in order to contribute to the State's prevention efforts. In addition, PCPs do not always know where to refer patients with substance abuse issues, and therefore, do not always feel comfortable performing screenings and brief interventions.

The judicial system presents a myriad of challenges. The first is availability. The court system in Maine is overtaxed and often times cannot spare staff to represent the system on an advisory board. Second, it can be difficult to provide education to the district attorneys and judges about their role in prevention. The education provided needs to be short, succinct, and focused directly on the judicial members. Third, in order to collaborate with the judicial system in diverting young people with alcohol violations, diversion or alternative programs must be available statewide.

Cultural competency issues arise at the state level in working with the Native American population. There is a need for education and training in cultural competency in order to

increase awareness and understanding of the culture. Evidence-based programs are often not appropriate for tribal communities and those that are may not be impactful to the tribes here in Maine, because they were developed for tribes in the western U.S. At the state level, there is also a lack accurate data pertaining to tribal health, including data on substance abuse.

Coordination of Local Services with HMPs

OSA's works with and through HMPs to coordinate prevention services as follows:

- All HMP sub-recipients of OSA grant funds are required to utilize the SPF SIG process when selecting evidence-based strategies to be implemented.
- HMPs are engaged in statewide health planning processes that include substance abuse issues identified in their communities. OSA takes a prescriptive approach to prevention by identifying state priorities through data sources and supplying a menu of specific evidence-based strategies from which sub-recipients choose to meet their local needs. Communities are encouraged to perform their own assessments, develop their own local strategic plans and seek other resources to accomplish outcomes.
- OSA has developed an evidenced-based approval process that includes a panel of experts who convene when a program or strategy that is not supplied in OSA's matrix of evidence-based programs is proposed for implementation. The seven-member panel provides a consistent process to review and judge whether the strategy submitted meets the "evidence-based" definition per SAMHSA guidelines. When the proposed strategies do not meet SAMHSA guidelines the grantee is given an opportunity to justify the proposal through criteria established during the SPF SIG process. This document can be found for review at:
<http://www.maine.gov/dhhs/osa/prevention/community/spfsig/index.htm> .

Examples of OSA's prevention work through HMPs to coordinate services locally include:

- *Enforcing Underage Drinking Laws.* The Prevention Team provided funds from the US Department of Justice for Enforcing Underage Drinking Laws to the HMPs for continued work on responsible beverage server trainings, the Card ME program and compliance checks. These were the only strategies HMPs could implement with these funds, which created more depth and coordination of services statewide. This not only met the needs of the funder, but also met requirements from other funding sources that shared the same objectives.
- *The Prescription Monitoring Program (PMP).* OSA made funds available for HMPs to work with OSA to create consistent statewide messages to promote health care provider registration and utilization of the PMP.
- *Higher Education Alcohol Prevention Partnership* has worked with HMPs who serve areas with a higher education institution to implement strategies known to work with this special population. This has helped to create a more coordinated effort between HMPs serving "gown towns."

OSA works with District Coordinating Councils (DCCs). Currently, about half of the nine DCCs include substance abuse prevention in their work plans. DCCs are in the early stages of development, and do not have the staff or infrastructure that HMPs have. For this reason,

district level planning and implementation also occurs through HMPs. Some of the Community Transformation Grant funds will be devoted to building regional capacity through the DCCs.

HMPs have leveraged additional resources. HMPs measurable successes allow them to prove they can produce measurable outcomes, which convinces funders of their potential future successes. This ability to leverage additional partners and additional funds has increased exponentially the state's ability to address underage drinking.

- *Drug Free Communities grants.* Seventeen HMPs have been successful in winning Drug Free Communities grants across the state.
- *Grants to Reduce Alcohol Abuse.* MSAD 49 in Fairfield was awarded funding for three years through the Grants to Reduce Alcohol Abuse program.
- *Prescription drug abuse.* In 2010, The Maine Drug Enforcement Agency awarded nearly \$160,000 to four programs aimed at reducing prescription drug abuse. OSA has funded a total of \$117,000 to the nine public health districts to work on promoting the Prescription Monitoring Program. The main focus of the project is encouraging providers to register (or re-register) for and to use the PMP on a regular basis. Additional work will focus on promotional efforts in the general public as the secondary population targeted for this project.

Networks currently in place for local coalition networking are:

- *HMPs.* HMP Directors in each district meet monthly in most areas of the state.
- *Substance Abuse Prevention Specialists* in each district meet monthly in most areas of the state.
- *Maine Alliance for the Prevention of Substance Abuse* hosts the annual Prevention Convention and other educational and networking opportunities, as well as monthly update meetings and sub-committees on policy and advocacy, communications, and training and technical assistance.
- *Distance learning.* OSA has held one-hour conference calls and webinars, based on issues identified by substance abuse prevention specialists, and plans to continue this.
- *Facebook.* OSA's new Facebook page provides an avenue for building awareness of effective prevention strategies in a social networking environment.
- *Access to training.* Each year OSA provides scholarships to The Prevention School. Attendance increases capacity and a common understanding for participants. The 2012 Prevention School will be held in Maine.
- *Prevention Listserv.* The Prevention Listserv provides an opportunity for instant communication across the state between professionals in the prevention field.
- *Prevention Calendar.* The Prevention Calendar promotes cross-disciplinary prevention trainings.
- *AdCare/NEIAS.* OSA contracts with AdCare Educational Institute/New England School of Addiction Studies to provide a variety of needed workforce development opportunities statewide.
- *Leadership Council* meets quarterly and provides HMP Directors an opportunity to network with each other, and with OSA and MCDC staff.

- *OSA Provider Day.* This education and networking opportunity is required of all recipients of OSA prevention funds. All prevention providers come together for training and networking. This is open to all OSA partners.
- *Maine Network of Healthy Communities* is a statewide network of comprehensive community health coalitions. All HMPs are members of the Network, which is an advocacy organization that also provides trainings and informal mentoring opportunities around community coalition issues.
- *Drug Free Communities* grantees. DFC grantees have begun meeting on their own, in order to coordinate their efforts, share resources and address sustainability. OSA staff have recently been engaged in the DFC grantee network.
- *PMP Promotion.* PMP Promotion Project champions are funded in each district and are tasked with coordinating and collaborating with one another and other stakeholders in their districts and statewide to address the reduction of prescription drug misuse by promoting the PMP with consistent messaging statewide. Grantees and OSA communicate using the PMP listserv, via monthly conference calls, face-to-face meetings and email to coordinate efforts.

Strengths of Coordination of Local Services with HMPs

OSA's work to develop substance abuse prevention infrastructure has resulted in the inclusion of substance abuse as a critical public health initiative delivered through partnerships with the HMPs. OSA staff are responsible for product development and guidance, contract monitoring, providing technical assistance and site visits to ensure quality of services being provided.

MCDC and OSA have worked collaboratively to ensure that there are consistent goals and objectives in HMP work plans across the state. This means that HMPs work on the same substance abuse prevention programs statewide; and OSA has intentionally limited the number of objectives to ensure that limited funding can have a larger impact and measurable outcomes. This consistency in focused work plan objectives and activities has allowed HMPs to work regionally. For example, Underage Drinking Task Forces in some areas of the state began as local HMP initiatives, but have expanded to focus regionally.

Collaboration and coordination among sectors at the local level is particularly strong through HMP coalitions, and OSA is interested in capitalizing on this strength. For example, in communities where the HMPs (and other coalitions such as Drug Free Communities and/or Communities for Children and Youth coalitions) work closely with an Underage Drinking Task Force, enforcement successes have been considerable. As a way to promote this collaboration in other areas of the state, the Prevention Team will require a bridge between law enforcement and HMPs in the next round of Enforcing Underage Drinking Laws funding. Although this happens in some areas now, it is not consistent statewide.

Local coalitions are also particularly skilled at networking with each other. There are several venues for HMP and other coalition staff to network, which often leads to HMPs choosing the same prevention objectives when there is a choice through OSA funding, and when work plans are developed for other funding sources.

Challenges of Coordination of Local Services with HMPs

Because some District Coordinating Councils have not identified substance abuse as a priority area, HMPs are the key players in delivering prevention services both locally and regionally.

Summary of Coordination of Services

Coordination of services should occur within OSA, with other Maine state agencies, with other partners, and at the local level through HMPs. Currently, internal OSA coordination works well. Since 2006, OSA has coordinated services with MCDC and DOE and is expanding to other state agencies. Successful efforts to braid funds encourage coordination of services, but are not without challenges.

The OSA Prevention Advisory Board is a multi-sector state level group with capacity and potential to coordinate services. The upcoming integration of OAMHS and OSA will provide additional opportunities and challenges, and additional communication and collaboration efforts will be needed as the process unfolds. Coordination at the local level through HMPs, coalitions and other partners has been successful in meeting work plan objectives, attracting other sources of funding for prevention work, and expanding prevention capacity statewide. An overall assessment of coordination efforts in Maine demonstrates a solid foundation for collaboration among all stakeholders in the prevention field and these efforts should be continued.

These coordination efforts should be expanded to include other partners. At this time, there is very little coordination with health care providers and the Maine judicial system. Coordination of prevention services with tribal communities is in the early stages. Coordination at the regional level does not occur in all areas of the state, as not all District Coordinating Councils have identified substance abuse as a priority.

A complete discussion of how to address the coordination of services at all levels, including goals, objectives and milestones, can be found in the Strategic Prevention Plan 2013-2018.

Attachment 1:

OSA Prevention Advisory Board Members

Geoffrey Miller, M.Ed. *Co-Chair*. Associate Director, Maine Office of Substance Abuse

Susan Kring. *Co-Chair*. Coordinator, Maine Alliance to Prevent Substance Abuse

Susan Berry. Health Education and Health Promotion Coordinator, Interim Director of Coordinated School Health Programs, Maine Department of Education

Roger Brawn, SFC, MEARNG. Joint Substance Abuse Prevention Coordinator, Maine National Guard

Carol Carothers. Executive Director, National Alliance on Mental Illness (NAMI)/Maine

Cheryl DiCara. Director, Injury Prevention Program, Maine Suicide Prevention Program, Maine Center for Disease Control & Prevention

Andrew Finch, M.S.W., L.C.S.W. Healthy Maine Partnership Senior Program Director, Maine Center for Disease Control & Prevention

Jerolyn Ireland, R.N. Tribal Public Health Liaison, Maine Tribes

Rebecca Ireland. Director, Maine's Higher Education Alcohol Prevention Partnership

Shannon King. Program Manager, Teen and Young Adult Health Program, Maine Center for Disease Control & Prevention

Kevin Lewis. Chief Executive Officer, Maine Primary Care Association

Randall A. Liberty. Sheriff, Kennebec County

William Lowenstein. Director of Maine Projects, AdCare and Executive Director, New England Institute of Addiction Studies

Kathryn McGloin. Juvenile Corrections Division, Department of Corrections

Rebecca Miller, B.S.N., M.P.H., C.S.P.I. Outreach Education Coordinator, Northern New England Poison Center.

Cheryl Peavey. Director, Early Childhood Initiative.

Anne Rogers. Data and Research Team Manager, Maine Office of Substance Abuse

Paula Thomson, Central Maine Public Health District Liaison, Office of Local Public Health,
Maine Center for Disease Control & Prevention

Clarissa Webber, R.N. Tribal Public Health Liaison, Maine Tribes

Cherie Wenzel, L.S.W. Integrated Services Coordinator, Department of Health and Human
Services Office of Adult Mental Health

Maine Office of Substance Abuse Prevention Team

Cheryl Cichowski. Prevention Specialist

Jacinda Goodwin. Prevention Specialist

Maryann Harakall. Prevention Specialist

Leanne Morin. Information and Resource Center Coordinator and Prevention Specialist

Appendix H

State Prevention Enhancement Assessment of Training and Technical Assistance

Contents

- I. Introduction
- II. Assessment of Training and Technical Assistance for Substance Abuse Prevention
- III. Summary of Training and Technical Assistance

I. Introduction

Training and technical assistance for substance abuse providers in Maine is critical to move prevention initiatives in a positive direction. A well-trained and educated workforce will enable the state to stay on the cutting edge of research and strategy implementation.

For the purpose of this assessment and the five-year comprehensive strategic plan, OSA will capture activities at the national, state and local levels. In addition to identifying and assessing training and technical assistance opportunities, this plan identifies gaps and needs.

Specific definitions and acronyms used in this report are in Appendix B of the Strategic Prevention Plan 2013-2018.

II. Assessment of Training and Technical Assistance for Substance Abuse Prevention

This assessment describes the current status of training and technical assistance for substance abuse prevention and identifies gaps, challenges and items to consider in developing a strategic plan. It focuses on career development, workforce development and professional development available to Maine substance abuse prevention professionals.

Career Development

National: Numerous online tools and resources are available to direct individuals to career development programs in higher education, and to Certification through the International Certification Reciprocity Consortium (IC&RC). The National Center for Education Statistics College Navigator is an online public search engine tool that allows individuals to search through a national database for institutions of higher education and/or by programs of study. (<http://nces.ed.gov/collegenavigator>)

The IC&RC has protected the public by establishing standards and facilitating reciprocity for the credentialing of addiction-related professionals. Today, IC&RC represents 76 member boards, including 44 U.S. states, the District of Columbia, two U.S. territories, and three branches of the U.S. military. Members also include 22 countries and six Native American territories. IC&RC's credentials include Alcohol and Drug Counselor, Advanced Alcohol and Drug Counselor, Clinical Supervisor, Prevention Specialist, Certified Criminal Justice Addictions Professional, Certified Co-Occurring Disorders Professional, and Certified Co-Occurring Disorders Professional Diplomat.

State of Maine: Opportunities for formal education on substance abuse prevention are sporadic throughout Maine's higher education system, and a specific "substance abuse prevention" educational track or degree does not currently exist. However, tools are available to educate those interested in the field about classes, certifications and degrees, as well as ways to build a track into existing mental health and community health degree programs.

The University of Maine System has an online tool to search throughout the system for Academic Programs. Nearly 600 majors, minors and concentrations available at Maine's public universities are searchable at <http://www.maine.edu/prospective/academics.php> For example, the University of Maine System offers programs ranging from Psychology to Mental, Social and Public Health to Public Administration and Social Services to Therapy and Rehabilitation.

The Maine Community College System has a list of programs offered throughout Maine at <http://www.mccs.me.edu/student/student.html>. For example, the Maine Community College System offers programs ranging from Nursing to Human Services to Mental Health to Psychology to Social Work.

Strengths

There is an opportunity to build a career path that allows the current prevention workforce to provide input on what information, beyond certification, would be beneficial to new professionals in the field. There are a number of substance abuse treatment and prevention providers who have worked at institutions of higher education as staff, faculty or adjunct faculty, or instructor. These providers are an untapped resource, and through a coordinated effort may be able to assist with developing a substance abuse prevention certification program or individual classes.

Challenges

OSA lacks partnerships within higher education institutions to create a “career path” for prevention specialists. Higher education institutions lack undergraduate and graduate level courses and tracks that focus on substance abuse and/or behavioral health. Classes that include substance abuse and/or behavioral health topics for social work, law and medical students should also be considered.

Additionally, there is no clear educational pathway or fully coordinated training plan to guide the substance abuse prevention workforce in a unified manner. The majority of substance abuse prevention knowledge is acquired “on the job” or by “trial and error.” For substance abuse treatment providers, Maine has a Registered Alcohol and Drug Counselor certification and a Licensed Alcohol and Drug Counselor certification. For prevention providers, Maine does not have a Prevention Specialist Certification.

Workforce Development

National: There are a number of trainings, conferences, and technical assistance opportunities at the national/federal level for the substance abuse prevention field. Professionals participate in trainings in person as well as through technical assistance calls and webinars. The following describes the training and technical assistance available:

- *Office of Juvenile Justice and Delinquency Prevention (OJJDP)* sponsors a national conference which brings juvenile justice researchers, practitioners, policy makers, law enforcement and advocates together to learn about the latest research findings and developments, and about initiatives within the Department of Justice and across the country. OJJDP also contracts with the Pacific Institute of Research (PIRE) to provide additional training and technical assistance to the Enforcing Underage Drinking Laws (EUDL) grantees. PIRE hosts monthly webinars on topics related to the enforcement of underage drinking laws. The webinars are free and open to anyone who would like to participate.
- *US Department of Education (US DOE)* provides access to a number of webinars to grantees as well as to the Office of Safe and Drug Free Schools national conference. The conference offers sessions on research based programs and best practices; new trends and approaches; and training from practitioners in the fields of mental health, health, alcohol, drug and violence prevention as well as other areas related to school and community based prevention.

- *The National Prevention Network* Prevention Research Conference provides a forum to explore the latest prevention research, application and practice to promote positive outcomes at the community, state and federal levels.
- *Community Anti-Drug Coalitions of America's (CADCA)* National Leadership Forum provides multiple opportunities to learn the latest strategies to fight substance abuse and to hear from nationally-known experts and policymakers. Numerous Maine coalitions are Drug Free Communities grantees and typically send staff to this conference. CADCA also provides training opportunities for community coalitions in problem solving, assessment, and planning around substance abuse prevention. As a member of CADCA, OSA is eligible to take advantage of the trainings (in person and online) offered.
- *Substance Abuse and Mental Health Services Administration (SAMHSA) - Center for Substance Abuse Prevention (CSAP)* provides national leadership in the federal effort to prevent alcohol, tobacco, and other drug problems.
- *Prevention Research Institute's* Under 21 program is used among Student Intervention and Reintegration Program (SIRP) grantees to address high risk youth. Grantee staff are eligible to become SIRP trainers, and grantees are eligible for continuing education and support for trainers.

One common characteristic of the national trainings and conferences listed above is the networking that takes place among attendees from different states. Information sharing among state counterparts is important for continuing progress made in preventing substance abuse. As OSA and the Office for Adult Mental Health Services (OAMHS) integrate, there will be opportunities to share information about available additional prevention resources, using the Institute of Medicine's 2009 *Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities* as a guide.

State of Maine: At the state level, there are a number of trainings, conferences, and technical assistance opportunities for substance abuse prevention providers. Professionals participate in trainings in person as well as through technical assistance calls and webinars. The following describes the training and technical assistance available:

- *AdCare Educational Institute/New England Institute of Addiction Studies (NEIAS)* provides workforce development training opportunities through the week long Prevention School. Additionally, AdCare provides a variety of workforce development opportunities statewide on topics ranging from prevention ethics to neurobiology for prevention.
- *Maine Alliance to Prevent Substance Abuse (MAPSA)* works with key stakeholders to strengthen Maine's substance abuse prevention infrastructure by offering trainings and sharing current research, best practices and resources.
- *The Juvenile Justice Advisory Group (JJAG)* was established in response to the federal Juvenile Justice Delinquency Prevention Act of 1974 and oversees the state's participation in the federal juvenile justice initiative. The JJAG supports programs for the improvement of juvenile justice and delinquency prevention and offers trainings and technical assistance to grantees as well as other state agencies, local partners such as

police departments and schools. For example, JJAG has supported Collaborative Problem Solving and Undoing Racism trainings.

- *Shared Youth Vision Council's (SYVC)* goal is to ensure that the public, private and nonprofit sectors work collectively and collaboratively to increase the high school graduation rate, reduce child abuse and neglect, and create economic opportunities for youth. In collaboration with a variety of state and local agencies, the Positive Youth Development Institute is held on an annual basis and addresses a variety of topics ranging from Bullying and Violence, Safe Schools and Substance Abuse Prevention.
- *Substance Abuse and the Workplace for Substance Abuse Prevention / Treatment Providers and Coalitions.* These workshops help build an infrastructure of trained prevention and treatment providers and coalitions who can assist local businesses with the development of a Drug Free Workplace Program (DFWP). Maine businesses may wish to implement a DFWP that is as basic as a DFWP policy and education of their employees and supervisors. By knowing about the resources in their communities to refer employees to for assistance, their policies and programs will be more effective. Connecting employers with trained service providers will set up their programs, employees, and their business for success.
- *How to Use the Maine Integrated Youth Health Survey (MIYHS) to Assess Need, Choose Evidence Based Strategies, and to Seek Funding* is a training program that educates prevention professionals on MIYHS results. MIYHS was first implemented in the spring of 2009 in 80% of Maine middle and high schools, and is administered every two years. The training gives an overview of the survey results, and offers suggestion on how local data can be used. There is an emphasis on procedures and partnering with school administrators to obtain local data, accessing data via the web, and the limitations and potential of the data. The training includes a description of funding opportunities and an opportunity for participants to network.
- *OSA Prevention Provider Day* focuses on the many facets of providing substance abuse prevention strategies, programs, and practices successfully. This conference serves as a forum for substance abuse prevention providers, other state agencies and various OSA partners to exchange information, develop skills, and foster collaboration and coordination.
- *Healthy Maine Partnerships Annual Conference* is hosted by MCDC, DOE and OSA and provides an opportunity to interface with local and state partners in public health and education. The conference offers opportunities for state staff and local HMP staff to receive professional development training that pertains to the core competencies outlined for the public health infrastructure.
- *Healthy Maine Partnership Professional Development Team* identifies need and facilitates professional development of staff who are involved with the HMP initiative. Trainings address coalition development, contract objectives, and contract deliverables. Note: OSA refers to professional development as “workforce development.”
- *Teen Driver Awareness Training* is for law enforcement officers and is offered through the Bureau of Highway Safety. OSA presents some training on Maine liquor laws, specifically those that directly impact teen drivers.
- *Maine Network of Healthy Communities (MNHC)* is a statewide network and advocacy organization comprised of comprehensive community health coalitions. All HMPs are

members of the Network. MNHC provides trainings and informal mentoring opportunities around community coalition issues.

- *Maine Afterschool Network (MASN)* works to enable every child to have access to quality, inclusive, affordable after school programming that meets the needs of the child, the family and the community. MASN is a collaboration of individual and organizational partners across the state and works to foster communication among policymakers and providers to assist in securing resources to develop and/or sustain programs, and assist with training and technical assistance.
- *Communities for Children and Youth (C4CY)* is an initiative of the Governor's Children's Cabinet that aims to measurably improve the wellbeing of children in every Maine community and to increase educational attainment and achievement levels of all Maine children. This has occurred by supporting 72 communities over the past twelve years. C4CY and currently works with fifteen communities and supports three grant projects: Diversion to Assets, College-Community Mentoring Project and Assets Getting to Outcomes for Maine.
- *Maine Military Clinical Outreach Network* educates training organizations, agencies and providers in the subtleties of working within the military culture as well prevention and treatment best practices within that culture.
- *Responsible Beverage Server/Seller Training* is available through the Department of Public Safety, Liquor Licensing and Compliance Division. These trainings target servers and sellers of alcohol in the state and provide detailed information about laws and the legal responsibilities of servers and sellers.
- *Prescription Monitoring Program (PMP) Promotion Project* offers grantees the opportunity to participate in monthly technical assistance phone calls with the OSA project officer and the PMP state coordinator.
- *Conference calls/webinars* are provided by OSA to all organizations receiving funds to implement prevention programming. The calls are scheduled approximately every other month and address a range of topics. Examples of calls in 2012 include evidence-based programming, medical marijuana, evaluation, and integrating substance abuse into the public health system in Maine. The calls are facilitated by OSA prevention team staff and conducted by an expert on the topic (who is not necessarily OSA staff).
- *Underage Drinking Law Enforcement* trainings are available across the state to increase the enforcement of underage drinking laws. The grantees, and any other law enforcement agency in Maine, have access to training pertaining to enforcement efforts. Training topics include effective party dispersal, compliance check procedures, and Maine liquor law. OSA grantees, specifically the HMPs, have access to training topics such as "how to work with law enforcement" and "how to work with licensees about legal sale of alcohol."
- *Maine Youth Action Network (MYAN)* provides trainings and technical assistance to the HMPs and other OSA grantees around youth strategies and initiatives to empower and prepare youth and adults to partner for positive change. MYAN's work is grounded in the models and philosophies of positive youth development. Annual events include the Peer Leadership Conference.
- *Drug Impairment Training for Education Professionals* is a program for school personnel to educate them on identifying students who have consumed drugs. This training is

available for any school in Maine by request through the Maine Criminal Justice Academy.

- *Prime for Life/Student Intervention and Reintegration Program (SIRP)* targets an *indicated population* of students who have engaged in alcohol and/or drug use behavior. SIRP is designed to empower youth to make healthy decisions, reduce risk for problems and focuses on two measurable behavioral prevention goals: increase abstinence for a lifetime and reduce high-risk choices. The chosen intervention is the PRIME For Life program used with young people ages 13-20. The PRIME For Life program is provided by the Prevention Research Institute, Inc. OSA grantees that are implementing SIRP have access to the PRIME For Life program training.
- *The Higher Education Alcohol Prevention Partnership (HEAPP)* offers trainings to increase statewide capacity for addressing underage and high-risk alcohol use by college students on and around campus. Trainings focus on applying environmental management strategies to campus settings, working with law enforcement on and around campuses, data-driven needs assessment and project evaluation, stakeholder engagement in coalitions and strategies, cultural competency, and implementing evidence-based prevention and intervention programs. HEAPP utilizes internal training capacity (staff and campus-based experts) as well resources from the U.S. DOE's Higher Education Center for Alcohol and Other Drug and Violence Prevention. Coalitions can access specialized training on how to implement environmental management strategies on and around campuses, as well as receive technical assistance on prevention programming best practices and evidence-based strategies that fit the needs and culture of this population and setting.
- *Maine Inhalant Abuse Prevention Task Force*. OSA, in partnership with the New England Inhalant Abuse Prevention Coalition, formed a statewide task force to identify the nature of the inhalant problem in Maine and recommend model prevention practices designed to reduce inhalant use.

Strengths

Numerous technical assistance and training opportunities are available nationally and statewide that encompass many topic areas that include substance abuse and provide opportunities for the enhancement of the workforce's knowledge base. The training opportunities that are available are of a high quality.

The management at OSA supports workforce development activities, including leadership development, for state staff, providers, and community leaders at all levels when funding and opportunities allow and when these activities may further the development of prevention infrastructure and services.

OSA has strong relationships with other state agencies including the Department of Public Safety, the Department of Education and the Maine Center for Disease Control. Such relationships allow for access to a variety of topics that include substance abuse. The development of strong relationships with other agencies has facilitated a good flow of communication that lends itself to offering relevant and targeted training for partners. These partnerships allow OSA and other state agencies to break down silos and model the types of

relationships that OSA and other state agencies encourage among the local coalitions and community organizations.

Additionally, strong and trusting relationships have been developed with other partners to empower consumers to feel comfortable in communicating opinions, needs and wants regarding available materials and trainings. In turn, feedback is considered when developing and planning training and technical assistance opportunities. OSA makes every effort to meet the training needs of its partners.

Challenges

While prevention providers in Maine at the state and local levels possess a diverse set of experience and skills, there is not a set of core competencies required for this profession. Maine does not have a Prevention Specialist Certification process or credentialing to help unify knowledge and training expectations. Additional workforce development is needed in core competencies as well as specific topic areas such as marijuana and prescription drug abuse prevention, strategies to address emerging issues such as bath salts, and linking substance abuse prevention strategies with mental health promotion strategies. Maine is in a transition period, moving to an integrated behavioral health approach. There is a great deal of work to be done to educate the field about behavioral health and to develop strategies to prevent behavioral health issues. This is a paradigm shift and will take time.

Currently, new employees on OSA's Prevention Team and in Maine's substance abuse prevention field do not receive an orientation or training that provides a shared and basic level of instruction on prevention, program planning, evaluation and grants management.

There are a limited number of trainings available in Maine that offer cutting edge research and strategies. National conferences and trainings provide opportunities for unique training and technical assistance as well as valuable networking with colleagues across the country. Budget reductions and travel constraints have limited access to national trainings for prevention staff across the state. Furthermore, despite many efforts by OSA, including seeking technical assistance from NE CAPT, cultural competence at the community level is weak. In particular, broadening the concept of cultural competence to include more than ethnic and racial heritage (e.g., socio-economic status, education levels, and professional affiliation) remain a challenge. When grantees do recognize the diversity within their community, they do not always incorporate this information into coalition functioning, planning and marketing.

Many of the HMPs and other grantees receive funds outside of OSA to work on substance abuse prevention and are able to attend national conferences/trainings as needed. It can be difficult to keep track of which grantees are attending which trainings/conferences, particularly those that OSA staff cannot attend.

The capacity to conduct academic research on substance abuse prevention and related issues does not exist in Maine. This represents a vital aspect of prevention infrastructure that could not be supported or sustained after the SPF SIG. OSA would need to partner actively with

research bodies within Maine's institutions of higher education to move this forward; this typically requires external funding.

Substance abuse issues are far reaching, and this impacts numerous partners at the state level and the work being implemented. There are many organizations that would benefit from learning about substance abuse and how prevention could be interwoven with current programming efforts. In some cases OSA lacks information about the work plans and projects of organizations that are not directly connected to the office so a determination of necessary training and materials is difficult to make. In addition, numerous organizations are working on initiatives that include substance abuse making it difficult to ensure the trainings offered by these partners offer messaging around substance abuse that would be endorsed by OSA.

Finally, time and capacity constraints play a role in the amount of training OSA can provide with other organizations. Staffing constraints within OSA can often limit the staff time available for these types of collaborations. Nonetheless, OSA is dedicated to meeting the needs of the HMPs and other OSA grantees. At times, due to capacity and rapidly changing research and trends, OSA struggles to keep up with emerging innovations and the ever-changing field of substance abuse prevention.

Professional Development

National: The following describes professional development efforts and activities that are recognized at the national level.

- Many professionals in the substance abuse prevention field are members of CADCA.
- OSA has a representative, usually the Prevention Team Manager, who represents the National Prevention Network for the State of Maine.
- OSA staff and numerous local coalition members have been asked to present at national conferences including CADCA, OJJDP, NEIAS School of Addictions Studies, the RR Forum, and the Alcohol Policy Conference.

State of Maine: The list below illustrates the various professional development efforts at the state level.

- *Staff Education and Training Unit (SETU)* of the DHHS designs, implements, monitors and evaluates a coherent and effective staff training system. Statewide, SETU offers core competency programs, specialized training and consulting services. The primary focus of the system is to meet the educational and training needs of DHHS, of foster and adoptive parents and of local provider agencies, in order to improve the quality and delivery of social services.
- *Maine Alliance to Prevent Substance Abuse (MAPSA)* works with key stakeholders to strengthen Maine's substance abuse prevention infrastructure by offering trainings and sharing current research, best practices and resources. Members have professional development opportunities through serving on the MAPSA steering committee and/or on its various sub-committees. Planning and presenting opportunities are a possibility through the annual MAPSA Prevention Convention.

- *Maine Public Health Association (MPHA)* is a member based organization with 350 members from all sectors of public health. The Association aims to protect individuals, families and communities in Maine from preventable, serious health threats and strives to assure community-based health promotion and disease prevention activities. Through its e-newsletters, advocacy alerts, annual conference and networking meetings, MPHA communicates the latest public health science and practice to members, opinion leaders and the public.

Strengths

Maine is a large rural state with a population of 1.3 million. People working in state government and for non-profit organizations often work within the same circles and attend the same conferences and other professional development opportunities, confirming the often-stated line, “Maine is a large town where everyone knows everyone else and what they are doing.” In many ways this helps create opportunities for networking, connecting people, disseminating information throughout the state, and moving work forward.

There are frequent opportunities for professional development in the state through conferences and workshops, as state staff become subject matter experts and are asked to present, plan, and facilitate events in Maine.

Many of Maine’s substance abuse prevention specialists have been in the field for many years, and possess the knowledge, skills, and abilities necessary for success in the field. These professionals could help integrate and orient new professionals into the field.

Challenges

The challenge of “Maine is a large town...” is that the exchange of new ideas and new information may be met with resistance due to lack of funds and capacity to do the work. In this environment, the professionals in the field need to work smarter, not necessarily harder. Using a simple process improvement model to look at the impact of a change over a short period of time, adopt the change, or evaluate and implement another change should be followed in this ever changing field.

State staff and providers deal with many demands in their day-to-day responsibilities and, due to the capacity of state staff, cannot always meet the requests for presentations in local communities. Often OSA staff members are limited to presenting at larger statewide events a few times a year. For local community events, state staff will help connect the community with the resources closest to them and will refer requests for presenters to local providers in the community where the request originates.

III. Summary of Current Training and Technical Assistance for Prevention

As demonstrated through this assessment, Maine has access to many training and technical assistance opportunities at the state and national levels that encompass substance abuse prevention initiatives. These opportunities are applicable for OSA staff, OSA partners, and OSA

grantees. While there are many opportunities for professional development, some prevention specialists do not take advantage of them.

There are several training and technical assistance areas that present the prevention field in Maine with opportunities for improvement. Currently, there is a lack of career path development for substance abuse prevention specialists. This presents an opportunity to develop a path that will not only elevate prevention knowledge, but also encourage retention of qualified prevention professionals. Additionally, OSA lacks an intentional orientation for new staff and grantees. Because of this, professionals do not all have the same basic level of prevention knowledge.

Additional opportunities for growth are through collaborative trainings with other partners. There are time and capacity constraints, but these collaborative efforts are vital to the sustainability of quality training and technical assistance in the prevention field. Developing strategies to address the challenges would benefit many of Maine's agencies. By way of example, there is a general lack of understanding of cultural competency and how to integrate cultural competence into every facet of workforce development. Many State agencies face this challenge.

In sum, Maine needs to focus on the following areas to improve training and technical assistance for prevention:

- Establish career paths for prevention through higher education institutions.
- Create an organized orientation for OSA and grantee staff to establish basic substance abuse prevention knowledge.
- Expand support for workforce development opportunities for all substance abuse prevention specialists.
- Research prevention specialist certification core competencies, policies and procedures.
- Integrate cultural competence into all phases of workforce development.
- Encourage sharing of information learned at trainings/conferences between state and local staff.

A complete discussion of how to address these areas of training and technical assistance, including goals, objectives and milestones, can be found in the Strategic Prevention Plan 2013-2018.

Appendix I

State Prevention Enhancement Data Collection, Analysis and Reporting Assessment

Contents

- I. Introduction
- II. Assessment of Data Collection, Analysis and Reporting for Prevention
- III. Summary of Data Collection, Analysis and Reporting for Prevention

Attachment 1: Inventory of Data Sources for Prevention

I. Introduction

This assessment focuses on the collection, analysis and reporting of data about substance abuse prevention. Its purpose is to assess the data sources and procedures currently in place and to identify opportunities for improvement. The subject is important both to the Maine Office of Substance Abuse (OSA) itself, as it assesses its priorities and informs its progress, and to the field, as represented by local coalitions, schools and other organizations that need data to prioritize need and measure progress.

There are essentially two types of prevention data: process data which gives information on the activities and efforts undertaken to prevent substance abuse; and outcome data which reports on the results of these efforts. The major system used to collect process data for prevention programs in Maine is KIT Solutions for Healthy Maine Partnerships (HMPs) and Substance Abuse Prevention and Treatment (SAPT) Block Grant recipients; other process sources include quarterly reports required by certain funding streams and the No Child Left Behind Performance Reporting System – Safe Schools Supplemental Report. Outcomes data is collected by the Statewide Epidemiology Outcomes Workgroup (SEOW) from many sources that cover areas of concern identified through the Strategic Prevention Framework State Incentive Grant (SPF SIG). The conceptual framework used in this analysis follows the SPF and considers outcome data in three categories: contributing factors, consumption patterns, and the consequences of substance use. An example of a consumption measure is the percent of teenagers who report binge drinking in the past month; a contributing factor example is the percent of young adults under the age of 21 who think they will get caught if they drink; and a consequence measure example is the rate of vehicle crashes per thousand where alcohol is a factor. This plan identifies and assesses the types of data currently available in Maine in each of these categories, how frequently the data are refreshed, and whether they are available at sub-state levels.

In addition to identifying and assessing the process and outcome data sources, this plan identifies gaps and needs.

Specific definitions and acronyms used in this report are in Appendix B of the Strategic Prevention Plan 2013-2018.

II. Assessment of Data Collection, Analysis and Reporting for Prevention

This assessment describes the current status of data collection, analysis and reporting in Maine and identifies gaps, challenges and items to consider in developing a strategic plan. The current available sources of process and outcomes data are summarized in Attachment 1.

To conduct this assessment of the data collection, analysis and reporting currently employed in Maine, the following criteria were applied (where applicable) to the various sources of data that are collected and/or tracked:

- Current capacity:
 - Are the data collection efforts consistent for trending purposes?
 - Are they consistently funded so they can be used as part of a five-year strategic plan?
 - Are data analyzed and reported for public use?
 - Are data collected regarding contributing factors, consumption and consequences of substance use and abuse?
- Data quality:
 - Is there any oversight for data collection?
 - How accurate are the data?
 - Are data collected in a standardized way?
- Frequency of data collection:
 - How often are data collected? (e.g., annually, quarterly)
- Ability to analyze at sub-state/sub-population level:
 - Can data be analyzed by demographics, such as race or gender?
 - Can data be analyzed at a sub-state geographic level, such as county or Public Health District?

Current Status of Process Data

Currently, several data sources exist that could be used to collect process information for prevention efforts. Though not specifically designed for use in evaluation and presenting various challenges, each source has potential uses in collecting valuable process data for analysis and reporting purposes.

KIT Solutions: The performance monitoring system for Maine is KIT Solutions, a database tracking software package based on CSAP's minimum data set standards. This platform enables OSA, the Maine Center for Disease Control and Prevention, and the Maine Department of Education to record and monitor the activities and accomplishments of the HMP grantees and SAPT Block Grant recipients. These organizations must develop and input annual work plans that include establishing their objectives and electing strategies they plan to implement, as well as quarterly updates of the activities they have undertaken. Data collected through KIT include: identification of risks and objectives, tracking of prevention activities designed to address these risks and objectives, and assessment of the progress towards stated goals. This system is used to track individual events, recurring programs, participants, local organizations, services, individual assessments (pre/post tests for participants) and other information pertaining to prevention activities. Data are used primarily by project officers to monitor grantee activities. If data are entered in a timely, standardized and accurate way, including follow-up information, and ways are developed to link these measures to outcome data, this is a valuable tool for evaluating programs in addition to describing their performance.

KIT Solutions is an important source of information about HMP and Block Grantees engaged in prevention efforts. It provides a platform for uniform reporting by the grantees to monitor their progress and establish goals; furthermore, data can be examined at the grantee level. Measurements of process and effort (e.g., number of agencies contacted, number of people

affected) are clearly defined and help to quantify the various prevention efforts. OSA project officers review the substance abuse prevention measures entered into KIT at least quarterly for quality control purposes. KIT Solutions also presents challenges. Data are difficult to extract and, when extracted, are challenging to use for analysis and reporting. Quality of data may be affected by the large number of required counts and the feasibility of obtaining the counts. Although data are reviewed by project officers, the process is not uniform; that is, project officers use their best judgment but do not follow an established set of quality control guidelines. Moreover, it is difficult to establish direct links to program effectiveness, e.g., outcome measures. By not demonstrating a clear connection between these process counts and outcomes measures, the utility of collecting the data is not clear to local grantees, who may consider entering information into KIT as a low priority.

No Child Left Behind Performance Reporting System – Safe Schools Supplemental Report: The information contained in these reports provides information about various efforts in which schools are engaged. As part of the No Child Left Behind reporting, Maine schools complete a supplemental report about substance use and violence prevention efforts. These reports provide annual counts about prevention programs in schools and enable comparisons among school districts. These data could help OSA understand whether different programs or emphases correlate to their intended intermediate outcomes and how these outcomes vary by school. However, these data have not been previously collected, accessed or analyzed so their actual utility is unknown at this time.

This reporting system also presents challenges when considering substance abuse prevention efforts because of how such programs are structured for schools. Many prevention programs are embedded within other programs designed to teach healthy decision-making skills. An equally challenging obstacle is that there is little oversight of data collection and reporting. This results in limited quality control or uniform reporting throughout Maine's schools.

Enforcing Underage Drinking Laws Quarterly Reports: The Enforcing Underage Drinking Laws (EUDL) quarterly reports focus on law enforcement-related activities of recipients of grants administered through OSA from the Office of Juvenile Justice and Delinquency. The EUDL grants provide training for law enforcement, support for statewide compliance checks, mini-grants for law enforcement agencies to increase enforcement of underage drinking laws and backing for projects like the Higher Education Alcohol Prevention Partnership (HEAPP). EUDL reports are collected quarterly and submitted to OSA. They provide information about the type of strategy being implemented, basic counts and resulting citations. To date, these are submitted through paper-based reports (not an electronic system) that require aggregation. They are available only for police departments that are currently receiving EUDL funds and previous recipients are not required to report ongoing efforts.

HEAPP Quarterly Reports: Though financially supported by OSA, this initiative is not solely overseen or supported by the agency. As part of the contract with OSA, however, data are collected about the number of participating campuses, quantity of program materials distributed, trainings conducted and training participants. HEAPP also administers mini-grants to colleges and universities. These grantees are required to report information to HEAPP such

as enforcement of alcohol violations and incidents of vandalism; these data are aggregated before being reported to OSA. Some process data are also recorded in KIT by OSA-funded coalitions for their work with participating campuses.

Ethos Marketing Quarterly Reports: OSA supports several social media campaigns intended to aid in the prevention of substance abuse. One campaign educates parents about the risk to their children and the importance of modeling and monitoring (“Find out more, do more”). Another campaign targets young adults to inform them about the negative short-term social consequences of high-risk drinking (“Party Smarter”). The third media campaign shows employers how alcohol and drug use impacts their business and educates them on how to develop a drug-free workplace policy (“Work Alert”).

These reports have similar strengths to those of KIT Solutions. They standardize measures and quantify efforts of the media campaign by counting ads, requested materials, exposures, duration of media, and page views. The availability of quantified measures of the social media campaigns’ efforts makes it possible to relate these efforts to the intermediate behaviors they are designed to change. However, these reports are submitted through Excel spreadsheet reports that require aggregation. Data are not reported at the sub-state level (although it has been recommended) and the quarterly reports only describe activities from the perspective of the marketing contractor, not the activities of grantees utilizing the materials across the state. Some process data are also recorded in KIT by OSA-funded coalitions in terms of their work with the materials although the two sources are not linked and the feasibility of doing so has not been explored.

Technical Assistance and Training Evaluation Data: OSA supports various technical assistance (TA) and training opportunities for prevention efforts. Basic data are collected and reported to OSA for all contract deliverables (meaning those activities or events funded by OSA). Data collected include participant demographics, such as geographic origin or educational attainment, and training program-specific data, such as overall satisfaction, assessment of whether learning objectives were met and suggestions for future training topics.

There are challenges associated with TA and training evaluation data. OSA has not conducted a recent review of established process measures for TA/Training to ensure consistent measures and methods are used throughout the prevention infrastructure. Data are not currently aggregated in a routine manner and it is unknown at this time whether TA/Training outputs can be linked to longer-term outcomes.

Keep ME Well Data: Keep ME Well is an on-line health assessment. Although the web tool was not designed as a data collection tool, it can provide basic demographic information and self-reported data about the people who use the system. The assessment includes a question about past 30 day alcohol use and is being promoted by HMPs and statewide health agencies. Basic demographic data are collected, such as zip code from which respondent is accessing the site and gender. However, the data suffers selection bias and only represents people who know about the assessment. It also cannot eliminate duplicate visitors, thus affecting the accuracy of reports indicating the number of times this resource is used.

Screening, Brief Intervention, and Referral to Treatment (SBIRT): This early intervention strategy is being implemented in some health care settings, mainly in primary care practices, but also in emergency rooms and trauma centers. These brief screenings use standardized tools to screen patients to detect potentially problematic substance use, with the aim of intervening before specialized treatment is needed. Reporting and billing data obtained from sources such as the All Claims database or MaineCare could be used to monitor such interventions although the necessary code to record these activities is not currently activated in those systems. Collecting information about the frequency and prevalence of these brief screenings that occur in health care settings would allow OSA to explore the effectiveness of this screening as a prevention tool. This information would provide a valuable addition to current process counts by incorporating the work of the medical community.

Current Status of Outcomes Data

Maine utilizes many state and national data sources to examine substance trends, factors contributing to substance abuse, consumption patterns, and consequences. Intermediate outcomes can be linked to process measurements to determine if more effort in certain programs results in desired changes; e.g., in attitudes, social norms, and perceptions of enforcement. Information from these sources provides data to analyze the success of specific strategies. For example, one could ask: did a campaign targeting parents that informed them of the importance of establishing rules with their teen regarding alcohol lead to an increased percentage of students reporting that their parents viewed their use of alcohol as wrong? Long-term outcomes such as reducing substance abuse related mortality, decreasing past month substance use among youth, and increasing age of initiation indicate whether targeting specific attitudes or behaviors (e.g., increasing perception of underage drinking law enforcement) affects specific behaviors.

Factors Contributing to Substance Abuse: Many data sources provide information about the factors contributing to substance abuse, e.g., attitudes, social norms, and perceptions of enforcement. Various prevention programs target specific contributing factors. For example, the EUDL grantees heighten awareness of underage drinking law enforcement, and so these data can be used to determine how these efforts affect the perception of enforcement, highlighted as a contributing factors associated with substance use and abuse. Extensive data are available at the state and sub-state levels for factors contributing to youth substance use through the Maine Integrated Youth Health Survey (MIYHS). These data can be trended from 2009 onward.

One challenge associated with data collection, analysis and reporting of factors contributing to substance abuse is that data associated with the adult population is limited. The National Survey on Drug Use and Health (NSDUH), one source that currently measures perceived risk of harm from alcohol, has a significant time delay (most recent data are from 2008-09). Moreover, access to raw data is limited, so only observational correlations can be made (but not tested). HEAPP survey data are extensive in this area but only apply to the college population; data were most recently collected in 2008. Plans are underway to re-administer the survey in 2012-

2013-2012. Data regarding parent/adult attitudes towards youth use and furnishing, monitoring and other contributing factors to substance use among youth are also limited to an annual telephone survey of parents that has been used to gauge the impact of the social media campaign. The future sustainability of that survey is uncertain. An additional challenge is that the sources listed above provide state level estimates; limited data are available to measure contributing factors at the sub-state level. NSDUH can be monitored by Public Health District only if multiple years of data are grouped and results are obtained only upon special request.

Consumption Patterns: Consumption patterns (e.g., past month binge drinking) are collected through various state and national sources indicated in Attachment 1. Extensive data are available through the MIYHS at the state and sub-state levels for youth consumption patterns related to a wide range of substances (e.g., alcohol, marijuana, inhalants, and prescription drugs). These data can be trended from 2009 onward.

In addition to limited sources of information available about factors contributing to substance abuse pertaining to the adult population, similar data limitations exist regarding this population's substance consumption. The Behavioral Risk Factor Surveillance System (BRFSS) contains alcohol-related indicators, but produces limited estimates at the sub-state level or for populations of concern due to the small sample size (e.g., young adults). In some cases, multiple years can be combined to examine patterns. NSDUH, one source that currently measures the use of alcohol, marijuana, cocaine and prescription pain relievers, has a significant time delay (most recent data is 2008-09). HEAPP data are extensive in this area but, as mentioned above, only apply to the college population and these data were most recently collected in 2008, with plans to re-administer in 2011-2012. NSDUH and HEAPP are not available at the sub-state level.

Consequences of Substance Use and Abuse: Numerous data sources are available at the state and sub-state levels for consequence data, many of which can be trended. For example, data are available for the following substance-related indicators: traffic fatalities, expulsions/suspensions from school, crime and arrests, hospital visits, injury/poisoning, morbidity, treatment and overdose deaths. These data are readily available from state and national reporting sources. However, many of these indicators are not available at the sub-state and sub-population level, or they are subject to unstable estimates due to small numbers.

Mental Health Indicators: Efforts to integrate mental health into substance abuse prevention can be aided by many sources of data that include mental health indicators. These currently include, but are not limited to MIYHS, BRFSS, NSDUH and Maine's Treatment Data System (TDS). Though this information is available, OSA has not fully explored the depth of mental health indicators/data sources. Some of the resources currently accessed are available only as static reports and, without access to the raw data, cannot be cross-tabulated. This means the relationship between mental health and substance use or abuse cannot be explored within those data (e.g., NSDUH). An additional challenge is in finding a consistent manner by which to measure mental health status as definitions and indicators differ across data sources. At the federal level within SAMHSA and among its partners, much work surrounding constructing

common measures, indicators and a conceptual framework is currently being undertaken; Maine hopes both to inform and to learn from the work being done nationwide.

Hidden Populations and Groups of Interest: At the federal level, *Leading Change: A Plan for SAMHSA's Roles and Actions 2011-2014* specifically names several "hidden" or "hard-to-reach" populations which SAMHSA has identified as priorities. These include: individuals who are Lesbian, Gay, Bisexual, Transgender or Questioning (LGBTQ); military and military families; American Indians and Alaska Natives; Hispanics/Latinos; and individuals with disabilities. In Maine, the Prevention Team at OSA and the current Statewide Epidemiology Outcomes Workgroup have also identified these groups as a priority. Some of the challenges are discussed in more detail below. However, additional assessments should be conducted to determine what data are currently available across the state to represent these populations.

Information pertaining to the LGBTQ population represents a data gap for prevention in Maine. For example, students are not asked explicitly about transgender identity or sexual orientation. Instead, this group is only identifiable through responses to sexual behavior questions, which do not capture homosexual students who are not sexually active, nor students who are unsure about their orientation or identity. This is similar among many sources of adult data, although HEAPP data can be analyzed for LGBTQ college students.

In addition, vulnerable youth (e.g., homeless youth, high school dropouts, hospitalized or incarcerated youth) represent a hard-to-reach population in Maine. The existing youth survey is administered through schools, and so the data do not represent youth who are not enrolled in school. These youth may exhibit different characteristics, risk behaviors and patterns of substance use consumption compared to their counterparts that are currently unknown.

Substance use and consequence data are limited for Maine's Tribal communities as well. Across all data sources, it is generally understood that tribes are under-sampled and/or that tribal affiliation is underreported by respondents. Due to the small sample sizes for this population, prevalence rates and other indicators are unstable. The Maine Office of Minority Health and Maine's tribes have recently completed the *Wabanaki Community Health Survey* to help to fill this gap; OSA has dedicated staff to work with the tribes to agree upon a mutually acceptable manner in which OSA might access the data.

Compared to its overall population, Maine has one of the highest proportions of veterans in the nation and military members and their families are a high priority for state prevention efforts. Prevalence rates and other indicators are generally unstable for this population due to the small sample sizes. (The MIYHS does not currently ask whether anyone in the respondent's home has served in the military.) The National Guard in Maine conducts a survey of its members that contains mental health and substance use questions but those data are available only through a Freedom of Information Act request.

Current Status of Analysis and Reporting

Process Data and Continuous Quality Improvement (CQI): Process data that are collected are reported as necessary to federal funders, state funders and legislators (on special request or as part of the annual report; see below) and on an as-needed basis. These data are also used to monitor the programs and coalitions that OSA supports. However, process data are rarely reported back to the sub-state level or used for overall program improvement. CQI consists of a set of actions designed to bring gradual but continual improvement through constant review. In Maine's prevention system, many elements of CQI exist. For example, OSA project officers review grantee work plans and approve proposed activities. They inspect quarterly reports and data entered into the KIT system or submitted to them on paper. When necessary, project officers contact grantees to ask questions, clarify the reports or provide feedback. However how these CQI activities are conducted, the components that are addressed and the feedback that is provided are determined largely by the individual project officer; OSA staff use no formal or standardized guidelines directing the CQI process. Moreover, OSA staff are not trained explicitly in providing useable and actionable feedback to program managers that would foster program improvement at the local level.

Outcomes Data: The Statewide Epidemiology Outcomes Workgroup (SEOW) produces an annual report that includes indicators that encompass the scope of data sources for consumption patterns, consequences, contributing factors, mental health and treatment in Maine. The SEOW has also produced eight profiles at the public health district level that follow a similar format. These reports are posted to the SEOW website and a link is distributed to the Prevention Listserv. When data questions arise, staff at OSA refer the public to these reports. Outcomes data are also distributed through subject-specific fact sheets that are posted to the SEOW website. Most recently, fact sheets have been developed to discuss priority consumption patterns (i.e., alcohol, marijuana and prescription drugs) and target populations (i.e., youth and young adults). However, the full range of data indicators presented in the district profiles and fact sheets are not currently available as part of a comprehensive interactive web-based platform although some individual data sources are available online (e.g., Treatment Data System).

Annual Report: The Office of Substance Abuse produces an annual report for the legislature that is also published on its website. The report covers the full scope of its activities and programs spanning prevention, intervention, treatment and recovery and discusses funding, accountability and results (outcomes).

III. Summary of Data Collection, Analysis and Reporting for Prevention

Maine has access to many statewide and national data sources that measure outcomes pertinent to prevention efforts. The state currently collects and tracks trends for outcomes data about contributing factors, consumption patterns and the consequences of substance use and abuse and reports on them annually. Maine also collects a wide range of information about prevention processes that can monitor prevention efforts and their effects on targeted attitudes and outcomes. However, some clear gaps emerge in Maine's overall capacity for data collection, analysis and reporting.

First, the quality, utility and process by which the process data are currently being collected and used should be addressed with the purpose of streamlining KIT Solutions. Increasing the ability of OSA and its grantees to use the data to inform their decisions would improve the quality of data; local providers would understand that their efforts were serving an important purpose.

Second, more data need to be collected on populations other than youth and special efforts need to be made to collect data from hidden populations of concern. The expansion of population-based survey capacity would aid in addressing the lack of data available for sub-populations and sub-state measures. It would also allow for the collection of information on consumption patterns of substances other than alcohol.

Third, efforts must be made to include all levels of prevention providers and policymakers in analysis and reporting efforts. By developing a data reporting platform that is interactive, live and useful to all levels of decision-makers, OSA would increase the accessibility of data and allow for meaningful associations between processes and outcomes. This in turn would increase the ability of the wider population to use and apply the process and outcomes data to inform their decisions and would increase the commitment to these programs and data sources.

In sum, Maine needs to focus on the following areas to improve data collection, analysis and reporting for prevention:

- Quality, accessibility and usefulness for process measures
- Data for adult populations/subpopulations
- Dissemination of outcomes data to a wider audience

A complete discussion of how to address these areas of data collection, analysis and reporting, including goals, objectives and milestones, can be found in the Strategic Prevention Plan, 2013-2018.

**Attachment 1:
Inventory of Data Sources for Prevention**

<i>Process Data</i>			
Data Source	Strategy/Intervention Counts	Population	Lowest Geo Level
KIT Solutions	Prevention programs and strategies implemented in communities <ul style="list-style-type: none"> • Number • Type • People Reached 	HMP Grantees Block Grant	HMP
No Child Left Behind Performance Reporting System – Safe Schools Supplemental Report	Prevention programs implemented at schools <ul style="list-style-type: none"> • Type • Number 	Maine Schools	Unknown (available upon request)
Enforcing Underage Drinking Laws (EUDL) Quarterly Reports	Law enforcement-related activities <ul style="list-style-type: none"> • Type • Number • Associated citations 	EUDL Grantees	Police Department
Higher Education Alcohol Prevention Project (HEAPP) Reports	Prevention efforts at colleges and universities <ul style="list-style-type: none"> • Number of participating campuses • Number of program materials distributed • Number of trainings conducted • Number of Participants 	Colleges and universities participating in HEAPP	State (data are aggregated)
Ethos Marketing Quarterly Reports	OSA media campaigns <ul style="list-style-type: none"> • Number of media ads • Number of materials requested • Number of exposures • Duration • Page views 	OSA Grantees	Public Health District
TA and Training Evaluation Data	Type of training Training Satisfaction/Meeting of Learning Objectives	Attendees at OSA-sponsored trainings	Participant demographic data are collected (e.g., geographic origin and educational attainment)
Keep ME Well Data (note: not designed as a data collection tool)	Health Risk Assessments	Individuals concerned about their health/self-report on assessment (Selection bias)	County, zip code
Health Care Billing or Patient Records	Needed: number of people or percentage of patients being screened for potentially risky substance use.	Patients in primary care settings	Unknown

Appendix J

State Prevention Enhancement Assessment of Performance Measurement and Evaluation

Contents

- I. Introduction
- II. Assessment of Performance Measurement and Evaluation for Prevention

Attachment 1: Sample Logic Model from OSA Social Marketing Campaigns—Parent Media Campaign

Attachment 2: Center for Disease Control Evaluation Standards

I. Introduction

This assessment focuses on how Maine can better use available data on the consumption and consequences of alcohol and drugs for purposes of Performance Measurement and Evaluation. While the Assessment of Data Collection, Analysis and Reporting focused on what data are available and how to access them, this plan focuses on how the data can be used for performance measurement with an eye to accommodating Substance Abuse and Mental Health Services Administration (SAMHSA) performance goals, measures and cost savings.

Its purpose is to assess the performance measurement and evaluation procedures currently in place and to identify opportunities for improvement. The subject is important both to OSA itself, as it assesses its priorities and informs its progress, and to the field, as represented by local coalitions, schools and other organizations who need to know the extent to which their initiatives are working and how to interpret the reasons for the results they are seeing.

There are essentially two types of prevention data, process data which gives information on the activities and efforts undertaken to prevent substance abuse, and outcome data which reports on the results of these efforts. This Assessment of Performance Measurement and Evaluation addresses how to relate the processes to the outcomes so people can conclude what efforts are making a difference, and with what populations.

The major standardized system used to collect process data for prevention programs in Maine is KIT Solutions for Healthy Maine Partnerships and Substance Abuse Prevention and Treatment (SAPT) Block Grant recipients; other process sources include quarterly reports required by certain funders. In addition, evaluators use other methods such as interviews and focus groups to collect process data for special initiatives. The Statewide Epidemiology Outcomes Workgroup (SEOW) collects outcome data from many sources that cover areas of concern identified through the Strategic Prevention Framework State Incentive Grant (SPF SIG). In addition, outcome data can be derived from specialized analyses of particular databases. For example, to determine whether a particular intervention saved money in preventing hospitalizations where alcohol is a factor, the All Payers All Claims database could be used for a focused analysis.

This plan identifies and assesses the types of performance measurement and evaluation efforts that currently exist in Maine for prevention. In addition, it identifies gaps and needs.

Specific definitions and acronyms used in this report are in Appendix B of the Strategic Prevention Plan 2013-2018.

II. Assessment of Performance Measurement and Evaluation for Prevention

This section describes the current status of performance measurement and evaluation systems in Maine and identifies gaps, challenges and items to consider in developing a strategic plan.

Performance measurement describes whether there have been changes in key indicators of substance abuse prevention, such as the reduction in the percent of underage youth who drink on a weekly basis. Performance measurement relies on selected indicators. Evaluation uses performance measurement, but goes further to describe not only what the differences are but why. Evaluation tries to explain change (or the failure to see change) by delving further into the logic behind the efforts; that is, did particular prevention efforts make sense to start with, and then did they relate to the factors that are expected to produce the change? Were the interventions delivered as planned, and with the same intensity and duration? Were the people reached those that were intended? For example, if the goal of a program is to stop binge drinking but the campaign reaches a demographic who are not binge drinkers, the indicator(s) for binge drinking would not be expected to change much. Are the desired changes observable? If they rely on self report, is there a way to collect the information that is reliable and timely?

This section addresses the major programs funded by the Office of Substance Abuse (OSA) and then looks at the ability to evaluate prevention efforts as a whole. To assess the needs, we first determine the strengths and challenges of their related process and outcomes measures. We then determine whether evaluation efforts are routinely conducted and, if not, we assess the feasibility of connecting the process counts with the outcomes measures available for the purposes of evaluation.

Current Status of Performance Measurement and Evaluation by OSA Programs

Prevention Services funded by the SAPT Block Grant: Prevention services funded by the block grant include those implemented by Healthy Maine Partnerships (HMPs).

Process Evaluation

The process data for these efforts are collected from local coalitions (grant recipients) through KIT Solutions. Maine compiles effort and reach counts for HMPs and other block grant recipients through this system. KIT also allows for the collection of narratives from grant recipients about their local prevention efforts that may demonstrate connections between processes and observed outcomes. OSA project officers for each grantee review content in KIT quarterly. The challenge for evaluation is that this information on effort and reach is used only to determine whether goals were met, not whether reaching these goals affected the outcome. Data recorded in KIT are rarely investigated in-depth for meaningful program enhancement. Additionally, information about efforts involving initiatives to improve mental health is not collected. Local coalitions do not have the option to record their progress in other substance abuse prevention efforts other than those funded by the block grant; that is, those strategies related to alcohol and engaging businesses in drug-free workplace programs.

Outcomes Evaluation

The efforts recorded in KIT target factors that contribute to OSA's priority consumption patterns and related consequences. Many indicators that measure long-term outcomes are collected through data sources like the Maine Integrated Youth Health Survey (MIYHS), the Higher Education Alcohol Prevention Partnership (HEAPP) survey and the Behavioral Risk Factor Surveillance Survey (BRFSS). These indicators are compiled annually in the State Epidemiology Profile. For middle and high school students, MIYHS also contains numerous measures related to the contributing factors that grantees address (e.g., perception of being caught by parents). Similarly, the HEAPP survey contains a number of indicators related to attitudes and behaviors, although data are not available at the sub-state level and only represent individuals enrolled in post-secondary institutions. However, measures of contributing factors related to alcohol use by adults (i.e., those behaviors being addressed by grantees) are not available with the exception of perceived risk, an indicator contained in the National Survey of Drug Use and Health (NSDUH); NSDUH has limited use in evaluation beyond an indicator that can be monitored as the data are untimely and raw data are not available. Other adult data are limited at the sub-state level and workplace related data are limited or non-existent.

Linking Process and Outcomes Data

The effects of these efforts are not formally evaluated on a regular basis at the state or sub-state level. KIT process counts are considered along with trends in the various outcomes measures, but linking process to outcome is challenging given the gaps in sub-state and subpopulation outcomes data.

Higher Education Alcohol Prevention Project (HEAPP): HEAPP is a collaborative effort of Maine's colleges and universities that is supported, in part, by OSA. HEAPP aims to establish an environment that supports healthy norms, and to create a unified effort within Maine's higher education community to address high risk alcohol use among students.

Process Evaluation

KIT process counts capture work being done with college campuses through OSA-funded coalitions, so there are some process measures available. However, HEAPP also receives funding from other sources. The counts collected and reported to OSA are only for activities funded by OSA and include number of participating campuses, quantity of program materials distributed, the number of trainings conducted and the number of training participants. HEAPP administers mini-grants to colleges and universities and requires them to report information such as enforcement numbers for alcohol violations. This process information is aggregated before it is reported. HEAPP does not report regularly to OSA on process counts from funded colleges/universities.

Outcomes Evaluation

The HEAPP survey of college students collects extensive outcomes measures about alcohol consumption and contributing factors. The project has plans to administer another survey in 2012. The outcomes measured in the HEAPP survey very clearly link the consumption with consequences (e.g., did you hurt yourself? Were you drunk when you hurt yourself?). An additional strength is that data collected through the HEAPP survey provides information about a population of concern (young adults enrolled in college). On the other hand, this outcomes information is reported publicly at the state level only. Because of this, OSA cannot use these data to identify college/university communities of concern, even though the HEAPP program does use data internally to do so. Nonetheless, the survey corroborates the patterns observed in other data sources for this age group and adds to knowledge about the use of other substances, such as marijuana or prescription drugs.

Linking Process and Outcomes Data

HEAPP currently shares school-level survey data with funded colleges and universities, but this information is not publicly available. The project has not compared how different approaches and efforts at different schools have affected targeted outcomes. Evaluation and data analysis have not taken into account the relationships and collaboration that occur between HMP coalitions and the HEAPP campuses.

Enforcement of Underage Drinking Laws (EUDL): EUDL is a grant from the federal Office of Juvenile Justice and Delinquency Prevention that is administered by the Office of Substance Abuse. OSA uses these funds for projects such as statewide compliance checks, mini-grants for law enforcement to increase the enforcement of underage drinking laws and training for law enforcement officers.

Process Evaluation

EUDL quarterly reports for mini-grant recipients capture information about enforcement efforts (e.g., policy changes, number of efforts such as party patrols, number of citations administered). Some information regarding collaboration among agencies (e.g., police departments and HMPs) is captured in KIT counts. The data in the quarterly reports are difficult to access since they are submitted on paper and recorded in Excel. An additional challenge is that once a law enforcement department no longer receives EUDL funding (after about 2 years), there is no information collection system in place that tracks ongoing efforts.

Outcomes Evaluation

Surveys such as the MIYHS collect information about the results these efforts (e.g., changing perceptions and attitudes regarding enforcement, and reducing underage drinking and binge drinking). The short-term results of EUDL efforts such as citations, adjudications and prosecution of furnishers are not recorded or accessed in a manner that allows for an evaluation of shorter-term outcomes.

Linking Process and Outcomes Data

Data linking current EUDL efforts, or examining past EUDL funded sites, are not regularly examined for trends in the number of citations for underage drinking issued, youth reporting increased enforcement or long-term reduction in youth drinking. Moreover, evaluation and data analysis have not accounted for the relationships and collaboration that occurs between HMP coalitions and the EUDL grantees (and former grantees).

Prescription Monitoring Program (PMP) Promotion Project: Maine's Prescription Monitoring Program (PMP) is a tool for healthcare providers to prevent and detect prescription drug misuse and diversion and to improve coordination of patient care. PMP maintains a database of all transactions for controlled pharmaceutical substances dispensed in the State of Maine (excluding medical marijuana) which is available online to prescribers and dispensers. A new project to encourage the use of the PMP and expand the number of medical professionals who register to use the database and access it regularly was completed in 2012.

Process Evaluation

An analysis of the implementation of the PMP was conducted in 2006; and since then no formal process evaluation has been performed. The PMP database tracks the number of new medical professionals registered to use the system as well as monthly utilization rates. These counts measure changes in use of the PMP over time which is the short-term goal of the new promotion program. These process data have not been analyzed yet.

Outcomes Evaluation

The database provides information on the number of prescriptions filled for controlled substances and can be used as a proxy measure of access and availability of prescription medications in a community. An epidemiological analysis of PMP data from 2005 to 2008 was completed in 2008 and identified trends in prescribing patterns for controlled substances, demographics of individuals who filled prescriptions, and information on the payer mix for filled prescriptions. Since that time, no analysis of PMP data has been published.

The use of PMP information is challenging. The number of prescriptions filled is not a measure of the actual amount prescribed (milligrams), or of prescription drug use, abuse or diversion. PMP generates automatic reports on cases in which certain prescribing thresholds are reached; but these reports do not distinguish between patients who have a legitimate need for higher doses and quantities and those who do not. In addition, data on adult use and abuse of prescription drugs are limited; the few surveys available, such as NSDUH and the HEAPP survey, define "use" differently (e.g., non-medical use of prescription drugs, or use of prescription pain relievers). There are indicators for long-term consequences of abuse of prescription medications, such as drug poisonings and unintentional drug overdose deaths.

Linking Process and Outcomes Data

PMP does not formally evaluate its efforts on a regular basis. It is difficult to link the efforts of expanding the program directly to the outcome of decreasing the availability of prescription

drugs, abuse of those drugs or the related consequences (e.g., referrals to treatment, unintentional drug overdose deaths).

Prescription take-back efforts that occur statewide and in some communities reduce the availability of unused and expired over-the-counter and prescription medications, but there is little information on the amount of controlled substances collected in these efforts. No analysis has been conducted that incorporates take-back efforts and PMP data to understand the effects these programs have on reducing access and availability of prescription medications.

Social Marketing Campaigns: OSA's social marketing campaigns are Find Out More, Do More (an informational campaign for parents), Party Smarter (a risk reduction campaign targeting young adults ages 21 to 25) and Work Alert (an informational campaign providing information to employers regarding resources for supporting a drug-free workplace).

Process Evaluation

Process counts are currently collected for each social marketing campaign. These counts include number of media ads, number of materials requested, number of exposures, duration of ads and page views (websites). Block grant recipients who distribute these materials also record their efforts in the KIT system. Using counts such as exposure or number of ads does not necessarily measure the actual reach of these efforts. For example, there may have been a number of media ads, but how many people actually listened to the radio commercials or watched television commercials closely enough to retain the message?

Outcomes Evaluation

The Find Out More, Do More campaign targets contributing factors and outcomes that are measured by surveys that are administered on a regular basis (e.g., MIYHS). The parent perspective regarding increased knowledge of the importance of talking to their child about substance abuse is measured through the Parent Survey, a small statewide sample that may not be sustained in the future. The Party Smarter campaign can adequately track young adult consumption (BRFSS) and some consequences, such as alcohol-related traffic accidents. For this campaign, interim behavior changes and other risky behaviors are not regularly or consistently captured; neither the HEAPP survey nor OSA's Low-Risk Survey can be trended and both have sustainability challenges. There is no mechanism to evaluate adult behavior changes that are targeted by the Work Alert campaign. Potential workplace surveys conducted by the Maine Department of Labor that capture employee attitudes and substance-related workplace consequences have not been adequately explored.

Linking Process and Outcomes Data

For all three social marketing campaigns, there is no formal program evaluation in place. As mentioned above, particularly for the Party Smarter and Work Alert campaigns, the lack of adequate measures of interim behavior changes makes it difficult to link process counts to observed changes in outcome measures. There is also a similar challenge in the difficulty obtaining data about adults. If there are no data available about contributing factors,

consumption and consequences for the adult population, how can one measure the efficacy of a media campaign targeting that population?

Special Projects: When evaluation is required for a special project, especially one that is supported by a federal agency or foundation, the funds allotted for this purpose generally range from 10 to 20 percent of the overall grant. The funding usually permits a credible evaluation to be conducted, even if new data collection efforts are needed. One example is the SPF SIG funded by SAMHSA. When a special project is locally funded or an evaluation is not required, there are generally no funds allotted for this purpose. It is often difficult for people to justify taking money away from direct service to fund evaluation if it is not mandated. Another challenge is that the reports that are done are often program-specific and not placed in the broader prevention framework.

Technical Assistance and Training: OSA has contracts with several agencies that provide direct services and advocacy for substance abuse prevention. Such organizations include the Maine Alliance to Prevent Substance Abuse (MAPSA), Ad Care Educational Institute of Maine and the Maine Youth Action Network (MYAN). The services of these organizations enhance OSA's prevention strategies and must be considered when evaluating prevention efforts to determine the effects these organizations have on program implementation of other prevention initiatives and outcomes.

Process Evaluation

These agencies submit reports to OSA as part of their contract agreements. These reports include process counts, such as number of trainings held, and participant demographic information, such as geographic origin. This information is not regularly analyzed.

Outcomes Evaluation

Training and advocacy are intended to enhance OSA's prevention infrastructure, but it is difficult to determine specific outcomes measures that can be directly related these activities and programs. A thoughtful evaluation of the efforts of these OSA-contracted agencies might consider how these services enhance program implementation and influence outcomes.

Linking Process and Outcomes Data

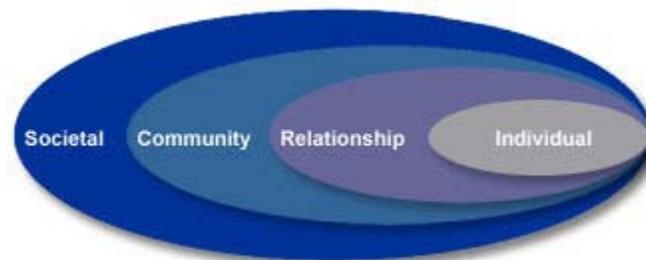
Currently, there are no procedures that direct how the process counts provided to OSA can be related to improving outcomes. As mentioned above, tracking participants in trainings and determining whether such training improves local level program implementation is one way to evaluate the effectiveness. What must also be considered, however, is how such trainings or services ultimately affect rates of substance abuse. For example, do communities with prevention professionals who attended more training programs see a greater decline in substance abuse? With increased emphasis on training and certification, it is especially important to determine how training participation and outcomes are related.

Comprehensive Evaluation of Prevention: The ability to evaluate the efficacy of each OSA-sponsored program provides some insight into the overall effectiveness of each prevention

initiative. However, program-specific evaluation does not gauge the overall impact of OSA's comprehensive approach (the combined effects of all these programs) and other prevention efforts not funded by OSA. Because OSA only supports the implementation of evidence-based strategies, the purpose of the evaluation efforts should not be solely concerned with whether individual programs are affecting outcomes; that is, the strategy's effectiveness has already been proven and it can reasonably be assumed that the use of that particular strategy is affecting the desired outcomes. The concern for OSA as it strengthens its prevention infrastructure is to determine the most effective combination of interventions, and to understand which target populations and/or substances need an increased focus of prevention efforts.

This overall consideration of substance abuse prevention requires a comprehensive approach to analyzing interventions. One such approach is the social-ecological model, a framework used by the Centers for Disease Control and Prevention to understand the factors affecting an undesirable behavior and to analyze the effects of prevention efforts targeting that behavior (e.g., efforts targeting violence prevention). The social-ecological model is illustrated below.

Figure 1: Social-Ecological Model¹



OSA has many of the elements required to analyze its substance abuse prevention efforts using the social-ecological framework. Process counts are collected as required, depending on the funding source. Since OSA supports the implementation of evidence-based strategies, these efforts can be categorized as promotion strategies or prevention strategies (universal indirect, universal direct, selective, and indicated), as defined by SAMHSA (see Table 1 on the following page). Additionally, OSA already collects and monitors many of the consumption, contributing factors and consequence outcomes measures (especially for alcohol). OSA also monitors statewide trends and tracks and reports significant outcomes measures.

¹ Taken from the CDC website: <http://www.cdc.gov/ViolencePrevention/overview/social-ecologicalmodel.html>

Table 1: Promotion and Prevention Strategies²

Promotion	Universal – Indirect Prevention	Universal – Direct Prevention	Selective Prevention	Indicated Prevention
<p>Target: general public and/or whole population</p> <p>Goal: to enhance individuals’ ability to achieve developmentally appropriate competencies and a positive sense of self-esteem, mastery, and well-being.</p>	<p>Target: general public and/or the whole population (not identified on the basis of individual risk)</p> <p>Goal: to change the social context that influences knowledge, attitudes and behavior.</p>	<p>Target: general public and/or the whole population (not identified on the basis of individual risk)</p> <p>Goal: to direct interventions to everyone in that group.</p>	<p>Target: individuals or a population subgroup whose risk of developing mental or substance abuse disorders is significantly higher than average (prior to the diagnosis of a disorder)</p> <p>Goal: to direct interventions to high risk individuals or groups.</p>	<p>Target: individuals at high risk who have minimal but detectable signs or symptoms of mental illness or substance abuse problems (prior to the diagnosis of a disorder)</p> <p>Goal: to direct interventions to high risk individuals already exhibiting symptoms.</p>

Using the social-ecological model, the strategies in Table 1 can be related to the various elements of the model: individual, relationship, community and societal factors. For example, alcohol prevention efforts that target perception of enforcement of drunk driving laws are designed to impact the community climate (e.g., thinking one will get caught if driving under the influence). In time, these changes will affect the relationships within the community (for instance, if everyone thinks they will get caught driving under the influence, friends will encourage one another to choose a designated driver or discourage friends from driving after drinking) and eventually the individual decision-making regarding alcohol use will change, and this will be reflected in outcome measures (e.g., decreased alcohol-related crashes).

As mentioned above, it is less useful to determine if a single intervention is effective; but rather, OSA should develop a system that categorizes the interventions used (e.g., by prevention strategy used or demographic targeted by the intervention). This will provide a comprehensive picture of the various programs by establishing what types of interventions are most often used and which problems are most often targeted. This standardized and comprehensive view of process measures would allow for a yearly consideration of prevention efforts. How does the focus or type of strategies used in 2007 differ from the same factors in 2009? How does a specific outcome measure (e.g., underage drinking) from the two years compare? The table on the following page could be used to organize and count the various interventions, and could demonstrate where the efforts are being directed. Depending on the

²National Research Council and Institute of Medicine. (2009). Defining the Scope of Prevention. In O’Connell, M.E., Boat, T. & Warner, K.E. (Eds.), *Preventing Mental, Emotional, and Behavioral Disorders among Young People: Progress and Possibilities* (p. 66). Washington, DC: The National Academies Press. Summary available at <http://captus.samhsa.gov/access-resources/mapping-interventions-different-levels-risk>

target population or problem, such an organizational tool could be used at various levels (state, sub-state, local) if the outcomes measures are available for trending purposes.

Table 2: Sample of How to Evaluate a Comprehensive Approach to Prevention

Target of Intervention 	Type of Prevention Strategy Used			
	Universal Indirect	Universal Direct	Selective	Indicated
Specific Demographic? (e.g., age)	<i>[How many of these types of prevention strategies/interventions used for the “target” indicated?]</i>			
Specific Substance? (e.g., alcohol)				
Specific Audience? (e.g., parents or law enforcement)				

Using an organizational tool such as this, it would be possible to determine where prevention efforts are being directed. Looking at prevention statewide, an evaluation could address the following questions:

- Is one type of strategy used more often?
- Is one population the target of greater effort?
- How have the strategies and focus of interventions changed over time (yearly)?
- Can we determine how the emphasis (or changes in emphasis from year to year) affects the intended outcome measures?

If outcomes data are available at the sub-state level:

- Are the strategies and targets different for the various sub-state groupings (e.g., counties)?
- Does an increased emphasis on one type of strategy or target result in different changes in outcome measures?
- Which combinations are most successful in terms of desired outcomes?

A second way to analyze the combination of prevention efforts is to consider whether an increased emphasis on a particular substance or population of concern (e.g., underage alcohol use or the young adult population) resulted in the desired outcomes. If the associated surveillance data did not change, the evaluation emphasis should then be placed on whether the evidence-based programs were implemented with fidelity. For example, if at the state level OSA placed an emphasis on universal indirect prevention strategies, yet attitudes remain unchanged, a closer examination of the programs implementing these strategies might reveal that they were not implemented as designed. A specific strategy may have been the one

implemented most often by local coalitions according to their quarterly reports; but closer inspection of the KIT counts may reveal that, while many organizations are implementing the strategy, they are not reaching their stated goals; alternatively, a universal indirect program may only reach a limited audience according to the KIT measures. Additionally, if the narrative accompanying the record is consulted, it may reveal that organizations are adapting programs to local conditions not implementing the program as designed and proven to be effective through research.

Evaluation of Selective and Indicated Prevention Strategies: While a comprehensive evaluation of prevention efforts is valuable to determine impacts of universal direct and universal indirect strategies on community and statewide consumption patterns, evaluating the effectiveness of selective and indicated strategies for individuals is also important. As these types of strategies are often labor intensive and expensive, it is important to know if they are changing individual behaviors as anticipated. Process counts collected through KIT for selective and indicated prevention strategies should be reevaluated to ensure that the information being collected provides insight into how these programs function.

An additional data collection technique for such programs is through the administration of pre- and post-tests that can be used to evaluate a strategy's effectiveness. It is also important that each strategy has uniform data collection procedures, for both process and outcomes, to allow for aggregation at the state level to determine effectiveness. By collecting the same data when strategies are implemented, communities are able to compare their success with other communities and gain insight into how appropriate an intervention is for their setting. Additionally, selective or indicated prevention strategies would benefit from longitudinal data collection that provides information about the long-term effectiveness of the interventions for participants.

Additional Gaps, Challenges or Considerations

The following items represent additional knowledge or data gaps, considerations or challenges facing evaluation of prevention efforts in Maine that are overarching across the various programs and funding sources; these have not been discussed in the previous sections.

Federal Reporting Requirements: When OSA receives federal dollars, the Government Performance and Report Act (GPRA) requires it to report specific measures related to that funding source. Similarly, many federal grants also have National Outcome Measures (NOMs), which relate to outcomes of individuals receiving the services or programs being funded. It is imperative to sustaining federal funding for prevention that Maine be able to demonstrate the capacity to fully report on GPRA measures and NOMs as required by the associated federal funding source. In cases where there is an inability to meet federal requirements, data collection and reporting capacity should be built. Moreover, OSA should explore whether it has the capacity to report on GPRA/NOMs for funding sources that it would like to pursue (e.g., Partnerships for Success grants that require measures for young adults) and build that infrastructure to demonstrate capacity in future applications.

Other Prevention Efforts: There are numerous prevention efforts in Maine that OSA does not fund, but that should be acknowledged since they are often closely aligned with OSA's programs. Examples include Drug Free Communities grants and school-based Grants to Reduce Alcohol Abuse. Such programs are part of community prevention efforts and, though not linked to OSA through finances or official oversight, are important to consider alongside OSA's efforts. As these programs are not part of OSA, access to process data is limited. For example, school-based programs present challenges for evaluation because reliable school data are difficult to obtain, especially after the elimination of funding through Safe and Drug-Free Schools. Although OSA is not responsible for the administration and evaluation of these programs, efforts should be made to incorporate information about collaboration with external agencies as part of routine process data collection. Knowledge of other community prevention efforts could provide insight into effective collaboration strategies that should be implemented throughout Maine's prevention infrastructure.

Evaluation of Cost-Benefits and Cost-Savings: Maine is concerned with the cost benefits and cost savings associated with substance abuse prevention. The most recent report addressing these areas was produced in 2005 and the analyses are not sustained or updated regularly. The state needs to research various methodologies and decide which indicators are most useful and feasible to track, analyze and report cost savings. Costs and other monetary measures are outcome measures that complement the consumption pattern and consequence data currently analyzed and reported for prevention. The capacity to collect, analyze and report projected cost saving measures would demonstrate additional benefits of prevention efforts. Less extreme consequences than mortality rates or crime associated with substance abuse could be reported through an analysis of cost. For example, determining the cost savings of a prevention approach to drunk driving compared to treatment programs required of individuals convicted of operating under the influence provides another perspective to the prevention approach.

Evaluation Methods: The evaluation efforts undertaken for prevention need to incorporate qualitative data collection methods to gain further insight into the connections between interventions and outcomes. Moreover, Maine should involve local coalitions in developing evaluation strategies. These groups are very interested in seeing how their efforts relate to outcomes data and understand the importance of using these data.

III. Summary of Performance Measurement and Evaluation

Process data are collected through various sources and reported quarterly as required by the funding source (e.g., KIT Solutions, Enforcement of Underage Drinking Laws). These data provide information about the strategies implemented, the number of collaborators and potential reach of the interventions. The specific evaluation challenges associated with each program vary according to unique program characteristics, the culture of target populations or the nature of data availability. Examples are the difficulty of obtaining consistent measures from police departments or the hesitance of higher education institutions to share information publicly. Due to limited sub-state outcomes data, however, it is difficult to compare the

outcomes measures of communities and relate them to the particular intervention efforts they implemented. The only way to determine the impact of prevention efforts is to consider whether the various target outcomes changed from year to year.

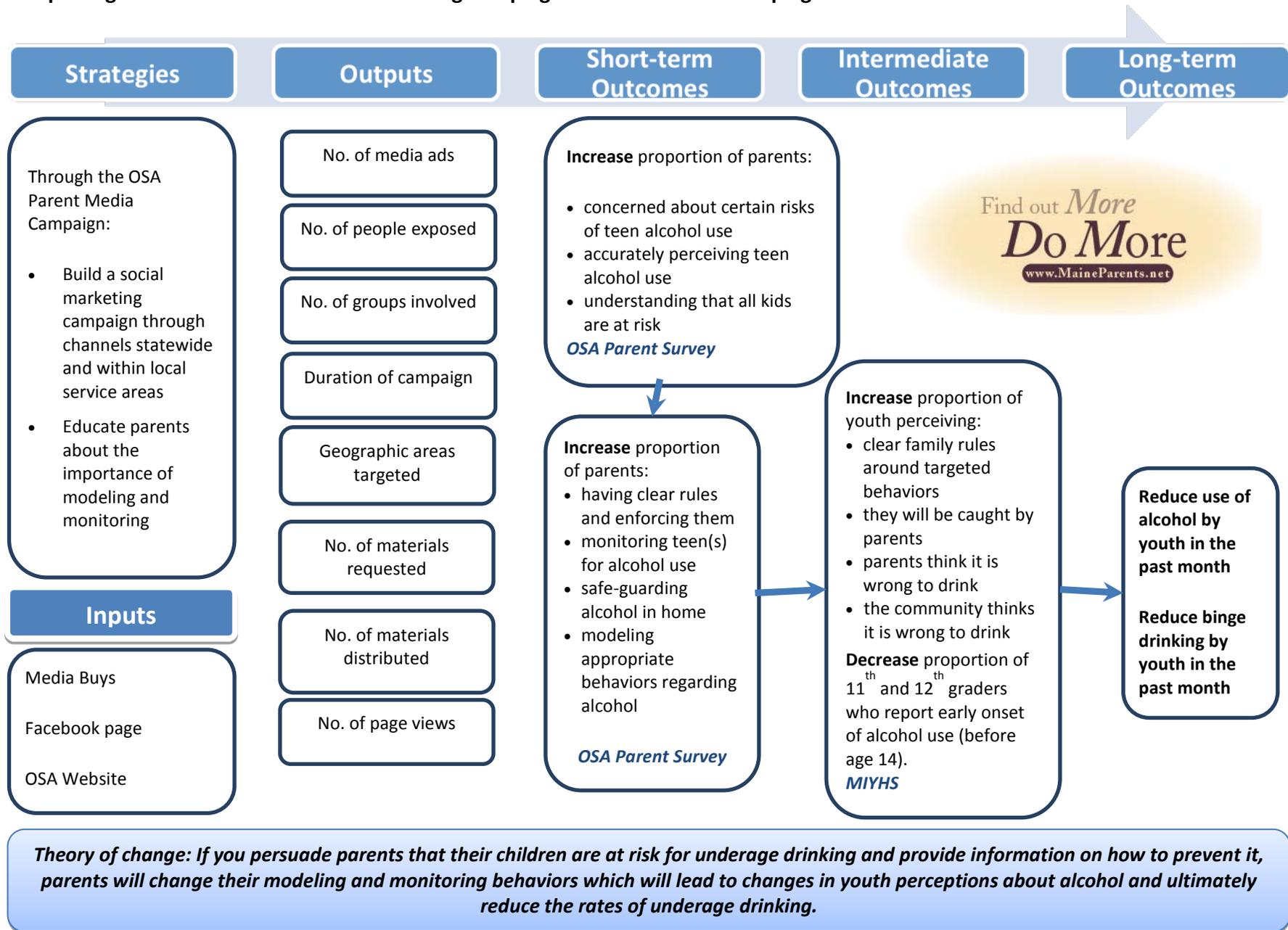
Maine does not have a comprehensive approach to evaluating all of its prevention efforts. Current evaluation efforts are project- and funding source-specific. As mentioned above, each funding source has its own reporting requirements and not all programs evaluate their efforts. None of the individual prevention efforts take into account the efforts of other programs if they are funded through different sources. They also do not take into account how the various strategies interact with one another to affect the outcomes measures within the same jurisdiction. It should be noted that the HEAPP and EUDL programs are making efforts to coordinate the type of process data they collect to allow for better comparisons and to avoid double-reporting of the same efforts in each of their reporting systems. The data collection and evaluation procedures for selective and indicated prevention strategies are not uniform, making use of these data at the statewide level or for comparison purposes difficult. The OSA Annual reports detail the percentage of OSA funds that are allocated to prevention and treatment as well as describe the outcomes trends. In addition, the report outlines the relationship among various stakeholders (e.g., public safety, schools, etc.). However, the data are observational and the report's utility as an evaluation tool is limited.

In sum, evaluation efforts for prevention in Maine are generally undertaken on a project-specific basis rather than building an ongoing and comprehensive capacity. Based on the assessment above, the following priority areas have emerged as the primary focus for enhancing performance measurement and evaluation for prevention in Maine:

- Collecting and reporting required federal measures (GPRA; NOMs)
- Routinely conducting cost-benefit and cost-savings analyses
- Linking process measures to outcomes to gauge program effectiveness
- Engaging in a comprehensive approach to prevention evaluation

A complete discussion of how to address these areas of performance measurement and evaluation, including goals, objectives and milestones, can be found in Strategic Prevention Plan 2013-2018.

**Attachment 1:
Sample Logic Model from OSA Social Marketing Campaigns—Parent Media Campaign**



Attachment 2: Center for Disease Control Evaluation Standards

Evaluation Standards

This set of 30 standards assesses the quality of evaluation activities, determining whether a set of evaluative activities are well-designed and working to their potential. These standards, adopted from the **Joint Committee on Standards for Educational Evaluation**, answer the question, "Will this evaluation be effective?" The standards are recommended as criteria for judging the quality of program evaluation efforts in public health.

The 30 standards are organized into the following groups:

1. **Utility standards** ensure that an evaluation will serve the information needs of intended users.
2. **Feasibility standards** ensure that an evaluation will be realistic, prudent, diplomatic and frugal.
3. **Propriety standards** ensure that an evaluation will capture what is proper, fair, legal, right and just in evaluations.
4. **Accuracy standards** ensure the dependability and truthfulness of evaluation representations, propositions, and findings, especially those that support interpretations and judgments about quality.
5. **Accountability standards** encourage adequate documentation of evaluations and a meta-evaluative perspective focused on improvement and accountability

Utility Standards

The utility standards are intended to increase the extent to which program stakeholders find evaluation processes and products valuable in meeting their needs.

1. **Evaluator Credibility** Evaluations should be conducted by qualified people who establish and maintain credibility in the evaluation context.
2. **Attention to Stakeholders** Evaluations should devote attention to the full range of individuals and groups invested in the program and affected by its evaluation.
3. **Negotiated Purposes** Evaluation purposes should be identified and continually negotiated based on the needs of stakeholders.
4. **Explicit Values** Evaluations should clarify and specify the individual and cultural values underpinning purposes, processes, and judgments.
5. **Relevant Information** Evaluation information should serve the identified and emergent needs of stakeholders.
6. **Meaningful Processes and Products** Evaluations should construct activities, descriptions, and judgments in ways that encourage participants to rediscover, reinterpret, or revise their understandings and behaviors.
7. **Timely and Appropriate Communicating and Reporting** Evaluations should attend to the continuing information needs of their multiple audiences.

- 8. Concern for Consequences and Influence** Evaluations should promote responsible and adaptive use while guarding against unintended negative consequences and misuse.

Feasibility Standards

The feasibility standards are intended to increase evaluation effectiveness and efficiency.

- 1. Project Management** Evaluations should use effective project management strategies.
- 2. Practical Procedures** Evaluation procedures should be practical and responsive to the way the program operates.
- 3. Contextual Viability** Evaluations should recognize, monitor, and balance the cultural and political interests and needs of individuals and groups.
- 4. Resource Use** Evaluations should use resources effectively and efficiently.

Propriety Standards

The propriety standards support what is proper, fair, legal, right and just in evaluations.

- 1. Responsive and Inclusive Orientation** Evaluations should be responsive to stakeholders and their communities.
- 2. Formal Agreements** Evaluation agreements should be negotiated to make obligations explicit and take into account the needs, expectations, and cultural contexts of clients and other stakeholders.
- 3. Human Rights and Respect** Evaluations should be designed and conducted to protect human and legal rights and maintain the dignity of participants and other stakeholders.
- 4. Clarity and Fairness** Evaluations should be understandable and fair in addressing stakeholder needs and purposes.
- 5. Transparency and Disclosure** Evaluations should provide complete descriptions of findings, limitations, and conclusions to all stakeholders, unless doing so would violate legal and propriety obligations.
- 6. Conflicts of Interests** Evaluations should openly and honestly identify and address real or perceived conflicts of interests that may compromise the evaluation.
- 7. Fiscal Responsibility** Evaluations should account for all expended resources and comply with sound fiscal procedures and processes.

Accuracy Standards

The accuracy standards are intended to increase the dependability and truthfulness of evaluation representations, propositions, and findings, especially those that support interpretations and judgments about quality.

1. **Justified Conclusions and Decisions** Evaluation conclusions and decisions should be explicitly justified in the cultures and contexts where they have consequences.
2. **Valid Information** Evaluation information should serve the intended purposes and support valid interpretations.
3. **Reliable Information** Evaluation procedures should yield sufficiently dependable and consistent information for the intended uses.
4. **Explicit Program and Context Descriptions** Evaluations should document programs and their contexts with appropriate detail and scope for the evaluation purposes.
5. **Information Management** Evaluations should employ systematic information collection, review, verification, and storage methods.
6. **Sound Designs and Analyses** Evaluations should employ technically adequate designs and analyses that are appropriate for the evaluation purposes.
7. **Explicit Evaluation Reasoning** Evaluation reasoning leading from information and analyses to findings, interpretations, conclusions, and judgments should be clearly and completely documented.
8. **Communication and Reporting** Evaluation communications should have adequate scope and guard against misconceptions, biases, distortions, and errors.

Evaluation Accountability Standards

The evaluation accountability standards encourage adequate documentation of evaluations and a meta-evaluative perspective focused on improvement and accountability for evaluation processes and products.

1. **Evaluation Documentation** Evaluations should fully document their negotiated purposes and implemented designs, procedures, data, and outcomes.
2. **Internal Meta-evaluation** Evaluators should use these and other applicable standards to examine the accountability of the evaluation design, procedures employed, information collected, and outcomes.
3. **External Meta-evaluation** Program evaluation sponsors, clients, evaluators, and other stakeholders should encourage the conduct of external meta-evaluations using these and other applicable standards.

Appendix K

Supporting Document: Cultural Competency

The following information was assembled as part of the Strategic Prevention Enhancement planning process.

Cultural Competency: Definitions of Cultural Competency

Identified eight definitions of cultural competency used by the following Maine State Agencies/Entities

- DHHS, Office of Substance Abuse
- DHHS, Maine CDC, Division of Population Health
- DHHS, Adult Mental Health Services
- DHHS, Adults with Cognitive and Physical Disabilities
- DHHS, Office of Multicultural Affairs
- DHHS, Office of Child and Family Services, Child Protective Services
- DHHS, Maine CDC, Maine Public Health Data Reports
- Maine Human Rights Act, [2005, c. 10, §1 (AMD).] §4552. Policy

Identified seven definitions of cultural competency used by the following Federal Agencies/Entities

- HHS, Substance Abuse and Mental Health Services Administration
- HHS, Administration for Children and Families, Office of Child Care/Office of Head Start
- HHS, Agency for Toxic Substance & Disease Registry
- HHS, Centers for Disease Control and Prevention, Office of Minority Health & Health Equity
- HHS, Health Resources and Services Administration
- HHS, Office of Minority Health
- HHS, Centers for Disease Control and Prevention

Definition of cultural competency used by National Center for Cultural Competence at Georgetown University

Cultural competence requires that organizations and their personnel have the capacity to: (1) value diversity, (2) conduct self-assessment, (3) manage the dynamics of difference, (4) acquire and institutionalize cultural knowledge, and (5) adapt to the diversity and cultural contexts of the individuals and communities served. Consistent with this framework, a major focus of the NCCC is the provision of technical assistance to conduct self-assessment within health care and human service agencies. The focus includes the development of assessment instruments and processes for both organizations and individuals.

Summary of Findings

- Many organizations (including Maine OSA) derive their definitions of cultural competence from Cross T., Bazron, B., Dennis, K., & Isaacs, M. (1989). *Towards a Culturally Competent System of Care, Volume I*. Washington, D.C.: Georgetown University Child Development Center, CASSP Technical Assistance Center.
- Cultural competence emphasizes the importance of understanding people from different backgrounds, whether it be communicating with a patient in his/her native language or approaching interactions with an understanding of an individual's customs and beliefs. This understanding leads to more appropriate and more effective care.
- Cultural competence stems from acknowledgement of and respect for differences.
- Cultural competence must be developed at all service levels of an organization.
- Definitions differ somewhat based on the "level" such as State Agency versus service provider.
- Definitions differ somewhat based on discipline (e.g., MH vs. SA vs. public health).
- Services need to be tailored to suit the needs of communities/patients; they cannot be one size fits all.

Recommendations

- The definition adopted by OSA should emphasize a commitment to continuously developing cultural competency at all levels of the organization.
- Follow CDC language because it follows public health model and aligns with ME CDC definitions already in place for public health.
- This definition should also incorporate MH considerations where applicable.
- Another good example is the definition from the National Registry of Evidence-based Programs and Practices (NREPP) glossary on the SAMHSA website:

In the context of public health, the knowledge and sensitivity necessary to tailor interventions and services to reflect the norms and culture of the target population and avoid styles of behavior and communication that are inappropriate, marginalizing, or offensive to that population. Generally used to describe people or institutions. Because of the changing nature of people and cultures, cultural competence is seen as a continual and evolving process of adaptation and refinement.

Definitions of Cultural Competency Used by Maine State Agencies

Agency/Source	Working Definition
<p>DHHS Office of Substance Abuse</p> <p>http://www.maine.gov/dhhs/osa/prevention/community/spfsig/projects/subpops.htm</p> <p>http://www.maine.gov/dhhs/osa/ppreventio/community/spfsig/plansdpla/county%20strategic%20plans_aassessment/knoxspepassessment.rtf</p>	<p>A Cultural Subpopulation is defined as any subpopulation in the state which shares a distinct set of cultural characteristics that appear to influence the substance abuse patterns and related impacts within that group. Culture is defined by the National Center on Cultural Competence, Georgetown University as “an integrated pattern of human behavior, which includes but is not limited to—thought, communication, languages, beliefs, values, practices, customs, courtesies, rituals, manners of interacting, roles, relationships and expected behaviors of a racial, ethnic, religious, social or political group; the ability to transmit the above to succeeding generations; dynamic in nature.</p> <p>Cultural Competence: Cultural competence is defined as attention to diversity, group symmetry, and inclusion in all thinking and action. It involves:</p> <ol style="list-style-type: none"> 1. Inclusion of individuals from diverse backgrounds within the leadership of SPEP prevention activities; 2. Participation of all segments of the community in the SPEP process; 3. Contributions of all segments of the community in substance abuse prevention efforts; and 4. Participation of all segments of the community in all aspects of substance abuse prevention.
<p>DHHS, ME CDC Division of Population Health</p> <p>http://www.maine.gov/dhhs/mecdc/population-health/cshn/culturalcompetency</p>	<p>Cultural and linguistic competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations. 'Culture' refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. 'Competence' implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities.</p> <p>(Adapted from Cross, 1989).</p>
<p>DHHS Adult Mental Health Services</p> <p>http://www.maine.gov/dhhs/mh/recovery/glossary.shtml</p>	<p>Cultural Competence: is knowledge, data and information from and about individuals and groups that is integrated and transformed into clinical standards, skills, service approaches, techniques, and marketing programs that match the individual's culture and increase both the quality and appropriateness of health care and health outcomes. As a multidimensional construct, cultural competence can be conceptualized from provider, program, agency, and health care system levels.</p>
<p>DHHS Adults with Cognitive and Physical Disabilities</p> <p>http://www.maine.gov/dhhs/OACPDS/DS/CommCaseManagement/Certification/definitions.html</p>	<p>Cultural competence: the ability to understand, respect and effectively work with persons/groups with various cultural backgrounds including age and gender.</p>

Agency/Source	Working Definition
<p>DHHS Office of Multicultural Affairs</p> <p>http://www.maine.gov/dhhs/oma/MulticulturalResource/interpreting.html</p>	<p>Interpreting Services & Referral Agencies [Cultural Competency relies on language competency]</p>
<p>DHHS, OCFS Child Protective Services</p> <p>http://www.maine.gov/dhhs/ocfs/ccp/cpstextonlyunit3.htm</p>	<p>Culturally Competent Practices for Child Protective Caseworkers</p> <ul style="list-style-type: none"> •The US Department of Health and Human Services offers these guidelines for culturally competent practice for Child Protective Caseworkers. •Cultural awareness. Understanding and identifying the critical cultural values important to children and the family as well as to the caseworker. • Knowledge acquisition. Understanding how these cultural values function as strengths in children and the family. • Skill development. Matching services that support the identified cultural values and then incorporating them into appropriate interventions. • Inductive learning. Seeking solutions that consider indigenous interventions as well as match cultural values to Western interventions. <p>The practice implications for CPS caseworkers include that they are asked to:</p> <ul style="list-style-type: none"> • Respect how clients differ from them; •Avoid judgments and decision-making resulting from biases, myths, or stereotypes; •Ask the client about a practice’s history and meaning if unfamiliar with it; •Elicit information from the client regarding strongly held family traditions, values, and beliefs, especially child rearing practices; •Understanding the family’s cultural values, principles of child development, child caring norms, and parenting strategies; •Gaining clarity regarding the family’s perceptions of the responsibilities of adults and children in the extended family and community network; •Determining the family’s perceptions of the impact of child abuse or neglect. •Assessing each risk factor with consideration of characteristics of the cultural or ethnic group; •Explaining why a culturally accepted behavior in the family’s homeland may be illegal here.

Agency/Source	Working Definition
<p>DHHS, ME CDC Maine Public Health Data Reports</p> <p>Maine Public Health Data Reports Glossary of Terms: http://www.maine.gov/dhhs/mecdc/phdata/glossary.htm</p>	<p>A set of behaviors and attitudes that enable us to understand and work effectively in cross-cultural situations. The result of cultural competency is the establishment of positive helping relationships that effectively engage people, and the significant improvement of quality of services such as public health and health care</p>
<p>Maine Human Rights Act</p> <p>[2005, c. 10, §1 (AMD).] §4552. Policy</p>	<p>To protect the public health, safety and welfare, it is declared to be the policy of this State to keep continually in review all practices infringing on the basic human right to a life with dignity, and the causes of these practices, so that corrective measures may, where possible, be promptly recommended and implemented, and to prevent discrimination in employment, housing or access to public accommodations on account of race, color, sex, sexual orientation, physical or mental disability, religion, ancestry or national origin;</p>

Current Status of Cultural Competency Trainings Available

Summary of Findings

- Identified very few Maine cultural competency training opportunities.
- Georgetown's National Center for Cultural Competence has a variety of resources online that can be used or adapted for use in Maine.
- Many of the Maine and online training opportunities focus on a medical/physical health perspective. The approach could be easily modified to teach the same skills to prevention professionals.
- The Cultural Competence Training Center of Central New Jersey offers cultural competency training specifically for mental health professionals and agencies that receive public mental health funding in New Jersey. (www.cctcnj.org)
- Maine does not have a central repository that gathers information about cultural competency training opportunities.
- Most cultural competency trainings are embedded within larger efforts to educate about diversity that are in turn embedded within a larger training.
- Uncertain if OSA/Prevention team accesses the resources on Georgetown's NCCC website.

Recommendations

- Encourage the use of the prevention calendar to promote cultural competency training opportunities.
- Better disseminate training announcements.
- Explore ways to offer regular trainings.
- Offer trainings specific to substance abuse/mental health.
- Develop a central repository of cultural competency training opportunities.
- Identify cultural competency trainings that are embedded in other trainings that address diversity and language.
- In addition to training in how to approach prevention efforts with a culturally competent perspective, educate prevention specialists about the various cultures in Maine and how differences (e.g., in beliefs, customs, languages) affect their work. In essence, awareness of cultural differences and an acknowledgement that they affect interactions in substance abuse prevention efforts is an important step, but is not as effective if professionals are uninformed about particular cultural beliefs and customs.

Cultural Competency: Trainings in Maine and Online

Who Conducts Training	Intended Audience	Types of training	SA/MH/Cultural Competence Specific Training	Source
Fox Intercultural Consulting Services	Businesses, individuals, educational institutions and local communities	Strategies for Effective Cross-Cultural Communication, China Briefings, South Korea Briefings, America for the Non-American, Cross-Cultural Issues in Patient Care	Programs can be custom designed based on specific needs.	http://www.maine.gov/dhhs/oma/MulticulturalResource/train.html
SETU (Maine)	DHHS Supervisors and Managers Only	This four day program is designed for new supervisors in State government, specifically those working for the Department of Health and Human Services	The Fourth day's agenda will include: Employee Discipline and Contract Administration; Drugs and Alcohol in the workplace; and Diversity and workplace respect. One of the trainers, Kate Carnes, is certified in Cultural Competency for Health Care providers	SETU training calendar MAY 3, 10, 17 & 24, 2012
New England Alliance for Public Health Workforce Development	Public Health Professionals	E-Learning - Cultural Competency and Diversity	<ul style="list-style-type: none"> Improving the Public's Health: Environmental Justice & Community Partnership Considerations for Public Health Nurses International Field Research 	http://sph.bu.edu/otlt/alliance/training_culturalcompetency.php

Who Conducts Training	Intended Audience	Types of training	SA/MH/Cultural Competence Specific Training	Source
UMaine Farmington Summer Course	Professional Ethics, Cultural Competence, and Evidence-based Practices in Early Intervention and Early Childhood Special	Graduate level course through UMaine	Through the course, students engage in reflective inquiry regarding developing personal cultural competency. Students identify and use current research to increase personal knowledge and skills, applying findings to present work settings. Related to course objectives and required assignments, students spend a minimum of 20 hours working in an early intervention or early childhood special education setting.	http://outreach.umf.maine.edu/pprogram-information/summer-2012-courses/sed-517-professional-ethics-cultural-competence-and-evidence-based-practices-in-early-intervention-and-early-childhood-special/
National Center for Cultural Competence (online)	Health professionals	Bridging the Cultural Divide in Health Care Settings: The Essential Role of Cultural Broker Programs		http://www.culturalbroker.info/
National Center for Cultural Competence (online)	Health professionals	Cultural and Linguistic Competence Self-assessment for Fetal and Infant Mortality Review Programs		http://nccc.georgetown.edu/Webinars.html

Who Conducts Training	Intended Audience	Types of training	SA/MH/Cultural Competence Specific Training	Source
National Center for Cultural Competence (online)	Division of Research, Training and Education-funded programs	Curricula Enhancement Module Series	<ul style="list-style-type: none"> • Cultural awareness • Cultural self-assessment • Process of inquiry -- communicating in a multicultural environment • Public health in a multicultural environment 	http://www.nccccurricula.info/
National Center for Cultural Competence (online)	health care providers, policy makers, public health professionals, researchers and agency staff	Data Vignettes	personal learning and development or to augment curricula and training activities for health care providers, policy makers, public health professionals, researchers and agency staff. Each vignette contains links to additional resources related to concepts discussed and a set of questions for discussion.	http://nccc.georgetown.edu/data_vignettes/index.html
National Center for Cultural Competence (online)	Health promotion trainers	Infusing Cultural and Linguistic Competence into Health Promotion Training	Designed to help experienced health promotion trainers assure that their approaches with diverse populations address culture and language in an effective, appropriate and respectful manner.	http://nccc.georgetown.edu/projects/sids/dvd/index.html
National Center for Cultural Competence (online)	Various	Self-Assessments		http://nccc.georgetown.edu/resources/assessments.html

Who Conducts Training	Intended Audience	Types of training	SA/MH/Cultural Competence Specific Training	Source
National Center for Cultural Competence (online)	Systems of care	Planning for Cultural and Linguistic Competence in Systems of Care	Designed to assist organizations and systems of care to develop policies, structures and practices that support cultural and linguistic competence.	http://nccc.georgetown.edu/documents/SOC_Checklist.pdf
Think Cultural Health (Office of Minority Health)	Health professionals	Continuing education programs	Designed to help individuals at all levels and in all disciplines promote health and health equity.	https://www.thinkculturalhealth.hhs.gov/Content/ContinuingEd.asp?chooselist=yes&menu=Other
The Cultural Competence Training Center of Central NJ	Mental health professionals and agencies that receive public mental health funding in NJ	Cultural Competence Exercises: Getting Started	Intensive Clinical Training Series Clinical Supervision Series Leadership Training/consultation Series	http://www.cctcnj.org/index.php?option=com_content&task=view&id=63&Itemid=27

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Cultural Competency: Annotated Bibliography

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Many organizations derive their definitions of cultural competence from this document.

“Bridging the Cultural Divide in Health Care Settings: The Essential Role of Cultural Broker Programs” Developed By: National Center for Cultural Competence, Georgetown University Center for Child and Human Development Georgetown University Medical Center, Spring/Summer 2004.

This guide is designed to assist health care organizations in planning, implementing, and sustaining cultural broker programs in ways including the following:

- Introduce the legitimacy of cultural brokering in health care delivery to underserved populations.
- Promote cultural brokering as an essential approach to increase access to care and eliminate racial and ethnic disparities in health.
- Define the values, characteristics, areas of awareness, knowledge, and skills required of a cultural broker.
- Provide guidance on establishing and sustaining a cultural broker program for health care settings that is tailored to the needs and preferences of the communities served.

This guide can serve as a resource to organizations and agencies that are interested in partnering with health care organizations to enhance the health and well-being of communities.

Miguel E. Gallardo & Shannon J. Curry (2009): *Shifting Perspectives: Culturally Responsive Interventions With Latino Substance Abusers*, *Journal of Ethnicity in Substance Abuse*, 8:3, 314-329.

In 2001, there were 35 million Latinos living in the United States. It is estimated that by 2050 Latinos will comprise 97 million people in the United States, or one-fourth of the U.S. population, establishing this ethnic group as the fastest growing and soon to be largest in the country (U.S. Census Bureau, 2001). These numbers highlight the need for a multicultural paradigm shift, or the inclusion of culture-specific skills and culturally responsive interventions in psychological practice. Latinos face challenges as a racial=ethnic group that the traditional Euro-American model of treatment neither addresses nor validates. Unfortunately, substance abuse serves a purposeful function for many Latinos as a means of escape from the problems related to the social, environmental, and political structures. The current article adapts the model set forth by Parham (2002) as a strength-based therapeutic framework for intervention. The following stages are outlined to serve as the basis for most therapeutic encounters with

clients from all racial and ethnic groups presenting with substance abuse problems: therapeutic alliance building, culturally appropriate assessment, sociopolitical awareness and liberation, creating collaborative change, and addressing sustainability of change.

Jeremy T. Goldbach, L.M.S.W., Sanna J. Thompson, Ph.D., and Lori K. Holleran Steiker, Ph.D., “Special Considerations for Substance Abuse Intervention with Latino Youth” *The Prevention Researcher*, Volume 18(2), April 2011.

Latino communities bring a vast and rich experience to the fabric of the United States. Latino adolescents’ unique experiences, stressors, and circumstances should be incorporated into prevention and treatment interventions (Ramirez et al., 2004; Strait, 1999). Their dynamic and diverse experiences suggest the need for developing culturally-appropriate prevention strategies and interventions to address the high-risk behaviors of Latino youth. Insight concerning stressors, as well as some evidence to support family-based interventions, provides a foundation for developing strategies that address the needs of these youth and the Latino community in general.

Erick Guerrero and Christina M. Andrews, “Cultural competence in outpatient substance abuse treatment: Measurement and relationship to wait time and retention,” *Drug and Alcohol Dependence*, 119 (2011), e13– e22.

Background: Culturally competent practice is broadly acknowledged to be an important strategy to increase the quality of services for racial/ethnic minorities in substance abuse treatment. However, few empirically derived measures of organizational cultural competence exist, and relatively little is known about how these measures affect treatment outcomes.

Method: Using a nationally representative sample of outpatient substance abuse treatment (OSAT) programs, this study used item response theory to create two measures of cultural competence—organizational practices and managers’ culturally sensitive beliefs—and examined their relationship to client wait time and retention using Poisson regression modeling.

Results: The most common and precisely measured organizational practices reported by OSAT managers included matching providers and clients based on language/dialect; offering cross-cultural training; and fostering connections with community and faith-based organizations connected to racial and ethnic minority groups. The most culturally sensitive belief among OSAT managers was support for language/dialect matching for racial and ethnic minority clients. Results of regression modeling indicate that organizational practices were not related to either outcome. However, managers’ culturally sensitive beliefs were negatively associated with average wait time ($p < 0.05$), and positively associated with average retention ($p < 0.01$).

Conclusions: Managers’ culturally sensitive beliefs—considered to be influential for effective implementation of culturally competent practices—may be particularly relevant in influencing wait time and retention in OSAT organizations that treat Latinos and African American clients.

Kelly L. Hazel and Gerald V. Mohatt, "Cultural and Spiritual Coping In Sobriety: Informing Substance Abuse Prevention for Alaska Native Communities," *Journal of Community Psychology*, Vol. 29, No. 5, 541–562 (2001).

Culture and spirituality have been conceptualized as both protecting people from addiction and assisting in the recovery process. A collaborative study, utilizing focus group and survey methods, defined and examined cultural and spiritual coping in sobriety among a select sample of Alaska Natives. Results suggest that the Alaska Native worldview incorporates a circular synthesis and balance of physical, cognitive, emotional, and spiritual processes within a protective layer of family and communal/cultural beliefs and practices embedded within the larger environment. Cultural-spiritual coping in sobriety is a process of appraisal, change, and connection that leads the person toward achieving an overarching construct: a sense of coherence. Cultural and spiritual processes provide important areas for understanding the sobriety process as well as keys to the prevention of alcohol abuse and addiction.

National Standards for Culturally and Linguistically Appropriate Services in Health Care Final Report, U.S. Department of Health and Human Services, OPHS Office of Minority Health, March 2001.

As the U.S. population becomes more diverse, medical providers and other people involved in health care delivery are interacting with patients/consumers from many different cultural and linguistic backgrounds. Because culture and language are vital factors in how health care services are delivered and received, it is important that health care organizations and their staff understand and respond with sensitivity to the needs and preferences that culturally and linguistically diverse patients/consumers bring to the health encounter. Providing culturally and linguistically appropriate services (CLAS) to these patients has the potential to improve access to care, quality of care, and, ultimately, health outcomes.

Unfortunately, a lack of comprehensive standards has left organizations and providers with no clear guidance on how to provide CLAS in health care settings. In 1997, the Office of Minority Health (OMH) undertook the development of national standards to provide a much-needed alternative to the current patchwork of independently developed definitions, practices, and requirements concerning CLAS. The Office initiated a project to develop recommended national CLAS standards that would support a more consistent and comprehensive approach to cultural and linguistic competence in health care.

Douglas Piper, Al Stein-Seroussi, Robert Flewelling, Robert G. Orwin, and Rebecca Buchanan, "Assessing state substance abuse prevention infrastructure through the lens of CSAP's Strategic Prevention Framework," *Evaluation and Program Planning*, 35 (2012) 66–77.

Although the organizational structures and operating procedures of state substance abuse prevention systems vary substantially across states, there is scant empirical research regarding approaches for rigorous assessment of system attributes and which attributes are most conducive to overall effectiveness. As one component of the national cross-site evaluation of

the SPF State Incentive Grant Program (SPF SIG), an instrument was developed to assess state substance abuse prevention system infrastructure in order to measure infrastructure change and examine the role of state infrastructure in achieving prevention-related outcomes. In this paper we describe the development of this instrument and summarize findings from its baseline administration. As expected, states and territories were found to vary substantially with respect seven key characteristics, or domains, of state prevention infrastructure. Across the six domains that were assessed using numeric ratings, states scored highest on data systems and lowest on strategic planning. Positive intercorrelations were observed among these domains, indicating that states with high capacity on one domain generally have relatively high capacity on other domains as well. The findings also suggest that state prevention infrastructure development is linked to both funding from state government and the presence of a state interagency coordinating body with decision-making authority. The methodology and baseline findings presented will be used to inform the ongoing national cross-site evaluation of the SPF SIG and may provide useful information to guide further research on state substance abuse prevention infrastructure.

Clayton Shorkey, PhD, LCSW, Liliane Cambraia Windsor, LMSW, Richard Spence, PhD, “Assessing Culturally Competent Chemical Dependence Treatment Services for Mexican Americans,” *Journal of Behavioral Health Services & Research*, 2008.

Mexican Americans struggling with chemical dependence are greatly underserved. Barriers to treatment include language, lack of culturally relevant services, lack of trust in programs, uninviting environments, and limited use and linkage with cultural resources in the community. This project aimed to develop a tool for assessing and planning culturally competent/relevant chemical dependence treatment services for Mexican Americans. Focus groups were conducted with experts in Mexican-American culture and chemical dependence from six substance abuse programs serving adult and adolescent Mexican Americans and their families. Sixty-two statements were developed describing characteristics of culturally competent/relevant organizations. Concept mapping was used to produce a conceptual map displaying dimensions of culturally competent/relevant organizations and Cronbach’s alpha was calculated to assess the internal consistency of each dimension. Analysis resulted in seven reliable subscales: Spanish language ($\alpha=0.84$), counselor characteristics ($\alpha=0.82$), environment ($\alpha=0.88$), family ($\alpha=0.84$), linkage ($\alpha=0.92$), community ($\alpha=0.86$), and culture ($\alpha=0.89$). The resulting instrument based on these items and dimensions enable agencies to evaluate culturally competent/relevant services, set goals, and identify resources needed to implement desired services for both individual organizations and networks of regional services.

Laurie M. Anderson, PhD, MPH, Susan C. Scrimshaw, PhD, Mindy T. Fullilove, MD, Jonathan E. Fielding, MD, MPH, MBA, Jacques Normand, PhD, and the Task Force on Community Preventive Services, “Culturally Competent Healthcare Systems: A Systematic Review,” *American Journal of Preventive Medicine*, 2003;24(3S).

Culturally competent healthcare systems—those that provide culturally and linguistically appropriate services—have the potential to reduce racial and ethnic health disparities. When

clients do not understand what their healthcare providers are telling them, and providers either do not speak the client's language or are insensitive to cultural differences, the quality of health care can be compromised. We reviewed five interventions to improve cultural competence in healthcare systems—programs to recruit and retain staff members who reflect the cultural diversity of the community served, use of interpreter services or bilingual providers for clients with limited English proficiency, cultural competency training for healthcare providers, use of linguistically and culturally appropriate health education materials, and culturally specific healthcare settings. We could not determine the effectiveness of any of these interventions, because there were either too few comparative studies, or studies did not examine the outcome measures evaluated in this review: client satisfaction with care, improvements in health status, and inappropriate racial or ethnic differences in use of health services or in received and recommended treatment.

Appendix L

Supporting Document: Grant Writing Competencies

Grant Writing in Maine

Grant writing in Maine is most often conducted by individuals with many other tasks and responsibilities, not by professional grant writers. Nonprofit organizations such as the Maine Association of Nonprofits and AdCare host workshops on various aspects of grant writing. Webinars provide additional training opportunities. However, most grant writers learn their craft through mentoring, experience, and trial and error.

Grant Professionals Certification

The Grant Professionals Certification Institute administers the Grant Professional Certification (GPC), a certification program that measures an individual's ability to provide quality grant-related services within an ethical framework. (<http://grantprofessionals.org/>) While a certification program is not a necessary part of workforce development in the area of grant seeking and grant writing, a coordinated approach should include competencies identified by experts in the field.

GPC identifies the following competencies and skills in the grants profession: ethics, proposal planning, resource knowledge and research, grant construction, professional development and grant management. More specifically, the GPC identifies the following competencies:

- Strong writing skills.
- Knowledge of how to craft, construct and submit an effective grant application.
- Knowledge of strategies for effective program and project design and development.
- Knowledge of how to research, identify and match funding resources to meet specific needs
- Knowledge of organizational development as it pertains to grant seeking.
- Knowledge of nationally recognized standards of ethical practice by grant developers.
- Knowledge of methods and strategies that cultivate and maintain relationships between fund-seeking and recipient organizations and funders.
- Knowledge of post-award grant management practices sufficient to inform effective grant design and development.
- Knowledge of practices and services that raise the level of professionalism of grant developers.

Detailed, Validated Competencies and Skills

Knowledge of how to research, identify, and match funding resources to meet specific needs

1. Identify major trends in public funding and public policy.
2. Identify major trends in private grant funding.
3. Identify methods of locating funding sources.
4. Identify techniques to learn about specific funders.
5. Identify methods for maintaining, tracking, and updating information on potential funders.
6. Identify effects of applicants' organizational cultures, values, decision-making processes, and norms on the pursuit of grant opportunities.
7. Identify fundable programs and projects for specific organizations.
8. Determine best matches between funders and specific programs.
9. Interpret grant application request for proposal (RFP) guidelines and requirements to accurately assess funder intent.

Knowledge of organizational development as it pertains to grant-seeking

1. Identify methods for coordinating organizations' grants development with various available funding streams.
2. Assess organizations' capacity for grant seeking.
3. Assess organizations' readiness to obtain funding for and implement specific projects.
4. Identify methods for assisting organizations to implement practices that advance grant readiness.
5. Identify values, purposes, and goals of fund-seeking entities' overall strategic plans in the grants process.
6. Identify methods of conducting mission-focused planning and needs assessments with applicant organizations.
7. Identify strategies and procedures for obtaining internal institutional support and approval of decision-makers for grant-seeking activities.
8. Identify appropriate methods of working with local, state, and federal agencies and stakeholders to support grant seeking.
9. Identify practices of grant seeking that are outside the boundaries of applicable laws and regulations.

Knowledge of strategies for effective program and project design and development

1. Identify methods of soliciting and incorporating meaningful substantive input and contributions by stakeholders, including client groups, beginning with the development of a new concept or program.
2. Identify methods of building partnerships and facilitating collaborations among applicants.
3. Identify strategies for educating grant applicants about financial and programmatic accountability to comply with funder requirements.

4. Identify structures, values, and applications of logic models as they relate to elements of project design.
5. Identify appropriate definitions of and interrelationships among elements of project design (e.g., project goals, objectives, activities, evaluation).
6. Identify design and development decisions that are data-based (e.g., descriptive, qualitative, environmental, statistical).
7. Identify existing community resources that aid in developing programs and projects.
8. Identify effects of accurate and defensible evaluation designs in program and project success and sustainability.

Knowledge of how to craft, construct, and submit an effective grant application

1. Interpret grant application request for proposal (RFP) guidelines and requirements (e.g., abstracts and summaries, problem statements and needs assessments, introductions of organizations and capability statements, references and past performance requirements, timelines, narrative formats, budget formats, standard forms and assurances, scoring rubrics) to ensure high quality responses.
2. Identify elements of standard grant proposal applications (e.g., needs assessments and statements, project objectives, project designs and methods, project narratives, activities, action plans, timelines, project evaluations, budgets, dissemination plans, future funding or sustainability statements, appendices, attachments).
3. Identify work strategies for submitting high-quality proposals on time.
4. Identify accurate and appropriate data sources to support proposal narratives.
5. Identify appropriate, sequential, consistent, and logical presentations of grant-narrative elements and ideas among or within proposal components.
6. Identify proposal-writing approaches, styles, tones, and formats appropriate for proposing organizations and various audiences.
7. Identify appropriate and accurate uses of visuals to highlight information.
8. Identify effective practices for developing realistic, accurate line-item and narrative budgets and for expressing the relationship between line-items and project activities in the budget narrative.
9. Identify sources of in-kind matches for project budgets.
10. Identify factors that limit how budgets should be written (e.g., matching requirements, supplanting issues, indirect costs, prevailing rates, performance-based fees, client fees, collective bargaining, allowable versus non-allowable costs).
11. Identify evaluation models and components appropriate to grant applications.
12. Identify methods for submitting proposals electronically.

Knowledge of post-award grant management practices sufficient to inform effective grant design and development

1. Identify standard elements of regulatory compliance
2. Identify effective practices for key functions of grant management.
3. Differentiate roles and responsibilities of project and management staff and other key principals affiliated with grant projects.
4. Identify methods of establishing transitions to post-award implementation that fulfill project applications (e.g., document transfer, accuracy in post-award fiscal and activity reporting).

Knowledge of nationally recognized standards of ethical practice by grants professionals

1. Identify characteristics of business relationships that result in conflicts of interest or give the appearance of conflicts of interest.
2. Identify circumstances that mislead stakeholders, have an appearance of impropriety, profit stakeholders other than the intended beneficiaries, and appear self-serving.
3. Identify effects of choices that foster or suppress cultural diversity and pluralistic values.
4. Distinguish between truthful and untruthful, and accurate and inaccurate representations in grant development, including research and writing.
5. Identify issues, effects, and countermeasures pertinent to grant Professionals' individual heritages, backgrounds, knowledge and experiences as they may affect the grant development process.
6. Identify funding sources that may present conflicts of interest for specific grant seekers and applicants.
7. Identify issues and practices pertinent to communicating information that may be considered privileged, proprietary, and confidential.
8. Identify unethical and illegal expenditures in a budget.
9. Distinguish between ethical and unethical methods of payment for the grant-development process.
10. Distinguish between ethical and unethical commitment, performance, and reporting of activities funded by a grant.

Knowledge of practices and services that raise the level of professionalism of grant professionals

1. Identify advantages of participating in continuing education and various grant review processes.
2. Identify advantages of participating in professional organizations that offer grant Professionals growth opportunities and advance the profession.
3. Identify how grants Professionals' networks (e.g., mailing list servers, community alliances) enhance individuals' professional growth and advance the profession.
4. Identify strategies that grant Professionals use in building social capital to benefit their communities and society at large.

Knowledge of methods and strategies that cultivate and maintain relationships between fund-seeking and recipient organizations and funders

1. Identify characteristics of mutually beneficial relationships between fund seekers and funders.
2. Identify strategies to determine funder-relation approaches that suit fund-seeking entities' missions, cultures, and values.
3. Identify methods to help fund-seeking organizations create effective collaborations with other organizations appropriate to funders' missions and goals.
4. Identify methods of relationship cultivation, communication, recognition, and stewardship that might appeal to specific funders.

Ability to write a convincing case for funding

1. Follow guidelines.
2. Use conventions of standard written English.
3. Organize ideas appropriately.
4. Convey ideas clearly.
5. Make a persuasive argument.

Grant Writing Trainings and Resources

Source	Description
<p>SAMHSA</p> <p><i>Developing Competitive SAMHSA Grant Applications</i>. March 2007.</p> <p>Available for download at http://www.samhsa.gov/grants/ta/index.aspx</p>	<p><i>Developing Competitive SAMHSA Grant Applications</i> manual was created to help grantees acquire the skills and resources needed to plan, write, and prepare a competitive grant application for SAMHSA funding.</p>
<p>Maine Association of Nonprofits</p> <p>www.mainenonprofit.org</p>	<p>“SkillBuilder” courses for beginner and intermediate grant writers, and specialty courses in developing a grant budget, government grant writing, foundation grant writing, etc. Courses are offered throughout the year.</p>
<p>University of Southern Maine</p> <p>www.usm.maine.edu/pdp/certificate-program-grant-writing</p>	<p>The Certificate Program in Grant Writing provides an intensive opportunity to acquire the knowledge and practice the skills necessary to succeed in today's competitive grant writing environment. This certificate program is composed of four courses held over five days.</p> <p>USM also offers individual grant writing courses through its Professional Development Program.</p>
<p>Maine Philanthropy Center</p> <p><i>Directory of Maine Grantmakers</i></p> <p><i>The Foundation Directory Online</i></p> <p>www.mainephilanthropy.org</p>	<p>Provides grant research tutorials and free access to the Directory of Maine Grantmakers Online, which provides basic information on grant-makers that fund projects and programs in Maine.</p> <p>Also provides tutorials and free access to The Foundation Directory Online, which provides instant access to data on foundations, corporate donors and grantmaking public charities. The Directory of Maine Grantmakers is available for purchase as well.</p>
<p>Maine Health Access Foundation</p> <p>www.mehaf.org/media/img/library/2012/03/06/other_health_funders.pdf</p>	<p>Informational document with basic information about grantmakers that fund health care initiatives in Maine. The list is a compilation of all foundations that:</p> <ul style="list-style-type: none"> • Have healthcare, health organizations, or medical research as one of their primary focuses according to the Maine Philanthropy Center database • Have previously funded projects in Maine • Have open applications or accept letters of inquiry (do not contribute only to pre-selected organizations) • Have assets approaching or exceeding \$20 million and therefore have the resources to make substantial contributions towards health projects each year

Appendix M

Supporting Document: International Certification and Reciprocity Consortium (IC&RC)



Credentialing of Prevention Professionals Is a Critical Component to Implementing National Health Care Reform

December 2010

Our Position

IC&RC is the largest substance abuse credentialing organization in the world, representing 75 organizations and more than 40,000 addiction professionals.

As the federal government calls for increased prevention efforts as a component of national health care reform, IC&RC urges the credentialing of prevention professionals to ensure the highest standard of ethics and professionalism.

Surveying the Landscape

Andrew Kessler, IC&RC's Federal Policy Liaison, has recently written:

“Prevention, in all areas of health, has been a centerpiece of President Obama’s health care agenda. Much of the recent legislation that focuses on improving health care across the country is centered around prevention. Substance abuse is no exception.”

The Affordable Health Care for America Act of 2010, Substance Abuse and Mental Health Services Administration's (SAMHSA) “8 Strategic Initiatives,” and the 2009 National Drug Control Strategy have placed prevention in the forefront of health care reform efforts across the country. Local, state, and national organizations are struggling to keep up with changes in the field. The anticipated demand for new prevention professionals is tremendous, and IC&RC is concerned that safeguards are not yet in place to protect the public through a high-quality, well-trained workforce.

The 2009 Institute of Medicine’s (IOM) publication, *Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities*, summarizes the need for the nation’s focus to shift from sickness and disease to wellness and prevention.¹ The report forwards the position that “the federal government should make the healthy mental, emotional, and behavioral development of young people a national priority” and “develop and implement a strategic approach” to achieving that goal.²

IC&RC works under the premise that prevention is health promotion – the “active, assertive process of creating conditions and/or fostering personal attributes that promote the well-being

¹ National Prevention and Health Promotion Council, *The National Prevention And Health Promotion Strategy*, 2010, [http://www.healthcare.gov/center/councils/nphpphc/draftframework .pdf](http://www.healthcare.gov/center/councils/nphpphc/draftframework.pdf).

² O’Connell, Boat and Warner, *Preventing Mental, Emotional and Behavioral Disorders Among Young People*, 378 (Recommendations 13-1 and 13-2), http://books.nap.edu/openbook.php?record_id=12480&page=378.

of people.”³ That mental and physical health are inseparable is one of the core concepts of prevention.⁴

IC&RC supports the IOM’s premise that the U.S. Departments of Health & Human Services (HHS), Education, and Justice should braid funding in order to develop coordinated systems of care that promote health and well-being.⁵ Furthermore, we also recommend specifically that the Centers for Disease Control division of HHS become a primary partner in creating healthy communities and evaluating the transferability of violence and substance abuse prevention to chronic disease prevention, inasmuch as they are strongly influenced by behavioral knowledge, skills, behaviors, and competencies.

IC&RC is concerned that substance abuse prevention funding will be harmed by changes in health care financing.⁶ For example, a recent SAMHSA solicitation – that was subsequently rescinded - “would result in a loss of funding for substance abuse prevention providers, because it would merge all prevention funding for [the mental health and substance abuse] block grants.”⁷

The IOM asserts that “Prevention is, by definition, an intervention that occurs before it is known who will develop a disorder and who will not.”⁸ While we do concur with its recommendation to include mental health promotion in the spectrum of mental health interventions, we strongly recommend that prevention resources not be co-mingled with other intervention and treatment resources, specifically because intervention and treatment services will have expanded access to other funding through The Mental Health Parity and Addiction Equity Act and The Affordable Care Act.

³ William A. Lofquist, *Discovering the Meaning of Prevention* (Tuscon, AZ: Associates for Youth Development, 1983).

⁴ Mary Ellen O’Connell, Thomas Boat, and Kenneth E. Warner (Editors), *Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities* (Washington, DC: National Research Council and Institute of Medicine of The National Academies/The National Academies Press) 17, http://books.nap.edu/openbook.php?record_id=12480&page=17#

⁵ O’Connell, Boat and Warner, *Preventing Mental, Emotional and Behavioral Disorders Among Young People*, 348, http://books.nap.edu/openbook.php?record_id=12480&page=348.

⁶ “SAMHSA document, made public in error, reveals changes for block grant,” *Alcoholism & Drug Abuse Weekly*, 22, no. 37 (2010): 1.

⁷ *Ibid*, 3.

⁸ O’Connell, Boat and Warner, *Preventing Mental, Emotional and Behavioral Disorders Among Young People*, 36, http://books.nap.edu/openbook.php?record_id=12480&page=36.

What's At Stake

Seventy percent of deaths in the U.S. are from chronic diseases. Heart disease, cancer, and strokes are responsible for 50 percent of U.S. deaths. Obesity, arthritis, and diabetes are also disabling people and escalating health care costs. All of these chronic diseases can be attributable to alcohol use, tobacco use, lack of physical exercise, and poor nutrition - and all can be prevented.⁹

In addition, prevention strategies can be effective in preventing and reducing the severity of some mental health conditions, such as depression and post-traumatic stress disorder. Further, good prevention strategies can delay onset and support treatment outcomes for those with mental health conditions.¹⁰

For example, research indicates there can be a link between substance abuse and child maltreatment. Substance abuse may be a contributing factor for between one-third and two-thirds of children in the child welfare system.¹¹ Research shows that exposure to abuse and to serious forms of dysfunction in the childhood family environment are likely to activate the stress response, thus potentially disrupting the developing nervous, immune, and metabolic systems of children.^{12 13 14} Such acute childhood events are associated with physical and mental health problems that emerge in adolescence and persist into adulthood, including cardiovascular disease, chronic obstructive pulmonary disease, autoimmune diseases, substance abuse, and depression.¹⁵

⁹ "Chronic Diseases and Health Promotion," Centers for Disease Control and Prevention, accessed November 30, 2010, <http://www.cdc.gov/chronicdisease/overview/index.htm>.

¹⁰ "Promoting Mental Health & Well Being," Prevention Institute, accessed November 30, 2010, <http://www.preventioninstitute.org/focus-areas/promoting-mental-health-a-well-being.html>

¹¹ "Substance Abuse," Child Welfare Information Gateway/U.S. Department of Health & Human Services Administration for Children & Families, accessed November 30, 2010, <http://www.childwelfare.gov/can/factors/parentcaregiver/substance.cfm>.

¹² M.D. DeBellis, M.S. Keshava, D.B. Clark, B.J. Casey, J.N. Giedd, A.M. Boring, et al, "A.E. Bennett Research Award. Developmental Traumatology. Part II: Brain Development," *Biological Psychiatry*, 45, no. 10 (1999):1271-84, <http://www.ncbi.nlm.nih.gov/pubmed/10349033>

¹³ M.B. Stein, C. Koverola, C. Hanna, M.G. Torchia, B. McClarty, "Hippocampal Volume in Women Victimized by Childhood Sexual Abuse," *Psychological Medicine*, 27, no. 4 (1997): 951-9, <http://www.ncbi.nlm.nih.gov/pubmed/9234472>

¹⁴ M.H. Teicher, Y. Ito, C.A. Glod, S.L. Andersen, N. Dumont, E. Ackerman, "Preliminary Evidence for Abnormal Cortical Development in Physically and Sexually Abused Children Using EEG Coherence and MRI," *Annals of the New York Academy of Sciences*, 821 (1997):160-75, <http://www.ncbi.nlm.nih.gov/pubmed/9238202>

¹⁵ Shanta R. Dube, Michelle L. Cook, Valerie J. Edwards, "Health-Related Outcomes of Adverse Childhood Experiences in Texas, 2002," *Preventing Chronic Disease: Public Health Research, Practice and Policy*, 7, no.3 (2010): 1, http://www.cdc.gov/pcd/issues/2010/may/pdf/09_0158.pdf

The Importance of Training

Fundamental to having an effective prevention system is an effective prevention workforce. Fundamental to equipping that workforce is a certification process based upon demonstrated practice competencies that are reflective of a high-quality, professional discipline. The demonstration of competency in prevention service delivery, through testing for certification and the continuing education required to maintain certification, helps enable providers to follow the advances in the prevention field and provides assurances to the public that state-supported prevention services are offered in an ethical and technically sound manner.

In keeping with its tradition of establishing high-quality practice standards for substance abuse counselors and clinical supervisors, IC&RC provided leadership in developing professional practice standards for prevention specialists. In cooperation with state agencies, prevention provider agencies, other professional organizations and individual prevention specialists, IC&RC champions the call for prevention practitioners to stay abreast of the latest research findings, employ science-validated practices, apply innovations in prevention methods, and follow industry trends in order to ensure that services are provided competently.

The IOM reports that “most training programs in major disciplines...do not include core components on the prevention of MEB [mental, emotional, and behavioral] disorders of young people.”¹⁶ IC&RC is uniquely positioned to offer the “training standards for certifying and accrediting training programs” that IOM recommends.¹⁷

As IC&RC offers the only internationally recognized prevention credential, it is committed to maintaining and aligning the highest prevention standards to the emerging research demonstrating positive outcomes in prevention, wellness and health promotion through its training and credentialing professionals.

With almost three decades of experience, IC&RC is the only organization with the background to provide well-tested, research-based resources, such as job task analyses, subject matter experts, core competencies and psychometric testing.

¹⁶ O’Connell, Boat and Warner, *Preventing Mental, Emotional and Behavioral Disorders Among Young People*, 376, http://books.nap.edu/openbook.php?record_id=12480&page=376.

¹⁷ Ibid.

Acknowledgments

IC&RC wants to recognize the contributions of a number of prevention leaders to this position paper. We are grateful to the efforts of Celenda Perry, Julie Stevens, Jessica Hestand, and Ruth Satterfield, as well as our Federal Policy Liaison Andrew Kessler.

About IC&RC

IC&RC sets the international standards for competency-based certification programs through testing and credentialing of addiction professionals. Incorporated in 1981, IC&RC represents 75 member boards, including 45 U.S. states, the District of Columbia, two U.S. territories, and all branches of the U.S. military. Members also include 21 countries and six Native American territories.

IC&RC's credentials include Alcohol and Drug Counselor (ADC), Advanced Alcohol and Drug Counselor (AADC), Clinical Supervisor (CS), Prevention Specialist (PS), Certified Criminal Justice Addictions Professional (CCJP), Certified Co-Occurring Disorders Professional (CCDP), and Certified Co-Occurring Disorders Professional Diplomate (CCDPD).

In January 2010, IC&RC announced that the number of professionals who hold its credentials has crossed the 40,000 mark. Up to half of all substance abuse professionals in the U.S. hold IC&RC certificates.

Direct questions and comments to:

IC&RC
298 S. Progress Avenue
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info@internationalcredentialing.org



Assuring Public Safety in the Delivery of Substance Abuse Prevention Services

An IC&RC Position Paper

May 2009

Introduction

Since 1981, the International Certification and Reciprocity Consortium (IC&RC) has been a leader in fostering the adoption of professional practice standards for individuals engaged in providing substance abuse services. IC&RC practice standards are applied to substance abuse counselors, clinical supervisors, prevention specialists, co-occurring disorders professionals, and criminal justice addictions professionals. Membership in IC&RC continues to grow, encompassing certifying boards in 43 states and territories, 13 international countries, all branches of the United States Military, The United States Indian Health Services, and the World Federation of Therapeutic Communities.

IC&RC member boards share a common belief that competency-based practice standards help to ensure the public's safety when receiving substance abuse services. This respect for consumer safety provides the basic rationale for the development and application of substance abuse practice credentialing. Psychometric industry standards, such as beginning with the development of Job Task Analyses, are the foundation for the credentialing process. Such rigorous practices in test development set IC&RC apart from other credentialing organizations. IC&RC member credentialing boards provide the opportunity for individuals employed in the substance abuse field to qualify for and receive recognition for achieving a standard of professional education and experience necessary to provide quality substance abuse services.

Understanding the Need for Prevention Credentialing

This paper was written to educate state and federal agencies, community-based providers, prevention practitioners, institutions of higher education, managed healthcare organizations and the general public about the importance of assuring that prevention practitioners meet a set of internationally recognized minimum practice standards.

Quick research into state laws and policies concerning the practice of substance abuse services, makes it clear that the majority, if not all, of the states require individuals to meet a set of minimum standards of practice to work as a substance abuse counselor or clinical supervisor. These requirements are in place because substance abuse counselors and clinical supervisors work within the context of a unique relationship with their clients. Substance abuse clients bring multiple health, economic and family concerns into the treatment setting, requiring counselors to address many personal and confidential issues. Without demonstrated practice competencies and adherence to a code of professional ethics, such relationships have the potential to become inappropriate. Consequently, states and community treatment agencies have long required counselors to hold a professional certification. With the advance of

managed healthcare over the past several years, many states have now adopted licensure standards that parallel certification requirements for substance abuse practitioners.

Recent changes in prevention service delivery focus in on the reality that prevention practitioner credentialing is as necessary as counselor credentialing. Further, it is the position of IC&RC that federal, state and community regulatory and funding agencies should require that prevention practitioners be certified to better ensure that prevention services are provided in an appropriate and ethical manner. Credentialing prevention practitioners enhances states and community prevention services in at least three important ways:

1. **Ensuring Public Safety:** The most compelling reason to certify substance abuse prevention practitioners is to ensure the public safety. Current headlines and daily television news offer countless examples of young people entrusted to adults or to adult supervised institutions that experience abuse, violence and unethical behavior. State agencies and community based organizations that adopt prevention practice standards and enforce those standards through the requirements of credentialing significantly increase their opportunity to teach practitioners appropriate and effective service delivery for young people and families. Further, it is reasonable for consumers of prevention services to expect protection in other areas of public safety such as misappropriation of funds, misrepresentation of credentials, conflicts of interest, and discrimination. Therefore, it is necessary for prevention professionals to adhere to a recognized code of professional ethics.
2. **Enhancing Public Funds Accountability:** Ethical practice demands accountability for public expenditures and accountability dictates that states and their programs utilize prevention staff who demonstrates proficiency with competency-based standards. This increases the likelihood that taxpayer funds spent in prevention service delivery will be used for programming that is research and evidence based and that offer reasonable hope of impacting the populations being served in a positive way.
3. **Providing Practitioner Benefits:** Prevention practitioners also gain significant benefits by achieving and maintaining a practice credential. Not only are they able to demonstrate practice competencies in their daily work, but they become part of an international cadre of advocates for quality prevention service delivery. Through the continuing education required for renewal of certification, practitioners are able to maintain their prevention knowledge, skills and attitudes while staying abreast of new and emerging trends in the field. Continued skill development often leads to an enhanced career standing and the potential for greater income.

For all of these reasons, the application of a set of minimum practice standards that demonstrate an individual prevention practitioner's competence to practice in the substance abuse prevention discipline is both necessary and prudent.

Making Prevention Certification a Requirement to Practice

Prevention services are changing. Early prevention efforts were cast as everything from puppet shows to juvenile offender diversion programs. Today's professionals make a concerted effort to affect the attitudes and values of communities, thereby promoting healthy behaviors and lifestyles in order to reduce risks associated with alcohol, tobacco and other drug abuse.

Additionally, practitioners need to demonstrate changes in specific individuals who participate in prevention programs. More recent research has led to prevention programming that today encompasses not only community environmental strategies but also individual and family focused services as well. Youth/adult leadership activities, tutoring services, parent and family management programs, and mentoring programs are but a few of the popular prevention services. These programs demand qualified, ethical and competent staff.

States and community agencies are also under pressure to demonstrate that programs like these and others have an impact on the people they serve. Increasing concerns for accountability in the delivery of public prevention services has made it a necessity for states and their publicly funded prevention programs to better demonstrate the efficacy and cost effectiveness of publicly supported services. National outcome measures that verify the efficacy of prevention services will track the performance of individuals as well as community-wide attitudes. To effectively demonstrate results, state and community based prevention programs need competent and knowledgeable staff that is skilled in the use of the latest and most ethical approaches to community based prevention service delivery.

As a consequence of the changing dynamics of prevention programming, there is an increasing need for states to require prevention practitioners to meet internationally accepted standards of prevention practice. As of 2009, 47 IC&RC member boards offer a prevention credential. However, in the majority of instances, certification is voluntary. Without the encouragement of a legislative or state policy requirement for certification, many states and their practitioners may not understand the need to be certified nor appreciate the risks of not having or requiring certification.

Who Should Be Credentialed in Prevention

IC&RC takes the position that, at a minimum, anyone who meets either or both the following criteria should be required to become certified in order to practice prevention service delivery: Practitioners who work in community-based prevention programs that receive state and/or federal funds for alcohol, tobacco and other drug abuse services and full or part-time paid

coordinators of volunteer prevention services in programs that receive state and/or federal funds.

For the most part, these criteria will affect community based prevention services that are funded with federal block grant and/or state general revenue funds managed through the Single State Agencies for Alcohol and Drug Abuse. However, other state agencies such as departments of education, agencies for children, youth, and families, juvenile corrections and diversion services, and departments of aging services target services to youth and adult populations affected by substance abuse. IC&RC believes that personnel from these agencies may not necessarily be required to be certified but should have the opportunity and be encouraged to become credentialed in substance abuse prevention. At a minimum, they should have access to continuing education programs offering competency-based substance abuse prevention course work.

IC&RC's Competency-Based Prevention Credential

In keeping with its tradition of establishing high quality practice standards for substance abuse counselors and clinical supervisors, IC&RC has also provided leadership in developing professional practice standards for prevention specialists. In cooperation with state agencies, prevention provider agencies, other professional organizations and individual prevention specialists, IC&RC champions the call for prevention practitioners to stay abreast of the latest research findings, employ best practices, apply innovations in prevention methods, and follow industry trends in order to ensure the competency of the services they provide.

Fundamental to having an effective prevention system is an effective prevention workforce. Fundamental to equipping that workforce is an effective certification process based upon demonstrated practice competencies that are reflective of a high quality, professional discipline. The demonstration of competency in prevention service delivery, through testing for certification and the continuing education required to maintain certification, helps enable providers to follow the advances in the prevention field and provides assurances to the public that state supported prevention services are offered in an ethical and technically sound manner.

Prevention Job Task Analysis

Working with a cross section of substance abuse prevention administrators, providers, practitioners, researchers and others, IC&RC utilizes a formal process to identify and gain consensus on the specific competencies needed to effectively practice substance abuse prevention services. An initial Role Delineation Study (RDS) was developed and published in 1993. The RDS identified specific practice domains and detailed the knowledge, skills, and attitudes appropriate for each domain. The use of a formally published RDS (now referred to as a Job Task Analysis) assures that prevention certification test questions used as the basis for certification are founded in those tasks and activities determined by the field as appropriate and necessary for effective prevention service delivery.

Formal updates to the Job Task Analysis occurred in 1999 and again in 2007 at which time IC&RC convened practitioners from the field to provide their expertise to updating the Job Task Analysis. The 2007 revision reflects an emphasis on science based prevention services and integrates both service delivery and service management domains. With this updated Job Task Analysis, IC&RC continues to be able to assure its member boards and the prevention specialists that they certify that certification is based on the latest and best information about the practice requirements of the field of substance abuse prevention service delivery.

IC&RC Prevention Specialist Written Examination

The development of a valid examination for the IC&RC Prevention Specialist Credential begins with a clear and concise definition of the knowledge, skills and abilities needed for competent job performance. Working with subject matter experts in the field of alcohol, tobacco, and other drug abuse prevention, the knowledge and skill bases for the questions in the examination are derived from the actual practice of the prevention specialist as outlined in the current IC&RC Prevention Specialist Job Task Analysis.

The Prevention Specialist Written Examination was one of the first examinations on an international level to test knowledge and skill related to substance abuse prevention. The examination was developed by IC&RC through the cooperation of the member boards and service providers.

Conclusion

In addition to the changing dynamics of the substance abuse prevention field, the political realities regarding today's publicly supported substance abuse services demonstrate the need to gain and maintain public confidence. One of the most important obligations that the field has to the public is to offer them a prevention workforce that demonstrates competency in the practice of substance abuse prevention strategies, programs, and services.

No other effort relative to the quality of prevention service delivery is as important as having knowledgeable and well-qualified individuals practicing prevention in our states, countries, and communities. IC&RC's competency-based approach to prevention credentialing offers a consistent standard of operation that requires prevention credentialing. Through this process, states and their publicly funded prevention providers will significantly increase their capability to ensure public safety. To that end, IC&RC is also pleased to announce the development of a credentialing process for prevention supervisors that will likely be available in 2010.

For information on the prevention certification process, contact IC&RC at:

298 S. Progress Avenue
Harrisburg, PA 17109
internationalcredentialing.org
info@internationalcredentialing.org
717-540-4457

About IC&RC

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In 2010, IC&RC announced that the number of professionals who hold its credentials has crossed the 40,000 mark. Up to half of all substance abuse professionals in the U.S. hold IC&RC certificates.

Prevention Specialist (PS)

To be eligible for reciprocity to other IC&RC jurisdictions, credentials obtained through Member Boards must meet the following IC&RC minimum standards:

Experience

2000 hours of Alcohol, Tobacco and Other Drug (ATOD) prevention work experience.

Education

100 hours of prevention specific education. Fifty hours of this education must be ATOD specific. Six hours must be specific to prevention ethics.

Supervision

120 hours specific to the domains with a minimum of ten hours in each domain.

Examination

Applicants must pass the IC&RC International Written Prevention Specialist Examination.

Code of Ethics

Applicants must sign a prevention specific code of ethics statement or affirmation statement.

Recertification

40 hours of continuing education earned every two years.

IC&RC credentials can only be obtained by meeting the requirements of the local Member Board where you live or work at least 51 percent of the time. The application process and specific requirements varies for each jurisdiction, so professionals seeking credentialing must contact the local board.

As a service to the profession, IC&RC provides a Prevention Specialist (PS) Candidate Guide for students preparing for examinations and their work in the field. IC&RC offers this resource free of charge and updates the publications on an ongoing basis.

PS Domains

1. Planning & Evaluation
2. Education & Skill Development
3. Community Organization
4. Public Policy & Environmental Change
5. Professional Growth & Responsibility

Prevention Resources

IC&RC recently released a position paper, "Credentialing of Prevention Professionals Is a Critical Component to Implementing National Health Care Reform." This is a valuable addition to the White Paper, "Assuring Public Safety in the Delivery of Substance Abuse Prevention Services."

Special issues of *IC&RC Insights*, our electronic newsletter, are dedicated to Prevention: February 26, June 11, September 10, and December 14.

You can also visit the IC&RC blog for the most up-to-date Prevention resources.

The Value of Credentialing

IC&RC is built on the belief that credentialing advances the addiction and prevention profession. Credentialing facilitates standardized practice across a wide variety of treatment settings and regulatory environments. Most importantly, it ensures trained, ethical professionals are available to clients, families, and communities around the globe.

For employers – and people who use their services, credentialing offers the security of knowing that counselors and preventionists are competent, knowledgeable of evidence-based practices and committed to ongoing enhancement of their skills.

Not to be overlooked are the benefits to certificants themselves. A credential offers a third-party, objective endorsement that enhances their professional reputation and increases opportunities for career advancement. Demonstrating the high level of commitment, knowledge, and skill required to qualify for a credential is a personal accomplishment to be proud of.

IC&RC establishes, monitors, and advances reciprocal competency standards for seven reciprocal credentials:

- Alcohol & Drug Counselor (ADC)
- Advanced Alcohol & Drug Counselor (AADC)
- Clinical Supervisor (CS)
- Prevention Specialist (PS)
- Certified Criminal Justice Addictions Professional (CCJP)
- Certified Co-Occurring Disorders Professional (CCDP)
- Certified Co-Occurring Disorders Professional Diplomate (CCDPD)

IC&RC provides the minimum standards for each reciprocal credential, but Member Boards may set higher standards for their credentials.

IC&RC also provides services to addiction and prevention professionals, in order to support the growth of the profession.

Reciprocity Information for Professionals

Uniform minimum standards allow certified professionals to transfer their credentials between IC&RC Member Board jurisdictions. Member Boards may offer reciprocity to certified or licensed professionals in other jurisdictions and have the authority to set reciprocity requirements for entry to their jurisdiction.

While many addiction professionals have sought the professionalism associated with licensing, the licensure process has complicated reciprocity in many IC&RC Member Board jurisdictions.

It is vitally important that certified professionals investigate reciprocity prior to relocating to another jurisdiction, because it can be a very complicated process. To make it go as smoothly as possible, it is recommended to reciprocate at least three months prior a credential's expiration.

Reciprocity Process

- 1) Professional contacts the IC&RC Member Board in the jurisdiction to which s/he wants to relocate to learn about the requirements to reciprocate credential.
- 2) Professional contacts current IC&RC Member Board for Reciprocity Application.
- 3) Professional complete the one-page application and returns it to current board with the appropriate fee.
- 4) Current board verifies application and sends it to IC&RC.
- 5) IC&RC approves the application, notifies the professional, and sends it to board in new location.
- 6) New board contacts professional when the process is completed.

Frequently Asked Questions

Can I reciprocate my credential to any IC&RC Member Board?

Your credential is reciprocal **only** with boards that offer that same credential. For example, if you hold a Prevention Specialist credential from Pennsylvania and you want to reciprocate that credential to Nebraska, you would be unable to do so, because Nebraska, although a Member Board in IC&RC, does not offer the Prevention Specialist credential. Therefore, reciprocity works only if the new jurisdiction to which you are moving offers that credential.

When should I begin the reciprocity process – before I move into my new jurisdiction or after?

It is best to start the process prior to moving into a new jurisdiction. There can be delays in processing reciprocity applications, so beginning early provides a better chance that your application will be completed before you begin work in your new jurisdiction. Waiting until after you move could result in a delay in starting new employment.

Can I maintain my credential in more than one jurisdiction?

Yes, you are permitted to maintain your credential in your original jurisdiction while holding it in your new jurisdiction, if you choose to do so. Maintaining credentials in more than one jurisdiction will require that you renew/recertify your credential in each jurisdiction.

When I reciprocate to a new jurisdiction, will my current expiration date on my credential change?

No, your new jurisdiction is required to provide you with the same expiration date that appears on your current certificate. In order to avoid credentials expiring during the reciprocity process, credentials must be valid for at least 30 days at the time of application.

Can I be denied reciprocity into a new jurisdiction?

IC&RC Member Boards have the right to require additional standards that must be met before accepting a credentialed professional from another jurisdiction. Sometimes these additional standards are minimal and can be met by most without difficulty. In others, additional standards are quite extensive and may take additional time and cost to complete.

It is **critical** that you check with the credentialing board in the jurisdiction to which you are relocating to determine what, if any, additional standards must be met.

How long will it take to hear about my reciprocity application after I send it my current Member Board?

Typically, a Member Board will send your reciprocity materials to IC&RC 10 to 14 days after they are received. IC&RC will then approve the reciprocity, and you will be notified via email directly from IC&RC.

If you have not heard from IC&RC within four weeks, contact your current Member Board first to inquire about the status of your reciprocity application. Please allow two to three weeks for your requested board to contact you after you receive notification of approval from IC&RC.

If I hold a license rather than a certification from my jurisdiction and then reciprocate, will I receive a license from my new jurisdiction?

Not necessarily. If the new jurisdiction is one that has licensure rather than certification, you would receive a license. If the new jurisdiction is one that has certification rather than licensure, you would receive a certification.

What is the difference between certification and licensure?

While these terms are often used interchangeably, there can be differences in actuality.

Certification is a process by which a non-governmental organization grants recognition to individuals who have met predetermined qualifications and have demonstrated a level of knowledge and skill required in a profession specified by that organization. Certification is typically a voluntary process but can be mandatory in some jurisdictions.

Confusion between the terms arises because many jurisdictions call their licensure processes “certification,” particularly when they incorporate the standards and requirements of private certifying bodies in their licensing statutes and require that an individual be certified in order to have jurisdictional authorization to practice.

Neither term is right or wrong, good or bad, nor is one term better than the other. It simply is how and by whom a profession is regulated in a particular jurisdiction.

If my credential has expired in my current jurisdiction, can I still reciprocate into a new jurisdiction?

No, your credential must be current and valid in order to reciprocate. If your credential has lapsed, you must successfully recertify prior to applying for reciprocity. In order to avoid credentials expiring during the reciprocity process, credentials must be valid for at least 30 days at the time of application.

Reciprocity Information for Member Boards

Uniform minimum standards allow certified professionals to transfer their credentials between IC&RC Member Board jurisdictions. Member Boards may offer reciprocity to certified or licensed professionals in other jurisdictions and have the authority to set reciprocity requirements for entry to their jurisdiction.

Professionals must contact the board where they are currently credentialed for a Reciprocity Application, then IC&RC facilitates the reciprocity process between boards.

Become an IC&RC Member Board

IC&RC is the only organization comprised entirely of addiction and prevention credentialing boards. Only certification boards can be members of IC&RC. The information on this page applies to certification boards only, not professionals interested in credentialing.

Benefits of Membership

- Reciprocity for certified professionals,
- Access to standards and written examinations that are evidence-based, valid, reliable, and legally defensible,
- Networking with representatives from 78 member credentialing boards worldwide,
- Issuance of an international certificate to all those holding a reciprocal credential, and
- Technical assistance for a wide variety of issues related to credentialing.

IC&RC can only have one certification board as a member in each jurisdiction. However, if an existing Member Board chooses not to offer an IC&RC credential, another credentialing board in that same jurisdiction can become a member board of IC&RC and offer that credential.

A list of current Member Boards and the credential each offers is available at our [Member Directory](#).

Learn More

IC&RC provides a helpful, informative packet of [Materials for Prospective Members](#) (ZIP compressed folder of Microsoft Word documents, 2.9MB).

If you are interested in your certification board becoming a member of IC&RC, please [submit an inquiry](#). IC&RC staff or leadership will contact you.

Option to Grandparent

Becoming a member board of IC&RC affords your board the opportunity to grandparent your professionals into any of the IC&RC credentials you choose to offer.

IC&RC allows boards to offer a three-month grandparenting window of opportunity to addiction professionals anytime within the first two years of your board becoming a member of IC&RC.

Find a Board



IC&RC Credentials Offered

» [Prevention Specialist \(PS\)](#)

[Change](#)

[Advanced search...](#)

Search: _____ Found: **51** Show:

21

Show:

Certification Board	Location	Credentials
<u>Addiction Counselor Certification Board of Oregon - Prevention</u>	Portland OR	Prevention Specialist (PS)
<u>Addiction Professionals Certification Board of New Jersey</u>	East Brunswick NJ	Advanced Alcohol and Drug Counselor (AADC), Alcohol and Drug Counselor (ADC), Certified Co-occurring Disorders Professional (CCDP), Certified Co-occurring Disorders Professional Diplomat (CCDPD), Certified Criminal Justice Addictions Professional (CCJP), Clinical Supervisor (CS), Prevention Specialist (PS)
<u>Alabama Alcohol & Drug Abuse Association</u>	Eva AL	Alcohol and Drug Counselor (ADC), Certified Co-occurring Disorders Professional (CCDP), Certified Co-occurring Disorders Professional Diplomat (CCDPD), Certified Criminal Justice Addictions Professional (CCJP), Clinical Supervisor (CS), Prevention Specialist (PS)
<u>Arizona Board for Certification of Addiction Counselors</u>	Phoenix AZ	Advanced Alcohol and Drug Counselor (AADC), Alcohol and Drug Counselor (ADC), Certified Criminal Justice Addictions Professional (CCJP), Clinical Supervisor (CS), Prevention Specialist (PS)
<u>Arkansas Prevention Certification Board</u>	Little Rock AR	Prevention Specialist (PS)
<u>Army Center for Substance Abuse Programs</u>	Alexandria VA	Prevention Specialist (PS)
<u>Bermuda Addictions Certification Board</u>	Hamilton Bermuda	Alcohol and Drug Counselor (ADC), Clinical Supervisor (CS), Prevention Specialist (PS)
<u>California Certification Board of Alcohol & Drug Abuse Counselors</u>	Sacramento CA	Advanced Alcohol and Drug Counselor (AADC), Alcohol and Drug Counselor (ADC), Certified Co-occurring Disorders Professional (CCDP), Certified Criminal Justice Addictions Professional (CCJP), Clinical Supervisor (CS), Prevention Specialist (PS)
<u>Canadian Addiction Counsellors Certification Federation</u>	Kitchener ON Canada	Advanced Alcohol and Drug Counselor (AADC), Alcohol and Drug Counselor (ADC), Certified Co-occurring Disorders Professional (CCDP), Certified Co-occurring Disorders Professional Diplomat (CCDPD), Clinical Supervisor (CS), Prevention Specialist (PS)
<u>Certification Board for Alcohol & Drug Professionals</u>	Sioux Falls SD	Alcohol and Drug Counselor (ADC), Prevention Specialist (PS)
<u>Certification Board for Professionals in Addiction & Alcoholism of Puerto Rico, Inc.</u>	San Juan PR	Advanced Alcohol and Drug Counselor (AADC), Alcohol and Drug Counselor (ADC), Certified Criminal Justice Addictions Professional (CCJP), Prevention Specialist (PS)

Certification Board	Location	Credentials
<u>Colorado Association of Alcohol and Drug Service Providers (aka The Colorado Providers Association – COPA)</u>	Denver CO	Prevention Specialist (PS)
<u>Connecticut Certification Board</u>	Wallingford CT	Alcohol and Drug Counselor (ADC), Certified Co-occurring Disorders Professional (CCDP), Certified Co-occurring Disorders Professional Diplomat (CCDPD), Clinical Supervisor (CS), Prevention Specialist (PS)
<u>Delaware Certification Board</u>	Harrisburg PA	Alcohol and Drug Counselor (ADC), Certified Co-occurring Disorders Professional (CCDP), Certified Co-occurring Disorders Professional Diplomat (CCDPD), Clinical Supervisor (CS), Prevention Specialist (PS)
<u>District of Columbia Addiction Professionals Consortium</u>	Washington DC	Advanced Alcohol and Drug Counselor (AADC), Alcohol and Drug Counselor (ADC), Certified Criminal Justice Addictions Professional (CCJP), Clinical Supervisor (CS), Prevention Specialist (PS)
<u>Florida Certification Board</u>	Tallahassee FL	Alcohol and Drug Counselor (ADC), Prevention Specialist (PS)
<u>Greece, Cyprus, Malta, Bulgaria Certification Board for Drug Counselors & Prevention Specialists</u>	Athens Greece	Alcohol and Drug Counselor (ADC), Prevention Specialist (PS)
<u>Hawaii Alcohol & Drug Abuse Division</u>	Kapolei HI	Alcohol and Drug Counselor (ADC), Certified Co-occurring Disorders Professional Diplomat (CCDPD), Certified Criminal Justice Addictions Professional (CCJP), Clinical Supervisor (CS), Prevention Specialist (PS)
<u>Idaho Board of Alcoholism/Drug Counselor's Certification</u>	Meridan ID	Advanced Alcohol and Drug Counselor (AADC), Alcohol and Drug Counselor (ADC), Clinical Supervisor (CS), Prevention Specialist (PS)
<u>Illinois Certification Board, Inc.</u>	Springfield IL	Advanced Alcohol and Drug Counselor (AADC), Alcohol and Drug Counselor (ADC), Certified Criminal Justice Addictions Professional (CCJP), Clinical Supervisor (CS), Prevention Specialist (PS)
<u>Indiana Counselors Association of Alcohol and Drug Abuse</u>	Indianapolis IN	Advanced Alcohol and Drug Counselor (AADC), Alcohol and Drug Counselor (ADC), Certified Co-occurring Disorders Professional (CCDP), Certified Co-occurring Disorders Professional Diplomat (CCDPD), Certified Criminal Justice Addictions Professional (CCJP), Clinical Supervisor (CS), Prevention Specialist (PS)

Certification Board	Location	Credentials
<u>Iowa Board of Certification</u>	Ankeny IA	Advanced Alcohol and Drug Counselor (AADC), Alcohol and Drug Counselor (ADC), Certified Co-occurring Disorders Professional (CCDP), Certified Co-occurring Disorders Professional Diplomat (CCDPD), Certified Criminal Justice Addictions Professional (CCJP), Clinical Supervisor (CS), Prevention Specialist (PS)
<u>Kansas Coalition of Prevention Programs & Services, Inc.</u>	Topeka KS	Prevention Specialist (PS)
<u>Kentucky Certification Board of Prevention Professionals</u>	Louisville KY	Prevention Specialist (PS)
<u>Louisiana Association of Substance Abuse Counselors & Trainers</u>	Baton Rouge LA	Advanced Alcohol and Drug Counselor (AADC), Alcohol and Drug Counselor (ADC), Certified Co-occurring Disorders Professional (CCDP), Certified Co-occurring Disorders Professional Diplomat (CCDPD), Certified Criminal Justice Addictions Professional (CCJP), Clinical Supervisor (CS), Prevention Specialist (PS)
<u>Maryland Association of Prevention Professionals and Advocates</u>	Cambridge MD	Prevention Specialist (PS)
<u>Michigan Certification Board for Addiction Professionals</u>	Okemos MI	Advanced Alcohol and Drug Counselor (AADC), Alcohol and Drug Counselor (ADC), Certified Co-occurring Disorders Professional (CCDP), Certified Co-occurring Disorders Professional Diplomat (CCDPD), Certified Criminal Justice Addictions Professional (CCJP), Clinical Supervisor (CS), Prevention Specialist (PS)
<u>Minnesota Certification Board</u>	Wyoming MN	Alcohol and Drug Counselor (ADC), Certified Criminal Justice Addictions Professional (CCJP), Clinical Supervisor (CS), Prevention Specialist (PS)
<u>Mississippi Association of Addiction Professionals</u>	Jackson MS	Advanced Alcohol and Drug Counselor (AADC), Alcohol and Drug Counselor (ADC), Certified Criminal Justice Addictions Professional (CCJP), Clinical Supervisor (CS), Prevention Specialist (PS)
<u>Missouri Substance Abuse Professional Credentialing Board</u>	Jefferson City MO	Advanced Alcohol and Drug Counselor (AADC), Alcohol and Drug Counselor (ADC), Certified Co-occurring Disorders Professional (CCDP), Certified Co-occurring Disorders Professional Diplomat (CCDPD), Certified Criminal Justice Addictions Professional (CCJP), Prevention Specialist (PS)
<u>Nashville Area Substance Abuse Certification Board</u>	Cherokee NC	Alcohol and Drug Counselor (ADC), Clinical Supervisor (CS), Prevention Specialist (PS)

Certification Board	Location	Credentials
<u>New Hampshire Prevention Certification Board</u>	Manchester NH	Prevention Specialist (PS)
<u>New Mexico Credentialing Board for Behavioral Health Professionals</u>	Albuquerque NM	Alcohol and Drug Counselor (ADC), Certified Criminal Justice Addictions Professional (CCJP), Clinical Supervisor (CS), Prevention Specialist (PS)
<u>New York Office of Alcohol & Substance Abuse Services</u>	Albany NY	Alcohol and Drug Counselor (ADC), Prevention Specialist (PS)
<u>Nordic/Baltic Regional Certification Board</u>	Reykjavik Iceland	Alcohol and Drug Counselor (ADC), Clinical Supervisor (CS), Prevention Specialist (PS)
<u>North Carolina Substance Abuse Professional Practice Board</u>	Raleigh NC	Advanced Alcohol and Drug Counselor (AADC), Alcohol and Drug Counselor (ADC), Certified Criminal Justice Addictions Professional (CCJP), Clinical Supervisor (CS), Prevention Specialist (PS)
<u>Ohio Chemical Dependency Professionals Board</u>	Columbus OH	Alcohol and Drug Counselor (ADC), Clinical Supervisor (CS), Prevention Specialist (PS)
<u>Oklahoma Drug & Alcohol Professional Counselor Certification Board</u>	Moore OK	Advanced Alcohol and Drug Counselor (AADC), Alcohol and Drug Counselor (ADC), Certified Criminal Justice Addictions Professional (CCJP), Clinical Supervisor (CS), Prevention Specialist (PS)
<u>Pacific Substance Abuse Mental Health Certification Board</u>	Tamuning GUAM	Alcohol and Drug Counselor (ADC), Prevention Specialist (PS)
<u>Pennsylvania Certification Board</u>	Harrisburg PA	Advanced Alcohol and Drug Counselor (AADC), Alcohol and Drug Counselor (ADC), Certified Co-occurring Disorders Professional (CCDP), Certified Co-occurring Disorders Professional Diplomat (CCDPD), Certified Criminal Justice Addictions Professional (CCJP), Clinical Supervisor (CS), Prevention Specialist (PS)
<u>Prevention Credentialing Consortium of Georgia</u>	Lawrenceville GA	Prevention Specialist (PS)
<u>Prevention Specialist Certification Board of Washington</u>	Spokane WA	Prevention Specialist (PS)
<u>Rhode Island Board for the Certification of Chemical Dependency Professionals</u>	Harrisburg PA	Advanced Alcohol and Drug Counselor (AADC), Alcohol and Drug Counselor (ADC), Certified Co-occurring Disorders Professional (CCDP), Certified Co-occurring Disorders Professional Diplomat (CCDPD), Certified Criminal Justice Addictions Professional (CCJP), Clinical Supervisor (CS), Prevention Specialist (PS)
<u>South Carolina Association of Prevention Professionals & Advocates</u>	Columbia SC	Prevention Specialist (PS)

Certification Board	Location	Credentials
<u>Southwest Certification Board</u>	Phoenix AZ	Alcohol and Drug Counselor (ADC), Certified Criminal Justice Addictions Professional (CCJP), Prevention Specialist (PS)
<u>Substance Abuse Certification Alliance of Virginia</u>	Richmond VA	Alcohol and Drug Counselor (ADC), Certified Co-occurring Disorders Professional (CCDP), Certified Criminal Justice Addictions Professional (CCJP), Clinical Supervisor (CS), Prevention Specialist (PS)
<u>Tennessee Certification Board</u>	Nashville TN	Prevention Specialist (PS)
<u>Texas Certification Board of Addiction Professionals</u>	Austin TX	Advanced Alcohol and Drug Counselor (AADC), Alcohol and Drug Counselor (ADC), Certified Criminal Justice Addictions Professional (CCJP), Clinical Supervisor (CS), Prevention Specialist (PS)
<u>United States Navy Certification Board</u>	San Diego CA	Alcohol and Drug Counselor (ADC), Clinical Supervisor (CS), Prevention Specialist (PS)
<u>West Virginia Certification Board for Addiction & Prevention Professionals</u>	Dunbar WV	Advanced Alcohol and Drug Counselor (AADC), Alcohol and Drug Counselor (ADC), Clinical Supervisor (CS), Prevention Specialist (PS)

Exam Information for Professionals

IC&RC develops and administers examinations for seven reciprocal credentials:

- Alcohol & Drug Counselor (ADC)
- Advanced Alcohol & Drug Counselor (AADC)
- Clinical Supervisor (CS)
- Prevention Specialist (PS)
- Certified Criminal Justice Addictions Professional (CCJP)
- Certified Co-Occurring Disorders Professional (CCDP)
- Certified Co-Occurring Disorders Professional Diplomat (CCDPD)

In addition, IC&RC administers the examination for the [Department of Transportation's Substance Abuse Professional \(SAP\)](#), developed by the [Professional Training Center, Inc.](#)

Each IC&RC [Member Board](#) offers examinations for only the credentials they carry, and exams can only be scheduled through your local board as a part of the credentialing process. Each board chooses whether to offer Computer Based Testing (CBT) or Paper & Pencil Exams and whether to administer exams during set periods or on demand.

Important Information About Pre-Testing Items

In December 2011, IC&RC began using pretest items on its exams. Pretesting allows IC&RC to streamline its exam development process, provide much needed data on questions, and increase the security of its exams.

Pretesting began in December 2011 for the Alcohol & Drug Counselor (ADC), Advanced Alcohol & Drug Counselor (AADC), and Clinical Supervisor (CS) exams. In March 2012, IC&RC implemented pretesting for the Prevention Specialist (PS), Certified Criminal Justice Addictions Professional (CCJP), and Certified Co-Occurring Disorders (CCDP) exams.

On each IC&RC exam there are 25 "unweighted" items that do not count toward candidates' final scores. Unweighted items are also called pretest items. Pretest items are not identified on exams and appear randomly on all exam forms. All exams are 150 questions in length, including the Advanced Alcohol and Drug Counselor (AADC), which was previously 175 questions.

It is important to include pretest items on an examination, because items should go through a trail period to ensure quality before they contribute to candidates' scores. Pretesting items provides verification that the items are relevant to competency and contribute toward measuring candidates' proficiency in the material. The statistical data received from pretesting is analyzed to determine if an item performs within an acceptable range. For example, item statistics tell us if an item is too difficult and possibly outside the candidates' scope of knowledge or practice, if an item is too easy and does not measure competency, or if the correct answer is misidentified. If an item exhibits acceptable statistical performance, the item can be upgraded to "weighted" status and be included on future examinations as a scored item.

In a larger context, pretesting items allows examinations to stay current with the profession. The field is constantly evolving, and it is important that examinations reflect current practice and the knowledge, skills, and abilities required of competent practitioners. Including pretest items also allows IC&RC to produce more test forms which increases the security of its examinations.

Overall, pretesting items is in the best interest of candidates as it helps to ensure the quality of future examinations. Pretest items have absolutely no effect on candidates' scores. For example, if two candidates both answer the same number of weighted items correctly, and one answers all of the pretest items correctly and the other answers none of the pretest items correctly, they both receive the same score and pass/fail status on the exam. In fact, candidates will be protected against poorly-performing items adversely affecting their scores, while at the same time taking an examination that is current with professional trends.

Study Guides

While IC&RC does not publish or endorse any specific study guide for our exams, there are a number of study guides available. Applicants are responsible for being informed consumers and buying the study guide best suited for their needs. It is also recommended that applicants contact their local [Member Board](#) to inquire about suggested study guide materials.

Please see the notice, "Important Information Regarding IC&RC Exams."

Exam Verification

If you have taken an IC&RC examination and need your scores verified and/or sent to an organization, download and submit the [Exam Verification Form](#) with payment to IC&RC.

Processing exam verifications can take up to two weeks, but supplying the exact date you took the IC&RC exam will expedite the process.

Computer Based Testing Demonstration

Candidates preparing to take a computer based IC&RC exam can preview the exam format by clicking [here](#).

Testing Information for Member Boards

Since 2007, IC&RC has relied on [Schroeder Measurement Technologies \(SMT\)](#) to administer its credential examinations. SMT offers a full range of test administration services, including computer-based testing, web-based testing, paper & pencil testing, candidate processing, recertification tracking and other related services. SMT administers examinations each year in over 40 professional categories and processes over 100,000 examinations per year.

Computer-based testing is administered through a division of SMT called [ISO-Quality Testing, Inc. \(IQT\)](#), which provides secure, user-friendly, high-quality, reasonably-priced computerized examination delivery services to credentialing bodies at available secure and monitored [locations around the world](#).

IC&RC Member Boards can choose to offer Computer Based Testing (CBT) or Paper & Pencil Exams. CBT can be offered On Demand by Member Boards or during four annual testing cycles, when Paper & Pencil must be offered:

<u>2011</u>	<u>2012</u>	<u>2013</u>
September 9 & 10	March 9 & 10	March 8 & 9
December 9 & 10	June 8 & 9	June 14 & 15
	September 14 & 15	September 13 & 14
	December 7 & 8	December 13 & 14

Please see the notice, "[Important Information Regarding IC&RC Exams](#)."

Testing Management

Member Boards can access and administer test information at the [SMT Portal](#).

The IQT website allows Boards to locate [Testing Centers around the world](#) and apply to become an approved [Testing Center](#).

Domain³⁰ 1: Planning and Evaluation

Number of Questions: 36

Use needs assessment strategies to gather relevant data for ATOD prevention planning.

Identify gaps and prioritize needs based on the assessment of community conditions.

Select prevention strategies, programs, and best practices to meet the identified needs of the community.

Develop an ATOD prevention plan based on research and theory that addresses community needs and desired outcomes.

Identify resources to sustain prevention activities.

Identify appropriate ATOD prevention program evaluation strategies.

Conduct evaluation activities to document program implementation and effectiveness.

Use evaluation findings to determine whether and how to adapt ATOD prevention.

Domain 2: Education and Skill Development

Number of Questions: 42

Develop ATOD prevention education and skill development activities based on target audience analysis.

Connect prevention theory and practice to implement effective prevention education and skill development activities.

Maintain program fidelity when implementing evidence-based programs.

Assure that ATOD education and skill activities are appropriate to the culture of the community being served.

Use appropriate instructional strategies to meet the needs of the target audience.

Ensure all ATOD prevention education and skill development programs provide accurate, relevant, timely, and appropriate content information.

Identify, adapt, or develop instructor and participant materials for use when implementing ATOD prevention activities.

Provide professionals in related fields with accurate, relevant, timely, and appropriate ATOD prevention information.

Provide technical assistance to community members and organizations regarding ATOD prevention strategies and best practices.

Domain 3: Community Organization

Number of Questions: 26

Identify the community's demographic characteristics and core values.

Identify key community leaders to ensure diverse representation in ATOD prevention programming activities.

Build community ownership of ATOD prevention programs by collaborating with key community leaders/members when planning, implementing, and evaluating prevention activities.

Provide technical assistance to community members/leaders in implementing ATOD prevention activities.

Develop capacity within the community by recruiting, training, and mentoring ATOD prevention-focused volunteers.

Assist in creating and sustaining community-based coalitions.

Domain 4: Public Policy and Environmental Change

Number of Questions: 20

Examine the community's public policies and norms to determine environmental change needs.

Make recommendations to policy makers/stakeholders that will positively influence the community's public policies and norms.

Provide technical assistance, training, and consultation that promote environmental change.

Participate in public policy development and enforcement initiatives to affect environmental change.

Use media strategies to enhance prevention efforts in the community.

Domain 5: Professional Growth and Responsibility

Number of Questions on Exam: 26

Maintain personal knowledge, skills, and abilities related to current ATOD prevention theory and practice.

Network with others to develop personal and professional relationships.

Adhere to all legal, professional, and ethical standards.

Build skills necessary for effectively working within the cultural context of the community.

Demonstrate self-care consistent with ATOD prevention messages.

Total number of examination questions: 150

Total time to complete the examination, Paper & Pencil: 3 ½ hours

Total time to complete the examination, Computer Based: 3 hours

For more information contact:

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Augusta, ME 04333-0011
(207) 287-2595
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*In accordance with federal and state laws,
The Maine Office of Substance Abuse, DHHS, does not discriminate on the basis of
disability, race, color, creed, gender, age, or national origin in admission or access
to treatment, services, or employment in its programs and activities.*

This information is available in alternate formats upon request.