Penobscot and Piscataquis Counties

Strategic Planning and Environmental Programming Assessment

August 2007

A partnership between
City of Bangor ● Katahdin Area Partnership ● MSAD 48
Piscataquis Public Health Council ● SPRINT for Life
The River Coalition ● Sebasticook Valley Healthy Communities Coalition

State of Maine Office of Substance Abuse Strategic Planning Framework State Incentive Grant

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A. Introduction

Penobscot and Piscataquis counties have a rich history of work in prevention and prevention coalitions like the Piscataquis Public Health Council, Sebasticook Valley Healthy Communities, Katahdin Area Partnership, SPRINT for Life, the River Coalitions and Bangor Region Partners for Health—the Healthy Maine Partnerships—have made considerable gains in reducing youth smoking rates and in working to create healthier communities.

Substance abuse rates, however, continue to increase, particularly among youth. For example

- Three-quarters of the 12th graders in Penobscot and Piscataquis counties report having used alcohol in their lifetime.
- About 50 percent of these same 12th graders report having used cigarettes and marijuana.
- One-fifth report misusing prescription drugs
- Almost 20 percent of **6th** graders in Penobscot and Piscataquis counties report having used alcohol in their lifetime.

The Office of Substance Abuse's Strategic Prevention State Incentive Grant was a chance to address these concerning use rates with a three to five year strategic plan.

In November 2007 Penobscot and Piscataquis counties made the decision to work collaboratively on OSA's SPF-SIG project. At that time Maine's Public Health Work Group was beginning to designate regions for the purpose of data, planning, administration, funding allocation, and the effective and efficient delivery of public health services. Penobscot and Piscataquis counties together were to comprise one of the state's eight regions; community leaders chose to begin working together on the SPF-SIG project in advance of this designation.

B. Vision

To decrease substance use disorders and underage use in Penobscot and Piscataquis Counties in order to produce healthier communities.

C. Description of Geographic Areas Covered in the Strategic Plan and Collaborating Partners

Description of Geographic Area Covered

In terms of geography Penobscot and Piscataquis counties together cover 7,216 square miles (over twice the size of Delaware and Rhode Island combined) with a total population of 165,721. While Piscataquis County is the second largest of all Maine counties, it is also the least populated with only 17,525 residents.[i] Penobscot County (the fourth largest county in the state), on the other hand, is home to the third largest city, Bangor, with a greater metropolitan population of just over 75,000 residents.

As with many areas of the state this region has experienced great job loss in recent years, particularly in the areas of paper-making, lumber and wood products, shoes and textiles. According to the Maine Department of Labor between 2001 and 2004, Eastern Maine (the area that also includes Hancock and Washington counties) lost 19.6% of its manufacturing jobs; Penobscot county alone lost 33.5% of its manufacturing jobs.

This job loss has impacted the area greatly and has had ripple effects on the economy and other areas of community life. As a service center with a more diversified economy and several colleges, Bangor, the third largest city in the state, has fared better than other parts of the Penobscot/Piscatquis region.[ii]

Data provided in Eastern Maine Healthcare System's 2007 Community Health Needs Assessment and Health Planning Report for Northern, Eastern, and Central Maine draws the picture.

The report divides the EMHS' service area into seven regions, each of which is comprised of between one to several Hospital Service Areas. A Hospital Service Area is a group of cities and towns that includes one or more hospitals. The residents of those cities and towns can be expected to seek the majority of their inpatient care from the HSA's hospital(s). represents local areas for community inpatient care. The Dover-Foxcroft HSA for example, refers to the cities and towns like Milo and Guilford whose residents seek the majority of their inpatient care at Mayo Hospital in Dover-Foxcroft

The study areas corresponding to the SPF-SIG Penobscot/Piscataquis region are:

Region	Hospital Service Area
Bangor	Bangor
Penquis	Dover-Foxcroft, Lincoln, Millinocket, Greenville

In the EMH study our Penobscot/Piscataquis SPF-SIG region is comprised of the EMH regions called Bangor and Penquis. The EMH Penquis region is the geographic area of Penobscot and Piscataquis counties minus the Bangor metro area. The addition of the EMH Bangor region enables a comparison between the rural and metro areas of the region.

The following table illustrates the differences between the Bangor region, Penquis region and the State

Indicator	Bangor	Penquis	State
Population not attaining high school diploma (>25 years)	12.6	19.3	14.6
% Labor Force Unemployed	4.0	9.6	5.1
Annual Household Income ($)	$36,170	$26,332	$37,240
% Population Below Poverty	12.8	18.6	Na
% Population 65 and Over	12.0	17.0	14.3
% Projected Population Change (2000-2015)	14.1	8.3	7.7
% Uninsured	14.5	12.8	12.8

The Bangor region is more socio-economically prosperous than the Penquis region, with a higher educational attainment, lower unemployment and poverty rates. The Penquis region has a lower number of uninsured and a higher number of residents over the age of 65.[iii]

Collaborating Partners

Collaborating partners in this project include the City of Bangor, the Piscataquis Public Health Council, Sebasticook Valley Healthy Communities Coalition, MSAD 48, Katahdin Area Partnership, SPRINT for Life, and The River Coalition (the latter three are currently working together as the Katahdin Shared Services Comprehensive Community Health Coalition).

CITY OF BANGOR

The City of Bangor's Health and Welfare Department is the fiscal and administrative agent for this project. The Department became the lead for the 2007 Healthy Maine Partnership grant and as such, a Comprehensive Community Health Coalition with coverage of the Penobscot County communities of Bangor, Brewer, Clifton, Eddington, Glenburn, Hampden, Hermon, Holden, Newburgh, Orono, Orrington, and Veazie.

SEBASTICOOK VALLEY HEALTHY COMMUNITIES COALITION

The Sebasticook Valley Healthy Communities Coalition (SVHCC) has been serving the Sebasticook Valley Region since 1999 and was the result of a two-year state grant secured by Sebasticook Valley Hospital (SVH) and various local organizations. SVHCC is the Comprehensive Community Health Coalition with coverage of the Penobscot County communities including: Carmel, Corinna, Dixmont, Etna, Levant, Newport, Plymouth, and Stetson.

MAINE SCHOOL ADMINISTRATIVE DISTRICT 48

MSAD 48 serves the Somerset and Penobscot County towns of Corinna, Hartland, Newport, Palmyra, Plymouth and St. Albans. MSAD 48 provides the School Health Coordinator piece for the Sebasticook Valley Healthy Communities Coalition/CCHC.

PISCATAQUIS PUBLIC HEALTH COUNCIL

The Piscataquis Public Health Council is a Healthy Maine Partnership and Comprehensive Community Health Coalition serving all of the towns in Piscataquis County in addition to Bradford, Charleston, Corinth, Dexter, Exeter, Garland, Hudson, Kenduskeag, and Lagrange in Penobscot County. PPHC is affiliated with Mayo Regional Hospital in Dover-Foxcroft.

SPRINT FOR LIFE

SPRINT for Life is a Healthy Maine Partnership covering school districts in Lee, Lincoln, Howland and surrounding towns in Penobscot County. SPRINT for Life is affiliated with Penosbcot Valley Hospital in Lincoln and shares a Drug Free Communities grant with the Katahdin Area Partnership. SPRINT for Life is part of the Katahdin Shared Services CCHC.

KATAHDIN AREA PARTNERSHIP

The Katahdin Area Partnership is affiliated with Millinocket Regional Hospitals and is the Healthy Maine Partnership serving the greater Millinocket area. KAP shares a Drug

Free Communities grant with SPRINT for Life and is one of three coalitions that comprise the Katahdin Shared Services Comprehensive Community Health Coalition.

THE RIVER COALITION

The River Coalition, a "Community That Cares®" organization, has been working toward building healthier and safer communities since its inception in 1994. Based in Old Town, the River Coalition also serves the surrounding communities of Alton, Bradley, Greenbush Indian Island, and Milford. The River Coalition addresses several factors in the community to target specific high risk issues from substance prevention and academic support to literacy and leadership development. The River Coalition has a Drug Free Communities grant and is part of Katahdin Shared Services Comprehensive Community Health Coalition.

KATAHDIN SHARED SERVICES

KSS is the Comprehensive Community Health Coalition comprised of Katahdin Shared Services, SPRINT for Life and The River Coalition. Together these groups serve: Alton, Argyle, Bradley, Burlington, Carroll Plantation, Chester, Drew Plantation, East Central Penobscot unorg., East Millinocket, Edinburg, Enfield, Greenbush, Howland, Kingman, Lakeville, Lee, Lincoln, Lowell, Mattawamkeag, Maxfield, Medway, Milford, Millinocket, Mount Chase, Old Town, Passadumkeag, Patten, Penobscot Indian Island, Prentiss, Springfield, Stacyville, Webster Plantation, Winn, and Woodville.

D. Description of Planning Team and Process (including data and information used)

Background

In November 2006 members of community organizations in Penobscot County and Piscataquis County, Maine met to discuss the possibility of collaborating together on the Maine Office of Substance Abuse Strategic Prevention Framework State Incentive Grant assessment (SPF-SIG). Penobscot and Piscataquis counties were being grouped together as a region in the forthcoming localization of the public health service delivery system; working together on this project would be the first step in this regional process and would provide experience in regional collaboration.

In December 2006 representatives of the City of Bangor, the Piscataquis Public Health Council and Katahdin Area Partnership interviewed applicants and unanimously agreed on the candidate to fill the Strategic Prevention and Environmental Programming (SPEP) coordinator position. This small but significant step symbolized the counties' ability to work together to achieve common goals in spite of the many differences between the coalitions, their service areas, cultures, and geography.

The SPF-SIG process kicked off in Penobscot and Piscataquis counties in the middle of January 2007.

Process

The advisory body and planning team for the Penobscot/Piscataquis SPF-SIG project is the 'Leadership Team'. This team has regional representation covering all towns within

the two counties; its members are affiliated with existing coalitions engaged in prevention work. Members of the Leadership Team are:

Member	Affiliation
Robin Mayo	Piscataquis Public Health Council
John Spieker	PPHC, Mayo Regional Hospital Counseling Department
Cheryl Roberts	PPHC, Mayo Regional Hospital
David Nelson	Katahdin Area Partnership, Millinocket Regional Hospital
Jane McGillicuddy	Katahdin Area Partnership, Millinocket Regional Hospital
Jeremy Weatherbee	SPRINT for Life, Penobscot Valley Hospital
Dawn Littlefield	Sebasticook Valley Health Communities, Sebasticook Valley Hospital
Penny Townsend	MSAD 48, Sebasticook Valley Healthy Communities
Micah Robbins	The River Coalition
Janet Spencer	Bangor Region Partners for Health
Shawn Yardley	City of Bangor

Several additional people participated throughout the planning process to provide data, analysis, or input on the direction of individual aspects of the project. These people are:

Member	Affiliation
Jessica Fogg	Penobscot Valley Hospital
Roni Thompson	Katahdin Area Partnership
Willow McVeigh	The River Coalition
Lisa Morin	The River Coalition
Rindy Fogler	City of Bangor

The coordinator's responsibilities included setting meetings, identifying project needs, educating the team on the SPF-SIG process, requesting information from team members to assist the process, collecting data, providing a bridge between the SPF-SIG SPEP assessment and the requirements for the Healthy Maine Partnership SPF-SIG component, and otherwise managing the project.

The Leadership Team provided connections to local geographies and communities, input on the direction of the project, ideas on how to meet project deliverables, and wonderful support for the project coordinator.

Structure

The team met for the first time on February 9, 2007 to review the state's SPF-SIG process as outlined in the SPF-SIG Guide, review findings from the epidemiological data

supplied by OSA, review preliminary interview data (see below) and to develop a strategy for moving forward. The team decided to focus additional MYDAUS data analysis on four indicators correlated with underage use of substances:

- Students' perception of harm and risk
- Students' perception of their parent's disapproval of use
- Past 30 day use
- Age of first use.

The team also designated representatives from each sub-region to attend the two Learning Community sessions.

The team met three times over the next two months specifically to discuss the Healthy Maine Partnership RFP and begin coordinating for that process. Conversations regarding the SPF-SIG process, progress and plans occurred at each of these meetings.

The team convened again on April 18th for a mini-training on the SPF-SIG process, modeled after the two-day Learning Community training which was attended by five members of the Leadership Team. The team agreed that the SPF-SIG logic model in the HMP grant mirrored their collective priorities, addressed the trends and concerns they'd seen over time in their own communities, and provided an avenue through which to engage in broader change of social and community norms around substance use. The team also engaged in the first of five brainstorming sessions around the intervening variables contained in the SPF Guide and in the SPF-SIG Logic Model and developed a plan to hold similar brainstorming sessions in each of the four CCHC areas.

The Leadership Team met for the last time on August 9, 2007 to discuss results of the brainstorming sessions and to review a proposed Year One workplan.

Brainstorming Sessions

Brainstorming sessions around intervening variables contained in the SPF Guide and SPF-SIG Logic Model were held in each of the four CCHC areas: Sebasticook, Piscataquis County, Greater Bangor, and Katahdin Shared Services. The separate geographic sessions were intended as a means to elicit information from as many community members as possible in a manner as convenient to them as possible; some participants traveled over an hour to attend their session.

The sessions also provided an opportunity for capacity building within the coalition hosting the session. The new Comprehensive Community Health Coalition structure requires engagement of a broader set of stakeholders; several coalitions used this session to begin this process.

Coalitions were responsible for arranging the meetings and inviting community representatives. Each meeting began with a review of the SPF-SIG process; community members then brainstormed around the intervening variables. Appendix H contains the results of the combined brainstorming sessions. Dates and attendees for these sessions are as follows:

- **Sebasticook Valley Healthy Communities**
  Date: April 24, 2007
  Attendance: Dawn Littlefield (Sebasticook Valley Healthy Communities Coalition), Penny Townsend (School Health Coordinator SAD 48), Denise Delorie (SCARP), Ann Johnston (Sebasticook Valley Healthy Communities Coalition), David Pease (Sebasticook Valley Hospital), Mike Gallagher (MSAD #53), Bill Braun (MSAD# 48), Kathryn Ruth (Pittsfield Town Manager), and Marc Inman (Sebasticook Valley Hospital), and Jamie Comstock (Penobscot/Piscataquis Counties OSA Coordinator)

- **Piscataquis Public Health Council—Session 1**
  Date: May 15, 2007
  Attendance: Heather Perry (Union 60), Dawna Blackstone (Union 60), Robyn Mayo (Piscataquis Public Health Council), Cheryl Roberts (Mayo Regional Hospital), Jeff Keane (Morton Avenue Elementary School), Pat Kelleher (Charlotte White Center), Beth Postlewaite (Foxcroft Academy), Lee Pearsall (Foxcroft Academy), Michelle Weirich (City of Bangor), and Jamie Comstock (Penobscot/Piscataquis Counties OSA Coordinator)

- **Piscataquis Public Health Council—Session 2**
  Date: May 22, 2007
  Attendance: Dawna Blackstone (Union 60), John Dirnbauer (MSAD 68) Jane Jones (Town of Milo), Michael Poulin (Milo Police), Pat Kelleher (Charlotte White Center), John Spieker (Mayo Counseling Center), Robyn Mayo (Piscataquis Public Health Council), Michelle Weirich (City of Bangor), and Jamie Comstock (Penobscot/Piscataquis Counties OSA Coordinator)

- **City of Bangor**
  Date: June 15, 2007
  Attendance: Elise Senecal (Women's Project), Debbie Dettor (Maine Alliance for Addiction Recovery), Cathy Sherman (Brewer Schools), Courtney Lehnhard (SAD 22), Annette Adams (Acadia Hospital), Sara Stevens (Congressman Michaud's Office), Pete Arno (Bangor Police Department), Shawn Yardley (Bangor Health and Welfare), Rindy Fogler (City of Bangor Health and Welfare), Sandy Ervin (Bangor Schools), Andy Orazio (Bangor Y), Amanda Cost (Spruce Run), Dennis Marble (Bangor Area Homeless Shelter), Pat Kimball (Wellspring), Charlie Liu (Salvation Army's Powerhouse Teen Center), Tamar Matthieu (Penquis CAP), and Jamie Comstock (Penobscot/Piscataquis Counties OSA Coordinator)

- **Katahdin Shared Services**
  Date: July 17, 2007
  Attendance: Jamie Pierce (University College of Bangor), Micah Robbins (River Coalition), Willow McVeigh (River Coalition), Bud Walker (University of Maine Substance Abuse Prevention Services), Lauri Sidelko (University of Maine Substance Abuse Prevention Services), Rhonda Thompson (Katahdin Area

Partnership), Donald Bolduc (Millinocket Police), Jane McGillicuddy (Katahdin Area Partnership), Tom Malcom (Millinocket Fire Department), Kyle Smart (Old Town Police), David Hainer (SAD 22), Jeremy Weatherbee (SPRINT For Life), Missy McLellen (SPRINT For Life), Tracy Cousineau (Health Access Network), Gus Burkett (University of Maine Substance Abuse Prevention Services), Jill Nitardy (Orono Old Town Y), and Jamie Comstock (Penobscot & Piscataquis Counties OSA Coordinator)

Additional Data

MYDAUS Analysis

As noted above, in the initial meeting the Leadership Team decided to focus additional MYDAUS data analysis on four indicators that are correlated with future substance use:

- Students' perception of harm and risk
- Students' perception of their parent's disapproval of use
- Past 30 day use
- Age of onset.

These indicators are used in the Drug Free Community grant work being done by Katahdin Area Partnership, SPRINT for Life and The River Coalition. The group felt that analysis of this data to include additional information on statistical significance between state and county numbers could shed light on use patterns, drugs of choice, and highlight any work needed to be addressed in the Year One workplan.

The Office of Substance Abuse agreed to release the raw MYDAUS data to the project coordinator; OSA's number cruncher agreed to perform the analysis to see if 6th through 12th grade students' use of certain drugs in Penobscot and Piscataquis counties differed significantly from each other or their peers in the state. The result of the analysis can be found in Appendix T. The group found that use of some substances in Piscataquis County is statistically significantly higher than their state peers. This same rate of use was not found in Penobscot County. Overall, however, there was no discernible pattern.

Survey of 18-25 year olds

In review of the data OSA made available for this project, the MYDAUS data, epidemiological data, and other assessment data the group realized that there was little data specific to the 18-25 cohort and their use patterns.

The team partnered with the University of Maine in Orono to deliver a Young Adult Health Assessment (Appendix S) over the course of two days during finals week in May 2007.

The survey asked questions about beliefs and use patterns of respondents' peers. Fifty (50) respondents completed survey, the majority of which (36) were female.

Students were asked how often a peer in their age group uses tobacco, alcohol, and other drugs. The results indicate highest use for tobacco, alcohol, marijuana, prescription drugs and opiates (see table below).

Substance	Monthly or More	Weekly or More
Tobacco	34	31
Alcohol	45	40
Marijuana	33	25
Cocaine	14	4
Amphetamines	16	4
Sedatives	14	5
Hallucinogens	11	4
Opiates	19	12
Inhalants	11	4
Designer Drugs (ecstasy)	12	4
Prescription Drugs	21	11

Over half of all respondents reported that their peers use alcohol three or more times per week, while thirteen respondents reported their peers use no tobacco at all.

Respondents also reported the following:

- While most of their peers would not disapprove of their trying marijuana or using it occasionally, most believe their peers would disapprove of their
    - smoking marijuana regularly
    - trying cocaine, amphetamines, or hallucinogens and using these drugs regularly
- Most feel their peers would not disapprove of their having a drink or two every day, but feel their peers would disapprove of their having five or more drinks every day
- The majority of respondents feel there is either no risk or a slight risk in smoking marijuana once or occasionally; the majority feel there is risk to smoking pot everyday
- The majority feel there is moderate to great risk in trying cocaine, hallucinogens, or amphetamines or taking these drugs regularly
- Over half felt there is a slight to moderate risk involved in having one or two drinks nearly everyday, and moderate to great risk for having four or five drinks nearly every day
- Almost seventy percent reported that
    - their friends were more likely to attend a social event if there are opportunities to drink or use drugs
    - their friends were more likely to go to a bar or restaurant with drink specials than they are an establishment with no drink specials, all things being equal

    - the price of a particular brand or type of alcohol influences their friends' decisions to purchase that particular brand/type of alcohol
- About half reported that in the last year their friends had been served alcohol by bartenders and wait staff when they (friend) were obviously intoxicated
- Over eighty percent reported that their friends are regularly carded for identification when buying alcohol from retail establishments
- About 60% reported that it is not easy for a person under the age of 21 to illegally purchase alcohol for themselves
- Ninety-five percent reported that it is easy for a person under 21 to get alcohol from friends who are purchasing it illegally
- Over eighty percent felt it was not ok to share prescription drugs with a friend who needs it for a medical condition
- Over eighty percent know where to get help for a friend with a substance abuse problem

Interviews
Forty-eight interviews with community members involved in substance abuse prevention efforts and/or affected by substance abuse were conducted across the Penobscot/Piscataquis Region during the course of this project.

The purpose of the interviews was several-fold. They were used to collect information patterns, trends, and consequences of substance use throughout the region; they were also used to build support for the project and increase local coalitions' capacity for implementing strategies to address identified priorities.

A list of community members interviewed in this process is located in Appendix J; interview questions can be found in Appendix K and common interview themes can be found in Appendix L.

Coordination with other efforts
In an effort to increase capacity and build further support for the project, the SPF-SIG project and process was integrated with other like community efforts whenever possible.

- Information on the SPF-SIG process was presented to the Piscataquis Public Health Council
- The SPEP Coordinator and a member of the Leadership Team facilitated a discussion on prescription drug misuse between middle and high school students in Howland following the showing of *Falling*
- The SPEP Coordinator presented social marketing basics to youth participating in Penquis CAP's Young Entrepreneur Program and solicited information from them regarding youth alcohol and tobacco use
- The SPEP Coordinator participated in the Katahdin Area Partnership/SPRINT for Life Drug Free Communities planning session

E. Process Used to Interpret Information and Make Decisions

The consensus model of decision making was used throughout the Penobscot/Piscataquis SPF-SIG process in an effort to promote the growth of this regional partnership and build trust between members. The coordinator had responsibility for the project's day to day operations and presented the group with larger, directional decisions. Input and ideas of all participants were gathered and synthesized to arrive at a final decision acceptable to all.

This process was employed during meetings as well.

The coordinator collected information from a variety of sources, including group members, and made the data available to group members for their own analysis. The coordinator then synthesized and analyzed the information and made the analysis available to the group to enable discussion around the data and decision-making.

F. Prioritization of Goals and Objectives (What are the priorities and why?)

Several factors contributed to the prioritization of goals and objectives set forth in the Penobscot/Piscataquis Problem Statements and Year One workplan. The first was the SPF-SIG Logic Model in the Healthy Maine Partnership RFP which was released in early March, less than two months after the Penobscot/Piscataquis began their SPF-SIG process. The second was OSA's refined priorities as presented at the Learning Community session in late March. The SPF-SIG Logic Model priorities were reinforced at the Learning Community session as OSA's refined priorities.

The Logic Model priorities differed from those presented in the SPF-SIG Guide (alcohol, marijuana, prescription drugs) in that they were more developed and had greater focus (underage drinking, high risk drinking in people ages 18-25, and misuse of prescription drugs in people ages 18-25.

The Penobscot Piscataquis Team adopted these priorities as their own because 1) the priorities were supported by Penobscot/Piscataquis data and 2) because they provided a vehicle to change social and community norms around the use of substances, which is the intervening variable that contributes most to the high substance use in these counties.

G. Problems Statements (Complete one of these tables for each problem statement)

Problem Statement: Reduce alcohol use among youth (with primary focus on high-school aged youth)

Goal: Reduce appeal of underage drinking

Objective (from intervening variables)	Strategies (to address contributing factors)	Benchmarks (How will you know you have achieved your objectives? When do you expect to achieve them?)
Objective 1: Increase effectiveness of law enforcement policies & practices (based on MCOPA/OSA model policy) Capacity Building Actions: Building relationships with town police departments and encourage them to implement the MCOPM policy and increase enforcement actions	1. Policy (Maine Chiefs of Police Model Policy) 2. Education of officers (training) on best practices, why policy is important etc. 3. Enforcement—increase enforcement actions related to underage drinking, furnishing and hosting laws	1. Towns whose police departments have implemented the model policy increases (Year One) 2. Number of officers region-wide who are trained on model policy and its importance increases (Year One) 3. Number of underage drinking, furnishing and hosting citations increases (Year Two)
Objective 2: Increase use of recommended parental monitoring practices Capacity Building Actions: Build relationships with local media, work with schools to implement policy	1. Communication—social marketing campaign targeted to parents (OSA's Parent Campaign) 2. Collaboration with local media, parent groups, to get the message out (OSA's Parent Campaign) 3. Policy—notification of parents required by school policy (OSA's 'How To Guide' for School Policy)	1. Number of parents aware of recommended monitoring practices increases (Year One) 2. Ads, press releases, speaking engagements around monitoring practices increases from present (Year One) 3. Number of schools with model policies increases (Year Two)

Objective 3: Increased knowledge of health risks of underage drinking Capacity Building Actions: Build relationships with local media, workplaces, community venues to increase awareness of risks associated with underage drinking	1. Communication—social marketing campaign targeted to parents about health risks (OSA's Parent Campaign) 2. Collaboration with local media, parent groups, to get the message out (OSA's Parent Campaign) 3. Education to broader community knowledge about health risks associated with underage drinking (OSA's Parent Campaign)	1. Number of parents aware of health risks of underage drinking increases (Year Two) 2. Ads, press releases, speaking engagements around monitoring practices increases (Year Two) 3. Community's awareness of health risks of underage drinking increases (Year Two)
Objective 4: Decrease counter-productive adult modeling behavior Capacity Building Actions: Build relationships with local media, workplaces, community venues to increase awareness of impact of modeling	1. Communication—social marketing campaign targeting parents to publicize penalties for hosting and other laws regarding underage drinking (OSA's Parent Campaign) 2. Collaboration—partnership with local media, parent groups, businesses and organizations (OSA's Parent Campaign) 3. Education of parents and community about impact of modeling (OSA's Parent Campaign)	1. Number of parents and community members aware of penalties for hosting and furnishing increases (Year One) 2. Ads, press releases, literature, speaking engagements around impact of modeling increases (Year One) 3. Number of parents and community members aware of the impact of modeling increases (Year Two)
Objective 5: Decrease advertising /promotions that appeal to youth Capacity Building Actions: Increase community awareness and encourage community to organize for	1. Collaboration—community organizing for policy changes to reduce youth access to alcohol through Maine Alcohol Impact Coalition 2. Policy—state, retailers to implement administrative penalties, minimum age of seller requirements, responsible retailing systems etc.	1. Number of coalitions and community organizations who have become members of the Maine Alcohol Impact Coalition increases (Year Two to Three) 2. Number of state policies around responsible retailing increases (Year Three and beyond)

policy changes	with assistance from Maine Alcohol Impact Coalition	
Objective 6: Increased effectiveness of school substance abuse policies Capacity Building Actions: Work with schools to implement school substance abuse policies	1. School policies (OSA's How To Guide for School Policies) 2. Enforcement (OSA's How To Guide for School Policies)	1. Number of schools with model substance abuse policies increases (Year Two) 2. Schools report increased and more consistent enforcement of school substance policies (Year Two)

(Complete one of these tables for each problem statement)

Problem Statement: Reduce alcohol use among youth (with primary focus on high-school aged youth)

Goal: Reduce Underage Access to Alcohol

Objective (from intervening variables)	Strategies (to address contributing factors)	Benchmarks (How will you know you have achieved your objectives? When do you expect to achieve them?)
Objective 1: Increase effectiveness of retailers' policies and practices that restrict underage access Capacity Building Actions: Build relationships with merchants	1. Education of merchants, clerk training etc through OSA's Card ME Program 2. Policy—Retailers to implement responsible retailing systems 3. Collaboration with Maine Alcohol Impact Coalition to have a stronger, collective, statewide impact	1. Number of merchants visited through Card ME program increases (Year One) 2. Number of retailers with responsible retailing systems increases (Year Two) 3. Number of coalitions and community organizations who have become members of the Maine Alcohol Impact Coalition increases (Year Two to Three)
Objective 2: Increase effectiveness of policies and practices that affect social access Capacity Building Actions: Build relationships and awareness within the media, work to fund increased enforcement, build relationships between law enforcement and prevention community	1. Communication of penalties for hosting, supplying minors etc through OSA's Sticker Shock Campaign, work with DA's office to publicize incidents of illegal hosting 2. Enforcement—increase enforcement related to underage drinking, furnishing, hosting laws 3. Collaboration and coalition building between law enforcement and prevention community to establish underage drinking enforcement as a shared priority (through Maine Chiefs of Police Model Policy)	1. News stories involving penalties for hosting increase, stores participating in Sticker Shock increases (Year Two) 2. Citations around underage drinking, furnishing and hosting increase (Year Two) 3. Membership of CCHC increases (including law enforcement entities and other community organizations)(Year Two)

(Complete one of these tables for each problem statement)

Problem Statement: Reduce High Risk Drinking Among Adults (With Primary focus on 18-25 Year Olds)

Goal: Reduce Appeal of High-Risk Drinking

Objective (from intervening variables)	Strategies (to address contributing factors)	Benchmarks (How will you know you have achieved your objectives? When do you expect to achieve them?)
Objective 1: Increase knowledge of health risks of high-risk drinking Capacity Building Actions: Build relationships with workplaces and colleges	1. Communication about available self assessment screening tools to raise awareness of the health risks associated with drinking 2. Education about web-based assessment feedback programs and web-based courses 3. Collaboration with colleges and workplaces to pass policies to institutionalize screening	1. Number of workplaces and colleges aware of self assessment tools increases (Year One) 2. Workplaces and colleges aware of the benefits of web-based assessment increases (Year One) 3. Number of workplaces and colleges with screening as policy increases (Year Two)
Objective 2: Decrease promotions and pricing that encourages high-risk drinking Capacity Building Actions: Build relationships with workplaces and colleges, other community entities to encourage organized approach to policy changed	1. Collaboration—community mobilizing for local and state level changes to limit promotions and increase pricing, in partnership with the Maine Alcohol Impact Coalition 2. Policy—implement college and workplace policies in accordance with OSA's Substance Abuse in the Workplace Program 3. Enforcement—ensure that Substance Abuse in the Workplace policies are enforced	1. Coalitions become members of the Maine Alcohol Impact Coalition and sign petition to increase alcohol tax (Year One) 2. Number of colleges and workplaces with substance abuse policies increases (Year One) 3. Number of colleges and workplaces enforcing substance abuse policies increases (Year One)

Objective 3: Establish mechanisms in health care systems that increase use of screening & brief intervention to reduce high-risk drinking Capacity Building Actions: Build relationships with health care community	1. Communication about available self assessment screening tools to raise awareness of the health risks associated with drinking 2. Education about web-based assessment feedback programs and web-based courses 3. Collaboration with health care systems to pass policies to institutionalize screening	1. Number of health care systems aware of self assessment tools increases (Year Three and beyond) 2. Health care systems aware of the benefits of web-based assessment increases (Year Three and beyond) 3. Number of workplaces and colleges with screening as policy increases (Year Three and beyond)

(Complete one of these tables for each problem statement)

Problem Statement: Reduce High Risk Drinking Among Adults (With Primary focus on 18-25 Year Olds)

Goal: Reduce Availability of Alcohol that encourages high-risk drinking

Objective (from intervening variables)	Strategies (to address contributing factors)	Benchmarks (How will you know you have achieved your objectives? When do you expect to achieve them?)
Objective 1: Increase effectiveness of retailer policies and practices to reduce sales/service to visibly intoxicated persons Capacity Building Actions: Build relationships with local merchants	1. Collaboration with merchants to establish and enforce responsible retailing practices through OSA's Card Me Program 2. Education of merchants and seller/servers through Responsible Beverage Server Training 3. Communication campaign with warning posters to remind servers of liability laws	1. Number of retailers with responsible retailing systems increases (Year Two) 2. Number of merchants participating in Responsible Beverage Server Training increases (Year Two) 3. Number of establishments with warning posters increases (Year Two)
Objective 2 Capacity Building Actions:	1. 2. 3.	
Objective 3: Capacity Building Actions:	1. 2. 3.	

(Complete one of these tables for each problem statement)

Problem Statement: **Reduce prescription drug abuse among young adults (ages 18-25)**

Goal: Reduce appeal of misuse of prescription drugs

Objective (from intervening variables)	Strategies (to address contributing factors)	Benchmarks (How will you know you have achieved your objectives? When do you expect to achieve them?)
Objective 1: Increase knowledge of health risks of misuse of prescription drugs Capacity Building Actions: Build relationships with local employers	1. Collaboration with employers to adopt HMP Worksite Health Framework incorporating a Drug-Free Workplace Program 2. Policy—Encourage employers to adopt a Drug Free Workplace policy 3. Communication to employees about the Drug-Free workplace policy and program to include information about health risks and consequences for violating policy	1. Number of employers interested in participating in Drug Free Workplace Program increases (Year Three and beyond) 2. Number of employers participating in Drug Free Workplace Program increases (Year Three and beyond) 3. Number of employees aware of health risks and consequences for violating Drug Free Workplace policy increases (Year Three and beyond)
Objective 2: Capacity Building Actions:	1. 2. 3.	

(Complete one of these tables for each problem statement)

Problem Statement: Reduce Prescription drug abuse among young adults (18-25 years old)

Goal: Reduce availability of prescription drugs for purposes other than prescribed

Objective (from intervening variables)	Strategies (to address contributing factors)	Benchmarks (How will you know you have achieved your objectives? When do you expect to achieve them?)
Objective 1: Increase prescribers' and dispensers' awareness of and use of the Prescription Monitoring Program Capacity Building Actions: Build relationships with local prescribers and dispensers	1. Collaboration to work with drug prescribers, dispensers, and their employers to increase use and usability of Maine's Prescription Monitoring Program 2. Education to prescribers and dispensers about the PMP, why it is important and how to use it 3. Communication using media to increase public knowledge about the proper storage and disposal of prescription drugs	1. Identification of prescribers and dispensers region-wide (Year Three and beyond) 2. Prescriber and Dispenser awareness of PMP increases (Year Three and beyond) 3. Press releases and news stories about PMP increases (Year Three and beyond)
Objective 2: Capacity Building Actions:	1. 2. 3.	

H. Capacity Building Priorities (Describe any additional capacity building priorities beyond those associated with specific objectives in the tables above)

According to the Prevention Centers of Excellence Capacity Assessment, the Penobscot/Piscataquis region has many strengths including a commitment to address substance abuse problems from those involved in prevention work, collaboration and networking within the two counties, strong external linkages, strong leadership in some areas, strong business capacity, strong technical knowledge of substance abuse prevention, a process in place to assess countywide magnitude of substance abuse consumption, to assess readiness and resources and to seek a diversified funding base.

The development of the strategic plan was greatly assisted by several of these strengths, including the technical knowledge of substance abuse prevention, a commitment to addressing these issues, and strong external linkages. Groups shared their substance abuse prevention expertise with the coordinator and with each other; each coalition provided local contacts for the coordinator to connect with, and each took on the responsibility for organizing localized meetings.

Moving forward and in order to carry out a broader, public health-focused agenda, groups in this region will need to increase and improve the collaboration and networking within the two counties that is already in place, creating additional external linkages and strengthen those already in place.

Using OSA's logic model as a guide, many aspects of the Penobscot/Piscataquis strategic plan are focused on increasing awareness and changing social norms. Achieving regional success with this plan will require continued coordination between prevention coalitions and the ability to demonstrate successes to the community at large in order to build momentum and continued support.

To that end the following Prevention Center of Excellence Capacity Assessment recommendations will be pursued

- Explore additional ways to build on current collaborative capacity and networking among prevention agencies within Penobscot and Piscataquis Counties
- Identify organizations not currently involved in substance abuse prevention that might be interested in exploring substance abuse issues
- Offer educational opportunities to community members and organizations to raise the level of awareness of substance abuse problems in Penobscot and Piscataquis Counties
- Develop a shared vision for substance abuse prevention amongst leaders of prevention activities
- Systematically plan and implement broad, inclusive and multi-media prevention dissemination
- Continue to build collaborative capacity of the two counties to build and implement sustainable prevention infrastructure
- Identify and increase preventionists' access to multiple local sources of substance abuse data to inform planning

- Explore ways to engage entities involved in substance abuse prevention in sharing information regarding prevention initiatives
- Identify relevant local data sources that can be used to inform prevention
- Identify potential resources to educate preventionists about conducting evaluation research
- Build capacity to conduct evaluation.

I. Action Plan

The Penobscot/Piscataquis Year One work plan is based on OSA's SPF SIG logic model located in the 2007 Healthy Maine Partnership RFP. The HMP process and priorities were emerging during the timeframe that the Penobscot/Piscataquis coalitions were working through the SPF-SIG process. The coalitions aligned their priorities with those identified in the logic model and chose to pursue the required objectives in their Year One workplan.

As envisioned by the emerging public health infrastructure, workplans for future years will be created by individual CCHCs using the SPF-SIG problem statements as a framework.

Penobscot/Piscataquis Counties
Year One SPF-SIG Workplan

MCP Required Objective:	Work to begin (approximate date)	Pre-approved Strategies**	Measurement
3.1 Increase effectiveness of local underage drinking law enforcement policies & practices (based on Maine Chiefs of Police/OSA model policy)	Fall 2007	1. Policy (Maine Chiefs of Police Model Policy) 2. Education of officers (training) on best practices, why policy is important etc.	1. Towns whose police departments have implemented the model policy increases (Year One) 2. Number of officers region-wide who are trained on model policy and its importance increases (Year One)
3.2 Increase use of recommended parental monitoring practices for underage drinking	Fall 2007	1. Communication—social marketing campaign targeted to parents (OSA's Parent Campaign) 2. Collaboration with local media, parent groups, to get the message out (OSA's Parent Campaign)	1. Number of parents aware of recommended monitoring practices increases (Year One) 2. Ads, press releases, speaking engagements around monitoring practices increases from present (Year One)
3.3 Increase effectiveness of retailers policies and practices that restrict access to alcohol by underage youth	August 2007	1. Education of merchants, clerk training etc through OSA's Card ME Program 2. Policy—Retailers to implement	1. Number of merchants visited through Card ME program increases (Year One) 2. Number of retailers with responsible retailing systems

		responsible retailing systems	increases (Year One)
3.10 Reduce appeal of high risk drinking (among 18-25 year olds) by increasing knowledge of the health risks	Fall 2007	1. Communication about available self assessment screening tools to raise awareness of the health risks associated with drinking 2. Education about web-based assessment feedback programs and web-based courses	1. Number of workplaces and colleges aware of self assessment tools increases (Year One) 2. Workplaces and colleges aware of the benefits of web-based assessment increases (Year One)
3.11 Decrease promotions and pricing that encourage high risk drinking among young adults (18-25 year olds)	Fall 2007	1. Communication—social marketing campaign targeting parents to publicize penalties for hosting and other laws regarding underage drinking (OSA's Parent Campaign) 2. Collaboration—partnership with local media, parent groups, businesses and organizations (OSA's Parent Campaign) 3. Education of parents and community about impact of modeling (OSA's Parent Campaign)	1. Coalitions become members of the Maine Alcohol Impact Coalition and sign petition to increase alcohol tax (Year One) 2. Number of colleges and workplaces with substance abuse policies increases (Year One) 3. Number of colleges and workplaces enforcing substance abuse policies increases (Year One)

Insert other optional objectives selected			
3.7 Decrease counterproductive adult modeling behaviors	January 2008	1. Communication—social marketing campaign targeting parents to publicize penalties for hosting and other laws regarding underage drinking (OSA's Parent Campaign) 2. Collaboration—partnership with local media, parent groups, businesses and organizations (OSA's Parent Campaign)	1. Number of parents and community members aware of penalties for hosting and furnishing increases (Year One) 2. Ads, press releases, literature, speaking engagements around impact of modeling increases (Year One)

J. Sustainability (Describe your plan for continuing the collaborative strategic planning process beyond the SPF SIG grant. Describe your funding plan to develop and attain the resources needed to implement the priority strategies identified)

As demonstrated by the attached MOU (Attachment Q) Penobscot/Piscataquis coalitions have agreed to continue working together to collaboratively achieve Year One objectives. Coalitions will meet quarterly, will partner to develop informational and educational materials, will work together to implement best practice strategies and to assess substance abuse prevention, control, and treatment programs, policies, practices.

Funding for Year One implementation of objectives is occurring through the 2007 Healthy Maine Partnership grant.

Potential future grant funding for objectives could include:

1. Drug Free Communities grants. Katahdin Area Partnership, SPRINT for Life, and the River Coalition currently hold these grants. This year KAP and SPRINT for Life are extending planning monies to the Piscataquis Public Health Council to enable PPHC to develop capacity to apply for their own DFC grant next year

2. National Institute on Alcohol Abuse and Alcoholism's (NIAAA) Screening and Brief Alcohol Interventions in Underage and Young Adult Populations grants program, which is aimed at generating research on screening and brief interventions to prevent and/or reduce alcohol use and its consequences.

2. The Peter F. McManus Charitable Trust offers grants for basic, clinical and social-environment research into the causes of alcohol and other drug abuse.

3. The Open Society Institute provides funding for its Sentencing and Incarceration Alternatives Project. An increase in jail diversion programs have been identified as a need in this region.

4. The Office of Juvenile Justice and Delinquency Prevention's Substance Abuse Prevention and Intervention funds substance abuse prevention and/or intervention projects

5. The U.S. Department of Education awards grants to prevent high-risk drinking and violent behavior among college students.

6. The National Institutes of Health provides funding for Drug Abuse Prevention and Intervention grants to develop novel drug-abuse prevention approaches.

7. The Association for Supervision and Curriculum Development (ASCD) awards grants that create healthy schools and include drug prevention curricula.

Sustainability of efforts will occur through subsequent HMP process and through additional funding opportunities as determined and identified by individual CCHCs. Increased networking and linkages via the CCHC and Regional Coordinating Council structure also has the potential for creating new sources of local private funding.

Appendix A: Major Activities Checklist

County Name:	Penobscot/Piscataquis
Person Completing Form:	Jamie Comstock
Completion Date:	August 2007

- ☒ Establish committee to oversee and conduct needs assessment
- ☒ Gather and review existing information (State EPI profile, County Profile Supplement, other local data)
- ☒ Gather and review previously conducted assessments
- ☒ Brainstorm factors that contribute to the intervening variables
- ☒ Identify gaps and plan information collection
- ☒ Collect additional information to address identified gaps
- ☒ Engage in a capacity assessment with PCoE staff
- ☒ Complete Assessment Report and submit to OSA by June 30, 2007
- ☒ Assemble a Planning Team
- ☒ Develop a vision statement and problem statements and identify goals, objectives and strategies for your planning model
- ☒ Complete MOUs for work on the strategic plan in 2007-2008 (submit to OSA with strategic plan)
- ☒ Complete strategic plan and submit to OSA staff by August 31, 2007

Appendix B: Assessment Committee Responsibilities

County: Penobscot/Piscataquis

Committee Member	Affiliation	Role/Responsibility
Robin Mayo	Piscataquis Public Health Council/Mayo Regional Hospital	Leadership Team (project steering committee), collect and review data, organize local participation, provide input for process, project vision and final plan
David Nelson	Katahdin Area Partnership/Millinocket Regional Hospital	Leadership Team Member (project steering committee), collect and review data
Jane McGillicuddy	Katahdin Area Partnership/Millinocket Regional Hospital	Leadership Team (project steering committee), collect and review data, organize local participation, provide input for process, project vision and final plan
John Spieker	Mayo Regional Hospital Counseling Department	Leadership Team (project steering committee), collect and review data, organize local participation, provide input for process, project vision and final plan
Cheryl Roberts	Mayo Regional Hospital	Leadership Team Member (project steering committee), collect and review data
Jeremy Weatherbee	SPRINT for Life/Penobscot Valley Hospital	Leadership Team (project steering committee), collect and review data, organize local participation, provide input for process, project vision and final plan
Jessica Fogg	Penobscot Valley Hospital	Leadership Team Supporting Member, provide input for process
Roni Thompson	Katahdin Area Partnership	Leadership Team Supporting Member, provide input for process
Dawn Littlefield	Sebasticook Valley Health Communities	Leadership Team (project steering committee), collect and review data, organize local participation, provide input for process, project vision and final plan
Penny Townsend	SAD 48	Leadership Team (project steering committee), collect and review data, organize local participation, provide input

		for process, project vision and final plan
Micah Robbins	The River Coalition	Leadership Team (project steering committee), collect and review data, organize local participation, provide input for process, project vision and final plan
Willow McVeigh	The River Coalition	Leadership Team Supporting Member, collect and review data
Lisa Morin	The River Coalition	Leadership Team Supporting Member, provide input for process, project vision and final plan
Janet Spencer	Bangor Region Partners for Health	Leadership Team (project steering committee), collect and review data, organize local participation, provide input for process, project vision and final plan
Shawn Yardley	City of Bangor	Leadership Team (project steering committee), collect and review data, organize local participation, provide input for process, project vision and final plan
Rindy Fogler	City of Bangor	Leadership Team Supporting Member

Appendix C: Indicator Data for Substance Use Among Middle and High School Students (from County Profile Supplement)—Penobscot County

Indicator	Overall Rate of use, 2006	Group with highest rates, 2006	Compared to state?	Other notes
Lifetime use: alcohol	51.7%	11 (72%) 12 (74.9%)	☐ Higher ☒ Lower ☐ About the same	State = 47.7%
Lifetime use: marijuana	26.6%	11 (44.8%) 12 (48.7%)	☐ Higher ☐ Lower ☒ About the same	State = 25%
Lifetime misuse: prescription drugs	11.6%	11 12	☐ Higher ☐ Lower ☒ About the same	State = 12%
Previous 30-day use: alcohol	30.5%	11 (43.8%) 12 (49.8%)	☐ Higher ☐ Lower ☒ About the same	State = 29%
Previous 30-day use: marijuana	14.2%	11 (23.3%) 12 (25.2%)	☐ Higher ☐ Lower ☒ About the same	State = 14.1%
Previous 30-day misuse: prescription drugs	6.1%	10 (9.1%) 12 (11%)	☐ Higher ☐ Lower ☒ About the same	State = 6%
Previous 2-week participation in binge drinking by grade		11 (24.9%) 12 (30.8%)	☒ Higher ☐ Lower ☒ About the same	Higher 8th, 10th About the same other grades
Previous 2-week participation in binge drinking by gender	M = 17.7% F = 14.3%		☒ Higher for **Males** ☒ Lower for **Females** ☐ About the same	State (M) = 14.9% State (F) = 13.2%
Age first tried alcohol	Over 14 = 52.3% Under 14 = 23.5% Never = 24.2%		N/A	Changes over time? 14+ up from 2002 14- same as 2004, down from 2002 Never = about the same

Indicator	Overall Rate of use, 2006	Group with highest rates, 2006	Compared to state?	Other notes
Age first tried marijuana	14 + = 32.7% 14 - = 15% Never = 52.3%		N/A	Changes over time? About the same over last four years

Substances of greatest concern in our county:

Alcohol

Subpopulations/age groups of particular concern in our county:

11th and 12th grades consistently higher use rates than other grades

Substances consumed in our county at a higher rate than the state:

Two-week binge drinking higher than state in 8th and 10th grades

Areas where we need more information (such as who, what, where, why and when):

Appendix D: Indicator Data for Substance Use Among Adults (from County Profile Supplement)—Penobscot County

Indicator	County: Rate of use	State: Rate of Use	Compared to state?	Other notes
Lifetime use among adults: alcohol	90.4%	91.8%	☐ Higher ☒ Lower ☐ About the same	
Lifetime use among adults: marijuana	33.1%	40.5%	☐ Higher ☒ Lower ☐ About the same	
Lifetime use among adults: prescription drugs		4.9%	☐ Higher ☐ Lower ☐ About the same	
Previous 30-day use among adults: alcohol	52.8%	56.6%	☐ Higher ☒ Lower ☐ About the same	
Previous 30-day use among adults: marijuana	This and above rolled together in EPI		☐ Higher ☐ Lower ☐ About the same	
Previous 12-month participation in binge drinking	56.2%	50.8%	☒ Higher ☐ Lower ☐ About the same	Binge drinking rates higher than state by 6%
Previous 30-day participation in binge drinking	29.5%	27.8%	☒ Higher ☐ Lower ☐ About the same	Rates are higher
Previous 12-month binge drinking by gender (not available for all counties)	Male = 64.8% Female = 48.4%		☒ Higher **Male** ☒ Lower **Female** ☐ About the same	
Individuals crossing the threshold for prescription drugs	Female: 63.2% Male: 36.7%	Female: 62.7% Male: 37.3%	☐ Higher ☐ Lower ☐ About the same	Not much difference
Median age of individuals crossing the threshold	42%	42%	☐ Higher ☐ Lower	Same

Indicator	County: Rate of use	State: Rate of Use	Compared to state?	Other notes
			☐ About the same	

Substances of greatest concern in our county:

Prescription drugs

Substances consumed in our county at a higher rate than the state:

Binge drinking rates higher

Areas where we need more information (such as who, what, where, why and when):

Binge Drinking and prescription drug misuse in ages 18-25

Consequences of concern in my county among particular subpopulations/age groups:

Appendix E: Indicator Data: Substance Use Consequences Among Youth (from County Profile Supplement)—Penobscot County

Indicator	Rate of consequence in most recent year: County	Compared to state?	Trends over time?	Other notes
Juvenile arrests for alcohol violations	530	☐ Higher ☒ Lower ☐ About the same	☒ Increase ☐ Decrease ☐ No change	Slight increase since 1991; state is 685
Juvenile arrests for drug violations	557	☒ Higher ☐ Lower ☐ About the same	☒ Increase ☐ Decrease ☐ No change	Several years lower, but general increase (more awareness?); state is 552
Percent of all youth drivers (under 21) in fatal crashes who were alcohol-involved	18.8	☐ Higher ☒ Lower ☐ About the same	☒ Increase ☐ Decrease ☐ No change	State is 22.7%
Suspensions/removals due to alcohol or drugs	N/A	☐ Higher ☐ Lower ☐ About the same	N/A	

Consequences of concern in my county:

Consequences in which my county exceeds the state:

Consequences where we need more information (such as who, what, where, why and when):

Appendix F: Indicator Data: Substance Use Consequences Among Adults (from County Profile Supplement)—Penobscot County

Indicator	Rate of consequence in most recent year: County	Compared to state?	Trends over time?	Other notes
Rates of reported crimes per 1,000 people, by type	Violent = 5.5% Property = 22.7%	N/A	☐ Increase ☐ Decrease ☒ No change	Both about the same since 1994
Arrests for alcohol violations, age 18 and older	928	☐ Higher ☒ Lower ☐ About the same	☐ Increase ☐ Decrease ☐ No change	Down since 1991; state is 984
Adult OUI arrests, age 18 and older	604	☐ Higher ☒ Lower ☐ About the same	☐ Increase ☒ Decrease ☐ No change	State is 656
Arrests for drug violations, age 18 and older	482	☒ Higher ☐ Lower ☐ About the same	☒ Increase ☐ Decrease ☐ No change	State is 431
Percent of total fatal crashes over 5 years that were alcohol-related	31.3%	☐ Higher ☐ Lower ☒ About the same	☐ Increase ☐ Decrease ☐ No change	Compared to other counties? About the same; higher than Piscataquis
Percent of all young adult drivers (21 to 29) in fatal crashes who were alcohol-involved	42	☐ Higher ☒ Lower ☐ About the same	☒ Increase ☐ Decrease ☐ No change	Increase from 31.7% in last 5-year period; state is 44.3%
Percent of all adult drivers (30 and older) in fatal crashes who were alcohol-involved	15.9%	☐ Higher ☒ Lower ☐ About the same	☒ Increase ☐ Decrease ☐ No change	1994 to 1998 was 11.4; state is 20
Deaths by underlying cause		N/A	☐ Increase ☐ Decrease ☐ No change	Cirrhosis decreased, drug use, suicide increase, homicide about the same
Overdose deaths	14.3%	☒ Higher ☐ Lower ☐ About the same	☒ Increase ☐ Decrease ☐ No change	Overdose deaths up a lot since 1997 (1.4); state is 11.4%

Indicator	Rate of consequence in most recent year: County	Compared to state?	Trends over time?	Other notes
Treatment admissions (all ages)	1127	☒ Higher ☐ Lower ☐ About the same	☒ Increase ☐ Decrease ☐ No change	State is 1085—More availability than in Piscataquis?
Percent of total treatment admissions (18 and older) involving alcohol	63.9	☐ Higher ☒ Lower ☐ About the same	☐ Increase ☒ Decrease ☐ No change	State is 71.8
Percent of total treatment admissions (18 and older) involving marijuana	32.5	☐ Higher ☐ Lower ☒ About the same	☐ Increase ☐ Decrease ☒ No change	State is 32
Percent of total treatment admissions (18 and older) involving prescription drugs (not available for all counties)	36.8	☒ Higher ☐ Lower ☐ About the same	☒ Increase ☐ Decrease ☐ No change	State is 24—doubled the 2000 rate

Consequences of concern in my county:

Prescription drug use

Consequences of concern in my county among particular subpopulations/age groups:

Consequences in which my county exceeds the state:

Overdose deaths, adult treatment admissions for prescription drug use

Consequences where we need more information (such as who, what, where, why and when):

Appendix C: Indicator Data for Substance Use Among Middle and High School Students (from County Profile Supplement)—Piscataquis County

Indicator	Overall Rate of use, 2006	Group with highest rates, 2006	Compared to state?	Other notes
Lifetime use: alcohol	55.6	10th (75.8) 12 (78.6)	☒ Higher ☐ Lower ☐ About the same	State is 47.7
Lifetime use: marijuana	27.6	12th (53.7)	☒ Higher ☐ Lower ☐ About the same	State is 25
Lifetime misuse: prescription drugs	16	12th (26.7)	☒ Higher ☐ Lower ☐ About the same	State is 12
Previous 30-day use: alcohol	34.2	10th (48.7) 12th (50.8)	☒ Higher ☐ Lower ☐ About the same	State is 29
Previous 30-day use: marijuana	15.1	12th (26)	☒ Higher ☐ Lower ☐ About the same	State is 14.1
Previous 30-day misuse: prescription drugs	7.7	10th (11.4)	☒ Higher ☐ Lower ☐ About the same	State is 6
Previous 2-week participation in binge drinking by grade		10th (25.9) 12th (33.7)	☒ Higher ☐ Lower ☐ About the same	
Previous 2-week participation in binge drinking by gender	Male = 16.5 Female = 16.6		☒ Higher ☐ Lower ☐ About the same	State Male is 14.9 State Female is 13.2
Age first tried alcohol	Never used increased from 18.8 to 23.4; less than 14 drop from 2002 to 2006; 14+ stays about same		N/A	Changes over time? In 2006, Over 14 is 48.2; under 14 is 28.4; never is 23.4

Indicator	Overall Rate of use, 2006	Group with highest rates, 2006	Compared to state?	Other notes
Age first tried marijuana	14+ is 28.2 14- is 20 Never is 51		N/A	Changes over time? 14+ use decreased 9% since 2002; Never increased 7%

Substances of greatest concern in our county:

Alcohol

Subpopulations/age groups of particular concern in our county:

Substances consumed in our county at a higher rate than the state:

All—this is a concern

Areas where we need more information (such as who, what, where, why and when):

Appendix D: Indicator Data for Substance Use Among Adults(from County Profile Supplement)—Piscataquis County

Indicator	County: Rate of use	State: Rate of Use	Compared to state?	Other notes
Lifetime use among adults: alcohol	93	91.8	☒ Higher ☐ Lower ☐ About the same	
Lifetime use among adults: marijuana	45.2	40.5	☒ Higher ☐ Lower ☐ About the same	
Lifetime use among adults: prescription drugs	Not available	4.9	☐ Higher ☐ Lower ☐ About the same	
Previous 30-day use among adults: alcohol	49.8	56.6	☐ Higher ☒ Lower ☐ About the same	
Previous 30-day use among adults: marijuana	5	4	☒ Higher ☐ Lower ☐ About the same	
Previous 12-month participation in binge drinking	62.9	50.8	☒ Higher ☐ Lower ☐ About the same	Higher by 10%
Previous 30-day participation in binge drinking	34.7	27.8	☒ Higher ☐ Lower ☐ About the same	Higher by 10%
Previous 12-month binge drinking by gender (not available for all counties)	Not available	Not available	☐ Higher ☐ Lower ☐ About the same	
Individuals crossing the threshold for prescription drugs	Female: 78.4 Male: 21.6	Female: 62.7 Male: 37.3	☐ Higher ☐ Lower ☐ About the same	Female higher by 16% Male lower by 16%
Median age of individuals crossing the threshold	39	42	☐ Higher ☐ Lower ☐ About the same	

Substances of greatest concern in our county:

Binge drinking, 30 day and 12 month higher than state by 10% or over

Substances consumed in our county at a higher rate than the state:

Alcohol, marijuana, prescription drugs

Areas where we need more information (such as who, what, where, why and when):

Female prescription drug use is higher than the state by 16%

Consequences of concern in my county among particular subpopulations/age groups:

Appendix E: Indicator Data: Substance Use Consequences Among Youth (from County Profile Supplement)—Piscataquis County

Indicator	Rate of consequence in most recent year: County	Compared to state?	Trends over time?	Other notes
Juvenile arrests for alcohol violations	632	☐ Higher ☒ Lower ☐ About the same	☒ Increase ☐ Decrease ☐ No change	State is 685
Juvenile arrests for drug violations	421	☒ Higher ☐ Lower ☐ About the same	☒ Increase ☐ Decrease ☐ No change	State is 552
Percent of all youth drivers (under 21) in fatal crashes who were alcohol-involved	0	☐ Higher ☒ Lower ☐ About the same	☐ Increase ☒ Decrease ☐ No change	State is 22.7
Suspensions/removals due to alcohol or drugs	N/A	☐ Higher ☐ Lower ☐ About the same	N/A	

Consequences of concern in my county:

Arrests for drugs and alcohol have increased over time. Due to increased patrols etc?

Consequences in which my county exceeds the state:

All consequences lower than the state

Consequences where we need more information (such as who, what, where, why and when):

Appendix F: Indicator Data: Substance Use Consequences Among Adults (from County Profile Supplement)—Piscataquis County

Indicator	Rate of consequence in most recent year: County	Compared to state?	Trends over time?	Other notes
Rates of reported crimes per 1,000 people, by type	Violent = 11.7 Property = 18.4	N/A	☐ Increase ☐ Decrease ☐ No change	Both slightly up from 1994
Arrests for alcohol violations, age 18 and older	992	☒ Higher ☐ Lower ☐ About the same	☐ Increase ☐ Decrease ☐ No change	About the same; state is 984
Adult OUI arrests, age 18 and older		☐ Higher ☐ Lower ☐ About the same	☐ Increase ☐ Decrease ☐ No change	
Arrests for drug violations, age 18 and older	636	☒ Higher ☐ Lower ☐ About the same	☐ Increase ☐ Decrease ☐ No change	Huge increase from 1999 to 2000 (almost 400%); state is 431
Percent of total fatal crashes over 5 years that were alcohol-related	28.4	☐ Higher ☒ Lower ☐ About the same	☐ Increase ☐ Decrease ☐ No change	Compared to other counties? About the same
Percent of all young adult drivers (21 to 29) in fatal crashes who were alcohol-involved	50	☐ Higher ☒ Lower ☐ About the same	☐ Increase ☐ Decrease ☐ No change	1994 to 1998 was 100%; state is 54%
Percent of all adult drivers (30 and older) in fatal crashes who were alcohol-involved	13.3	☐ Higher ☒ Lower ☐ About the same	☐ Increase ☐ Decrease ☐ No change	1994 to 1998 was 3.3%; state is 20%
Deaths by underlying cause	No real changes	N/A	☐ Increase ☐ Decrease ☐ No change	
Overdose deaths	17.2	☒ Higher ☐ Lower ☐ About the same	☐ Increase ☐ Decrease ☐ No change	Up lots since 1997 (5.7%); state is 11.4

Indicator	Rate of consequence in most recent year: County	Compared to state?	Trends over time?	Other notes
Treatment admissions (all ages)	759	☐ Higher ☐ Lower ☐ About the same	☒ Increase ☐ Decrease ☐ No change	State is 1085
Percent of total treatment admissions (18 and older) involving alcohol	81.7	☐ Higher ☐ Lower ☐ About the same	☐ Increase ☒ Decrease ☐ No change	State is 71.8
Percent of total treatment admissions (18 and older) involving marijuana	32.1	☐ Higher ☐ Lower ☐ About the same	☐ Increase ☐ Decrease ☒ No change	State is 32.0
Percent of total treatment admissions (18 and older) involving prescription drugs (not available for all counties)	N/A	☐ Higher ☐ Lower ☐ About the same	☐ Increase ☐ Decrease ☐ No change	

Consequences of concern in my county:

Consequences of concern in my county among particular subpopulations/age groups:

Overdose deaths

Consequences in which my county exceeds the state:

Adul arrest for alcohol violations, drug violations, overdose deaths

Consequences where we need more information (such as who, what, where, why and when):

Appendix G: Review of Past Needs Assessments

County Name:	Penobscot & Piscataquis
Person Completing Form:	Jamie Comstock
Completion Date:	August 2007

Once you have collected the past assessments that have been conducted in your county, fill out the grid below.

Who conducted it and when?	What geographic area did it cover?	What age group(s) did it cover?	What type of information is in the assessment ?	What were the key findings relevant to substance abuse prevention?
1. Katahdin Area Partnership August, 2004	Towns of Millinocket, East Millinocket, Medway, Patten, Sherman, Island Falls, Stacyville, Woodville, Benedicta	All	Demographics, Income Status, Poverty, Unemployment, Education, Government, Pubic Safety, Health (Cause of Death), General Health, Physical Health Risk Factors, Community Opinion	1. Students in Millinocket and School Union 113 reported higher use of alcohol, cigarettes, and chewing tobacco compared to the state rates 2. Binge drinking rates for students in KAP are lower than the state rate 3. Student's report of lifetime illicit drug use are almost equal to the state rates across the varying drugs 4. The greatest difference in which the KAP rate is higher than the state rate is with Oxycontin (by about 1.5%) 5. KAP students reported use of prescription drugs and ecstasy is lower than the state rate

				6. Close to a third of the KAP students participating in the survey reported use of marijuana—slightly higher than the state rate
2. Maine Center for Public Health: Public Health Assessment—A Systems Approach; Bangor Region Local Public Health System, Assessment Report	Bangor Region: City of Bangor, Eddington, Holden, Orono, Old Town, Glenburn, Hermon, Hampden, Brewer, Veazie, Orrington	All	The purpose of the report is to help identify strengths, limitations, gaps and needs of the local public health system and its ability to regionally deliver the 10 Essential Public Health Services	No findings specific to substance abuse
3. Acadia Hospital, Eastern Maine Healthcare Systems	Eastern Maine—32 zip codes within the Bangor Health Service Area	Mainly adults, average age of respondents was 54 years, only one in five households had children, average annual income was nearly $45,000	This study is a market assessment of consumers' perceptions of various issues related to opiate abuse	Residents in study area are generally aware of what opiates are, the risks of addiction and populations at most risk of becoming addicted
4. Mayo Regional Hospital—One Maine Needs and Resource Assessment	Piscataquis County	6th through 12th grade—analysis of MYDAUS data	MYDAUS data, community interviews with schools, parks and recreation, and law enforcement, in addition to community focus groups that included parents, youth, grandparents and	See attached Appendix R—Piscataquis County One Maine Results 2005'

			professionals.	
5. Bangor Region Partners for Health—2004	Alton, Argyle, Bangor, Bradford, Bradley, Brewer, Carmel, Clifton, Corinth, Dixmont, Eddington, Etna, Glenburn, Greenbush, Hampden, Hermon, Holden, Hudson, Kenduskeag, Levant, Milford, Newburgh, Old Town, Orono, Orrington, Penobscot Reservation, Veazie, Winterport	All	Population, education, poverty, worker location, occupations, housing, transportation, child health, adult health, government and civic activity, air and water, public safety, culture, arts, recreation	1. Region is ranked 16th (out of 16 possible) for mental health and substance abuse discharges for people between the ages of 0 and 19 2. Binge drinking rates for people between the ages of 18 and 64 are equal to the state rate 3. Drug-related arrest rate is higher than the state rate
6. Eastern Maine Healthcare Systems Community Health Needs Assessment 2007	Northern, Eastern, Central Maine: Hospital Services areas including Bangor, Presque Isle, Fort Kent, Fort Fairlfield, Caribou, Houlton, Dover-Foxcroft, Lincoln, Millinocket, Greenville, Machias, Calais, Ellsworth, Blue Hill, Bar Harbor, Waterville, Skowhegan, Pittsfield, Rockland, Belfast	All	Population profile, health-based social and economic characteristics, care access and insurance, primary care, quality and effectiveness of care, chronic disease burden and population wellness, functional health status. Key findings in areas of cardiovascular health, respiratory health, diabetes, cancer health, reproductive health, mental health, substance abuse, youth health, oral health, community	Among the key findings for the **adult** population: 1. The prevalence of chronic heavy drinking has increased since 2001, particularly among 18-64 year-olds 2. Higher rates of acute alcohol-related mental disorder hospitalizations and ED visits occur in Washington and Bangor that in other study regions and the state 3. Overall substance abuse hospital admissions have dropped dramatically since 2001 Among the key findings for

			perceptions of health and health service need, unintentional injury, arthritis, bone and joint health infectious disease	the **youth** population: 1. Rates pf current tobacco use are higher than state or peer rates in Penquis, Knox-Waldo, Hancock and Bangor regions Rates of alcohol consumption in the past 30 days are higher than state or peer rates in Penquis, Knox-Waldo, and Bangor
7.				
8.				

List any regions in your county in which an assessment that included substance abuse has not been conducted and why (if known):

None.

Appendix H: Brainstorming Contributing Factors

County Name:	Penobscot/Piscataquis
Person Completing Form:	Jamie Comstock
Completion Date:	August 2007

UNDERAGE DRINKING LOGIC MODEL

ALCOHOL

Access/Availability

- Parents—Buying it for them, Unlocked refrigerator/cabinets
- Friends—peers—older kids—college kids coming home and having house parties, feel obligation to buy for their younger friends, kids going to local college campuses
- Older siblings
- Utilizing camps with/out permission, breaking in (rural communities see more camp use)
- Retail seems to be doing its job, but alcohol has become more available since the state has quit regulating sales at state run stores. The clerk turnover rate is high and some don't' know what to look for in an ID check. The bigger the establishment the better the training and monitoring of alcohol. When kids get it from a retail establishment they are either stealing it or purchasing it outright with or without a fake ID
- 18 to 25 population may be the key to access for underage drinking

Adult Modeling

- Alcohol use is an acceptable culture norm. Kids grow up with adults drinking at the dinner table
- Drinking is seen as a right of passage. They're just going to do it, so parents help them
- Alcohol use is an acceptable cultural norm. It is used as a coping mechanism, to celebrate ups and deal with downs, culturally we do what we know
- There is a lack of conversations between parents and children around use and when those conversations occur (is parent drunk when telling kid not to drink?)
- Adult response to messages around alcohol in the media—do we laugh at Superbowl commercials, do we laugh at drunk people on television
- Television shows – HBO, Entourage – everyone meeting in bar—the 'cool' place to be
- Older siblings' behavior has an effect on younger siblings. Kids who are 18-21 are old enough to do some things, not others and there is a balance that needs to be achieved in order to honor those things they are old enough to do, but still respect that they are role models for the younger kids
- Parents can feel alone and isolated in raising their kids. We make assumptions that parenting is genetic, but it is a learned skill and they need help. Many times there is generation after generation of poor modeling
- Need social marketing campaign to show parents doing good things; kids need to see and understand that adults drink responsibly

Parental Monitoring

- Some parents would rather have kids getting alcohol at home—they can educate them and be the 'first ones' to use alcohol with them. Some continue using with them
- Parents want to be friends with their kids and to keep a friendly relationship. But developmentally, kids need boundaries
- Often no monitoring because parents aren't home—kids 4th grade or younger not monitored and out in town by themselves
- Messages to kids seem to revolve around safe use. As long as kids are at camp, or not driving, or under the supervision of parents in order that consequences might be minimized or avoided, use is ok
- Parents aren't aware of how much alcohol they have in the house and when it might be disappearing (kids take one beer at a time)
- The closer parents stay to their children, have ongoing conversations, strategies, know where they are, kiss them when they get home—the better the children do
- There needs to be consistency in parent's messaging and in the consequences children receive
- Parents need to be willing to stay awake and to do the job of parenting ALL THE TIME
- Divorce or split families, grandparents raising the kids makes consistency/balance more difficult
- Parents need to be aware of the red flags and aware of what is normal behavior, then have a plan based on those flags and a place to get help or assistance
- BUT, there are no supports and nowhere to go for parents of high-risk kids beginning use, on the verge of use (this applies to <u>all</u> socio-economic groups)

School Policies

- School policies may not align with what municipalities are doing. There needs to be better ties, follow through. People are doing their best, but there needs to be more coordination.
- Policies are very broad, and they run from discipline to instructional policies. We need to integrate substance use into all policies in a K-12 continuum and they all need to include safety, treatment, prevention, consistency
- Co-Curricular activities need to be included in school policy—not just sports
- Idea of zero tolerance versus giving opportunities for second and third chances. There needs to be accountability for additional chances, but we also need to keep the kids engaged in school, in positive things. Zero tolerance isolates them from the good things. This is a balance and a struggle
- Additional opportunities can give some kids the wrong message—ok to use because you get more chances (that's why it's important to have accountability for second chances)
- Policies sometimes don't have the effect you think it will. Drug testing, for example, actually deters kids from participating in extra curricular activities
- Some SADs are implementing year round policies (not just sports season)
- Tough to define parameters (is a kid whose parents won't pick them up from a party when there is alcohol in use in violation of the school agreement?) and difficult to enforce. Parents will lie for their kids
- We need to enforce policies more consistently—underage drinking is illegal

- There are many things not covered in policy i.e. Kool-Aid huffing

Law Enforcement

- There is a lack of coordination of all law enforcement bodies who might be in touch with criminal behavior and a limit to whom law enforcement can speak—they might have information but can't pass it on for a variety of reasons. These hands are tied at all levels including court, probation, etc
- Parents need to be held more accountable
- Parents and the community need to model following the law, taking responsibility for violation of the law, "I was speeding, I deserve a ticket."
- Disappearance of Alcohol Beverage Control pushed alcohol monitoring responsibilities to the local level, local level is stretched and lacks the resources it needs to be responsive. Reinstating those positions would impact use and would be of considerable help in enforcement.
- There are differences in enforcement of laws are enforced—enforcement varies between police departments and between police departments and sheriff departments.
- There needs to be more pressure from top down—more consistency. Enforcement gets dealt at higher levels, reduced to misdemeanor. Sometimes stings are hassled by AG office, judges. Parents with money can buy their (and their kid's) way out of trouble with a good attorney who can get them out of a citation. This is discouraging to local law enforcement entities trying to keep underage drinking under control
- There are many areas of the county (Penobscot) covered by Sheriff's Department and underage drinking can't be a priority
- Local legislators are not part of effort
- At UMaine on College Avenue there are also issues of jurisdiction. Orono, Old Town and the University all have jurisdiction, which makes enforcement and coordination all the more.
- 21 and 22 year old's hosting parties don't seem to care if they get arrested or not for hosting
- In small towns, once a kid is branded a trouble maker he has no employment options
- Difficult for a police department to find funding for prevention activities

Knowledge of Health Risks

- Kids feel they are invincible and know what the risks are but continue using anyway
- There is mixed messaging about the health risks
- Kids ages 6^{th} – 7^{th} grade have more fear and heed health impacts more than older kids who are braver and more rebellious
- Kids are very used to medications, using medicine, so fear is decreased there
- Increased use of technology has decreased interpersonal contact. People are less comfortable in social settings—alcohol may make us more comfortable. The more kids are engaged, the less use is an issue

Advertising

- There is a sophistication in advertising
- We can take this sophistication and apply it to intervention and prevention

- Advertisers have HUGE budgets. Their ‘social messaging’ legitimizes them and encourages support (buying Coors supports the Rocky Mountains—an environmental cause)
- The media is particularly going after young women with its advertising
- Niki Miller of the NH Taskforce on Women & Recovery, uses t-shirts (as low cost advertising) to publicize messages like "The Liquor Industry Targets Girls--Girls Have Other Plans"
- Magazines like Maxim have a Badge of Honor where people glamorize their drunken exploits with photographs etc. These people don’t realize how stupid, bad they look.
- Itunes has a list of songs for ‘Power Hour’—where you take a shot a minute for an hour

Appendix H: Brainstorming Contributing Factors

County Name:	Penobscot/Piscataquis
Person Completing Form:	Jamie Comstock
Completion Date:	August 2007

HIGH RISK (18-25) DRINKING LOGIC MODEL

ALCOHOL

Knowledge of Health Risks

- This group is not aware of all of the health risks. People are not educated, are misinformed. Kids don't understand the difference between a glass of wine and binge drinking
- 'It won't happen to me'—the risk of addiction doesn't deter use
- Most of the public doesn't understand the risks of use. We reinforce it through our acceptance
- Everything is instant gratification
- Kids are going out to get drunk now—not just to have a few drinks
- Mothers, young mothers, pregnant women could absorb the health message

Promotions & Pricing

- Cheap food and alcohol are targeted to college kids, but happy hour specials are expanding to include all age groups
- Congregating in bars is a social event—people get together there
- Specialty drinks (bright colors, fruity flavors) target young women and new drinkers
- They sell small kegs in stores now
- College kids buy kegs, sell beer by the cup to others, also sell tickets to pay for keg—winning ticket gets leftover money
- Drink specials don't necessarily matter. If you pregame (drink before going out) you spend less $ at the bar or party. Spending less cash is what college kids are in search of
- Maine Distributors needs to support any ideas in this category
- Soda not included in bar/happy hour specials

Retail Sales/Over-service

- Management of many college-area bars recognize this is an issue and are working with The River Coalition on trainings/awareness etc.

Lack of Screening/Early Intervention

- There are more possibilities on campus than off campus.
- If you get an OUI you are referred to DEEP classes, if you are employed you can go to EAP, the military has a place for people who need help, but if you don't fall into any of these categories there isn't much available beyond AA meetings. Even then the demographics of the meeting might not be yours
- Most people don't have addiction issues but they are hosting or doing something that can be harmful to the community

Appendix H: Brainstorming Contributing Factors

County Name:	Penobscot/Piscataquis
Person Completing Form:	Jamie Comstock
Completion Date:	August 2007

PRESCRIPTION DRUG MISUSE (18-25) LOGIC MODEL

PRESCRIPTION DRUGS

Knowledge of Health Risks

- This group is not aware of all of the health risks
- People are not educated, are misinformed. For example, Washington County has the highest rate of Hepatitis C in the nation
- 'It won't happen to me'—the risk of addiction doesn't deter use
- Most of the public doesn't understand the risks of use. We reinforce it through our Acceptance

Availability

- Kids are selling their own drugs—cutting their own doseage in order to have extra to sell
- People steal drugs, break into homes with drugs, steal from their own families
- Kids are taking leftover drugs from legitimate prescriptions
- People forge prescriptions
- Older people living with younger family members who may steal pills (oxy $80 - $100 per pill)
- Theft rate increases with oxy addiction. People steal from Reny's in Ellsworth and return merchandise to local Reny's get cash to buy pills
- Prescribers over-prescribe for small injuries (may be doing so to help patients avoid additional co-pay = economics of scale). Physicians also prescribing to 'shut people up'
- Unfilled scripts
- Trafficking of drugs from Canada occurring; Sunday pm to Monday am and nights—many police departments don't have officers on duty after midnight. Car break-ins happening – thieves taking change because the charge (if caught) is less; they still get money to buy drugs
- Healthcare field is cracking down on availability
- The Center on Aging recently kicked off an effort to collect unused medications in mailers, UMaine working with health center to get rid of old medications
- Older folks tend to hold onto medication for longer periods of time and need education on the perils of keeping their meds around
- People share prescriptions with each other
- Lots of Aderral (ADHD drug) on UMaine campus (amphetamine)
- Some 18-25 year olds decide not to take their meds when they go to college—turn over new leaf, no one knows me here—which equals lots of unused meds laying around
- Togus prescribes large amounts of drugs (many months worth) and kids take them from their parents or grandparents or relatives and sell them

Community Norms

- There are many more medications on the market—many more people using them; these people are addicts
- Medications are incredibly pervasive. For example, guests at the Bangor Area Homeless Shelter can rattle off each of the 12 meds they are on
- Our society treats everything with a pill. We like to consume and fix—immediately. Ads on television encourage us to talk to your doctor about medications—to self diagnose. We need to address the whole system (manufacturers, pharmaceutical companies)
- People share medications with each other

Family Norms

- People share their medications with each other—friends, families etc
- Many families treat everything with a pill
- Taking medications are the norm in many families

Enforcement

- Difficult to catch people dealing pills
- Many people steal or collect a little here and there
- Increase in property crimes is directly correlated with the increase in opiate use/addiction
- Consequences (property crime) more evident in metro vs rural areas
-
- Taking medications are the norm in many families

Appendix H: Brainstorming Contributing Factors

County Name:	Penobscot/Piscataquis
Person Completing Form:	Jamie Comstock
Completion Date:	August 2007

Marijuana

Retail Access/Availability

- N/a

Social Access/Availability

- Marijuana is obtained mainly through social channels: friends, families

Community Norms

- The community generally doesn't find much wrong with marijuana use—as opposed to heroin, cocaine use etc.
- Seen as 'lesser of evils'—at least they're not using hard, addictive drugs

Family Norms

- Many families use together
- There are generations of users
- When a kid comes from a family in which marijuana use is condoned, encouraged, etc he/she has fewer barriers to trying other, harder substances
- Kids need to know what the difference between using marijuana recreationally and using marijuana medicinally is

Enforcement

- Marijuana is at the bottom of much of law enforcement's list. There are other issues to address that are more important

Perception of Risk

- There are no risks associated with use of marijuana (runs very counter to much of the research coming out now)
- Use is considered safe because pot is not considered to be a 'hard' drug
- People have been using marijuana for generations, so it must be safe

Appendix I: Information Collection Plan

County Name: Penobscot/Piscataquis
Person Completing Form: Jamie Comstock
Completion Date: August 2007

Research Questions **What do else do we need to know?** **(this should be driven largely by gaps that exist in knowledge that relate to intervening variables and their contributing factors)**	Information Source **From whom or from what will you get the information?**	Collection Procedure **What methodology will be used to collect the information?** **(e.g., focus groups, interviews)**	Timeline **When will the information be collected?**	Persons Responsible **Who will gather the information?**
Community member's perception of substance use in community	Community members throughout region—see attached list and themes	Interviews	January 2007 through August 2007	Jamie Comstock
More information on use patterns of 18-25 year olds	18-25 year olds	Survey	May 2007	Jamie Comstock
More grade specific MYDAUS information—need to know if age of onset, previous 30-day use is significantly different from the state's	MYDAUS data—Office of Substance Abuse	Deeper analysis of existing data	March 2007	OSA, Jamie Comstock

Appendix J: Completed Interviews

County Name: Penobscot & Piscataquis

Person Completing Form: Jamie Comstock

Completion Date: August 2007

Name	Organization	County	Date of Interview
John Plourde	Health Educator, Hampden Academy	Penobscot	Monday, January 22nd
Pete Arno	Deputy Chief of Police, Bangor Police Department	Penobscot	Tuesday, January 23rd
Alan Comeau	Community Relations and Development Director, Acadia Hospital	Penobscot	Tuesday, January 23rd
Robin Mayo	Community Partnership Director for the Piscataquis Public Health Council	Piscataquis	Wednesday, January 24th
Barbara McDade	Director, Bangor Public Library	Penobscot	Wednesday, January 24th
Courtney Lehnhard	School Health Coordinator, SAD 22 (Hampden)	Penobscot	Friday, January 26th
Mike Roberts	Penobscot County District Attorney's Office	Penobscot	Friday, January 26th
Drug Court Committee	Penobscot County	Penobscot	Friday, January 26th
Drug Court	Penobscot County	Penobscot	Friday, January 26th
Bill Braun, Penny Townsend	Superintendent, School Health Coordinator SAD 48 (Corinna, Hartland, Newport, Palmyra, Plymouth, St. Albans)	Penobscot	Wednesday, January 31st
John Spieker	Director of Counseling, Mayo Regional Hospital	Piscataquis	Wednesday, January 31st
Shirley Wright	Superintendent, SAD 41 (Milo, Atkinson, Lagrange, Brownville,	Piscataquis	Wednesday, January 31st
Jeremy Weatherbee	SPRINT for Life, Lincoln	Penobscot	Wednesday, February 7th
David Nelson, Jane McGillicuddy, Roni Thompson	Katahdin Area Partnership	Penobscot	Wednesday, February 7th

Heather Perry	Superintendent, Greenville School System—Union #60	Piscataquis	Thursday, February 8th
Paul Stearns	Superintendent, SAD #4 (Guilford)	Piscataquis	Thursday, February 8th
Dave Barrett	Penobscot County Youth Corrections	Penobscot	Friday, February 9th
Dan Lee	Superintendent, Brewer Schools	Penobscot	Tuesday, February 13th
Brenda Quill	Counselor, Old Town High School	Penobscot	Tuesday, February 13th
Diane Vatne	Communities That Care	Penobscot	Wednesday, February 20th
Bette Hoxie	Co-founder and Liaison Director, Adoptive and Foster Families of Maine	Penobscot	Wednesday, February 20th
Don Bolduc	Chief, Millinocket Police	Penobscot	Monday, February 26th
Josh Ash, Rebecca Roberts	Juvenile Community Corrections Officer, State of Maine Department of Corrections (northern Penobscot County	Penobscot	Monday, February 26th
Dick Brown	Executive Director, Charlotte White Center	Piscataquis	Tuesday, February 27th
Micah Robbins	The River Coalition	Penobscot	Wednesday, February 28th
Kathy Hunt and Ann Acheson	Margaret Chase Smith Center for Public Policy	Region	Wednesday, February 28th
John Yasenchak	Director of Counseling, Indian Island Health Center	Penobscot	Wednesday, February 28th
Sandy Ervin	Superintendent, Bangor Schools	Penobscot	Wednesday, February 28th
Troy Morton	Penobscot County Sheriff's Department	Penobscot	Thursday, March 1st
Beth Postlewate, Lee Pearsall, Angie Smart	Foxcroft Academy	Piscataquis	Monday, March 5th
Dawna Blackstone	School Health Coordinator, Union 60	Piscataquis	Wednesday, March 21st
Dave Hainer	School Health Coordinator, MSAD 67	Penobscot	Thursday, March 22nd

Chris Bailey	School Resource Officer, Hampden Academy	Penobscot	Thursday, March 22nd
Sara Albert	Superintendent, Millinocket and Union 113	Penobscot	Friday, March 23rd
Hank Dusenbury	Chief, Lincoln Police Department	Penobscot	Friday, March 23rd
Bob Young	Piscataquis County Sheriff's Department	Piscataquis	Thursday, April 12th
Janet Spencer	Bangor Region Partners for Health	Penobscot	Thursday, May 3rd
John Dirnbauer	MSAD 68	Piscataquis	Thursday, April 12th
Jeff Keene	Morton Avenue Elementary School		Thursday, April 19th
Kelly McFadyen	Piscataquis Community Middle School/High School	Piscataquis	Thursday, April 12th
Fred Andrews	Piscataquis Community Middle School	Piscataquis	Thursday, April 12th
Pat Kimball	Wellspring	Penobscot	Friday, April 20th
Dr. Mark Brown	EMMC Neonatal Intensive Care Unit	Region	Friday, May 11th
Charlie Liu	Director, Powerhouse Teen Center	Penobscot	Wednesday, May 16th

Appendix K: Interview Questions

County Name:	Penobscot & Piscataquis
Person Completing Form:	Jamie Comstock
Completion Date:	August 2007

Name: _____
Date: _____
Organization: _____
Address: _____
Phone: _____
Email: _____

What is your coverage area?
What substance(s) (alcohol, marijuana, prescription drugs or other) pose a threat to the community? Why?
What consequences of substance use have you witnessed?
Do policies on substance use exist? If so, on what level (formal of informal)?
Are there clearly defined penalties for violations?
Are laws and policies enforced? Are they enforced consistently? If not, where are the variations?
Do substance abuse prevention plans currently exist in your area?

Are there any gaps in prevention service delivery?

Are there any subpopulations or geographies that aren't addressed?
What prevention programming exists in your area?
Are they evidence based?
What assessment data exists in your area? Do you know of any informal studies that have been done?
What data do you use substantiate the programming you are involved with?
Do you know of any other types of prevention plans in place in your area (health promotion, public health etc.)
What are opportunities to providing better prevention efforts in your area?
What are the barriers to providing better prevention efforts in your area?

Appendix L: Interview Themes

County Name:	Penobscot & Piscataquis
Person Completing Form:	Jamie Comstock
Completion Date:	August 2007

- MYDAUS reports of binge drinking and age of first use are the most concerning statistics for school districts. Kids are using at increasingly younger ages (6th grade and up, usually) and several of the districts reported anywhere from 40-55% of their juniors and/or seniors engaging in binge drinking in the last 2 weeks. In Greenville 47.4% of 7th graders reported prior 30 day use of alcohol

- Kids say availability is high—they can get any substances they want any time they want them

- The community sees nothing wrong with substance use by minors and in many communities, assists underage kids with procuring alcohol

- Family norm is accepting of marijuana and alcohol use. Some families smoke pot together

- Kids perceive that the community and families don't disapprove of substance use

- Some kids don't have enough to do—boredom is part of the issue

- Other kids are very connected to their families and communities—yet still report high levels of binge drinking

- Difficult to engage the 18-25 age group—this group uses alcohol heavily and will buy for younger kids

- Prescription drug use has not been highlighted as an issue generally, save for meetings with the Bangor Police Department, Penobscot District Attorney's Office, Acadia Hospital

- Parents and educators need training in identifying symptoms/signs of use

- Difficult to include or expand substance abuse curriculum because of the planning, time, scheduling involved, but it is needed. Curriculum is all over the board, some from kindergarten going through sophomore, some doesn't even exist

- Very rural, lots of places to go to use substances

- Many areas with little police patrol, lots of issues where a town police department abuts county sheriff territory in rural areas—many instances of people going to the lesser patrolled area to party etc.

- Many folks mentioned the public health messages around tobacco use as being successful in reducing smoking rates in their communities

- Kids will do anything to have friends

- We need to find ways to help families keep their kids occupied and challenged. There is a gap in recreational activities for kids as they age

- Parents have to issue a clear message that substance abuse is not accepted and not tolerated

- A kid can be in the system for a long time without facing consequences

- Lack of aspirations and hope seem to contribute to culture of use, particularly in rural communities

- School staff and parents need more education so they know the signs of use

- Rural communities lack a critical mass of good mentors for kids

- You can turn out more parents for a basketball game than you can an educational session

Appendix M: Unique Ideas From Brainstorming Sessions and Interviews

County Name:	Penobscot & Piscataquis
Person Completing Form:	Jamie Comstock
Completion Date:	August 2007

- Spell out the consequences of hosting with detailed descriptions of what could happen (parents could go to jail, lose employment opportunities, kids could go to jail and jeopardize their future)
- Retailers are more apt to listen to kids making a request to move alcohol/change displays
- Legislature more apt to listen to kids' testimony and lobbying
- A business can get a reduction in liability insurance if there is an alcohol policy in place
- Responsible server trainings also reduce liability insurance costs
- The chamber of commerce is a mechanism by which information on state alcohol policy, and other information to aid retailers can be distributed
- Sticker shock for parents around modeling
- In Bangor parents are ticketed for under-18 curfew violation. Could others implement this?
- More jail diversion programs for youth
- Is it possible to change the reporting process to make it 'easier' for people to report parties, underage drinking etc? In a small community it is very easy to connect the dots and tell who has contacted the police etc—which may deter people from reporting parties.
- Can law enforcement participate in collaborative meetings to foster increased coordination?
- Include soda in Happy Hour specials for same price or free
- Designated Driver's meal could be included (absorbed by) the friends they are driving around
- Could develop a certificate of appreciation for businesses for participating in policies that are more DD friendly
- Meet with primary care docs to hear their frustrations around this issue
- Perhaps some modifications to the Prescription Monitoring Program
- It would be helpful if there were more community involvement and employers would be willing to work with a recovering population
- Tap into organizations with like values and work differently to increase capacity ie churches and Y's have a lot in common in terms of values and could be working more closely together
- Get the word out to kids via text messaging. In rural areas messages can be sent across towns, which reduces isolation. There is also the opportunity to tell an adult about a party
- Parents are still very involved with their children when they are in kindergarten. They seem to lose that connection as time goes on. We need to get to parents when they are still that close with their children and impress upon them the importance of staying close as the kids grow up

Appendix N: Assessment

CENTER FOR

COMMUNITY INCLUSION & DISABILITY STUDIES

Maine's University Center for Excellence in Developmental Disabilities Education, Research, and Service

Prevention Center of Excellence

Strategic Planning and Environmental Programming (SPEP) Grantee Capacity Summary

PENOBSCOT & PISCATAQUIS COUNTIES

Lead Agency: City of Bangor Department of Health and Welfare

Respondent: Jamie Comstock, City of Bangor

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Final summary prepared July 23, 2007 by

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Note 1: Content in the *Summary* sections of this document reflects the views communicated by the respondent to the interviewer. Content in the *Feedback* and *Analysis* sections of this document reflect the thoughts and responses to respondent perspectives from the University of Maine Prevention Center of Excellence (PCoE).
Note 2: Information provided in this document reflects the viewpoints of the respondent and PCoE personnel.
Note 3: In the content of this document, locally based, grassroots agencies are defined as informal groups organized to achieve one or more prevention goals. "Formal agencies", are defined as organizations with an established structure and purposive representation from relevant county groups.

Analysis: Penobscot and Piscataquis counties have significant strengths. These include a commitment to address substance abuse problems from those involved in prevention work, collaboration and networking within the two counties, strong external linkages, strong leadership in some areas, strong business capacity, strong technical knowledge of substance abuse prevention, a process in place to assess countywide magnitude of substance abuse consumption, to assess readiness and resources and to seek a diversified funding base. Training and/or technical assistance would be warranted in order to:

- To build and enhance leadership and increase awareness of leadership in communities throughout both counties.
- Build capacity to engage community members who historically have been more difficult to engage in county prevention activities.
- Build upon current capacity of the counties to implement planning that is inclusive and universally accessible.
- Identify and increase preventionists' access to multiple local substance abuse data to inform planning and for consumption and consequence prevalence data collection.
- Explore ways to engage entities involved in substance abuse prevention in sharing information regarding prevention initiatives.
- Identify potential resources to educate preventionists about conducting evaluation research.
- Systematically implement plan to engage the full diversity of the counties in prevention planning and implementation.
- Systematically plan and implement broad, inclusive and multi-media prevention dissemination.
- Evaluate dissemination and use findings to improve inclusive, universally accessible dissemination.
- Continue to build collaborative capacity of the two counties to build and implement sustainable prevention infrastructure.

Capacity Domain – Readiness:

1. Community members' recognition that substance abuse is a problem;
2. Community commitment to prevention; and
3. Community willingness to commit resources to prevention.

SUMMARY

According to the respondent, substance abuse problems are generally recognized in Penobscot and Piscataquis Counties. While there is some understanding of substance abuse problems, community members who are not directly connected with substance abuse work or prevention work with children and health may need increased awareness regarding these issues.

The respondent reported that among community members who are aware of substance abuse in Penobscot and Piscataquis Counties, there is commitment to address substance abuse problems. It was the understanding of the respondent that substance abuse organizations in these counties share an opinion that prevention is more effective than intervention. However, increased education regarding substance abuse prevention, for organizations not currently involved in substance abuse prevention, would potentially increase their level of commitment to addressing problems.

FEEDBACK

1. Identify organizations, not currently involved in substance abuse prevention that might be interested in exploring substance abuse issues.
2. Offer educational opportunities to community members and organizations to raise the level of awareness of substance abuse problems in Penobscot and Piscataquis Counties.

Capacity Domain – Internal Linkages: Community or organizational capacity to collaborate and/or network with other organizations, entities and resources **within** its regional area as demonstrated by:

1. Awareness of substance abuse prevention efforts throughout the county;
2. Collaboration; and
3. Networking (informal sharing of information/services among individuals/groups who share a common interest).

SUMMARY

The respondent indicated that those who specifically work in substance abuse prevention are certainly aware of other prevention efforts throughout Penobscot and Piscataquis Counties. Additionally, there may be other groups who unknowingly engage in activities that could support prevention efforts. The respondent gave the example of the Retired Senior Volunteer Program (RSVP) through the Center on Aging. This group connects seniors with youth in

Piscataquis County by creating groups to do traditional activities such as knitting. The respondent explained that while programs like RSVP are not specifically aimed at preventing youth involvement in substance abuse activities, the program indirectly benefits youth by involving them in activities with the senior participants.

According to the respondent, while preventionists in Penobscot and Piscataquis Counties collaborate on substance abuse prevention there is more collaboration that could occur. Preventionists in Penobscot and Piscataquis Counties are breaking new ground by coming together to work on this substance abuse prevention project for the first time. The respondent identified joint development of a substance abuse prevention media campaign as a potential new way for the two counties to collaborate.

The respondent explained that there is networking amongst preventionists in Penobscot and Piscataquis Counties however, some groups have more formal networks than others. Prevention information is shared between preventionists either through these formal networks or through ties preventionists have within the more formal networks.

FEEDBACK

1. Explore additional ways to build on current collaborative capacity and networking among prevention agencies within Penobscot and Piscataquis Counties.

Capacity Domain – External Linkages: Awareness of and ability to access information and other resources (e.g. substance abuse prevention expertise, best practice information, etc.) from organizations based outside of the boundaries of the community. This includes:

1. Awareness of prevention efforts outside the county; and
2. Having a working relationship with the Maine Office of Substance Abuse.

SUMMARY

The respondent expressed that preventionists in Penobscot and Piscataquis Counties are quite aware of where to access prevention resources outside their

counties. Preventionists are aware of and connected with the Maine Office of Substance Abuse, Community Alcohol-Drug Coalitions of America (CADCA) and the Prevention List Serve. Preventionists are also knowledgeable of where to access prevention resources via the Internet. The respondent explained that preventionists are aware of prevention efforts outside the two counties to some extent. The closer proximity a county has to Penobscot or Piscataquis County the more aware preventionists are of other county prevention efforts. While preventionists might not be acutely aware of efforts in York County, they are highly capable of obtaining this information through resources such as the statewide HMP network.

According to the respondent, some preventionists have a working relationship with the Maine Office of Substance Abuse. The respondent stressed that even the preventionists that do not currently have a working relationship with OSA know OSA is accessible and feel able to develop a relationship.

FEEDBACK

1. External linkages are strong in this county.

Capacity Domain – Leadership: The ability to:

1. Articulate a clear and compelling vision for the future;
2. Take action to implement the vision;
3. Mobilize others toward the vision (for this characteristic, the capacity assessment asks how well community members know leaders of prevention activities); and
4. Work collegially with other leaders.

SUMMARY

Leaders of substance abuse prevention activities have been identified to some extent in Penobscot and Piscataquis Counties. Leadership is found in pockets throughout the two counties. The respondent identified the geographic area of Millinocket and Lincoln as having substance abuse prevention leadership. The respondent explained that currently there is not leadership spanning both Penobscot and Piscataquis Counties. However, the hope is that a network of leaders will develop as this process evolves.

According to the respondent, leaders of county prevention activities have not yet established a common vision for substance abuse prevention but are planning to

address this area in the future. The respondent stated that although leaders of substance abuse prevention did not previously work together, across the two counties, to achieve prevention goals, leaders located in smaller geographic areas within the two counties have started working together in this way.

Community member knowledge of leaders of county prevention activities is scattered across the two counties. According to the respondent, community members in Lincoln, Millinocket, Old Town and Piscataquis communities have a clear understanding of prevention activity leadership while members of the Bangor community have a less clear understanding. The respondent expressed that the extensive prevention work of the Old Town River Coalition could be largely credited for Old Town community member understanding.

According to the respondent, engaging community members in prevention activities is a struggle for all prevention leaders in Penobscot and Piscataquis Counties. The respondent acknowledged that there are some sections of communities that are much more difficult to engage than others but shared an suggestion for overcoming barriers to engagement involving integration of substance abuse prevention education at venues where community members normally frequent. The respondent used half time at a high school sporting event as a venue for reaching parents.

FEEDBACK

1. Explore ways to create a network of leaders spanning Penobscot and Piscataquis Counties.
2. Develop a shared vision for substance abuse prevention amongst leaders of prevention activities.
3. Identify areas were leaders of prevention activities are unknown and explore ways to increase community member awareness of prevention activity leadership.
4. Build capacity to engage community members who historically have been more difficult to engage in county prevention activities.

Capacity Domain – Planning Process: A collaborative process involving information gathering, needs assessment, goal setting, strategizing and action steps, with multi-level community involvement. The process is:

1. Universally accessible;
2. Includes diverse populations from relevant individuals;
3. Includes plans to improve community capacity;

4. Includes negotiation of rules to guide how planning will occur;
5. Results in consensus on desired prevention outcomes;
6. Informed by substance abuse data; and
7. Includes an annual review of prevention initiatives.

SUMMARY

According to the respondent, preventionists are currently in the process of using systematic decision-making processes to facilitate prevention planning. At this point, preventionists are at the beginning stages of the process and are unsure of the community input they will be seeking in the future so issues regarding universal accessibility have not been discussed much. However, the respondent explained, that if they do conduct community events these events would be held in an accessible building and the respondent expressed interest in gaining a better understanding of ways to make their presentations more accessible. The respondent noted that any notices for community prevention events would be presented at or below 6th grade reading level and would include a statement regarding the availability of accommodations.

The respondent reported that key informant interviews have been conducted to obtain diverse perspectives from relevant individuals. Although at this point, they are not sure as to how they will get further community input, they plan to use the HMP 12 different community sectors guidelines in seeking information.
The respondent indicated that plans to improve community capacity will be included in the planning process. Through input from representatives of different populations, those involved in planning will negotiate the rules regarding how planning will occur. Although the Counties are still in the early stages of planning, the respondent anticipates that planning will result in consensus regarding the desired outcomes of prevention.

While preventionists do have access to county data such as MYDAUS, the respondent reports barriers to obtaining local level data on substance abuse indicators.

According to the respondent, prevention entities in smaller geographic areas like Lincoln and Millinocket meet annually to review prevention initiatives however, the respondent did not identify other areas within Penobscot or Piscataquis Counties that were doing so.

FEEDBACK

1. Build upon the current capacity of the counties to implement planning that is inclusive and universally accessible.
2. Continue to seek input from diverse populations to negotiate rules to guide how planning will occur.
3. Identify and increase preventionists' access to multiple local sources of substance abuse data to inform planning.
4. Explore ways to engage entities involved in substance abuse prevention in sharing information regarding prevention initiatives.

Capacity Domain – Business Capacity: The human, fiscal, structural and technical ability to initiate and carry out policies, programs and services with accountability and credibility. Financial capacity is the ability to leverage funding to implement desired programs. Characteristics of organizational business capacity include having:

1. A legal status with a governance structure, executive leadership, and clearly defined roles;
2. Systems for budgeting, accounting, financial/inventory controls, reporting, personnel management, information/data management, and monitoring prevention costs;
3. Information and data inform decision-making; and
4. Ability to find and write grants.

SUMMARY

According to the respondent, substance abuse prevention coordinating organizations in Penobscot and Piscataquis Counties do not have a legal status with a governance structure. The respondent hopes that the Memorandum of Understanding process will help to create such a structure.

The City of Bangor is the fiscal agent for this project and has legal status with executive leadership, a comprehensive system that includes budgeting, accounting, financial/inventory controls, and reporting as well as a personnel management system with clear lines of reporting.

The respondent manages the collective of information related to prevention activities that are filtered down from the coordinating prevention organizations. The respondent expressed the importance of having knowledge as to where this prevention information is located.

The respondent indicated that information/data inform decision-making and that prevention costs are carefully monitored. According to the respondent, preventionists know how to find grant sources and although all of the coalition members, for this project, write grant proposals there are some more skilled in this area than others. Those who are not as skilled in grant writing generally hire someone who is.

According to the respondent, preventionists have clearly defined roles to some extent. The respondent explained that in this business everyone has to where multiple hats and sometimes roles from one area are carried over into another, even into social situations.

FEEDBACK

1. There is strong business capacity in Penobscot and Piscataquis Counties.

Capacity Domain – Technical Knowledge of Substance Abuse Prevention: Knowledge of:

1. What substance are being abused by various age groups, locally, in Maine, and nationally;
2. How to obtain and interpret consumption and consequence prevalence rates;
3. Laws governing abused substances and related anti-social behaviors;
4. Understanding of what individual and ecological factors increase or decrease the risk for abusing substances;
5. Metrics for assessing consumption;
6. Sound indicators for measuring the consequences of substance abuse;
7. Understanding of what is meant by evidence-based prevention, what interventions are supported by current evidence; and
8. Understanding of the influence of environmental factors on substance abuse issues.

SUMMARY

According to the respondent, preventionists are knowledgeable about substance abuse prevention theories and they understand what is meant by evidence-based prevention. Preventionists in the two counties know what evidence-based prevention methods are available however they find that not many strategies take

the rural environment of Maine into consideration. As preventions become more aware of strategies, they either adapt them for use in this area or simply do not use them if they do not apply.

The respondent reported strong knowledge among preventionists throughout Penobscot and Piscataquis Counties of what substances are being abused by diverse groups locally. Preventionists know of substances being abused by diverse groups in Maine to some extent. The respondent explained that preventionists are aware of alcohol use rates, that smoking rates are high and that meth hasn't really hit yet however, for instance, preventionists in the Millinocket area probably do not know about ecstasy use in the Somali population in more southern Maine. According to the respondent, preventionists are as knowledgeable of what substances are being abused by diverse groups in the Nation as they are knowledgeable of abuse within Maine.

According to the respondent, preventionists know how to obtain and interpret substance abuse prevalence rates. Preventionists are also knowledgeable about laws that influence substance abuse in the general population such as laws about OUIs and selling alcohol to minors. Likewise, preventionists are knowledgeable about laws governing substance abuse related anti-social behaviors.

The respondent stated that preventionists are knowledgeable of the stigma surrounding substance abuse and how community attitudes and standards influence substance abuse in the general population. According to the respondent, preventionists are knowledgeable about individual, family-related and peer-related risk factors for substance abuse.

According to the respondent, preventionists are knowledgeable about current metrics for assessing consumption. Preventionists know about MYDAUS data and how to interpret it. Preventionists also possess awareness about other consumption pattern and treatment rates. The respondent explained how those working with substance abuse prevention have been working with these metrics for the last 6 years. The respondent expressed a desire for preventionists to obtain more accessible, reliable, local data. Currently preventionists use what they find to be the most reliable and pair it with other information they may find. Preventionists are also knowledgeable about sound indicators for measuring substance abuse consequences such as OUI rates, crashes, crime rates and treatment admissions.

FEEDBACK

1. Technical knowledge of substance abuse prevention has strong capacity in these counties.
2. Increase the capacity of preventionists to access multiple sources of local substance abuse consumption and consequence prevalence data.

Capacity Domain – Skill in Monitoring Use and Abuse: Skills in assessment of needs/resources/readiness and substance abuse consumption and consequences. Skill in monitoring use and abuse includes:

1. A process in place to assess consumption and consequences, resources, and readiness to develop a substance abuse prevention infrastructure;
2. A process in place for evaluation of substance abuse prevention activities;
3. Access to local data on substance abuse indicators;
4. Review of local data to inform prevention planning; and
5. Knowledge of where to get resources to conduct evaluation research.

SUMMARY

According to the respondent, preventionists have completed prevention related assessments to some extent. The respondent explained how most of this work has been done at the local level and organizations will collaborate more as the coalition moves forward in the process.

The respondent reported that there is a process in place to assess countywide magnitude of substance abuse consumption and consequences. There is also a process in place to assess countywide readiness and resources to develop a substance abuse prevention infrastructure. The respondent stated that a process will be in place for evaluating substance abuse prevention activities.

According to the respondent, preventionists have some access to local data on substance abuse indicators and review it for prevention planning efforts but the reliability of the local data is in question. Currently, the respondent is working with all local police departments to flag all substance related calls in an effort to gain access to more local data. At this point, preventionists are trying not to rely on other sources for obtaining local data; they are trying to get it on their own.

The respondent explained that preventionists do not conduct as much evaluation research as they should. The respondent expressed a strong desire for technical assistance in this area.

FEEDBACK

1. Identify relevant local data sources that can be used to inform prevention.
2. Identify potential resources to educate preventionists about conducting evaluation research.

Capacity Domain – Use of Systematic Evaluation Strategies: Systematic strategies to generate knowledge that is logical, confirmable understandable and useful. This includes:

1. Use of systematic evaluation strategies to test prevention outcomes; and
2. Use of findings from outcome evaluations to make judgments about program effectiveness.

SUMMARY

The respondent reported that preventionists use systematic evaluation strategies to test the outcomes of substance abuse prevention efforts to some extent. According to the respondent, although preventionists do their best to use systematic evaluation strategies, technical assistance would be greatly appreciated. Preventionists use whatever evaluation information they gather to make judgments about program effectiveness.

FEEDBACK

1. Build capacity to conduct evaluation.

Capacity Domain – Cultural Competence: Cultural competence is defined as attention to diversity, group symmetry, and inclusion in all thinking and action. It involves:

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.

SUMMARY

According to the respondent, leaderships of SPEP countywide prevention activities include individuals from diverse backgrounds to some extent. The respondent explained that they are only 2 months into the process and their current leadership is reflective of the HMP structure. At this point, the respondent is unsure as to how this leadership will evolve but it currently is geographically representative. The respondent was not sure if the current leadership is reflective of socioeconomic diversity however, those within the leadership represent the continuum of people within their communities. The respondent expressed that in these early stages of the process, cultural competence has not yet been discussed much.

The respondent reported that the coalition acknowledges the need to develop a plan through which to recruit all segments of the community to participate in the SPEP decision-making process and when the coalition arrives at that point in the process they will develop a plan. According to the respondent, the coalition acknowledges the need for the community to be involved in the creation of substance abuse prevention efforts and the coalition plans to be as inclusive as possible in the engagement of all segments of the community in substance abuse prevention efforts. The respondent reported the unknown of the status of this project after August as a difficulty in exploring engagement of all areas of the community.

FEEDBACK

1. Systematically implement plans to engage the full diversity of Penobscot and Piscataquis Counties in prevention planning and implementation.

Capacity Domain – Dissemination: Sharing information with relevant and interested groups and individuals to inform, educate, empower and mobilize. It includes:

1. Dissemination of important prevention evaluation findings throughout the community;
2. Organization of visible prevention projects;
3. Use of electronic media (radio, Internet, television, CD-ROM), print, and oral presentations to disseminate information; and
4. Dissemination efforts that reach all community members.

SUMMARY

The respondent reported plans for preventionists to disseminate important prevention evaluation findings and to organize visible prevention projects throughout the community. According to the respondent, electronic media, such as television, radio, CD ROM and web pages will be utilized in the dissemination of substance abuse prevention information. The respondent also identified print media and oral presentations as planned modes for dissemination of information regarding substance abuse prevention.

According to the respondent, the coalition will attempt to make disseminated substance abuse prevention information available to all community members. The respondent is aware of resources such as the Center for Community Inclusion and Disability Studies for making community presentation more universally accessible.

FEEDBACK

1. Systematically plan and implement broad, inclusive and multi-media prevention dissemination.
2. Evaluate dissemination and use findings to improve inclusive, universally accessible dissemination.

Capacity Domain – Sustainability: Development of the organizational structure, procedures, policies, and cooperative agreements that enable and support continuation of countywide substance abuse prevention activities. It includes:

1. A stable prevention infrastructure;
2. Community commitment to sustain prevention efforts;
3. Seeking out a diversified funding base;
4. Agency incorporation to sustain core functioning;
5. Making progress in implementing strategies to achieve outcomes; and
6. Making changes to prevention programs in response to changes in community needs.

SUMMARY

According to the respondent, preventionists are working towards creating a stable prevention infrastructure throughout Penobscot and Piscataquis Counties. The respondent explained that organized efforts demonstrating progress in the prevention of substance abuse activities is crucial to sustaining community member commitment towards substance abuse prevention. The more community

members know about the condition of substance abuse issues in their communities, the more they will be invested in substance abuse prevention efforts.

Preventionists seek a diversified funding base and the respondent expressed that as the project progresses, preventionists will need to continue to seek a varied funding base and possibly consider looking to additional funding sources not accessed in the past.

According to the respondent, organizations tend to work through lead fiscal agencies rather than proceeding with incorporation to sustain core functioning. The respondent gave the example of how Millinocket Regional Hospital applies for grant funding on behalf of Katahdin Area Partnership but the two are not incorporated. In the respondent's experience, incorporation has been the exception rather than the rule.

The respondent reported that preventionists make changes to prevention programs in response to changes in community needs. The respondent further explained how Sprint for Life (Lincoln's HMP) wanted to address the 18-25 year old age range utilizing a video that addressed alcohol abuse. Upon using the video, Sprint for Life found it to not be entirely relevant for this population. Based on this finding, Sprint for Life is currently revising the video to make it more applicable to the needs of this sector of their community.

According to the respondent, preventionists are currently paying close attention to key strategies, the efficacy of these strategies and their capacity to implement such strategies.

FEEDBACK

1. Continue to build collaborative capacity of the two counties to build and implement sustainable prevention infrastructure.
2. Explore opportunities for incorporation of organizations across Penobscot and Piscataquis Counties as a means to sustain core functioning.

Appendix O: Assessment Report

County Name:	Penobscot/Piscataquis
Person Completing Form:	Jamie Comstock
Completion Date:	August 2007

Section 1: What you learned initially

From your initial review of existing data and prior assessments,

1. What consumption patterns are of particular concern in your county? Why? Among which population(s)? Please make sure you list the source of your information.

Youth: age of onset, previous 30-day use, perception of risk/harm from use, perception of parent's disapproval of use—MYDAUS data
All ages: misuse of prescription drugs—Epidemiological data, previous 12-month and 30-day binge drinking rates for people over the age of 18—Epidemiological data

2. What consequences are of concern? Why? Please make sure you list the source of your information.

From Epidemiological data:

Youth—High Risk Drinking

Penobscot: Increase in juvenile arrests for alcohol violations and an increase in the percent of all youth drivers (under 21) in fatal crashes who were alcohol involved; previous two-week binge drinking rates for males higher than state rates.
Piscataquis: lifetime use of alcohol, previous 30-day use of alcohol, previous 2-week participation in binge drinking by grade (all 10^{th} and 12^{th} grade) are higher than state; previous 2-week binge drinking higher for males and females.
Both: rates of alcohol consumption in the past 30 days are higher than state or peer rates in Penquis, Know-Waldo, and Bangor

Youth—Marijuana

Penobscot: lifetime use of marijuana and previous 30-day use about the same as state rate. 47% of kids over 14 have tried marijuana
Piscataquis: lifetime use of marijuana, previous 30-day use is higher than the state rate. 49% of kids over 14 have tried marijuana

Youth—Prescription Drugs

Penobscot: lifetime and previous 30-day misuse of prescription drugs about same as state; juvenile arrests for drug violations increased slightly since 1991

Piscataquis: lifetime and previous 30-day misuse of prescription drugs higher than state by **a lot (13% average).**

Young Adults—High Risk Drinking

Penobscot: Increase in the percent of young adult drivers (21 to 29) in fatal crashes who were alcohol-involved; treatment admissions of all ages increased

Piscataquis: Lifetime use of alcohol among adults, previous 12-month and 30-day participation in binge drinking higher than state; violent and property crimes slightly up from 1994; arrests for alcohol violations age 18 and older is higher than state rate; treatment admissions increased

Young Adults—Marijuana

Penobscot: arrests for drug violations, age 18 and older higher than state, percent of total treatment admissions involving marijuana (18 and older) about same as state

Piscataquis: lifetime use of marijuana, previous 30-day use higher than state rate; arrests for drug violations, age 18 and older higher than state, percent of total treatment admissions (18 and older) involving marijuana about same as state

Young Adults—Prescription Drugs

Penobscot: females crossing the threshold for prescription drugs a little higher than state; arrests for drug violations, age 18 and older, overdose deaths higher than state, treatment admissions higher than state and increasing over time, percent of total treatment admissions (18 and older) involving prescription drugs high than state. Current rate doubled the 2000 rate.

Piscataquis: females crossing the threshold much higher than state rate (by 16%). Median age of people crossing the threshold lower than state rate; arrests for drug violations, age 18 and older higher than state and a 400% increase from 1999 to 2000; overdose deaths up since 1997 and higher than the sate rate; treatment admissions (all ages) increasing.

Adults (30 and over)—High Risk Drinking

Penobscot & Piscataquis: Treatment admissions for people of all ages increased, EMHS assessment indicates that the prevalence of chronic heavy drinking has increased since 2001, particularly among 18-64 year olds

Penobscot: higher rates of acute alcohol-related mental disorder hospitalizations and ED visits occur in Bangor (and Washington County) than in other study regions and the state

Adults (30 and over)—Marijuana

Penobscot: arrests for drug violations, age 18 and older higher than state, percent of total treatment admissions involving marijuana (18 and older) about same as state

Piscataquis: lifetime use of marijuana, previous 30-day use higher than state rate; arrests for drug violations, age 18 and older higher than state, percent of total treatment admissions (18 and older) involving marijuana about same as state

Adults (30 and over)—Prescription Drugs

Penobscot: females crossing the threshold for prescription drugs a little higher than state; arrests for drug violations, age 18 and older, overdose deaths higher than state, treatment admissions higher than state and increasing over time, percent of total treatment admissions (18 and older) involving prescription drugs high than state. Current rate doubled the 2000 rate.
Piscataquis: females crossing the threshold much higher than state rate (by 16%). Median age of people crossing the threshold lower than state rate; arrests for drug violations, age 18 and older higher than state and a 400% increase from 1999 to 2000; overdose deaths up since 1997 and higher than the sate rate; treatment admissions (all ages) increasing.

From interviews/brainstorming sessions:
Culturally we accept use. Underage drinking is regarded as a right of passage; marijuana use is viewed as being 'safer' than other drugs, so ok to use; there is a proliferation of prescription drugs used properly and improperly—they are part of our everyday lives and we turn to them for a quick fix. Because we are so used to being around them we have a decreased perception of the risk and harm their misuse can bring.

3. What knowledge gaps exist?
   None.

Note: Before completing Section 2, you must have completed your additional information collection efforts (i.e., Needs Assessment Part II).

Appendix P: Putting It All Together

Section 2: Putting It All Together

1. High-risk Drinking Among Youth (12-17):

What are the consequences of high-risk drinking among youth in your county?

Penobscot: Increase in juvenile arrests for alcohol violations and an increase in the percent of all youth drivers (under 21) in fatal crashes who were alcohol involved; previous two-week binge drinking rates for males higher than state rates.
Piscataquis: lifetime use of alcohol, previous 30-day use of alcohol, previous 2-week participation in binge drinking by grade (all 10^{th} and 12^{th} grade) are higher than state; previous 2-week binge drinking higher for males and females.
Both: rates of alcohol consumption in the past 30 days are higher than state or peer rates in Penquis, Know-Waldo, and Bangor

In your county, is there a connection between the following intervening variables and the consumption of alcohol or the consequences of high-risk drinking?	If yes, what is the connection (contributing factors) and how do you know this?
Enforcement	Laws enforced unevenly between local police and sheriff dept; 'good' kids get off more consistently than 'bad' kids; underage drinking laws not viewed with the same importance between local community, DA etc—interviews, brainstorming sessions
Retail access	
Social access	Kids get alcohol from older friends, siblings, parents etc. 18-25 year olds seem to be the access point for underage drinking
Promotion	

Perceived risk of harm of use	Kids are invincible—interviews, brainstorming sessions
Community norms	Alcohol is an integral part of our culture—interviews, brainstorming sessions
Family norms	Alcohol viewed as 'right of passage'; present in many family celebrations, part of day to day life, culture of alcoholism more prevalent in rural communities where opportunities for role models, other social opportunities not as great as in metro area—interviews, brainstorming sessions

2. High-risk Drinking Among Young Adults (18-29):

What are the consequences of high-risk drinking among young adults in your county?

Penobscot: Increase in the percent of young adult drivers (21 to 29) in fatal crashes who were alcohol-involved; treatment admissions of all ages increased
Piscataquis: Lifetime use of alcohol among adults, previous 12-month and 30-day participation in binge drinking higher than state; violent and property crimes slightly up from 1994; arrests for alcohol violations age 18 and older is higher than state rate; treatment admissions increased

In your county, is there a connection between the following intervening variables and the consumption of alcohol or the consequences of high-risk drinking?	If yes, what is the connection (contributing factors) and how do you know this?
Enforcement	Many of the college-aged kids don't seem to realize the implications of an offense involving furnishing minors with alcohol—brainstorming sessions
Retail access	
Social access	Parties, older peers purchasing is the way people under 21 are getting alcohol—interviews, brainstorming sessions, survey
Promotion	Promotions reinforce concept of alcohol as part of our culture; much of the socializing for this age group done in bars, around alcohol etc.—interviews, brainstorming sessions
Perceived risk of harm of use	People this age aren't necessarily educated on the risks associated with binge drinking—brainstorming session, survey
Community norms	Alcohol is an integral part of our culture—interviews, brainstorming sessions
Family norms	Alcohol is a part of family life, the way it's always been—interviews, brainstorming sessions

3. High-risk Drinking Among Other Adults (30 and over):

What are the consequences of high-risk drinking among other adults in your county?

Penobscot & Piscataquis: Treatment admissions for people of all ages increased, EMHS assessment indicates that the prevalence of chronic heavy drinking has increased since 2001, particularly among 18-64 year olds
Penobscot: higher rates of acute alcohol-related mental disorder hospitalizations and ED visits occur in Bangor (and Washington County) than in other study regions and the state

In your county, is there a connection between the following intervening variables and the consumption of alcohol or the consequences of high-risk drinking?	If yes, what is the connection (contributing factors) and how do you know this?
Enforcement	
Retail access	
Social access	
Promotion	Promotions reinforce concept of alcohol as part of our culture—brainstorming session
Perceived risk of harm of use	
Community norms	Alcohol is an integral part of our culture—interviews, brainstorming sessions
Family norms	Alcohol is a part of family life, the way it's always been—interviews, brainstorming sessions

4. Marijuana Use Among Youth (12-17):

What are the consequences of marijuana use among youth in your county?

Penobscot: lifetime use of marijuana and previous 30-day use about the same as state rate. 47% of kids over 14 have tried marijuana
Piscataquis: lifetime use of marijuana, previous 30-day use is higher than the state rate. 49% of kids over 14 have tried marijuana

In your county, is there a connection between the following intervening variables and the consumption of marijuana or the consequences of its use?	If yes, what is the connection (contributing factors) and how do you know this?
Enforcement	Marijuana is not at the top of the law enforcement community's list; it really is seen as lesser of the evils—interviews
Retail access	
Social access	Kids are getting marijuana from their friends and family. Selling marijuana is the only income some folks have—interviews
Promotion	
Perceived risk of harm of use	Marijuana use still thought to be harmless—interviews, brainstorming sessions
Community norms	We accept marijuana use because it is not 'as bad' as prescription drug use—interviews
Family norms	Many families smoke marijuana together and perpetuate a culture of pot use. This is particularly dangerous for youth and young adults because their threshold for experimentation is lower and they are more likely to use 'harder' drugs because they are familiar with marijuana—interviews

5. Marijuana Use Among <u>Young Adults (18-29)</u>:

What are the consequences of marijuana use among young adults in your county?

Penobscot: arrests for drug violations, age 18 and older higher than state, percent of total treatment admissions involving marijuana (18 and older) about same as state
Piscataquis: lifetime use of marijuana, previous 30-day use higher than state rate; arrests for drug violations, age 18 and older higher than state, percent of total treatment admissions (18 and older) involving marijuana about same as state

In your county, is there a connection between the following intervening variables and the consumption of marijuana or the consequences of its use?	If yes, what is the connection (contributing factors) and how do you know this?
Enforcement	Marijuana is not at the top of the law enforcement community's list; it really is seen as lesser of the evils—interviews
Retail access	
Social access	People get marijuana from their friends and family. Selling marijuana is the only income some folks have—interviews
Promotion	
Perceived risk of harm of use	Marijuana use still thought to be harmless—interviews, brainstorming sessions, survey
Community norms	We accept marijuana use because it is not 'as bad' as prescription drug use—interviews
Family norms	Many families smoke marijuana together and perpetuate a culture of pot use. This is particularly dangerous for youth and young adults because their threshold for experimentation is lower and they are more likely to use 'harder' drugs because they are familiar with marijuana—interviews

6. Marijuana Use Among Other Adults (30 and over):

What are the consequences of marijuana use among other adults in your county?

Penobscot: arrests for drug violations, age 18 and older higher than state, percent of total treatment admissions involving marijuana (18 and older) about same as state
Piscataquis: lifetime use of marijuana, previous 30-day use higher than state rate; arrests for drug violations, age 18 and older higher than state, percent of total treatment admissions (18 and older) involving marijuana about same as state

In your county, is there a connection between the following intervening variables and the consumption of marijuana or the consequences of its use?	If yes, what is the connection (contributing factors) and how do you know this?
Enforcement	Marijuana is not at the top of the law enforcement community's list; it really is seen as lesser of the evils—interviews
Retail access	
Social access	People get marijuana from their friends and family. Selling marijuana is the only income some folks have—interviews
Promotion	
Perceived risk of harm of use	Marijuana use still thought to be harmless—interviews, brainstorming sessions
Community norms	We accept marijuana use because it is not 'as bad' as prescription drug use—interviews
Family norms	Many families smoke marijuana together and perpetuate a culture of pot use—interviews

7. Non-medical Use of Prescription Drugs <u>Among Youth (12-17)</u>:

What are the consequences of non-medical use of prescription drugs among youth in your county?

Penobscot: lifetime and previous 30-day misuse of prescription drugs about same as state; juvenile arrests for drug violations increased slightly since 1991
Piscataquis: lifetime and previous 30-day misuse of prescription drugs higher than state by **a lot (13% average).**

In your county, is there a connection between the following intervening variables and the consumption of prescription drugs for non-medical use or the consequences of this type of use?	If yes, what is the connection (contributing factors) and how do you know this?
Enforcement	Difficult to apprehend dealers, tight communities where 'snitching' is looked down upon—interviews
Retail access	Over prescription increases the amount of prescription drugs—interviews, brainstorming sessions
Social access	Folks are over prescribed, don't know how to dispose of drugs which makes them more available—interviews, brainstorming sessions
Promotion	Commercials advertising drugs makes them seem more accessible, less harmful—brainstorming sessions, interviews
Perceived risk of harm of use	Kids are prescribed many drugs in their own right, are used to taking them which decreases the perceived risk—interviews, brainstorming sessions
Community norms	We're all looking for a quick fix, drugs are a way to achieve this—brainstorming sessions
Family norms	We're all looking for a quick fix, drugs are a way to achieve this and it's institutionalized at the family level—brainstorming sessions

8. Non-medical use of Prescription Drugs Among Young Adults (18-29):

What are the consequences of non-medical use of prescription drugs among young adults in your county?

Penobscot: females crossing the threshold for prescription drugs a little higher than state; arrests for drug violations, age 18 and older, overdose deaths higher than state, treatment admissions higher than state and increasing over time, percent of total treatment admissions (18 and older) involving prescription drugs high than state. Current rate doubled the 2000 rate.
Piscataquis: females crossing the threshold much higher than state rate (by 16%). Median age of people crossing the threshold lower than state rate; arrests for drug violations, age 18 and older higher than state and a 400% increase from 1999 to 2000; overdose deaths up since 1997 and higher than the sate rate; treatment admissions (all ages) increasing.

In your county, is there a connection between the following intervening variables and the consumption of prescription drugs for non-medical use or the consequences of this type of use?	If yes, what is the connection (contributing factors) and how do you know this?
Enforcement	Difficult to apprehend dealers, tight communities where 'snitching' is looked down upon—interviews
Retail access	Over prescription increases the amount of prescription drugs—interviews, brainstorming sessions, survey
Social access	Folks are over prescribed, don't know how to dispose of drugs which makes them more available—interviews, brainstorming sessions
Promotion	Commercials advertising drugs makes them seem more accessible, less harmful—brainstorming sessions, interviews
Perceived risk of harm of use	They're prescribed, so they're safe—interviews, brainstorming
Community norms	We're all looking for a quick fix, drugs are a way to achieve this—brainstorming sessions

Family norms	We're all looking for a quick fix, drugs are a way to achieve this and it's institutionalized and perpetuated at the family level—brainstorming sessions

9. Non-medical use of Prescription Drugs Among Other Adults (30 and over):

What are the consequences of non-medical use of prescription drugs among other adults in your county?

Penobscot: females crossing the threshold for prescription drugs a little higher than state; arrests for drug violations, age 18 and older, overdose deaths higher than state, treatment admissions higher than state and increasing over time, percent of total treatment admissions (18 and older) involving prescription drugs high than state. Current rate doubled the 2000 rate.
Piscataquis: females crossing the threshold much higher than state rate (by 16%). Median age of people crossing the threshold lower than state rate; arrests for drug violations, age 18 and older higher than state and a 400% increase from 1999 to 2000; overdose deaths up since 1997 and higher than the sate rate; treatment admissions (all ages) increasing.

In your county, is there a connection between the following intervening variables and the consumption of prescription drugs for non-medical use or the consequences of this type of use?	If yes, what is the connection (contributing factors) and how do you know this?
Enforcement	Difficult to apprehend dealers, tight communities where 'snitching' is looked down upon—interviews
Retail access	Over prescription increases the amount of prescription drugs on the street—interviews, brainstorming sessions
Social access	Folks are over prescribed, don't know how to dispose of drugs which makes them more available—interviews, brainstorming sessions
Promotion	Commercials advertising drugs makes them seem more accessible, less harmful—brainstorming sessions, interviews
Perceived risk of harm of use	They're prescribed, so they're safe—interviews, brainstorming
Community norms	We're all looking for a quick fix, drugs are a way to achieve this—brainstorming sessions

Family norms	We're all looking for a quick fix, drugs are a way to achieve this and it's institutionalized and perpetuated at the family level—brainstorming sessions

Appendix R: Piscataquis County One Maine Results 2005

From a press release located at http://www.greenvilleme.com/news/101405.html[iv]

According to the MYDAUS County Reports on 30-day use of cigarettes, smokeless tobacco, and binge drinking ninth grade appears to be the year of increased use and experimentation. In looking at which substance (tobacco or alcohol) appears to be more of a problem at an earlier age in Piscataquis County, the data indicates that cigarettes are the bigger problem because more youth are using earlier; however, alcohol poses the most immediate and catastrophic level of risk.

Based on the OSA Indicator Data, Piscataquis County has a higher than state average of youth alcohol related arrests. The data also showed that Drug Law violations are below state average for youth, but significantly higher for adults.
Risk factors that were identified for Piscataquis County include ease of access to drugs, community norms tolerant of use, economic and social deprivation, family history of substance abuse, parental attitudes accepting of drug use, and early initiation to alcohol or drug use.

Based on the community interviews with schools, parks and recreation, and law enforcement professionals, 7 out of 9 indicated that underage drinking is a serious problem in Piscataquis County; and 8 out of 9 indicated that youth tobacco use is a serious problem in Piscataquis County.

All schools take these issues seriously and all have clear policies to deal with these issues, according to area superintendents. School policies commonly utilize consequences, education and parental involvement with each incident. Police are usually involved at the discretion of the administrator – depending on the circumstances. Schools recognize that their influence has limitations because they can only impact this issue while youth are on school grounds or involved in school activities. Most use/abuse takes place off school grounds and not on school time. Parks and recreation interviews indicated that use/abuse in parks is almost non-existent in our County. Most use by youth takes place in private homes or deep in rural areas. As a result, it is important that the issue is viewed as a broader community and family issue, with very real law enforcement consequences.

Law enforcement policies are generally consistent across the county. Parents are always informed and citations are issued for alcohol and tobacco use by minors. However, buyers of alcohol are the most difficult to target and appear to be plentiful. Enforcement resources are readily accessible. Parents can contribute to underage drinking by indifference or actual support of behaviors, according to the study results. At the same time, parents are often one of the most powerful determinant of effective interventions.

The focus groups participated in very open and candid discussions around the issues of alcohol, tobacco, and other drug use. From these discussions the Piscataquis Public Health Council and Mayo Regional Hospital's Counseling Program obtained the following information:

1. Youth obtain alcohol and tobacco products from friends and relatives, at parties, and taken from parents without parental consent.
2. Settings in which youth are most commonly found to be drinking alcohol or using tobacco products is at friend's homes, in vehicles, and in their own homes.

3. When asked is underage drinking a serious problem in your community, several observations were made including "use by youth appears to be high" and "youth using is not considered a big deal by itself – but drinking and driving is the thing to be concerned about". Some participants considered "any use by youth as a significant problem".

4. When asked what do you think causes underage drinking, participants noted "peer pressure and easy availability", "Lack of things to do-boredom", "culture of acceptance of kids using, by both youth and adults", "few strong DO NOT DRINK messages for many kids", "Economy and poverty of many people in the area", and "many people willing to buy for youth – motivated by various reasons."

5. When asked what messages are youth getting from the community about drinking, the major themes that emerged were "drinking and driving is not acceptable", "its acceptable to use because use is so common among peers and adults", and "Excessive use is not a big deal because many adults do it"

6. When asked what are the barriers to solving the problem of alcohol use by youth, participants suggested that "use is part of the local culture, both for youth and adults," "Parents and other significant adults are not providing expectations, examples, and consequences for youth using."

7. When asked for suggestions for preventing alcohol and tobacco use by youth, the groups concluded that "confronting kids' use behavior," "creating stronger consequences for people who provide alcohol to youth", "Stricter enforcement", "Consistent community messages about not using", "relating smoking and alcohol use to individual health and happiness", "showing consequences of smoking and alcohol use, make it personal", "Teaching kids to be reflective and analytical of personal behavior", "Teaching your kids and grandkids", and "Talking about it."

Youth show an increase in use around ages 13-14 and from ages 13-18, there is a steady increase in use rates. Risk factors that Mayo Regional Hospital's Counseling Program and the Piscataquis Public Health Council will be looking to address are strategies that change community norms and reduce drug and alcohol accessibility to youth.

The Piscataquis Public Health Council is one of 31 local Healthy Maine Partnerships, working on tobacco-prevention and control, physical activity and nutrition using tobacco settlement funds provided through the Fund for a Healthy Maine.

Appendix S: 18-25 Year Old Survey Results

Penobscot/Piscataquis County Young Adult Health Assessment

We are collecting information about substance use patterns of young people who live and work in Penobscot and Piscatquis counties. We hope to use this information to better identify and respond to needs. Your feedback is important!

Directions: Please take a few minutes to complete this survey by checking the appropriate box. Your participation is voluntary. **Do not write your name on this survey!** Your answers will remain anonymous. If you are uncomfortable answering any question you may leave it blank.

Section #1: About You

1. Which of the following best describes how you identify your gender?
   15 Male 36 Female 0 Transgender 0 Other

2. How old are you? _____ (enter your age)
   2:17—1:18—11:19—10:20—7:21—5:23—1:24—2:25—1:32

3. Are you currently enrolled in college... 44 Full Time 3 Part Time 1 Not Enrolled

4. What is your employment status?
   7 Employed full-time, that is 35 or more hours per week
   26 Employed part-time, that is **less than** 35 hours per week. How many hours per week? _____
   4 Unemployed and actively looking for work
   9 Unemployed and not actively looking for work

5. How often do you attend religious services or activities?
   18 Never 23 Rarely 6 1-2 times a month 2 About once a week or more

Section #2: Use

7. How often do you think a peer in your age group use the following *on average* (mark one for each line):

		Did not use	Once/year	6 times/year	Once/month	Twice/month	Once/week	3 times/week	5 times/week	Every day
a.	Tobacco (smoke, chew, snuff)	13	2	3	1	2	4	6	4	17
b.	Alcohol (beer, wine, liquor)	3	0	3	1	4	12	17	6	5
c.	Marijuana (pot, hash, hash oil)	12	1	4	3	5	7	9	2	7
d.	Cocaine (crack, rock, freebase)	26	4	5	6	4	1	1	0	2
e.	Amphetamines (diet pills, speed)	23	3	8	6	6	0	0	1	3
f.	Sedatives (downers, ludes)	22	5	9	8	1	2	0	0	3
g.	Hallucinogens (LSD, PCP)	22	12	5	6	1	1	1	0	2
h.	Opiates (heroin, smack, horse)	24	10	3	3	4	2	1	0	9
i.	Inhalants (glue, solvents, gas)	29	5	5	5	2	2	0	0	2
j.	Designer drugs (ecstacy, MDMA)	21	14	3	4	4	1	1	0	2
k.	Steroids	22	8	4	8	1	4	0	0	3
l.	Other illegal drugs	23	8	4	8	3	0	2	0	2
m.	Prescription Drugs not prescribed for a medical condition, or overuse of drugs prescribed for a medical condition	17	4	7	5	5	5	3	1	2

8. How do you think your close friends feel (or would feel) about your... (mark one for each line):

		Don't disapprove	Disapprove	Strongly Disapprove
a.	Trying marijuana once or twice	38	9	2
b.	Smoking marijuana occasionally	30	13	5
c.	Smoking marijuana regularly	12	24	14
d.	Trying cocaine once or twice	2	18	32
e.	Taking cocaine regularly	4	9	37
f.	Trying LSD once or twice	6	19	25
g.	Taking LSD regularly	2	12	36
h.	Trying amphetamines once or twice	2	17	31
i.	Taking amphetamines regularly	2	11	34
j.	Having one or two alcoholic beverages (beer, wine, liquor,) nearly every day	21	22	5
k.	Having four or five alcoholic beverages nearly every day	5	20	26
l.	Having five or more alcoholic beverages in one sitting	21	12	18
m.	Taking steroids for body building or improved athletic performance	5	12	33

9. How much do you think people risk harming themselves (physically or in other ways) if they...
(mark one for each line):

		No risk	Slight risk	Moderate risk	Great risk	Can't say
a.	Trying marijuana once or twice	22	21	3	2	2
b.	Smoking marijuana occasionally	19	25	14	3	0
c.	Smoking marijuana regularly	1	14	23	13	0
d.	Trying cocaine once or twice	2	7	16	26	0
e.	Taking cocaine regularly	0	4	4	41	2
f.	Trying LSD once or twice	0	9	11	29	0
g.	Taking LSD regularly	0	2	6	40	3
h.	Trying amphetamines once or twice	0	9	13	28	0
i.	Taking amphetamines regularly	0	2	6	40	1
j.	Taking one or two drinks of an alcoholic beverage (beer, wine, liquor,) nearly every day	7	16	16	10	0
k.	Taking four or five drinks nearly every day	1	2	17	29	1
l.	Having five or more drinks in one sitting	1	12	16	21	1
m.	Taking steroids for body building or improved athletic performance	2	5	12	29	3

10. In the first column indicate whether any of the following have happened to a friend of yours within the last year. If you answered yes to any of these items, indicate in the second column if your friend had consumed alcohol or other drugs shortly before these incidents. In the third column indicate whether any of the following behaviors has ever been initiated by a friend. If you answered yes to any of these items, indicate in the fourth column if your friend had consumed alcohol or drugs shortly before these incidents.

Not enough answers from respondents

		Happened to Friend			Consumed Alcohol or			Initiated by a Friend			Consumed Alcohol or	
		yes	no		yes	no		yes	no		no	yes
a.	Ethnic or racial harassment	☐	☐		☐	☐		☐	☐		☐	☐
b.	Threats of physical violence	☐	☐	if	☐	☐		☐	☐	if	☐	☐
c.	Actual physical violence	☐	☐	yes	☐	☐		☐	☐	yes	☐	☐
d.	Theft involving force or threat of force	☐	☐		☐	☐		☐	☐		☐	☐
e.	Forced sexual touching or fondling	☐	☐		☐	☐		☐	☐		☐	☐
f.	Unwanted sexual intercourse	☐	☐		☐	☐		☐	☐		☐	☐

11. Mark the most appropriate answer for each of the following statements:

		True	False
a.	My friends are more likely to attend a social event/outing etc if there are opportunities to drink or use drugs	34	16
b.	All things being equal, my friends are more likely to go to a bar/restaurant with drink specials than they are an establishment with no drink specials	34	15
c.	The price of a particular brand or type of alcohol influences my friend's decisions to purchase that particular brand/type of alcohol	37	12
d.	In the last year my friends have been served alcohol by bartenders and wait staff when they (my friends) obviously were intoxicated	26	23
e.	My friends are carded regularly when they purchase alcohol from retail establishments	41	7
f.	It is easy for a person under 21 to illegally purchase alcohol for themselves	15	34
g.	It is easy for a person under 21 to get alcohol from friends who are purchasing it legally	48	1
h.	It is ok to share my prescription drugs with a friend if they need it for a medical condition	8	42
i.	If I suspected a friend had a substance abuse problem I would know where to get help for them	41	7

12. When/if my friends engage in recreational use of prescription drugs they are most likely to obtain the drugs from...(choose all that apply)

Physician	12	Friend	39	Relative	11
Leftover from old prescription	28	Buy them	26		

Thank you very much for your time!

Appendix T: MYDAUS Analysis

[i] Piscataquis County Economic Development Council. http://www.pcedc.org/. Dover-Foxcroft, Maine. 2007

[ii] Access Atlantica Northeast Trade Corridor. Eastern Maine Corridor. http://www.shiftportal.com/bangor-saintjohn/editor/index.cfm?fuseaction=main&sectionid=5&subsectionid=6. Bangor, Maine: 2007.

[iii] University of New England's Center for Health Policy, Planning and Research. Eastern Maine Healthcare Systems Community Health Needs Assessment. Portland, Maine. 2007.

[iv] Piscataquis County Public Health Council. Youth Use of Tobacco Alcohol in Piscataquis County. http://www.greenvilleme.com/news/101405.html. Dover-Foxcroft, Maine. 2005