Maine

UNIFORM APPLICATION
FY 2020/2021 Substance Abuse Prevention and Treatment Block Grant Plan

SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT

OMB - Approved 04/19/2019 - Expires 04/30/2022
(generated on 01/31/2020 1:35:12 PM)

Center for Substance Abuse Prevention
Division of State Programs

Center for Substance Abuse Treatment
Division of State and Community Assistance
State Information

Plan Year
Start Year 2020
End Year 2021

State DUNS Number
Number 80-904-559

I. State Agency to be the Grantee for the Block Grant
Agency Name Department of Health and Human Services
Organizational Unit Office of Substance Abuse and Mental Health Services (SAMHS)
Mailing Address 11 SHS, 41 Anthony Ave
City Augusta
Zip Code 04333-0011

II. Contact Person for the Grantee of the Block Grant
First Name Sheldon
Last Name Wheeler
Agency Name Office of Substance Abuse and Mental Health Services
Mailing Address 11 SHS, 41 Anthony Ave.
City Augusta
Zip Code 04333-0011
Telephone 207-287-2595
Fax 207-287-4334
Email Address Sheldon.Wheeler@maine.gov

III. Expenditure Period
State Expenditure Period
From
To

IV. Date Submitted
Submission Date 10/1/2019 5:33:53 PM
Revision Date 1/31/2020 1:34:12 PM

V. Contact Person Responsible for Application Submission
First Name Tara
Last Name Pelotte
Telephone (207) 287-2595
Fax
Email Address Tara.M.Pelotte@maine.gov

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022
### Title XIX, Part B, Subpart II of the Public Health Service Act

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As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.

2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.

3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.

4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.

5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM’s Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).

6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.

7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.


10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions


14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.

18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.
LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
   a. Checking the Exclusion Extract located on the System for Award Management (SAM) at http://sam.gov
   b. Collecting a certification statement similar to paragraph (a)
   c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free workplace in accordance with 2 CFR Part 182 by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;

b. Establishing an ongoing drug-free awareness program to inform employees about--
   1. The dangers of drug abuse in the workplace;
   2. The grantee's policy of maintaining a drug-free workplace;
   3. Any available drug counseling, rehabilitation, and employee assistance programs; and
   4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;

d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
   1. Abide by the terms of the statement; and
   2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;

e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d)(2), with respect to any employee who is so convicted?
   1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
   2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"
generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)

3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children’s services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children’s services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children’s services and that all subrecipients shall certify accordingly.
The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

**HHS Assurances of Compliance (HHS 690)**


The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.

4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.
I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-construction Programs and other Certifications summarized above.

State: ____________________________

Name of Chief Executive Officer (CEO) or Designee:

Signature of CEO or Designee¹:

Title: ____________________________

Date Signed: ______________________

mm/dd/yyyy

¹If the agreement is signed by an authorized designee, a copy of the designation must be attached.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:
## State Information

**Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority**

**Fiscal Year 2020**

U.S. Department of Health and Human Services  
Substance Abuse and Mental Health Services Administrations  
Funding Agreements  
as required by  
Substance Abuse Prevention and Treatment Block Grant Program  
as authorized by  
Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act  
and  
Title 42, Chapter 6A, Subchapter XVII of the United States Code

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4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.

5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM’s Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).

6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to nondiscrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.

7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.


10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EC 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §1451 et seq.); (f) conformity of Federal actions...
to State (Clear Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.);
(g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and


14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.

18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.
LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
   a. Checking the Exclusion Extract located on the System for Award Management (SAM) at http://sam.gov
   b. Collecting a certification statement similar to paragraph (a)
   c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free workplace in accordance with 2 CFR Part 182 by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;

b. Establishing an ongoing drug-free awareness program to inform employees about--
   1. The dangers of drug abuse in the workplace;
   2. The grantee's policy of maintaining a drug-free workplace;
   3. Any available drug counseling, rehabilitation, and employee assistance programs; and
   4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;

d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
   1. Abide by the terms of the statement; and
   2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;

e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
   1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
   2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR § 75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"
generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, “Disclosure of Lobbying Activities,” in accordance with its instructions. (If needed, Standard Form-LLL, “Disclosure of Lobbying Activities,” its instructions, and continuation sheet are included at the end of this application form.)

3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.
The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

**HHS Assurances of Compliance (HHS 690)**


The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

**THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:**

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.

4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.
I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-construction Programs and other Certifications summarized above.

State: __________________________

Name of Chief Executive Officer (CEO) or Designee: __________________________

Signature of CEO or Designee:

Title: __________________________

Date Signed: __________________________

If the agreement is signed by an authorized designee, a copy of the designation must be attached.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:
August 14, 2019

Odessa Crocker
Grants Management Officer, Substance Abuse and Mental Health Services Administration
5600 Fishers Lane
Rockville, MD 20857

Re: Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority

Dear Ms. Crocker:

This letter is to serve as authorization for Bethany L. Hamm, Deputy Commissioner, Department of Health and Human Services, to sign for the SAMHSA Substance Abuse Prevention and Treatment Block Grant Application and Assurances for the State of Maine.

Questions concerning this application should be directed to the contract administrator, Sheldon Wheeler, Director of the Office of Substance Abuse and Mental Health Services at (207) 287-2595.

Sincerely,

[Signature]
Janet T. Mills
Governor

cc: Jeanne Lambrew, Ph.D., Commissioner, Maine DHHS
Bethany L. Hamm, Deputy Commissioner, Maine DHHS
Sheldon Wheeler, Director of the Office of Substance Abuse and Mental Health Services, Maine DHHS
November 25, 2019

Attn: Grants Management Specialist(s)
Office of Financial Resources
U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administration
5600 Fishers Lane, 17E25A
Rockville, MD 20857


Dear Grants Management Specialist:

I certify that as the Authorized Business Official for the SAMHSA funds for the State of Maine and all subrecipients, Maine will comply with the following NoA language:

Grant funds may not be used, directly or indirectly, to purchase, prescribe, or provide marijuana or treatment using marijuana. Treatment in this context includes the treatment of opioid use disorder. Grant funds also cannot be provided to any individual who or organization that provides marijuana use for the purposes of treating substance use or mental disorders. See, e.g., 45 C.F.R. § 75.300(a) (requiring HHS to “ensure that Federal funding is expended . . . in full accordance with U.S. statutory . . . requirements.”); 21 U.S.C. §§ 812(c) (10) and 841 (prohibiting the possession, manufacture, sale, purchase or distribution of marijuana). This prohibition does not apply to those providing such treatment in the context of clinical research permitted by the DEA and under an FDA-approved investigational new drug application where the article being evaluated is marijuana or a constituent thereof that is otherwise a banned controlled substance under federal law.

If you have any questions regarding this letter, please feel free to contact me at (207) 287-1921.

Sincerely,

Bethany L. Hamm, Deputy Commissioner
Authorized Business Official
State Information

Disclosure of Lobbying Activities

To View Standard Form LLL, Click the link below (This form is OPTIONAL)

Standard Form LLL (click here)

Name

Title

Organization

Signature: ___________________ Date: ____________

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:
Planning Steps

Step 1: Assess the strengths and organizational capacity of the service system to address the specific populations.

Narrative Question:
Provide an overview of the state’s M/SUD prevention, early identification, treatment, and recovery support systems, including the statutory criteria that must be addressed in the state’s Application. Describe how the public M/SUD system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SMHA, the SSA, and other state agencies with respect to the delivery of M/SUD services. States should also include a description of regional, county, tribal, and local entities that provide M/SUD services or contribute resources that assist in providing the services. The description should also include how these systems address the needs of diverse racial, ethnic, and sexual and gender minorities, as well as American Indian/Alaskan Native populations in the states.

Footnotes:
Step I: Assess the strengths and needs of the service system to address the specific populations.

Overview and Organizational Structure of the Public Behavioral Health System in Maine

Maine’s Behavioral Health System is under the purview of the Maine Department of Health and Human Services. It currently consists of the following offices; Office of Substance Abuse and Mental Health Services, Office of Child and Family Services, Office of Aging and Disability Services, Office of Family Independence, the Maine Centers for Disease Control and Prevention, and the Office of Maine Care Services.

Maine’s Department of Health and Human Services’ Office of Substance Abuse and Mental Health Services (SAMHS) provides statewide leadership in defining, measuring and improving the quality of services and supports to individuals in need of substance abuse services across the continuum of care: intervention, treatment and recovery. In September 2012, the Office of Substance Abuse and the Office of Adult Mental Health Services were merged to form one state agency; Substance Abuse and Mental Health Services (SAMHS). The rationale for this change was to bring the various behavioral health agencies in the state together to further integrate and provide a more holistic milieu of services and support to the people of Maine. The new organization consists of the office of the Director and Associate Directors, Treatment and Recovery staff, Quality and Data Team, Special Projects, and Financial and Administrative personnel (see attached organization chart).

The Office of Substance Abuse and Mental Health Services and Maine CDC is centralized in the capital of the state, and contracts with providers statewide to administer necessary services. Through these contracts SAMHS and Maine CDC contribute resources at the public health district level, though unlike other offices, they do not have staff located at the public health district level. SAMHS staff is responsible for contract monitoring, providing technical assistance, and site visits to ensure quality of services being provided.

Maine Office of Substance Abuse and Mental Health Services and Maine CDC existing funders for substance use prevention and treatment include:

- State of Maine General Fund
- Fund for Healthy Maine (Tobacco Settlement Funds)
- SAMHSA’s Substance Abuse Prevention and Treatment Block Grant
- U.S. Department of Education via MOU with Maine Department of Education (DOE)
- US CDC’s Prescription Drug Overdose: Prevention for States 2015 Grant
- SAMHSA’s Strategic Prevention Framework for Prescription Drugs (SPF Rx) Grant
- SAMSHA’s Maine Youth State Treatment Implementation grant
- SAMSHA’s Opioid State Targeted Response grant

For several years, the state’s substance abuse prevention program was housed under the SSA, the Maine Office of Substance Abuse and Mental Health Services (SAMHS) in Augusta, Maine. In February 2016, the prevention program was moved from SAMHS to the Maine Center for Disease Control and Prevention (Me CDC), to be merged with the tobacco prevention and control program. As a result of this merger, a new program has emerged and is named the Tobacco and Substance Use Prevention and Control Program (TSUPC.) While the new program is still responsible for implementing the 20% set aside of the SAPTBG, they are also responsible for implementing the state’s tobacco prevention and
control program. This has provided increased visibility of substance use prevention as a public health issue and has provided increased opportunities to collaborate with other public health programs. The new TSUPC program has 4 teams that work together with the common goal to reduce substance and tobacco use in Maine and eliminate the consequences of such use. These four teams include the Prevention Team, Clinical Interventions and Data Team, Policy and Communications Team, and Adolescent Health and Injury Prevention Team. In total, there are 12 staff in this program.

While the discussion of how prevention services are delivered in Maine under the Maine CDC will be covered later, there are local and community level prevention providers that are housed across the state. These providers are funded through Maine’s federal substance use prevention grants, state funds, and Drug Free Community (DFC) funding.

The State of Maine operates the public behavioral health system under the guidance of the consent decree that was established in 1988. The consent decree requires the State of Maine to meet established goals or measures listed out in detail as part of the document. The State reports on those measures to the Court Master on a quarterly basis. As a partial result of the consent decree, SAMHS, is minimally involved in the provision of direct client services, rather, SAMHS contracts out direct, mental health services to independent mental health agencies across the state. As such, the role of SAMHS and the CDC is to provide leadership to individuals, their families, and the community in the realm of Prevention, Intervention, Treatment and Recovery from addiction and/or mental illness. SAMHS, in collaboration with all state agencies and community partners, develops, monitors, and improves the lives of those affected by addiction and mental illness across the lifespan.

Operating from a recovery-orientated framework, direct services provided by contracted agencies include peer-to-peer services, intensive case management, outreach through community workers, and outpatient counseling. All community mental health providers contracted with SAMHS are “co-occurring capable,” and DHHS is striving to have all providers integrate mental health and substance abuse services into their practices. DHHS’s MaineCare Services (state Medicaid program) created and launched the first stage of its Health Homes initiative for members in chronic condition in January 2013. Building off the Maine multi-payer Patient Centered Medical Home model, starting April 1, 2014, the Department launched Behavioral Health Home services to manage the physical and behavioral health needs of eligible adults and children. Both organizations receive a per member, per month (PMPM) payment for Health Home services provided to enrolled members. Behavioral Health Homes build on the existing care coordination and behavioral health expertise of community substance abuse and mental health providers.

In keeping with the requirements of the Substance Abuse Prevention and Treatment Block Grant, all contracted providers are obligated to adhere to the programmatic requirements outlined in their agency contract’s Rider E, which captures the SAPTBG’s expectations to prioritize certain populations, such as Pregnant and Parenting Women and IV Drug Users.

PWWDC: Maine has contracts with four agencies for the specific provision of services to pregnant women and women with dependent children from birth through age five. (There are no programs that serve only pregnant women or only women with dependent children, only programs that serve women and families, or block-grant funded contracts where they are prioritized.)
TB: In addition to contractually outlining all the SAPTBG programmatic obligations, the SSA works with the TB Control Officer’s Office at the Maine CDC to effectively coordinate services for Persons at Risk for Tuberculosis and a synopsis of the program’s efforts is offered below:

The Maine CDC runs a state and federally funded Tuberculosis (TB) Program which serves to eliminate TB by: assuring proper identification and treatment of persons who have active TB disease, preventing the spread of disease to others, finding, screening and treating persons exposed to those with active TB disease, diagnosis and treatment to patients with latent TB infection (LTBI). Federal funds provide program staff to enable surveillance and education of active TB disease. State funds are utilized for diagnosis and treatment efforts for all patients with active TB disease and patients with LTBI who are referred to the program.

Public Health Nursing (PHN) efforts are utilized to support high-risk persons (immunocompromised, substance abuse, homeless, foreign-borne, etc.) with LTBI. These patients receive treatment and monthly monitoring through their four- to nine-month course of therapy. They also provide daily directly observed therapy for patients with active TB disease which typically lasts six to nine months, but can be up to twenty-four months. LTBI and active TB disease therapy can be toxic for the liver and is especially dangerous for those with risk factors such as alcohol abuse. PHN uses part of their monthly or daily visits to monitor for medication side-effects to help prevent potentially fatal outcomes.

PWID: The SSA has also further consulted with the Maine CDC, who has oversight of the Needle Exchange Programs, which are “embedded” in their contracted agencies programming, with the understanding that the syringes legally cannot be paid for with federal/State funding (ref. Section 11). All syringes are paid for private funding, such as donations, fundraising, or occasionally “community” grants made by private organizations.

Finally, staff at treatment agencies, schools, health care offices, and social services providers are often from Maine and are sensitive to any economic, educational and/or other healthcare disparities. In addition, the Department’s and provider’s written materials are most often written in “plain language” that is appropriate for people with low literacy skills. Agencies that serve Native Americans have access to culturally appropriate resources and materials, as well as links to the broader Indian communities. Further, the State of Maine adheres to the U.S. Department of Health and Human Service Office of Minority Health regulations regarding the provision of culturally and linguistically appropriate services (CLAS). The State has a strategic plan in place to provide equitable and effective treatment to all those seeking health care. The providers also provide services according to CLAS and are monitored to ensure they are in compliance.

See below for the local and regional entities that provide services funded by the Substance Abuse Prevention and Treatment Block Grant for SFY 2018 and 2019, which are:

**SAMHS Community Substance Abuse Services Block Grant Allocation SFY 2020**

<table>
<thead>
<tr>
<th>Vendor Name</th>
<th>Service</th>
<th>FY2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</table>
Maine continues to have opioids/opiates as high prevalence substances, with an increase in heroin use and overdoses. Maine is attempting to address this and other substance abuse issues through the continued analysis of the data, resources, and capacity of the substance abuse services system at the state and local levels. The allocations of the above funding will shift with the determined need of communities and capacity of service providers to deliver services over this two-year period. This analysis, review, and adjustment process will be ongoing as the state and its partners across all services attempt address substance abuse in Maine.

The role of the SSA is to provide leadership in the realm of the prevention, intervention, treatment and recovery of individuals with addiction, their families and communities. The Office of Substance Abuse and Mental Health Services collaborates with all state agencies and community partners, develops, monitors and improves the lives of those affected by substance use, abuse and addiction across the lifespan.

Intervention Services include: Maine Driver Evaluation and Education Program.

Treatment Services include ASAM – PPC2 Levels of Care as listed in the following: Detoxification Management, Residential Care, Intensive Outpatient, Outpatient, Co-Occurring Treatment, Medication Assisted Treatment, and Opiate Health Homes. Outpatient and Intensive Outpatient are also being provided through the Drug Court System in Maine.

Recovery Services will include Substance Abuse Peer Recovery Support Centers currently being finalized under the request for proposal review process. These are expected to be located in underserved areas of the state.

1. Description of substance abuse prevention organization at all levels (i.e. state, regional, and local levels).

The Tobacco and Substance Use Prevention and Control Program (TSUPC) lives within the Maine Center for Disease Control and Prevention (Me CDC) within the Maine Department of Health and Human Services. The TSUPC program is responsible for implementing the 20% primary prevention set aside of the SAPTBG in addition to implementing the state’s tobacco prevention and control program and state suicide prevention programming. The TSUPC program has 4 teams that work together with the common goal to reduce substance and tobacco use in Maine, eliminate the consequences of such use, improve adolescent health and decrease suicide in Maine. These four teams include the Prevention Team, Tobacco Prevention and Control Team, Policy and Communications Team, and Adolescent Health and Injury Prevention Team. In total, there are 13 staff in this program. A combination of staff implements state level prevention services while community prevention services are implemented under a structure managed by the TSUPC program known as Maine Prevention Services. These providers are funded through Maine’s federal substance use prevention grants, state funds, and federal Drug Free Community (DFC) funding. More information on this structure is outlined below.
2. **Description of how substance abuse prevention services are delivered, including the role of the Single State Authority (SSA) and other state agencies with respect to the delivery of prevention services.** For example, the state should indicate if prevention services are delivered directly by the SSA, through another entity or entities, or both.

Maine has a somewhat newly created (3 years old) structure for the implementation of prevention services in the state. This system called Maine Prevention Services (MPS) includes 5 domains (Domain 1: Substance Use Prevention, Domain 2: Tobacco Use and Exposure Prevention, Domain 3: Youth Engagement, Domain 4: Mass Reach Health Communications, and Domain 5: Obesity.) The state of Maine contracts with 5 vendors to provide statewide services under each domain. Each Domain (with the exception of Domain 4) has sub-recipients who provide these services to local communities across Maine.

Statewide Substance Use Prevention services are being implemented through a Maine CDC contract with the University of New England (Domain 1 of Maine Prevention Services) who has 21 sub-recipients across Maine who are implementing prevention by using the Strategic Prevention Framework Model (SPF.) They are required to complete an assessment of their communities utilizing data from the SEOW, local level data, and environmental scanning and then determine capacity to implement prevention services. Sub-recipients then develop a work plan based on those assessments after they are provided with a pre-approved list of interventions and activities that they can implement. (See chart below) The sub-recipients then implement the interventions, report on these monthly, and go through a process to evaluate the effectiveness of that intervention for their community.

<table>
<thead>
<tr>
<th>Strategic Approaches (based on CSAP’s strategies)</th>
<th>(Must adhere to evidence-based programs and best practice)</th>
</tr>
</thead>
</table>
| **Information Dissemination**: This strategy provides awareness and knowledge of the nature and extent of alcohol and other drug use, abuse and addiction and their effects on individuals, families and communities. It also increases knowledge and awareness of available prevention programs and services. This strategy is one-way communication from the source to the audience, with limited interaction. | - Media campaigns  
- Brochures  
- Radio/TV public service announcements  
- Health fairs/health promotion  
- Information line  
- Newsletter Development  
- Social media (e.g. Facebook, Twitter)  
- Web posting (e.g. YouTube, pages, blog)  
- Clearinghouse/resource center(s)/directories |
| **Education**: This strategy involves two-way communication and is distinguished from the Information Dissemination strategy by the fact that interaction between the educator/facilitator and the participants is the basis of its activities. Activities under this strategy aim to affect critical life skills, decision-making, critical analysis, judgment abilities (i.e. Media literacy, classroom) | - Prime For Life program in universal settings  
- Parenting and family management classes  
- Peer educators  
- Education programs for youth groups  
- Substance Abuse Education Sessions, such as: safe storage, proper disposal of prescription pills, harmful effects of substance abuse  
- Responsible Beverage Server Seller training |
| **Environmental**: This strategy establishes or changes population-based factors* which | - Promoting the establishment or review of alcohol and drug use policies in schools |
influence substance use and related problem behaviors.

*Research-based environmental factors are:
Access/Availability, Pricing and Promotion, Enforcement of Policy and Laws, Community Norms and Attitudes

<table>
<thead>
<tr>
<th>Problem Identification and Referral: This strategy aims to identify and refer individuals who have illegally used or abused substances. The goal of this strategy is to assess behavior and its impact that can be addressed through education in a non-clinical manner.</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Advise and train regarding enforcement around use and availability of substances such as compliance checks, party patrols, drug take back events, tip lines</td>
</tr>
<tr>
<td>- Working with businesses around pricing and advertising strategies for substances.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Community-Based Process: This strategy builds capacity, readiness and engagement of community stakeholders and target populations in activities that address intervening variables known to impact substance use and abuse.</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Promote substance use components of employee and student assistance programs</td>
</tr>
<tr>
<td>- Promote use of screening to identify youth for targeted prevention programming.</td>
</tr>
<tr>
<td>- Educational intervention/diversion programs for policy/law offenses or incidents including but not limited to Prime for Life.</td>
</tr>
</tbody>
</table>

Other services funded through state and/or discretionary grant funds:

- Enforcing Underage Drinking Laws- This is one vendor that coordinates services and distributes funding to sub-recipients (law enforcement agencies) across Maine to implement evidenced based underage drinking enforcement details. This includes funding for details, training for law enforcement, and coordination of a statewide task force.

- Tobacco Compliance (SYNAR)-This is a requirement of the SAPTBG and includes compliance inspections to ensure that tobacco is not being sold to minors in Maine.

- Statewide Clearinghouse of Materials-Housed at the Maine CDC is a statewide clearinghouse of materials (Maine Prevention Store) that the public can obtain free of charge to disseminate prevention messages, education, and information to youth, young adults, and adults across Maine. This is utilized by UNE sub-recipients as well as several other social service providers across Maine. For more information visit: www.mainepreventionstore.org

- Substance Exposed Infants Prevention (SEI) - The Maine Center for Disease Control and Prevention, the Maine Office of Substance Abuse and Mental Health Services, along with the Office of Child and Family Services have joined resources to raise awareness about Substance Exposed Infants and Children across the state of Maine. Over the past several years, materials and resources such as posters, rack cards, brochures, magnets, and public service announcements have been developed and are now available, free of charge for public dissemination. In addition, the State of Maine has had a Statewide Steering Committee comprised of the above stakeholders as well as an SEI Community Level Task Force with local providers. The goals of both groups are to provide macro and micro services and support to state and community providers in an effort to reduce the number of substance exposed infants in Maine.

- Youth Engagement- The Maine Youth Action Network (MYAN) oversees a statewide network of prevention-focused youth-adult partnerships and youth groups with the overall goals of increasing resilience among youth and reducing youth substance use. This is Domain 3 of Maine Prevention Services. Youth groups include youth policy boards at the district and state level designed to research and implement public health policy change projects, as well as youth groups working more generally on health- and prevention-related efforts. MYAN provides technical assistance to bolster
and develop youth-adult partnerships across the state through education and training grounded in positive youth development and social-emotional learning principles.

- **Advisory Board**-The Tobacco and Substance Use Prevention and Control program in Maine has had an existing Tobacco and Substance Use Prevention Advisory Board that has met bimonthly to provide the program with oversight and consultation in matters related to tobacco and substance abuse prevention and intervention. It is comprised of state and community-level stakeholders (including Department of Education, Department of Labor, Department of Corrections, community providers, poison center, Child welfare, etc..) with the possibility of the establishment of time-limited subcommittees to tackle specialized tasks and issues as needed. Members of the board serve as advisors and are asked to participate in meetings every other month (for two hours) where the ongoing assessment of the state’s prevention and health promotion infrastructure and state strategic prevention plan occurs.

- **Social Emotional Learning**-The TSUPC has utilized discretionary funding from the State Opiate Response Grant and the Garett Lee Smith Suicide Prevention Grant to implement Sources of Strength and Second Step social emotional learning curriculums in over 40 schools total in Maine.

3. Description of regional, county, tribal, and local entities that provide prevention services or contribute resources that assist in providing the services.

Local entities that are providing prevention services are established community coalitions who as stated earlier are sub-recipients of a larger organization (UNE) who provides oversight to the work being implemented at the community level. Sub-recipients are required to employ a certified prevention specialist to implement substance use prevention interventions

Maine also has 18 Drug Free Community Grantees (DFC) in the State. Some of these DFC’s also overlap with the MPS sub-recipients and there has been increased work to ensure collaboration and coordination between the two when agencies within a community are not one in the same.

Maine has a public health infrastructure that includes 9 Public Health Districts (one of them being a tribal public health district) Each district has a District Coordinating Council (DCC) that is managed by a District Liaison. Some DCC’s may also implement substance use prevention strategies outside of SAPTBG funding and a protocol of communication has been created to ensure there is collaboration with the MPS structure to prevent overlap and to ensure coordination.

4. Description of how the substance abuse prevention system addresses the needs of diverse racial, ethnic, and sexual gender minorities, as well as American Indian/Alaskan Native populations in the states.

Through each community level assessment, coalitions can identify the special populations in their community that may be at greater risk of substance use based on the Maine Integrated Youth Health Survey data. Each community makes decisions about what strategies to implement based on this data. With that, the TSUPC program has convened a health disparities workgroup to ensure that we are sharing and developing resources for community providers as they are implementing these strategies for special populations.

5. Description of the strengths and needs of the state’s primary substance abuse prevention systems. Examples of system strengths might include long-standing interagency
relationships, coordinated planning, training systems, and an active network of prevention coalitions. The lack of such strengths might be considered needs of the system.

The TSUPC program has many strengths. The program has had a strong collaboration with community partners over the years as well as state agencies including the Department of Education, Office of Child and Family Services, Department of Corrections, Office of Mainecare Services and the Office of Substance Abuse and Mental Health Services. With that, the 2016 merger of tobacco and substance use programs within the Maine CDC has allowed for increased visibility of substance use prevention as a public health issue. Also, the state’s Prevention Credentialing Board as well as existing training programming has brought about increased credibility and support of prevention specialists in Maine. The infrastructure of Maine Prevention Services has allowed a system for funding to get to communities with a lead agency providing oversight and support.

The current primary prevention needs and gaps center around the limited financial resources that are available for Prevention that limits the ability to implement larger evidenced based boxed primary prevention programs and provide for evaluation of the overall prevention programming in Maine. Maine has chosen over the years to fund all communities in Maine with primary prevention funding to support all communities with prevention activities. With that, each community gets smaller amounts of money versus a few communities getting larger pools of funding. This limits the ability for communities to purchase boxed programming and implement with fidelity. With newly acquired discretionary funding from the State Opiate Response Grant (about $600,000), the Maine CDC has been able to develop pilot sites for the Second Step social emotional learning programming in an effort to make this a statewide program in the future.

Another gap that we are making some progress on is in relation to collaboration with other substance use systems in the state. With the removal of primary prevention from the Office of Substance Abuse and Mental Health services, there has been a greater need to ensure effective communication and collaboration between programs. This has been significantly improved over the past year, but prevention is interested in increasing collaboration efforts with recovery and treatment services to ensure we are utilizing every resource we can for prevention.
Planning Steps

Step 2: Identify the unmet service needs and critical gaps within the current system.

Narrative Question:
This step should identify the unmet service needs and critical gaps in the state’s current M/SUD system as well as the data sources used to identify the needs and gaps of the required populations relevant to each block grant within the state’s M/SUD system. Especially for those required populations described in this document and other populations identified by the state as a priority. This step should also address how the state plans to meet the unmet service needs and gaps.

A data-driven process must support the state’s priorities and goals. This could include data and information that are available through the state’s unique data system (including community-level data), as well as SAMHSA’s data sets including, but not limited to, the National Survey on Drug Use and Health (NSDUH), the Treatment Episode Data Set (TEDS), the National Facilities Surveys on Drug Abuse and Mental Health Services, and the Uniform Reporting System (URS). Those states that have a State Epidemiological and Outcomes Workgroup (SEOW) should describe its composition and contribution to the process for primary prevention and treatment planning. States should also continue to use the prevalence formulas for adults with SMI and children with SED, as well as the prevalence estimates, epidemiological analyses, and profiles to establish mental health treatment, substance use disorder prevention, and SUD treatment goals at the state level. In addition, states should obtain and include in their data sources information from other state agencies that provide or purchase M/SUD services. This will allow states to have a more comprehensive approach to identifying the number of individuals that are receiving services and the types of services they are receiving.

In addition to in-state data, SAMHSA has identified several other data sets that are available to states through various federal agencies: CMS, the Agency for Healthcare Research and Quality (AHRQ), and others.

Through the Healthy People Initiative HHS has identified a broad set of indicators and goals to track and improve the nation’s health. By using the indicators included in Healthy People, states can focus their efforts on priority issues, support consistency in measurement, and use indicators that are being tracked at a national level, enabling better comparability. States should consider this resource in their planning.

Footnotes:

Unmet Need within specific Substance Abuse Services for Maine

Maine is geographically expansive and demographically diverse. Service delivery challenges in the more populated, urban areas of south and south-central Maine often differ from those in the other, more rural regions of the state.

The State of Maine Office of Substance Abuse and Mental Health Services use data driven decision making in substance use program planning. Using timely and relevant substance use/risk data enables the Office to ensure substance use prevention and treatment interventions are being implemented statewide, that the intervention is prescriptive/focused, and flexible enough to meet the specific needs of the community. Evaluation of the interventions undertaken is of a high priority, ensuring the intervention has been effective and was an efficient use of allotted funds.

The data sources used to identify the unmet service needs and critical gaps within Maine’s substance abuse prevention, education and treatment system include: Web Infrastructure Treatment System (WITS), National Survey on Drug Use and Health (NSDUH), Behavioral Risk Factor Surveillance System (BRFSS), Maine Integrated Youth Health Survey (MIYHS), and Youth Risk Behavioral Surveillance System (YRBSS). To capture variances, unmet need data is compiled by county and/or Public Health District then tabulated statewide. Recent data indicate the following statewide unmet need areas in the 4th quarter SFY17:

**Reported Unmet SA Treatment Resource Needs (from WITS)**

![May 2017 Wait List](image-url)
The following table, from the Kaiser Family Foundation website, demonstrates Maine’s long standing commitment to serving the uninsured. Maine SAMHS uses SAPTBG funds, as well as other State and federal funds, to support only the vulnerable, uninsured populations for overall Intervention, Treatment and Recovery services.

### Health Insurance Coverage of the Total Population, 2016

<table>
<thead>
<tr>
<th>Location</th>
<th>Employer</th>
<th>Non-Group</th>
<th>Medicaid</th>
<th>Medicare</th>
<th>Other Public</th>
<th>Uninsured</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>United States</td>
<td>49%</td>
<td>7%</td>
<td>19%</td>
<td>14%</td>
<td>2%</td>
<td>9%</td>
<td>100%</td>
</tr>
<tr>
<td>Maine</td>
<td>49%</td>
<td>5%</td>
<td>21%</td>
<td>16%</td>
<td>1%</td>
<td>7%</td>
<td>100%</td>
</tr>
</tbody>
</table>

[http://www.kff.org/other/state-indicator/total-population/?currentTimeframe=0&selectedRows=%7B%22states%22:%7B%22maine%22:%7B%7D%7D%22wrapups%22:%7B%22united-states%22:%7B%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D](http://www.kff.org/other/state-indicator/total-population/?currentTimeframe=0&selectedRows=%7B%22states%22:%7B%22maine%22:%7B%7D%7D%22wrapups%22:%7B%22united-states%22:%7B%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D)

### Treatment Admissions for IV Drug Users in Maine

The State of Maine has seen a significant increase in treatment admissions for IV Drug Users over the past several years, as evidenced by SAMSHA’s recent preselection of Maine to apply for the Medication Assisted Treatment – Targeted Capacity Expansion funding opportunity. This information was collected and reported through the State of Maine WITS system. The most recent CY16 and C17 admissions data shows promise (but not enough data to reflect a trend), and demonstrates Maine’s serious commitment to pivoting resources where hot-spotting has broadcast the area of greatest need, as well as expanding the availability of treatment and recovery services wherever possible. Maine continues to lead the nation on the topic of substance abuse prevention and treatment, and the efforts seem to be paying dividends as more affected Mainers are able to lead safe, healthy and productive lives.

#### Population: Total Clients in Service CY 2016 (raw data)

- Pregnant Women: 251
- Women w/children: 2,797
- Co-Occurring: 2,745
- IVDU: 4,687
- Homeless: 2,116

#### Population: Total Clients in Service CY 2017 (raw data)

- Pregnant Women: 117
- Women w/children: 1,225
- Co-Occurring: 1,265
- IVDU: 2,365
- Homeless: 1,273

The State of Maine does not currently have the ability to accurately track the number of Data 2000 Waived Physicians in our state or the number of patients receiving Buprenorphine Services. As of September 2017 the state of Maine has 10 OTP’s that provide Methadone Maintenance Treatment (MMT). Six (6) of the OTP’s also provide Buprenorphine. Three (3) OTP’s currently provide IOP services to patient’s and seven (7) have recently been approved as Opioid Health Homes; an integrated care delivery model which links primary care with traditional MAT/Behavioral Health therapies and recovery supports. Due to the vast size of the state patients often must travel up to 5 hours a day to access treatment.

#### Maine IVDU Admissions by Age Group: (chart)
**This information was not available at the time of submission, but is expected to be made available shortly.**

**IVDU Admissions* by Age at the time of Admission (table)**

**This information was not available at the time of submission, but is expected to be made available shortly.**

**Pregnant Women and Women with Dependent Children**

Healthcare providers file reports with the Office of Child and Family Services (OCFS) when infant exposure to illegal substances is suspected, the infant demonstrates withdrawal symptoms or the infant has fetal alcohol spectrum disorder. The data is collected in the Maine Automated Child Welfare Information System (MACWIS). The data shows that the total number of drug affected babies born in the State has steadily increased over a nine year period. The average rate of drug affected babies per 10,000 residents by public health district indicates that the highest rates occur in the State’s more rural districts (Central, Penquis, Downeast, Western and Aroostook) where there are fewer services and challenges to accessing treatment. There are fewer DAB births per 10,000 residents in the higher populated districts (Cumberland, Midcoast, York) where more treatment options and supportive services are available. (Please see the SEOW (State Epidemiological Outcomes Workgroup) Short Report, Drug Affected Babies by County and Public Health District (2006-2014) at:

Also see the CY16 raw data, county-level referral report from MACWIS:

<table>
<thead>
<tr>
<th>COUNTY</th>
<th>COUNT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Androscoggin</td>
<td>134</td>
</tr>
<tr>
<td>Aroostook</td>
<td>76</td>
</tr>
<tr>
<td>Cumberland</td>
<td>83</td>
</tr>
<tr>
<td>Franklin</td>
<td>10</td>
</tr>
<tr>
<td>Hancock</td>
<td>38</td>
</tr>
<tr>
<td>Kennebec</td>
<td>109</td>
</tr>
<tr>
<td>Knox</td>
<td>36</td>
</tr>
<tr>
<td>Lincoln</td>
<td>18</td>
</tr>
<tr>
<td>Oxford</td>
<td>32</td>
</tr>
<tr>
<td>Penobscot</td>
<td>213</td>
</tr>
<tr>
<td>Piscataquis</td>
<td>21</td>
</tr>
<tr>
<td>Sagadahoc</td>
<td>10</td>
</tr>
<tr>
<td>Somerset</td>
<td>58</td>
</tr>
<tr>
<td>Waldo</td>
<td>54</td>
</tr>
<tr>
<td>Washington</td>
<td>41</td>
</tr>
<tr>
<td>York</td>
<td>91</td>
</tr>
<tr>
<td><strong>STATEWIDE TOTAL</strong></td>
<td><strong>1024</strong></td>
</tr>
</tbody>
</table>

There is no data available specific to women with dependent children in need of substance abuse treatment, however, SAMHS is currently working with providers to provide waitlist information on a monthly basis. Once this is instituted,
SAMHS will have the capability to estimate need based on those waiting for services. However, SAMHS’ treatment data for FY12, FY13 and FY14 show that 19% of all clients in treatment are parenting women. In addition, family risk factors identified in child protective assessments give us an indication of the incidence of parental substance use in child protective cases. As reported in Maine’s Child Protective Services Annual Report 2014, alcohol misuse by a parent is a risk factor in 11% of cases (average across three years) and drug misuse by a parent is a risk factor in 19.3% of cases. Mental health problems are also identified as a risk factor in 45% of the assessments. ([http://www.maine.gov/dhhs/ocfs/cw/reports/cps_reports.shtml](http://www.maine.gov/dhhs/ocfs/cw/reports/cps_reports.shtml))

Services which focus on the priority population of pregnant women and women with dependent children are limited in the State. As discussed in Section 19 there are four programs. One of these programs is a residential treatment, one is a home-based outpatient program and two are women’s substance abuse case management. Only the women’s case management program is statewide. There is a need for more services which provide various levels of treatment and which extend to women in underserved areas of the state.

**Tuberculosis cases in Maine**

SAMHS collaborates with the Maine Center for Disease Control and Prevention to improve outreach to those in substance abuse treatment services to have TB screening and treatment services available to this population. Included in the substance abuse treatment services contracts with agencies is language that these services (screening, testing, counseling, and case management) must be made available to those in Substance Abuse treatment. All contracted SA treatment agencies must report all active TB cases to the Maine Center for Disease Control and Prevention.

**TB Trend Data:**
The most recently published data comes from the Maine CDC TB/LTBI Registry. Number of positive TB cases reported: SFY 15 there were 9 cases; SFY 14 was 19 cases; SFY 15 had 18 confirmed cases.

(See the full report for more information and subdata):

Background
Tuberculosis (TB) is caused by the bacteria *Mycobacterium tuberculosis*. The bacteria are spread through the air by droplets when a person with infectious TB coughs, talks, sings, or sneezes. Tuberculosis is only infectious when the disease is in the lungs (pulmonary) or larynx. Extrapulmonary disease occurs outside of the lungs or larynx and is not infectious. Latent tuberculosis infection (LTBI) occurs when the body's immune system keeps the bacteria under control and inactive, so that disease does not develop. Individuals with LTBI are not symptomatic and not infectious to others.

Methods
Two tests are available to screen for tuberculosis. The TB skin test, called the tuberculin skin test (TST), has been used for many years. A newer blood test called interferon gamma release assay (IGRA) is also available. Neither test differentiates between latent or active TB. All positive results require additional evaluation.

Maine monitors the incidence of active TB through mandatory reporting by health care providers, clinical laboratories, and other public health partners. Although not reportable, Maine also monitors LTBI diagnoses.

All TB patients in Maine are evaluated by a healthcare provider in consultation with a TB consultant physician and receive case management services and directly observed therapy (DOT) by a Public Health Nurse (PHN). Maine's TB Control Program routinely reviews case management with PHN and the Medical Epidemiologist. The cases are also reviewed with TB Consultants at quarterly meetings.

A patient with confirmed TB must meet either clinical criteria or be laboratory confirmed with one of the following tests: isolation of *M. tuberculosis*; demonstration of *M. tuberculosis* by polymerase chain reaction (PCR); or demonstration of acid-fast bacilli when a culture has not been or cannot be obtained. Positive cultures for *M. tuberculosis* complex are tested for drug resistance.

Results
A total of 18 confirmed cases of TB were reported in 2015 (Figure 1). Of these, one case was resistant to pyrazinamide and one case was extensively drug resistant (XDR).

Figure 1. Number of Tuberculosis Cases by Year, Maine, 2011-2015

The incidence rate of TB in Maine in 2015, 1.4 cases per 100,000 persons, was less than the national rate of 3.0 (Figure 2). Nationwide, the case rate increased from 2014 by 3.4%.

Figure 2. Incidence of Tuberculosis, Maine and United States, 2006-2015

The median age of TB cases was 46 years (range 1 - 87 years). Cases resided in five counties, Androscoggin (7), Cumberland (8), Piscataquis (1), Somerset (1), and York (1).

Substance Use Prevention Data:

1. Description of data sources used to identify primary prevention needs.

The Tobacco and Substance Use Prevention and Control Program (TSUPC) relies heavily on the State Epidemiological Outcomes Workgroup (SEOW) to gather and collate data for the program to assist with the identification of strengths, gaps, and needs. While there are many sources of data utilized by the program, the following outcome data is used most prevalent: Maine Integrated Youth Health Survey (MIYHS), Behavioral Risk Factor and Surveillance Systems.
(BRFSS), Maine Department of Transportation (MDOT), National Survey on Drug Use and Health (NSDUH), Unified Crime Report (UCR), Maine Health Data Organization (MHOD).

<table>
<thead>
<tr>
<th>Outcome Measure</th>
<th>Data Source(s)</th>
<th>Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Past 30-day Alcohol Use</td>
<td>MIYHS</td>
<td>Mid School, High School</td>
</tr>
<tr>
<td>Binge Alcohol Use (Past 30 day)</td>
<td>MIYHS</td>
<td>Mid School, High School</td>
</tr>
<tr>
<td>Prescription Drug Misuse (Past 30 day, Lifetime use)</td>
<td>MIYHS</td>
<td>Mid School, High School</td>
</tr>
<tr>
<td>Marijuana Use (Past 30 day, Lifetime use)</td>
<td>MIYHS</td>
<td>Mid School, High School</td>
</tr>
<tr>
<td>Perception of parental disapproval</td>
<td>MIYHS</td>
<td>Mid School, High School</td>
</tr>
<tr>
<td>Perceived risk of harm</td>
<td>MIYHS</td>
<td>Mid School, High School</td>
</tr>
<tr>
<td>Alcohol/drug related car crashes (Annually)</td>
<td>MDOT</td>
<td>16-25</td>
</tr>
<tr>
<td>Alcohol and drug related crime (Annually)</td>
<td>UCR</td>
<td>Under 18, 18+</td>
</tr>
<tr>
<td>Family communication around drug use (Annually)</td>
<td>MIYHS</td>
<td>Mid School, High School</td>
</tr>
<tr>
<td>Alcohol and prescription drug-related ER visits (Annually)</td>
<td>MHDO</td>
<td>Under 18, 18+</td>
</tr>
</tbody>
</table>

2. Description of the state’s SEOW, including its membership, and how the SEOW contributes to the process for prevention planning.

Maine’s SEOW identifies substance use patterns in defined geographical areas, examines substance use trends and consequences, detects emerging substances, and provides information for policy development and program planning. The group meets twice per year to bring together representatives from multiple state level agencies and organizations, and prevention, intervention, treatment, and recovery program sub recipients who work across Maine. The SEOW encourages sharing of data across organizations by providing opportunities to present and learn about the data. The SEOW reviews data through the Strategic Prevention Framework lens, develops and maintains reports and products such as fact sheets, and makes recommendations to both the Tobacco and Substance Use Prevention Advisory Board and the Tobacco and Substance Use Prevention and Control Program (who oversees state and community level prevention efforts.)

Multiple data sources are routinely analyzed by the SEOW to help identify needs at the community and state levels. These data sources include but are not limited to the following: Behavioral Risk Factor Surveillance System (BRFSS); Maine Emergency Medical Services (EMS); Maine Department of Transportation (MDOT); Maine Drug Enforcement Agency (MDEA); Maine Health Data Organization (MHDO); Maine Integrated Youth Health Survey (MIYHS); National Survey on Drug Use and Health (NSDUH); Northern New England Poison Center (NNEPC); Office of the Chief Medical Examiner (OCME); Office of Data, Research and Vital Statistics (ODRVS); Prescription Monitoring Program (PMP); Pregnancy Risk Assessment Monitoring System (PRAMS); WITS Treatment Data System; Uniform Crime Reports (UCR). A more in-depth description and analysis of each data source is available in the latest SEOW report online at http://www.maineseow.com

The annual State Epidemiological Profile highlights data and progress related to all the prevention priorities identified in the state prevention strategic plan: underage drinking, high-risk drinking among 18-25 year olds,
misuse of prescription drugs among 18-25 year olds, marijuana use in 12-25 year olds. The SEOW produces Community Epidemiology Profiles, for each public health district in Maine which mirrors the state-level analysis and includes any data sources that are available and reliable at the sub-state level. Key findings of the reports are highlighted in biannual webinar presentations facilitated by the SEOW Coordinator and in factsheets and briefs regarding Maine data on alcohol use, prescription drug misuse, and marijuana use, as well as mental health. In addition, the SEOW produces factsheets on substance use and mental health among vulnerable populations such as those who are 18 to 25 years old, veterans, and those who identify as LGBTQ (Lesbian, Bisexual, Transgender, Transgender, or Questioning). Factsheets are designed for dissemination among prevention coalitions, parents, community members, stakeholders, and decision-makers and use infographics that are eye catching and easy to read. All SEOW resources are widely distributed on the Maine Prevention field and Maine community coalition list-serves and posted on the State of Maine website for prevention professionals to utilize. Within the past two years, an SEOW data dashboard has been developed to make data more accessible to the state, providers, and public in general.

3. Discussion of primary prevention needs and gaps within the current system and how the state plans to meet these unmet service needs and gaps.

The current consequence and surveillance data that is collected both through our Maine Integrated Youth Health Survey and through national data sets are delayed and not real time. With the ever-changing landscape of prevention with trends of use changing regularly, the data collection is providing some limitations to assessing impact of programming in real time. With that there are limitations to evaluation of prevention programming based on the limited amount of prevention dollars available.

- Quality and Data Collection Readiness Narrative

1. Briefly describe the state's data collection and reporting system and what level of data is able to be reported currently (e.g., at the client, program, provider, and/or other levels).

Outside of what has been discussed above regarding the state’s SEOW workgroup, local level data is collected to provide information to program about the interventions being implemented at the community level. UNE and its sub-recipients are required to collect and report to the state data that is relevant to their prevention activities to meet SAPTBG and other grant funding reporting requirements. Community coalitions are required to develop and submit their work plan to the state for approval and are UNE and Maine CDC program staff are able to monitor progress and change related to strategy implementation. The Maine CDC requires the collection of two types of counts, the number of interventions and the number of people reached with the interventions. With that, as a result of feedback from SAMHSA, Maine has instituted a new system whereby we are also receiving data on the money spent on the intervention so we have a more accurate depiction of funding spent on each intervention. On a monthly basis, UNE provides the Maine CDC with reports on intervention, reach, funding spent, and macro level work conducted by UNE in overseeing the sub-recipients. These are reviewed monthly by program for accountability and determining areas of success and need. Another gap is that with our state and community level data (the Maine Integrated Youth Health Survey), is received every two years which provides some gaps in data management on an annual basis. The program does have data on implementation annually but not results of implementation (consequence data.)
Planning Steps

Quality and Data Collection Readiness

Narrative Question:

Health surveillance is critical to SAMHSA’s ability to develop new models of care to address substance abuse and mental illness. SAMHSA provides decision makers, researchers and the general public with enhanced information about the extent of substance abuse and mental illness, how systems of care are organized and financed, when and how to seek help, and effective models of care, including the outcomes of treatment engagement and recovery. SAMHSA also provides Congress and the nation reports about the use of block grant and other SAMHSA funding to impact outcomes in critical areas, and is moving toward measures for all programs consistent with SAMHSA’s NBHQF. The effort is part of the congressionally mandated National Quality Strategy to assure health care funds – public and private – are used most effectively and efficiently to create better health, better care, and better value. The overarching goals of this effort are to ensure that services are evidence-based and effective or are appropriately tested as promising or emerging best practices; they are person/family-centered; care is coordinated across systems; services promote healthy living; and, they are safe, accessible, and affordable.

SAMHSA is currently working to harmonize data collection efforts across discretionary programs and match relevant NBHQF and National Quality Strategy (NQS) measures that are already endorsed by the National Quality Forum (NQF) wherever possible. SAMHSA is also working to align these measures with other efforts within HHS and relevant health and social programs and to reflect a mix of outcomes, processes, and costs of services. Finally, consistent with the Affordable Care Act and other HHS priorities, these efforts will seek to understand the impact that disparities have on outcomes.

For the FY 2016-2017 Block Grant Application, SAMHSA has begun a transition to a common substance abuse and mental health client-level data (CLD) system. SAMHSA proposes to build upon existing data systems, namely TEDS and the mental health CLD system developed as part of the Uniform Reporting System. The short-term goal is to coordinate these two systems in a way that focuses on essential data elements and minimizes data collection disruptions. The long-term goal is to develop a more efficient and robust program of data collection about behavioral health services that can be used to evaluate the impact of the block grant program on prevention and treatment services performance and to inform behavioral health services research and policy. This will include some level of direct reporting on client-level data from states on unique prevention and treatment services purchased under the MHBG and SABG and how these services contribute to overall outcomes. It should be noted that SAMHSA itself does not intend to collect or maintain any personal identifying information on individuals served with block grant funding.

This effort will also include some facility-level data collection to understand the overall financing and service delivery process on client-level and systems-level outcomes as individuals receiving services become eligible for services that are covered under fee-for-service or capitation systems, which results in encounter reporting. SAMHSA will continue to work with its partners to look at current facility collection efforts and explore innovative strategies, including survey methods, to gather facility and client level data.

The initial draft set of measures developed for the block grant programs can be found at [http://www.samhsa.gov/data/quality-metrics/block-grant-measures](http://www.samhsa.gov/data/quality-metrics/block-grant-measures). These measures are being discussed with states and other stakeholders. To help SAMHSA determine how best to move forward with our partners, each state must identify its current and future capacity to report these measures or measures like them, types of adjustments to current and future state-level data collection efforts necessary to submit the new streamlined performance measures, technical assistance needed to make those adjustments, and perceived or actual barriers to such data collection and reporting.

The key to SAMHSA’s success in accomplishing tasks associated with data collection for the block grant will be the collaboration with SAMHSA’s centers and offices, the National Association of State Mental Health Program Directors (NASMHPD), the National Association of State Alcohol Drug Abuse Directors (NASADAD), and other state and community partners. SAMHSA recognizes the significant implications of this undertaking for states and for local service providers, and anticipates that the development and implementation process will take several years and will evolve over time.

For the FY 2016-2017 Block Grant Application reporting, achieving these goals will result in a more coordinated behavioral health data collection program that complements other existing systems (e.g., Medicaid administrative and billing data systems; and state mental health and substance abuse data systems), ensures consistency in the use of measures that are aligned across various agencies and reporting systems, and provides a more complete understanding of the delivery of mental health and substance abuse services. Both goals can only be achieved through continuous collaboration with and feedback from SAMHSA’s state, provider, and practitioner partners.

SAMHSA anticipates this movement is consistent with the current state authorities’ movement toward system integration and will minimize challenges associated with changing operational logistics of data collection and reporting. SAMHSA understands modifications to data collection systems may be necessary to achieve these goals and will work with the states to minimize the impact of these changes.

States must answer the questions below to help assess readiness for CLD collection described above:

1. Briefly describe the state’s data collection and reporting system and what level of data is able to be reported currently (e.g., at the client, program, provider, and/or other levels).

2. Is the state’s current data collection and reporting system specific to substance abuse and/or mental health services clients, or is it part of a larger data system? If the latter, please identify what other types of data are collected and for what populations (e.g., Medicaid, child welfare,
3. Is the state currently able to collect and report measures at the individual client level (that is, by client served, but not with client-identifying information)?

4. If not, what changes will the state need to make to be able to collect and report on these measures? Please indicate areas of technical assistance needed related to this section.

Footnotes:
Quality and Data Collection Readiness

States must answer the questions below to help assess readiness for CLD collection described above:

1. Briefly describe the state's data collection and reporting system and what level of data is able to be reported currently (e.g., at the client, program, provider, and/or other levels).

Providers of substance abuse services must provide client, program, and provider data per state regulation and contractual obligations. The platform for the collection of substance abuse treatment data is WITS. WITS data is transferred at least twice monthly into TEDS.

Maine currently collects the following information on all substance abuse clients treated at a licensed agency and by many private providers: Name or initials, social security number, date of birth, agency and facility treated at, type of service, demographic information, substance use, dates of first call, admission and discharge, living situation, employment, prior service, MH and SA hospital admissions, special population data, payment source and financial status, legal status, if co-occurring, children/dependents, attendance at self-help; most information as required by TEDS.

Maine is currently seeking to upgrade its WITS infrastructure by 1) incorporating data for use by Maine’s drug court system and 2) an upgrade to assist in the interconnectivity with electronic health records (EHR) of large organizations. Currently, those organizations with their own EHR’s have to double enter data to comply with state regulations.

Maine also has a pending TA Tracker request which it expects to submit shortly, which requests federal guidance in navigating 42 cfr in order to implement a proposed, fully-integrated, multi-program, co-occurring supportive, information technology treatment system.

Finally, prior to implementing any new project plan, SAMHS visits the NREPP site, which is SAMSHA’s warehouse of EBPs, and SAMHS also reviews SAMSHA’s other recommendations on EBPs and Best Practice. This is done in order to verify that any data collected is in accordance with documented evidence based or emerging practice.

Substance use prevention services implementation data is collected through an elaborate excel system that is housed with the University of New England (the lead vendor for substance use prevention services.) This system collects data from community level sub-recipients on intervention type, demographics of those served, number of people served/reached, and geographical information of service. The Maine CDC receives these reports monthly. Other prevention services provided utilizing SAPTBG funding report to the State of Maine through monthly reports including similar data sets depending on the service. Prevalence data which is used to assist with program planning as well as identifying areas of strength and improvement is collected typically through the Maine Integrated Youth Health Survey (MIYHS) every other year. This measures consumption, perception of harm, perception of getting caught, and other risk factors. Maine also utilizes BRFSS and NSDUH data for program planning.
2. Is the state's current data collection and reporting system specific to substance abuse and/or mental health services clients, or is it part of a larger data system? If the latter, please identify what other types of data are collected and for what populations (e.g., Medicaid, child welfare, etc.)

*The Office of Mental Health and Substance Abuse Services utilizes two systems for the collection of substance abuse and mental health data. As stated in #1, WITS captures all substance abuse data. Kepro Acquisitions, using their Atrezzo platform, is the mental health utilization review provider. This data is transferred into a state-owned system, EIS.*

*WITS captures all substance abuse data for adolescents and adults. It captures gender, ethnicity, race, special needs, veteran’s status, pregnant/not, HIV status, injection drug user, hep c, and shared needles.*

*At the time of admission and discharge, payment source is captured.*

3. Is the state currently able to collect and report measures at the individual client level (that is, by client served, but not with client identifying information)?

   Yes.

4. If not, what changes will the state need to make to be able to collect and report on these measures?
**Planning Tables**

**Table 1 Priority Areas and Annual Performance Indicators**

<table>
<thead>
<tr>
<th>Priority #</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Priority Area</td>
<td>Youth &amp; Young Adults at risk for Substance Use</td>
</tr>
<tr>
<td>Priority Type</td>
<td>SAP</td>
</tr>
<tr>
<td>Population(s)</td>
<td>PP</td>
</tr>
</tbody>
</table>

**Goal of the priority area:**

To reduce the use, misuse, and abuse of alcohol, marijuana, and prescription medications among youth 12-17 years old and young adults aged 18-25.

**Objective:**

Reduce the use, misuse, and abuse of alcohol, marijuana, and prescription medications among youth 12-17 years old and young adults aged 18-25. Year 1 targets represent a 2.5% reduction from baseline estimates. Year 2 targets represent a 5% reduction from baseline estimates.

**Strategies to attain the objective:**

1. Engage local public health coalitions to implement evidence-based environmental strategies utilizing the Strategic Prevention Framework Model (SPF) in their service area to reduce use and misuse of alcohol, marijuana, and prescription drugs.
2. Support the PMP promotion project with resources to educate health care providers and the public about the misuse of prescription medications.
3. Support the PMP with resources to educate health care providers about evidence based responsible prescribing practices.
4. Create statewide messages and material for use by prevention providers on alcohol, marijuana and prescription medications.
5. Provide Education and Technical Assistance to support the enforcing underage drinking laws environmental strategies statewide.
6. Provide evidence-based universal, indicated and selected population prevention programming throughout the state based on data and evidence of effectiveness.
7. Collaborate with other state agencies on systems level change necessary to ensure community level strategy implementation is successful (e.g.: school policy, underage drinking laws, etc.)

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**Annual Performance Indicators to measure goal success**

<table>
<thead>
<tr>
<th>Indicator #</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator</td>
<td>Past 30 Day Alcohol Use of 7th – 8th graders in Maine</td>
</tr>
<tr>
<td>Baseline Measurement</td>
<td>SFY20 – 3.7% of 7th – 8th graders in Maine used alcohol in the past 30 days.</td>
</tr>
<tr>
<td>First-year target/outcome measurement</td>
<td>SFY21 – 3.61% of 7th – 8th graders in Maine/past 30 days alcohol use</td>
</tr>
<tr>
<td>Second-year target/outcome measurement</td>
<td>SFY22 – 3.52% of 7th- 8th graders in Maine/past 30 days alcohol use</td>
</tr>
<tr>
<td>Data Source</td>
<td>Maine Integrated Youth Health Survey</td>
</tr>
</tbody>
</table>

**Description of Data:**

This survey is conducted of all participating middle/high schools in Maine. Survey is conducted every two years with 2019 being the next implementation and reporting. Data is not yet available as of the time of this application.

**Data issues/caveats that affect outcome measures:**

The state has no alternative data source for this indicator for this population. and only receives this data every two years.
**Second-year target/outcome measurement:** SFY22 – 21.4% of 9th-12th graders in Maine/past 30 days alcohol use

**Data Source:**
Maine Integrated Youth Health Survey

**Description of Data:**
This survey is conducted of all participating middle/high schools in Maine. Survey is conducted every two years with 2019 being the next implementation and reporting. Data is not yet available as of the time of this application.

**Data issues/caveats that affect outcome measures:**
The state has no alternative data source for this indicator for this population and data is only available every two years.

---

**Indicator #:** 3

**Indicator:** Past 30 Day Alcohol Use of 12 to 20 year olds in Maine

**Baseline Measurement:** SFY20 – 24.1% of 12-20 year olds in Maine used alcohol in the past 30 days.

**First-year target/outcome measurement:** SFY21 – 23.5% of 12-20 year olds in Maine/past 30 days alcohol use

**Second-year target/outcome measurement:** SFY22 – 22.9% of 12-20 year olds in Maine/past 30 days alcohol use

**Data Source:**
National Survey on Drug Use and Health

**Description of Data:**
National Survey on Drug Use and Health is an annual survey done of all 50 states that collects data on tobacco, alcohol, and drug use, mental health and other health-related issues in the United States.

**Data issues/caveats that affect outcome measures:**
Receipt of survey data is delayed and not current year data.

---

**Indicator #:** 4

**Indicator:** Past 30 Day Alcohol Use of 18 to 20 year olds in Maine

**Baseline Measurement:** SFY20 – 40.0% of 18-20 year olds in Maine used alcohol in the past 30 days.

**First-year target/outcome measurement:** SFY21 – 39.0% of 18-20 year olds in Maine/past 30 days alcohol use

**Second-year target/outcome measurement:** SFY22 – 38.0% of 18-20 year olds in Maine/past 30 days alcohol use

**Data Source:**
Behavioral Risk Factor Surveillance System (BRFSS)

**Description of Data:**
The Behavioral Risk Factor Surveillance System (BRFSS) is an annual health-related telephone surveys that collects state data about U.S. residents regarding their health-related risk behaviors, chronic health conditions, and use of preventive services.

**Data issues/caveats that affect outcome measures:**
Survey is done annually but data received annually is not for current year and is for 1-2 years prior.

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**Indicator #:** 5

**Indicator:** Past 30 days prescription drug misuse among Maine’s 7th-8th grade population.

**Baseline Measurement:** SFY20 – 1.5% of 7th – 8th graders engaged in past 30 day prescription drugs misuse

**First-year target/outcome measurement:** SFY21 – 1.46% of 7th – 8th graders past 30 days prescription drugs misuse

**Second-year target/outcome measurement:** SFY22 – 1.43% of 7th – 8th graders past 30 days prescription drugs misuse
<table>
<thead>
<tr>
<th>Indicator #</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator</td>
<td>Past 30 days prescription drug misuse among Maine’s 9th to 12th grade population</td>
</tr>
<tr>
<td>Baseline Measurement</td>
<td>SFY20 – 5.9% of 9th - 12th graders engaged in past 30 days prescription drugs misuse</td>
</tr>
<tr>
<td>First-year target/outcome measurement</td>
<td>SFY21 – 5.8% of 9th - 12th graders past 30 days prescription drug misuse.</td>
</tr>
<tr>
<td>Second-year target/outcome measurement</td>
<td>SFY22 – 5.6% of 9th - 12th graders past 30 days prescription drug misuse.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Data Source</th>
<th>Maine Integrated Youth Health Survey</th>
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<tr>
<th>Indicator #</th>
<th>7</th>
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</thead>
<tbody>
<tr>
<td>Indicator</td>
<td>Lifetime misuse of prescription drugs among Maine’s 18-25 year old population</td>
</tr>
<tr>
<td>Baseline Measurement</td>
<td>SFY20 – 7.3% of 18 - 25 year olds report misuse of prescription drugs in their lifetime.</td>
</tr>
<tr>
<td>First-year target/outcome measurement</td>
<td>SFY21 – 7.1% of 18 - 25 year olds misuse of prescription drugs in their lifetime.</td>
</tr>
<tr>
<td>Second-year target/outcome measurement</td>
<td>SFY22 – 6.9% of 18 - 25 year olds misuse of prescription drugs in their lifetime.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Data Source</th>
<th>Behavioral Risk Factor Surveillance System</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Indicator #</th>
<th>8</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator</td>
<td>Past 30 day use of Marijuana among Maine’s 7th – 8th grade population.</td>
</tr>
<tr>
<td>Baseline Measurement</td>
<td>SFY20 – 3.6% of 7th – 8th graders in Maine used marijuana in the past 30 days</td>
</tr>
<tr>
<td>First-year target/outcome measurement</td>
<td>SFY21– 3.5% of 7th – 8th graders in Maine/past 30 days marijuana use</td>
</tr>
<tr>
<td>Second-year target/outcome measurement</td>
<td>SFY22– 3.4% of 7th – 8th graders in Maine/past 30 days marijuana use</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Data Source</th>
<th>Maine Integrated Youth Health Survey</th>
</tr>
</thead>
</table>

Data issues/caveats that affect outcome measures:

The state has no alternative data source for this indicator for this population and data is only available every two years.
Maine Integrated Youth Health Survey

Description of Data:
This survey is conducted of all participating middle/high schools in Maine. Survey is conducted every two years with 2019 being the next implementation and reporting. Data is not yet available as of the time of this application.

Data issues/caveats that affect outcome measures:
The state has no alternative data source for this indicator for this population and data is only available every two years.

Indicator #:
9
Indicator: Past 30 days use of Marijuana among Maine’s 9th - 12th grade population.
Baseline Measurement: SFY20 – 19.3% of 9th – 12th graders used marijuana in the past 30 days.
First-year target/outcome measurement: SFY21 – 18.8% of 9th – 12th graders used marijuana in the past 30 days.
Second-year target/outcome measurement: SFY22 – 18.3% of 9th – 12th graders used marijuana in the past 30 days.

Data Source:
Maine Integrated Youth Health Survey

Description of Data:
This survey is conducted of all participating middle/high schools in Maine. Survey is conducted every two years with 2019 being the next implementation and reporting. Data is not yet available as of the time of this application.

Data issues/caveats that affect outcome measures:
The state has no alternative data source for this indicator for this population and data is only available every two years.

Indicator #:
10
Indicator: Past 30 days use of marijuana among Maine’s 18 – 25 year old population.
Baseline Measurement: SFY20 – 34.4% of 18 - 25 year olds in Maine used marijuana in the past 30 days.
First-year target/outcome measurement: SFY21 – 33.5% of 18 – 25 year olds in Maine/past 30 days of use of marijuana
Second-year target/outcome measurement: SFY22 – 32.7% of 18-25 year olds in Maine/past 30 days of use of marijuana.

Data Source:
National Survey on Drug Use and Health

Description of Data:
National Survey on Drug Use and Health is an annual survey done of all 50 states that collects data on tobacco, alcohol, and drug use, mental health and other health-related issues in the United States.

Data issues/caveats that affect outcome measures:
Receipt of survey data is delayed and not current year data.

Priority #:
2
Priority Area: Improved Outcomes for IV Drug Users
Priority Type: SAT
Population(s): PWID

Goal of the priority area:
To increase positive outcomes for IV Drug Users receiving substance use treatment through timely access and retention of services
Objective:
Assure timely access, completion of treatment services, and support services to assist and support employment

Strategies to attain the objective:
Contract deliverables prioritizing substance abuse treatment to this population with review and non-compliance enforcement.

### Annual Performance Indicators to measure goal success

<table>
<thead>
<tr>
<th>Indicator #</th>
<th>Indicators</th>
<th>Baseline Measurement</th>
<th>First-year target/outcome measurement</th>
<th>Second-year target/outcome measurement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Retention of Intravenous Drug Using (IVDU) in Outpatient Treatment for at least (4) sessions</td>
<td>SFY19 – 80% of Intravenous Drug Using (IVDU) in OP Services remained in treatment for (4) or more sessions</td>
<td>SFY20 - 85% of Intravenous Drug Using (IVDU) in OP Services remained in treatment for (4) or more sessions</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Intensive Outpatient Services and Outpatient Services will begin within seven (7) calendar days of initial contact for IVDU.</td>
<td>SFY19 – 100% of IVDU began Intensive OP or Outpatient Services within seven (7) calendar days of initial contact.</td>
<td>SFY20 – 100% of IVDU began Intensive OP or Outpatient Services within seven (7) calendar days of initial contact.</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Increase employment rate for IVDU’s individuals in Substance Abuse Treatment</td>
<td>50% of IVDU’s in substance abuse treatment are employed.</td>
<td>55% of IVDU’s in substance abuse treatment are employed.</td>
<td></td>
</tr>
</tbody>
</table>
Priority #: 3
Priority Area: Improved Outcomes for Pregnant and Parenting Women
Priority Type: SAT
Population(s): PWWDC

Goal of the priority area:
To increase positive outcomes for Pregnant and Parenting Women receiving substance use treatment through timely access and retention of services

Objective:
Assure timely access, completion of treatment services, and support services to assist and support employment

Strategies to attain the objective:
Contract deliverables prioritizing substance abuse treatment to this population with review and non-compliance enforcement.

Annual Performance Indicators to measure goal success

Indicator #:
1
Indicator: Retention of Pregnant Women in Outpatient Treatment for at least (4) sessions
Baseline Measurement: SFY19 – 80% of Pregnant Women in OP Services remained in treatment for (4) or more sessions.
First-year target/outcome measurement: SFY20 – 85% of Pregnant Women in OP Services remained in treatment for (4) or more sessions.
Second-year target/outcome measurement:

Data Source:
SAMHS Treatment Data System

Description of Data:
This is an existing measurement within our Treatment Data System

Data issues/caveats that affect outcome measures:
This population is traditionally difficult to maintain in services and providers often have very little recourse to address retention.

Indicator #:
2
Indicator: Intensive Outpatient Services and Outpatient Services will begin within seven (7) calendar days of initial contact for pregnant women.
Baseline Measurement: SFY19 – 100% of Pregnant Women began Intensive OP or Outpatient Services within seven (7) calendar days of initial contact.
First-year target/outcome measurement: SFY20 – 100% of Pregnant Women began Intensive OP or Outpatient Services within seven (7) calendar days of initial contact.
Second-year target/outcome measurement:

Data Source:
SAMHS Treatment Data System

Description of Data:
This is an existing measurement within our Treatment Data System

Data issues/caveats that affect outcome measures:
This population is traditionally difficult to maintain in services and providers often have very little recourse to address retention.
**Indicator #**: 3  
**Indicator**: Increase employment rate for pregnant and parenting women in Substance Abuse Treatment.  
**Baseline Measurement**: SFY19 – 64% of pregnant and parenting women in substance abuse treatment are employed.  
**First-year target/outcome measurement**: SFY20 – 74% of pregnant and parenting women in substance abuse treatment are employed.  
**Second-year target/outcome measurement**:  
**Data Source**: SAMHS Treatment Data System  
**Description of Data**: This is an existing measurement within our system  
**Data issues/caveats that affect outcome measures**: Resources to promote employment for substance abuse treatment individuals available via federal and state funds

---

**Priority #:** 4  
**Priority Area**: Improved Outcomes for all Individuals Receiving Substance Use Treatment  
**Priority Type**: SAT  
**Population(s)**: PWWDC, PWID, TB, Other (Adolescents w/SA and/or MH, Students in College, Criminal/Juvenile Justice, Homeless, Asian, Native Hawaiian/Other Pacific Islanders, Underserved Racial and Ethnic Minorities, Veterans)  
**Goal of the priority area**: Population(s): All individuals receiving substance use treatment.  
Goal of the priority area: To increase positive outcomes for IV Drug Users receiving substance use treatment through timely access and retention of services.  
**Data caveat**: Regarding "Other," additional populations may be able to be tracked in Treatment Data System based on existing definitions not provided here.

**Objective**:  
Assure timely access, completion of treatment services, and support services to assist and support employment

**Strategies to attain the objective**:  
Contract deliverables prioritizing substance abuse treatment to this population with review and non-compliance enforcement.

---

**Annual Performance Indicators to measure goal success**  
**Indicator #:** 1  
**Indicator**: Retention of all individuals in Outpatient Treatment for at least (4) sessions  
**Baseline Measurement**: SFY19 – 80% of Individuals in OP Services remained in treatment for (4) or more sessions  
**First-year target/outcome measurement**: SFY20 – 85% of Individuals in OP Services remained in treatment for (4) or more sessions
### Second-year target/outcome measurement:

**Data Source:**
SAMHS Treatment Data System

**Description of Data:**
This is an existing measurement within our Treatment Data System.

**Data issues/caveats that affect outcome measures:**
This population is traditionally difficult to maintain in services and providers often have very little recourse to address retention.

<table>
<thead>
<tr>
<th>Indicator #</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Indicator:</strong></td>
<td>Intensive Outpatient Services and Outpatient Services will begin within seven (7) calendar days of initial contact for MaineCare or Grant-Funded (at admission) individuals.</td>
</tr>
<tr>
<td><strong>Baseline Measurement:</strong></td>
<td>SFY19 – 100% of MaineCare or Grant-Funded (at admission) individuals began Intensive OP or Outpatient Services within seven (7) calendar days of initial contact.</td>
</tr>
<tr>
<td><strong>First-year target/outcome measurement:</strong></td>
<td>SFY20– 100% of MaineCare or Grant-Funded (at admission) individuals began Intensive OP or Outpatient Services within seven (7) calendar days of initial contact.</td>
</tr>
</tbody>
</table>

### Second-year target/outcome measurement:

**Data Source:**
SAMHS Treatment Data System

**Description of Data:**
This is an existing measurement within our system

**Data issues/caveats that affect outcome measures:**
Resources available to promote timely access into services include both state and federal funds.

<table>
<thead>
<tr>
<th>Indicator #</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Indicator:</strong></td>
<td>Increase employment rate for individuals in Substance Abuse Treatment.</td>
</tr>
<tr>
<td><strong>Baseline Measurement:</strong></td>
<td>SFY19 – 50% of individuals in substance abuse treatment are employed</td>
</tr>
<tr>
<td><strong>First-year target/outcome measurement:</strong></td>
<td>SFY20 – 55% of individuals in substance abuse treatment are employed</td>
</tr>
</tbody>
</table>
| **Second-year target/outcome measurement:**

**Data Source:**
SAMHS Treatment Data System

**Description of Data:**
This is an existing measurement within our system

**Data issues/caveats that affect outcome measures:**
Resources to promote employment for substance abuse treatment individuals available via federal and state funds.
To ensure availability of TB services for persons in substance abuse treatment services

Objective:

To increase positive outcomes for Persons at Risk for TB receiving substance use treatment through referrals and timely access to appropriate medical and support services provided by the Maine CDC or equally qualified private provider.

Strategies to attain the objective:

Collaborate with the Maine CDC to improve outreach to those in substance abuse treatment services to have TB screening and treatment services available to this population. Include in substance abuse treatment contracts with agencies language that these services (screening, testing, counseling and case management) must be made available to those in substance abuse treatment. The SSA also includes in all treatment contracts that the agencies must report all active TB cases to the Maine CDC.

Annual Performance Indicators to measure goal success

| Indicator # | 1 |
| Indicator: | Increase Substance Abuse provider referrals for TB screening and other appropriate services |
| Baseline Measurement: | SFY19 - 95% of Substance Abuse providers will refer for TB screening and services within (7) days |
| First-year target/outcome measurement: | SFY20 - 95% of Substance Abuse providers will refer for TB screening and services within (7) days |

Second-year target/outcome measurement:

Data Source:

Contract Performance Measures Reports (Quarterly)

Description of Data:

SAMHS' Contracted Substance Abuse providers will refer for TB screening and services within (7) days of admission to the Maine CDC Public Health Nursing/TB Control Program or an equally qualified provider.

Data issues/caveats that affect outcome measures:

The new Contract Performance Measures will not go into effect for SFY19 unless there is an amendment before 7/18. Also, this data is only reflective of the uninsured/grant-funded.

Footnotes:

In FY19 Maine noted a change in indicators between reports - State Level revisions may be requested at a future date.
**Planning Tables**

### Table 2 State Agency Planned Expenditures

States must project how the SSA will use available funds to provide authorized services for the planning period for state fiscal years FFY 2020/2021. ONLY include funds expended by the executive branch agency administering the SABG.

Planning Period Start Date: 7/1/2019     Planning Period End Date: 6/30/2021

<table>
<thead>
<tr>
<th>Activity (See instructions for using Row 1.)</th>
<th>A. Substance Abuse Block Grant</th>
<th>B. Mental Health Block Grant</th>
<th>C. Medicaid (Federal, State, and Local)</th>
<th>D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)</th>
<th>E. State Funds</th>
<th>F. Local Funds (excluding local Medicaid)</th>
<th>G. Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Substance Abuse Prevention* and Treatment</td>
<td>$9,658,107</td>
<td>$33,359,944</td>
<td>$3,041,138</td>
<td>$22,814,464</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>a. Pregnant Women and Women with Dependent Children*</td>
<td>$2,621,396</td>
<td>$0</td>
<td>$0</td>
<td>$2,439,052</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>b. All Other</td>
<td>$7,036,711</td>
<td>$33,359,944</td>
<td>$3,041,138</td>
<td>$20,375,412</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>2. Primary Prevention</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>a. Substance Abuse Primary Prevention</td>
<td>$3,971,859</td>
<td>$0</td>
<td>$4,095,152</td>
<td>$1,182,118</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>b. Mental Health Primary Prevention</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Evidenced Based Practices for First Episode Psychosis (10% of the state’s total MHBG award)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Tuberculosis Services</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>5. Early Intervention Services for HIV</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>6. State Hospital</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Other 24 Hour Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Ambulatory/Community Non-24 Hour Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Administration (Excluding Program and Provider Level)</td>
<td>$306,380</td>
<td>$0</td>
<td>$0</td>
<td>$3,190,692</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>10. Total</td>
<td>$13,936,346</td>
<td>$0</td>
<td>$33,359,944</td>
<td>$7,136,290</td>
<td>$27,187,274</td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>

* Prevention other than primary prevention

** The 20 percent set-aside funds in the SABG must be used for activities designed to prevent substance misuse.
In FY20 Maine increased the SAPTBG Prevention set aside to 30%
Planning Tables

Table 3 SABG Persons in need/receipt of SUD treatment

<table>
<thead>
<tr>
<th></th>
<th>Aggregate Number Estimated In Need</th>
<th>Aggregate Number In Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Pregnant Women</td>
<td>137</td>
<td>137</td>
</tr>
<tr>
<td>2. Women with Dependent Children</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>3. Individuals with a co-occurring M/SUD</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>4. Persons who inject drugs</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>5. Persons experiencing homelessness</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Please provide an explanation for any data cells for which the state does not have a data source.
1/31/20: The SSA is working with the treatment data system vendor, FEI Systems to establish Need for PWWDC, Co-Occurring, PWID and Persons experiencing Homelessness. The overall, Aggregate Number Estimated in Need in FY20 is 9,142 persons.

Footnotes:
SAMHS is currently working with FEI WITS and SUD Tx providers to provide waitlist information on a monthly basis. Once this is instituted, SAMHS will have the capability to estimate need based on those waiting for services.

*Additionally, SAMHS is reviewing past reporting, and in partnership with the State sister agencies, plans to report on the entire SUD system of care in F20/F21, and not just uninsured #s as captured by WITS above.
## Table 4 SABG Planned Expenditures

Planning Period Start Date: 10/1/2019  Planning Period End Date: 9/30/2021

<table>
<thead>
<tr>
<th>Expenditure Category</th>
<th>FFY 2020 SA Block Grant Award</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 . Substance Abuse Prevention and Treatment*</td>
<td>$4,829,054</td>
</tr>
<tr>
<td>2 . Primary Substance Abuse Prevention</td>
<td>$1,985,929</td>
</tr>
<tr>
<td>3 . Early Intervention Services for HIV**</td>
<td>$0</td>
</tr>
<tr>
<td>4 . Tuberculosis Services</td>
<td>$0</td>
</tr>
<tr>
<td>5 . Administration (SSA Level Only)</td>
<td>$153,190</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$6,968,173</strong></td>
</tr>
</tbody>
</table>

* Prevention other than Primary Prevention

** For the purpose of determining the states and jurisdictions that are considered ?designated states? as described in section 1924(b)(2) of Title XIX, Part B, Subpart II of the Public Health Service Act (42 U.S.C. § 300x-24(b)(2)) and section 45 CFR § 96.128(b) of the Substance Abuse Prevention and Treatment Block Grant; Interim Final Rule (45 CFR 96.120-137), SAMHSA relies on the HIV Surveillance Report produced by the Centers for Disease Control and Prevention (CDC), National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention. The most recent HIV Surveillance Report will be published on or before October 1 of the federal fiscal year for which a state is applying for a grant is used to determine the states and jurisdictions that will be are required to set-aside 5 percent of their respective SABG allotments to establish one or more projects to provide early intervention services for regarding the human immunodeficiency virus (EIS/HIV) at the sites at which individuals are receiving SUD treatment services. In FY 2012, SAMHSA developed and disseminated a policy change applicable to the EIS/HIV which provided any state that was a ?designated state? in any of the three years prior to the year for which a state is applying for SABG funds with the flexibility to obligate and expend SABG funds for EIS/HIV even though the state a state?s AIDS case
rate does not meet the AIDS case rate threshold for the fiscal year involved for which a state is applying for SABG funds. Therefore, any state with an AIDS case rate below 10 or more such cases per 100,000 that meets the criteria described in the 2012 policy guidance would will be allowed to obligate and expend SABG funds for EIS/HIV if they chose to do so.

Footnotes:
## Table 5a SABG Primary Prevention Planned Expenditures

Planning Period Start Date: 10/1/2019  
Planning Period End Date: 9/30/2021

<table>
<thead>
<tr>
<th>Strategy</th>
<th>IOM Target</th>
<th>A</th>
<th>B Block Grant Award</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Universal</td>
<td>$205,313</td>
<td></td>
</tr>
<tr>
<td>1. Information Dissemination</td>
<td>Selective</td>
<td>$91,250</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Indicated</td>
<td>$45,625</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Unspecified</td>
<td>$22,812</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>$365,000</td>
<td></td>
</tr>
<tr>
<td>2. Education</td>
<td>Universal</td>
<td>$57,500</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Selective</td>
<td>$28,750</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Indicated</td>
<td>$28,750</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Unspecified</td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>$115,000</td>
<td></td>
</tr>
<tr>
<td>3. Alternatives</td>
<td>Universal</td>
<td>$75,000</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Selective</td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Indicated</td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Unspecified</td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>$75,000</td>
<td></td>
</tr>
<tr>
<td>4. Problem Identification and Referral</td>
<td>Universal</td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Selective</td>
<td>$42,500</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Indicated</td>
<td>$42,500</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Unspecified</td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>$85,000</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Universal</td>
<td>$288,750</td>
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</table>
### Community-Based Process

<table>
<thead>
<tr>
<th>Type</th>
<th>Selective</th>
<th>Indicated</th>
<th>Unspecified</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Universal</td>
<td>$0</td>
<td>$0</td>
<td>$96,250</td>
<td>$385,000</td>
</tr>
<tr>
<td>Selective</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Indicated</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Unspecified</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>

### Environmental

<table>
<thead>
<tr>
<th>Type</th>
<th>Selective</th>
<th>Indicated</th>
<th>Unspecified</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Universal</td>
<td>$225,000</td>
<td>$0</td>
<td>$75,000</td>
<td>$300,000</td>
</tr>
<tr>
<td>Selective</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Indicated</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Unspecified</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>

### Section 1926 Tobacco

<table>
<thead>
<tr>
<th>Type</th>
<th>Selective</th>
<th>Indicated</th>
<th>Unspecified</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Universal</td>
<td>$100,000</td>
<td>$0</td>
<td>$0</td>
<td>$100,000</td>
</tr>
<tr>
<td>Selective</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Indicated</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Unspecified</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>

### Other

<table>
<thead>
<tr>
<th>Type</th>
<th>Selective</th>
<th>Indicated</th>
<th>Unspecified</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Universal</td>
<td>$23,391</td>
<td>$0</td>
<td>$0</td>
<td>$31,188</td>
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<tr>
<td>Selective</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Indicated</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Unspecified</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>

### Total Prevention Expenditures

<table>
<thead>
<tr>
<th>Type</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Prevention</td>
<td>$1,456,188</td>
</tr>
</tbody>
</table>

### Total SABG Award*

<table>
<thead>
<tr>
<th>Type</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total SABG Award</td>
<td>$6,968,173</td>
</tr>
</tbody>
</table>

### Planned Primary Prevention Percentage

<table>
<thead>
<tr>
<th>Type</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planned Primary</td>
<td>20.90 %</td>
</tr>
</tbody>
</table>

*Total SABG Award is populated from Table 4 - SABG Planned Expenditures

0930-0378 Approved: 09/11/2017 Expires: 09/30/2020

**Footnotes:**

This table reflects primary prevention expenditures in the amount of $1,456,188. Resource Development primary prevention expenditures are $529,939 totaling $1,986,127 for primary prevention expenditures.
### Table 5b SABG Primary Prevention Planned Expenditures by IOM Category

**Planning Period Start Date:** 10/1/2019  
**Planning Period End Date:** 9/30/2021

<table>
<thead>
<tr>
<th>Activity</th>
<th>FFY 2020 SA Block Grant Award</th>
</tr>
</thead>
<tbody>
<tr>
<td>Universal Direct</td>
<td>$826,678</td>
</tr>
<tr>
<td>Universal Indirect</td>
<td>$350,135</td>
</tr>
<tr>
<td>Selective</td>
<td>$162,500</td>
</tr>
<tr>
<td>Indicated</td>
<td>$116,875</td>
</tr>
<tr>
<td><strong>Column Total</strong></td>
<td><strong>$1,456,188</strong></td>
</tr>
<tr>
<td><strong>Total SABG Award</strong></td>
<td><strong>$6,968,173</strong></td>
</tr>
<tr>
<td><strong>Planned Primary Prevention Percentage</strong></td>
<td><strong>20.90 %</strong></td>
</tr>
</tbody>
</table>

*Total SABG Award is populated from Table 4 - SABG Planned Expenditures*

0930-0378 Approved: 09/11/2017 Expires: 09/30/2020

**Footnotes:**
### Table 5c SABG Planned Primary Prevention Targeted Priorities

States should identify the categories of substances the state BG plans to target with primary prevention set-aside dollars from the FFY 2020 and FFY 2021 SABG awards.

**Planning Period Start Date:** 10/1/2019  
**Planning Period End Date:** 9/30/2021

<table>
<thead>
<tr>
<th>Targeted Substances</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
</tr>
<tr>
<td>Tobacco</td>
</tr>
<tr>
<td>Marijuana</td>
</tr>
<tr>
<td>Prescription Drugs</td>
</tr>
<tr>
<td>Cocaine</td>
</tr>
<tr>
<td>Heroin</td>
</tr>
<tr>
<td>Inhalants</td>
</tr>
<tr>
<td>Methamphetamine</td>
</tr>
<tr>
<td>Synthetic Drugs (i.e. Bath salts, Spice, K2)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Targeted Populations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Students in College</td>
</tr>
<tr>
<td>Military Families</td>
</tr>
<tr>
<td>LGBTQ</td>
</tr>
<tr>
<td>American Indians/Alaska Natives</td>
</tr>
<tr>
<td>African American</td>
</tr>
<tr>
<td>Hispanic</td>
</tr>
<tr>
<td>Homeless</td>
</tr>
<tr>
<td>Native Hawaiian/Other Pacific Islanders</td>
</tr>
<tr>
<td>Asian</td>
</tr>
<tr>
<td>Rural</td>
</tr>
<tr>
<td>Underserved Racial and Ethnic Minorities</td>
</tr>
</tbody>
</table>
## Planning Tables

### Table 6 Non-Direct Services/System Development [SA]

Planning Period Start Date: 10/1/2019   Planning Period End Date: 9/30/2021

<table>
<thead>
<tr>
<th>Activity</th>
<th>A. SABG Treatment</th>
<th>B. SABG Prevention</th>
<th>C. SABG Combined*</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Information Systems</td>
<td></td>
<td>$55,540</td>
<td></td>
</tr>
<tr>
<td>2. Infrastructure Support</td>
<td></td>
<td>$114,274</td>
<td></td>
</tr>
<tr>
<td>3. Partnerships, community outreach, and needs assessment</td>
<td></td>
<td></td>
<td>$20,000</td>
</tr>
<tr>
<td>4. Planning Council Activities (MHBG required, SABG optional)</td>
<td>$38,000</td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td>5. Quality Assurance and Improvement</td>
<td>$408,500</td>
<td>$235,125</td>
<td></td>
</tr>
<tr>
<td>6. Research and Evaluation</td>
<td></td>
<td>$30,000</td>
<td></td>
</tr>
<tr>
<td>7. Training and Education</td>
<td>$503,500</td>
<td>$75,000</td>
<td></td>
</tr>
<tr>
<td><strong>8. Total</strong></td>
<td><strong>$950,000</strong></td>
<td><strong>$529,939</strong></td>
<td><strong>$0</strong></td>
</tr>
</tbody>
</table>

*Combined refers to non-direct service/system development expenditures that support both treatment and prevention systems.

0930-0378 Approved: 09/11/2017 Expires: 09/30/2020
Footnotes:
Resource development expenditures for primary prevention is $529,939. Expenditures for other Primary Prevention activities as indicated in table 5a is $1,456,188 totaling $1,986,127 for primary prevention.
Environmental Factors and Plan

1. The Health Care System, Parity and Integration - Question 1 and 2 are Required

Narrative Question

Persons with mental illness and persons with substance use disorders are likely to die earlier than those who do not have these conditions. Early mortality is associated with broader health disparities and health equity issues such as socioeconomic status but “[h]ealth system factors" such as access to care also play an important role in morbidity and mortality among these populations. Persons with mental illness and substance use disorders may benefit from strategies to control weight, encourage exercise, and properly treat such chronic health conditions as diabetes and cardiovascular disease. It has been acknowledged that there is a high rate of co-occurring M/SUD, with appropriate treatment required for both conditions.

Currently, 50 states have organizationally consolidated their mental and substance use disorder authorities in one fashion or another with additional organizational changes under consideration. More broadly, SAMHSA and its federal partners understand that such factors as education, housing, and nutrition strongly affect the overall health and well-being of persons with mental illness and substance use disorders. SMHAs and SSAs may wish to develop and support partnerships and programs to help address social determinants of health and advance overall health equity. For instance, some organizations have established medical-legal partnerships to assist persons with mental and substance use disorders in meeting their housing, employment, and education needs.

Health care professionals and persons who access M/SUD treatment services recognize the need for improved coordination of care and integration of physical and M/SUD with other health care in primary, specialty, emergency and rehabilitative care settings in the community. For instance, the National Alliance for Mental Illness has published materials for members to assist them in coordinating pediatric mental health and primary care.

SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders. The state should illustrate movement towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders. The plan should describe attention to management, funding, payment strategies that foster co-occurring capability for services to individuals and families with co-occurring mental and substance use disorders. Strategies supported by SAMHSA to foster integration of physical and M/SUD include: developing models for inclusion of M/SUD treatment in primary care; supporting innovative payment and financing strategies and delivery system reforms such as ACOs, health homes, pay for performance, etc.; promoting workforce recruitment, retention and training efforts; improving understanding of financial sustainability and billing requirements; encouraging collaboration between M/SUD providers, prevention of teen pregnancy, youth violence, Medicaid programs, and primary care providers such as Federally Qualified Health Centers; and sharing with consumers information about the full range of health and wellness programs.

Health information technology, including EHRs and telehealth are examples of important strategies to promote integrated care. Use of EHRs - in full compliance with applicable legal requirements - may allow providers to share information, coordinate care, and improve billing practices. Telehealth is another important tool that may allow M/SUD prevention, treatment, and recovery to be conveniently provided in a variety of settings, helping to expand access, improve efficiency, save time, and reduce costs. Development and use of models for coordinated, integrated care such as those found in health homes and ACOs may be important strategies used by SMHAs and SSAs to foster integrated care.

Training and assisting M/SUD providers to redesign or implement new provider billing practices, build capacity for third-party contract negotiations, collaborate with health clinics and other organizations and provider networks, and coordinate benefits among multiple funding sources may be important ways to foster integrated care. SAMHSA encourages SMHAs and SSAs to communicate frequently with stakeholders, including policymakers at the state/jurisdictional and local levels, and State Mental Health Planning Council members and consumers, about efforts to foster health care coverage, access and integrate care to ensure beneficial outcomes.

SMHAs and SSAs also may work with state Medicaid agencies, state insurance commissioners, and professional organizations to encourage development of innovative demonstration projects, alternative payment methodologies, and waivers/state plan amendments that test approaches to providing integrated care for persons with M/SUD and other vulnerable populations. Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.

One key population of concern is persons who are dually eligible for Medicare and Medicaid. Roughly, 30 percent of persons who are dually eligible have been diagnosed with a mental illness, more than three times the rate among those who are not dually eligible. SMHAs and SSAs also should collaborate with state Medicaid agencies and state insurance commissioners to develop policies to assist those individuals who experience health insurance coverage eligibility changes due to shifts in income and employment. Moreover, even with expanded health coverage available through the Marketplace and Medicaid and efforts to ensure parity in health care coverage, persons with M/SUD conditions still may experience challenges in some areas in obtaining care for a particular condition or in finding a provider. SMHAs and SSAs should remain cognizant that health disparities may affect access, health care coverage and integrated care of M/SUD conditions and work with
partners to mitigate regional and local variations in services that detrimentally affect access to care and integration. SMHAs and SSAs should work with partners to ensure recruitment of diverse, well-trained staff and promote workforce development and ability to function in an integrated care environment. Psychiatrists, psychologists, social workers, addiction counselors, preventionists, therapists, technicians, peer support specialists, and others will need to understand integrated care models, concepts, and practices.

Parity is vital to ensuring persons with mental health conditions and substance use disorders receive continuous, coordinated, care. Increasing public awareness about MHPAEA could increase access to M/SUD services, provide financial benefits to individuals and families, and lead to reduced confusion and discrimination associated with mental illness and substance use disorders. Block grant recipients should continue to monitor federal parity regulations and guidance and collaborate with state Medicaid authorities, insurance regulators, insurers, employers, providers, consumers and policymakers to ensure effective parity implementation and comprehensive, consistent communication with stakeholders. The SSAs, SMHAs and their partners may wish to pursue strategies to provide information, education, and technical assistance on parity-related issues. Medicaid programs will be a key partner for recipients of MHBG and SABG funds and providers supported by these funds. The SSAs and SMHAs should collaborate with their states’ Medicaid authority in ensuring parity within Medicaid programs. SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action, states can develop communication plans to provide and address key issues.

Another key part of integration will be defining performance and outcome measures. The Department of Health and Human Services (HHS) and partners have developed the National Quality Strategy, which includes information and resources to help promote health, good outcomes, and patient engagement. SAMHSA’s National Behavioral Health Quality Framework includes core measures that may be used by providers and payers. SAMHSA recognizes that certain jurisdictions receiving block grant funds - including U.S. Territories, tribal entities and those jurisdictions that have signed a Compact of Free Association with the United States and are uniquely impacted by certain Medicaid provisions or are ineligible to participate in certain programs. However, these jurisdictions should collaborate with federal agencies and their governmental and non-governmental partners to expand access and coverage. Furthermore, the jurisdiction should ensure integration of prevention, treatment, and recovery support for persons with, or at risk of, mental and substance use disorders.

26 http://www.samhsa.gov/health-disparities/strategic-initiatives

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Please respond to the following items in order to provide a description of the healthcare system and integration activities:

1. Describe how the state integrates mental health and primary health care, including services for individuals with co-occurring mental and substance use disorders, in primary care settings or arrangements to provide primary and specialty care services in community-based mental and substance use disorders settings.

   Individuals with M/SUD’s have a complex set of needs that are best addressed through an integrated approach to treatment that includes assessment, diagnosis, treatment planning, psychosocial treatment, medication monitoring, referrals and on-going recovery supports which are offered through the Opioid Health Home model in Maine. Specifically, our uninsured have access to Opiate Health Home levels of care which have been designed from the ground up to integrate primary care with behavioral health care. The wrap-around, team based approach to care concepts are embedded into MaineCare/Medicaid rule for both the Health Home models and are designed with the expectation of a comprehensive care management system that pro-actively links recipients of care to both Primary and Behavioral health treatments. In addition to the explicit incorporation of Peer supports in the Opioid model, it also identifies and values shared decision making, health promotion, individual and family support, and referrals to community and natural supports.

2. Describe how the state provides services and supports towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders, including management, funding, payment strategies that foster co-occurring capability.


   These innovative Health Home models are already formally established in MaineCare/Medicaid rule that has been developed jointly with the Office of MaineCare Services and the Office of Substance Abuse and Mental Health Services. Both the Behavioral and Opioid Health Home models provide a fully integrated, evidence based approach in response to earlier studies in Maine and across the nation indicating that persons with mental illness and substance use disorders are dying 25 years younger than their socioeconomic peers. Access to a proactively linked behavioral health and primary care setting for our targeted population groups is an imperative in improving health outcomes for all Mainers including the uninsured. All contractual reimbursement for the uninsured participating in these models is identical to the MaineCare reimbursement models embedded in existing rule so that consumers can receive the same high quality, level of care.

3. a) Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs?

   Yes

   No

   b) Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through Medicaid?

   Yes

   No

4. Who is responsible for monitoring access to M/SUD services by the QHP?

   [ ]

   [ ]
5. Is the SSA/SMHA involved in any coordinated care initiatives in the state?  
- Yes  - No

6. Do the M/SUD providers screen and refer for:
   a) Prevention and wellness education  
   - Yes  - No
   b) Health risks such as
      i) heart disease  
      - Yes  - No
      iii) hypertension  
      - Yes  - No
   iv) high cholesterol  
     - Yes  - No
   v) diabetes  
     - Yes  - No
   c) Recovery supports  
     - Yes  - No

7. Is the SSA/SMHA involved in the development of alternative payment methodologies, including risk-based contractual relationships that advance coordination of care?  
- Yes  - No

8. Is the SSA and SMHA involved in the implementation and enforcement of parity protections for mental and substance use disorder services?  
- Yes  - No

9. What are the issues or problems that your state is facing related to the implementation and enforcement of parity provisions?

10. Does the state have any activities related to this section that you would like to highlight?

   Please indicate areas of technical assistance needed related to this section

Footnotes:
Environmental Factors and Plan

2. Health Disparities - Requested

Narrative Question

In accordance with the HHS Action Plan to Reduce Racial and Ethnic Health Disparities\textsuperscript{42}, Healthy People, 2020\textsuperscript{43}, National Stakeholder Strategy for Achieving Health Equity\textsuperscript{44}, and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and M/SUD outcomes among individuals of all cultures, sexual/gender minorities, orientation and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (i.e., racial, ethnic, limited English speaking, tribal, sexual/gender minority groups, etc.) vulnerable to health disparities and (2) implement strategies to decrease the disparities in access, service use, and outcomes both within those subpopulations and in comparison to the general population. One strategy for addressing health disparities is use of the recently revised National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS)\textsuperscript{45}.

The Action Plan to Reduce Racial and Ethnic Health Disparities, which the HHS Secretary released in April 2011, outlines goals and actions that HHS agencies, including SAMHSA, will take to reduce health disparities among racial and ethnic minorities. Agencies are required to assess the impact of their policies and programs on health disparities.

The HHS Secretary’s top priority in the Action Plan is to “assess and heighten the impact of all HHS policies, programs, processes, and resource decisions to reduce health disparities. HHS leadership will assure that program grantees, as applicable, will be required to submit health disparity impact statements as part of their grant applications. Such statements can inform future HHS investments and policy goals, and in some instances, could be used to score grant applications if underlying program authority permits.”\textsuperscript{46}

Collecting appropriate data is a critical part of efforts to reduce health disparities and promote equity. In October 2011, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status\textsuperscript{47}. This guidance conforms to the existing Office of Management and Budget (OMB) directive on racial/ethnic categories with the expansion of intra-group, detailed data for the Latino and the Asian-American/Pacific Islander populations\textsuperscript{48}. In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA’s and HHS’s attention to special service needs and disparities within tribal populations, LGBTQ populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide M/SUD services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence-based and promising practices in a manner that meets the needs of the populations they serve.

In the block grant application, states define the populations they intend to serve. Within these populations of focus are subpopulations that may have disparate access to, use of, or outcomes from provided services. These disparities may be the result of differences in insurance coverage, language, beliefs, norms, values, and/or socioeconomic factors specific to that subpopulation. For instance, lack of Spanish primary care services may contribute to a heightened risk for metabolic disorders among Latino adults with SMI; and American Indian/Alaska Native youth may have an increased incidence of underage binge drinking due to coping patterns related to historical trauma within the American Indian/Alaska Native community. While these factors might not be pervasive among the general population served by the block grant, they may be predominant among subpopulations or groups vulnerable to disparities.

To address and ultimately reduce disparities, it is important for states to have a detailed understanding of who is and is not being served within the community, including in what languages, in order to implement appropriate outreach and engagement strategies for diverse populations. The types of services provided, retention in services, and outcomes are critical measures of quality and outcomes of care for diverse groups. For states to address the potentially disparate impact of their block grant funded efforts, they will address access, use, and outcomes for subpopulations.

44 https://www.minorityhealth.hhs.gov/npa/files/plans/NSS/NSS_07_Section3.pdf
45 http://www.ThinkCulturalHealth.hhs.gov
Please respond to the following items:

1. Does the state track access or enrollment in services, types of services received and outcomes of these services by: race, ethnicity, gender, sexual orientation, gender identity, and age?
   - Race [ ] Yes  [ ] No
   - Ethnicity [ ] Yes  [ ] No
   - Gender [ ] Yes  [ ] No
   - Sexual orientation [ ] Yes  [ ] No
   - Gender identity [ ] Yes  [ ] No
   - Age [ ] Yes  [ ] No

2. Does the state have a data-driven plan to address and reduce disparities in access, service use and outcomes for the above sub-population?
   [ ] Yes  [ ] No

3. Does the state have a plan to identify, address and monitor linguistic disparities/language barriers?
   [ ] Yes  [ ] No

4. Does the state have a workforce-training plan to build the capacity of M/SUD providers to identify disparities in access, services received, and outcomes and provide support for improved culturally and linguistically competent outreach, engagement, prevention, treatment, and recovery services for diverse populations?
   [ ] Yes  [ ] No

5. If yes, does this plan include the Culturally and Linguistically Appropriate Services (CLAS) Standards?
   [ ] Yes  [ ] No

6. Does the state have a budget item allocated to identifying and remediating disparities in M/SUD care?
   [ ] Yes  [ ] No

7. Does the state have any activities related to this section that you would like to highlight?
   On November 6, 2012, Maine citizens were among the first in the country in voting to approve Marriage Equality for all. This substantial support and recognition of diversity in our state is further demonstrated by Maine’s Department of Health and Human Services’ Office of Multicultural Affairs.
   In order to improve services to racial, ethnic, linguistic minorities, and specific cultural subpopulations in Maine, DHHS with the support of the Governor’s Office, strategically established the Office of Multicultural Affairs (OMA). The Office provides support to state agencies, non-governmental organizations, and community partners in order to develop sustainable projects and initiatives that will address the needs of the above mentioned multicultural communities. SAMHS implements the recommendations of OMA Sub-Cabinet, acknowledging the importance and need to provide strategic planning, policy development and program implementation of services to Maine residents who belong to racial, ethnic, linguistic, and specific cultural subpopulation minorities. These services assist recipients in the achieving educational, financial, and social self-sufficiency. SAMHS promotes mutual cooperation, exchange, and understanding among the various populations served which is vital to the provision of meaningful and effective service delivery.
   SAMHS also requires via the Substance Abuse and Mental Health Services contracts Language Access that includes Interpretation Services (Communication Access), Accessibility for the Deaf and Hard of Hearing, and provider responsibilities for the Deaf and/or Severely Hard of Hearing and/or nonverbal.
   Providers conduct bio-social-psychological assessments upon intake with clients that include a domain related to physical health and mental health. They are also required to screen for TB and HIV and refer out for services (if they do not provide them). As part of the treatment plan they discuss wellness and prevention skills.
   As a clarification to Question 1, Maine’s data system, WITS, tracks enrollment in various types of services. Although WITS could track language services, this field is not required by SAMHS of providers. The outcomes listed may be tracked with the exception of sexual orientation and gender identity.
   Office of Health Equity In addition, Maine DHHS’s Center for Disease Control and Prevention’s Office of Health Equity was established in 2006, with the goal of achieving the highest level of health for all people regardless of differences in social, economic or environmental conditions. The Office of Health Equity is comprised of four separate groups that focus on a specific area in the public health domain:
   • Maine Families Home Visiting
   • Women, Infants and Children (WIC)
   • Minority Health & Special Populations
   • Women’s Health
   Maine’s Office of Health Equity program addresses disease prevention, health promotion, risk reduction, healthier lifestyle

References:
choices, use of health care services, and barriers to health care. The office also:
1. Promotes the collection of health data by racial, ethnic, gender, LGBT, age, and primary language categories and strengthening infrastructure for data collection, reporting, and sharing;
2. Works to increase awareness of the major health problems of racial and ethnic minorities and factors that influence health;
3. Establishes and strengthens networks, coalitions, and partnerships to identify and solve health problems; develops and promotes policies, programs, and practices to eliminate health disparities and achieve health equality; and
4. Provides technical assistance, training, and seminars.

In order to accomplish the goals of this Office, the overall approach is to effect system changes within the Maine Center for Disease Control & Prevention (Maine CDC), the Department of Health and Human Services (DHHS), grantee agencies, and community partners. The primary strategies are leadership engagement and community collaboration. We work with, and fully engage with communities to address health inequities for its vulnerable populations; taking the knowledge and information obtained through our engagement with the communities back to the legislature and policy makers.

Please indicate areas of technical assistance needed related to this section

Footnotes:
Environmental Factors and Plan

3. Innovation in Purchasing Decisions - Requested

Narrative Question

While there are different ways to define value-based purchasing, its purpose is to identify services, payment arrangements, incentives, and players that can be included in directed strategies using purchasing practices that are aimed at improving the value of health care services. In short, health care value is a function of both cost and quality:

Health Care Value = Quality ÷ Cost, \( V = \frac{Q}{C} \)

SAMHSA anticipates that the movement toward value based purchasing will continue as delivery system reforms continue to shape states systems. The identification and replication of such value-based strategies and structures will be important to the development of M/SUD systems and services.

There is increased interest in having a better understanding of the evidence that supports the delivery of medical and specialty care including M/SUD services. Over the past several years, SAMHSA has collaborated with CMS, HRSA, SMAs, state M/SUD authorities, legislators, and others regarding the evidence of various mental and substance misuse prevention, treatment, and recovery support services. States and other purchasers are requesting information on evidence-based practices or other procedures that result in better health outcomes for individuals and the general population. While the emphasis on evidence-based practices will continue, there is a need to develop and create new interventions and technologies and in turn, to establish the evidence. SAMHSA supports states’ use of the block grants for this purpose. The NQF and the IOM recommend that evidence play a critical role in designing health benefits for individuals enrolled in commercial insurance, Medicaid, and Medicare.

To respond to these inquiries and recommendations, SAMHSA has undertaken several activities. SAMHSA’s Evidence Based Practices Resource Center assesses the research evaluating an intervention’s impact on outcomes and provides information on available resources to facilitate the effective dissemination and implementation of the program. SAMHSA’s Evidence-Based Practices Resource Center provides the information & tools needed to incorporate evidence-based practices into communities or clinical settings.

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions for individuals with mental illness and substance use disorders, including youth and adults with chronic addiction disorders, adults with SMI, and children and youth with SED. The evidence builds on the evidence and consensus standards that have been developed in many national reports over the last decade or more. These include reports by the Surgeon General, The New Freedom Commission on Mental Health, the IOM, NQF, and the Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC). The activity included a systematic assessment of the current research findings for the effectiveness of the services using a strict set of evidentiary standards. This series of assessments was published in “Psychiatry Online.”

SAMHSA and other federal partners, the HHS’ Administration for Children and Families, Office for Civil Rights, and CMS, have used this information to sponsor technical expert panels that provide specific recommendations to the M/SUD field regarding what the evidence indicates works and for whom, to identify specific strategies for embedding these practices in provider organizations, and to recommend additional service research.

In addition to evidence-based practices, there are also many promising practices in various stages of development. Anecdotal evidence and program data indicate effectiveness for these services. As these practices continue to be evaluated, the evidence is collected to establish their efficacy and to advance the knowledge of the field.

SAMHSA’s Treatment Improvement Protocol Series (TIPS) are best practice guidelines for the SUD treatment. SAMHSA draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPS, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPS is expanding beyond public and private SUD treatment facilities as alcohol and other drug disorders are increasingly recognized as a major health problem.

SAMHSA’s Evidence-Based Practice Knowledge Informing Transformation (KIT) was developed to help move the latest information available on effective M/SUD practices into community-based service delivery. States, communities, administrators, practitioners, consumers of mental health care, and their family members can use KIT to design and implement M/SUD practices that work. KIT covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice demonstration videos, and training manuals. Each KIT outlines the essential components of the evidence-based practice and provides suggestions collected from those who have successfully implemented them.
SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is concerned with what additional information is needed by SMHAs and SSAs in their efforts to continue to shape their and other purchasers’ decisions regarding M/SUD services.

1. Is information used regarding evidence-based or promising practices in your purchasing or policy decisions?  
   - Yes  
   - No

2. Which value based purchasing strategies do you use in your state (check all that apply):
   - a) Leadership support, including investment of human and financial resources.
   - b) Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.
   - c) Use of financial and non-financial incentives for providers or consumers.
   - d) Provider involvement in planning value-based purchasing.
   - e) Use of accurate and reliable measures of quality in payment arrangements.
   - f) Quality measures focus on consumer outcomes rather than care processes.
   - g) Involvement in CMS or commercial insurance value based purchasing programs (health homes, ACO, all payer/global payments, pay for performance (P4P)).
   - h) The state has an evaluation plan to assess the impact of its purchasing decisions.

3. Does the state have any activities related to this section that you would like to highlight?

   Behavioral Health Homes and Opioid Health Homes are able to link behavioral health and primary care. This allows for information sharing and results in a more comprehensive plan of care for each unique individual.

   Please indicate areas of technical assistance needed related to this section.

   Information technology/infrastructure support would help Maine’s overall integration to support uninsured populations. The prohibition of information sharing as a result of 42 C.F.R. Part 2 is a barrier to service delivery; any assistance offered pertaining to this challenge would be appreciated.

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Footnotes:


50 The President’s New Freedom Commission on Mental Health (July 2003). Achieving the Promise: Transforming Mental Health Care in America. Rockville, MD: Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.


53 http://psychiatryonline.org/

54 http://store.samhsa.gov

55 http://store.samhsa.gov/shin/content//SMA08-4367/HowtoUseEBPKITS-ITC.pdf
Environmental Factors and Plan

6. Program Integrity - Required

Narrative Question

SAMHSA has placed a strong emphasis on ensuring that block grant funds are expended in a manner consistent with the statutory and regulatory framework. This requires that SAMHSA and the states have a strong approach to assuring program integrity. Currently, the primary goals of SAMHSA program integrity efforts are to promote the proper expenditure of block grant funds, improve block grant program compliance nationally, and demonstrate the effective use of block grant funds.

While some states have indicated an interest in using block grant funds for individual co-pays, deductibles and other types of co-insurance for M/SUD services, SAMHSA reminds states of restrictions on the use of block grant funds outlined in 42 U.S.C. §§ 300x-5 and 300x-31, including cash payments to intended recipients of health services and providing financial assistance to any entity other than a public or nonprofit private entity. Under 42 U.S.C. § 300x-55(g), SAMHSA periodically conducts site visits to MHBG and SABG grantees to evaluate program and fiscal management. States will need to develop specific policies and procedures for assuring compliance with the funding requirements. Since MHBG funds can only be used for authorized services made available to adults with SMI and children with SED and SABG funds can only be used for individuals with or at risk for SUD. SAMHSA guidance on the use of block grant funding for co-pays, deductibles, and premiums can be found at: http://www.samhsa.gov/sites/default/files/grants/guidance-for-block-grant-funds-for-cost-sharing-assistance-for-private-health-insurance.pdf. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The MHBG and SABG resources are to be used to support, not supplant, services that will be covered through the private and public insurance. In addition, SAMHSA will work with CMS and states to identify strategies for sharing data, protocols, and information to assist our program integrity efforts. Data collection, analysis, and reporting will help to ensure that MHBG and SABG funds are allocated to support evidence-based, culturally competent programs, substance use disorder prevention, treatment and recovery programs, and activities for adults with SMI and children with SED.

States traditionally have employed a variety of strategies to procure and pay for M/SUD services funded by the MHBG and SABG. State systems for procurement, contract management, financial reporting, and audit vary significantly. These strategies may include: (1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including essential health benefits (EHBs) as per the state benchmark plan; (2) ensuring that individuals are aware of the covered M/SUD benefits; (3) ensuring that consumers of M/SUD services have full confidence in the confidentiality of their medical information; and (4) monitoring the use of M/SUD benefits in light of utilization review, medical necessity, etc. Consequently, states may have to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment.

Please respond to the following items:

1. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers?  
   [ ] Yes  [ ] No

2. Does the state provide technical assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards?  
   [ ] Yes  [ ] No

3. Does the state have any activities related to this section that you would like to highlight?
   Please indicate areas of technical assistance needed related to this section

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Footnotes:
Environmental Factors and Plan

7. Tribes - Requested

Narrative Question

The federal government has a unique obligation to help improve the health of American Indians and Alaska Natives through the various health and human services programs administered by HHS. Treaties, federal legislation, regulations, executive orders, and Presidential memoranda support and define the relationship of the federal government with federally recognized tribes, which is derived from the political and legal relationship that Indian tribes have with the federal government and is not based upon race. SAMHSA is required by the 2009 Memorandum on Tribal Consultation to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications.

Improving the health and well-being of tribal nations is contingent upon understanding their specific needs. Tribal consultation is an essential tool in achieving that understanding. Consultation is an enhanced form of communication, which emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information and opinion among parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process that results in effective collaboration and informed decision-making with the ultimate goal of reaching consensus on issues.

In the context of the block grant funds awarded to tribes, SAMHSA views consultation as a government-to-government interaction and should be distinguished from input provided by individual tribal members or services provided for tribal members whether on or off tribal lands. Therefore, the interaction should be attended by elected officials of the tribe or their designees and by the highest possible state officials. As states administer health and human services programs that are supported with federal funding, it is imperative that they consult with tribes to ensure the programs meet the needs of the tribes in the state. In addition to general stakeholder consultation, states should establish, implement, and document a process for consultation with the federally recognized tribal governments located within or governing tribal lands within their borders to solicit their input during the block grant planning process. Evidence that these actions have been performed by the state should be reflected throughout the state’s plan. Additionally, it is important to note that approximately 70 percent of American Indians and Alaska Natives do not live on tribal lands. The SMHAs, SSAs and tribes should collaborate to ensure access and culturally competent care for all American Indians and Alaska Natives in the states.

States shall not require any tribe to waive its sovereign immunity in order to receive funds or for services to be provided for tribal members on tribal lands. If a state does not have any federally recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect.

56 https://www.energy.gov/sites/prod/files/Presidential%20Memorandum%20Tribal%20Consultation%20%282009%29.pdf

Please respond to the following items:

1. How many consultation sessions has the state conducted with federally recognized tribes?
   1

2. What specific concerns were raised during the consultation session(s) noted above?

   SAMHSA conducts an annual site review of this contract, the most recent one completed on 9/20/17. Compliance with contract requirements was reviewed at that time and SABG requirements were discussed in detail with clinical and executive staffs. Additionally, SAMHS staff remains in close email and phone contact with the Passamaquoddy Health Center treatment staff throughout the year. The issue of confidentiality and historic trauma was raised by the executive director during the recent site review. This issue has been referred to the SAMHS director for discussion. SAMHS is considering a training regarding cultural issues and working with the tribes. Technical assistance in this Treatment area would be welcome.

3. Does the state have any activities related to this section that you would like to highlight?

   The State of Maine, through the Department of Health and Human Services, Maine Center of Disease Control and Prevention has created a Public Health Infrastructure in the state of Maine consisting of 8 geographical Public Health Districts encompassing the entire state, and one Tribal Health District encompassing all of the Tribes in Maine. Through this Public Health Infrastructure, the state is able to dispense funds and funding opportunities to deliver services; Substance Abuse Prevention Services being one. The tribes in Maine have had representation on a variety of SAMHS workgroup and through this effort, partnering with the tribes through the work done through the Tribal Public Health District; SAMHS continues to have conversations, discussions, and providing support to the tribes to address substance abuse issues within the tribal communities and with its people. In the area of Prevention, SAMHS has historically provided funding to the 5 tribal communities that exist in Maine for substance abuse prevention services through the Tribal Public Health District. With that, there are representatives from the tribes that serve on several of SAMHS workgroups including Prevention Advisory Board and Marijuana Workgroup. SAMHS has no technical assistance needs with regards to prevention services with the tribes.
SAMHS is working with internally established liaisons for collaboration and input from the tribes on both our Mental Health and Substance Abuse Prevention and Treatment Block Grants. Staff within our office is already sharing information and ideas regarding improving linkages with the Tribal communities in Maine. The consumer run, Quality Improvement Council has also reach out to the Maine Tribal community for their representation and membership on the QIC. More work needs to be done in this arena and both the QIC and SAMHS continue to proactively conduct outreach to Maine’s tribal communities.

There are four Native federally recognized Indian tribes in Maine: Maliseet, Passamaquoddy, Penobscot and Micmac, collectively known as the Wabanaki. Most of the native population of Maine resides on tribal land, although there are others who live in Maine’s towns and cities. Each tribe maintains their own government, land, resources, schools, and cultural centers. Three of them have their own health centers.

Two of the tribes (three facilities) are licensed by the State of Maine to provide substance abuse treatment services. SAMHS has a substance abuse treatment contract with the Passamaquoddy Tribe of Indian Township. The contract, in the amount $50,000, is funded by State General Funds and Substance Abuse Block Grant funds. Outpatient substance abuse treatment services are provided at the Passamaquoddy Health Center (PHC) located at Indian Township, Princeton, Maine.

Please indicate areas of technical assistance needed related to this section.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022
Environmental Factors and Plan

8. Primary Prevention - Required SABG

Narrative Question
SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. **Information Dissemination** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;

2. **Education** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;

3. **Alternative programs** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;

4. **Problem Identification** and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;

5. **Community-based Process** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and

6. **Environmental Strategies** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Please respond to the following items

Assessment

1. Does your state have an active State Epidemiological and Outcomes Workgroup (SEOW)?

2. Does your state collect the following types of data as part of its primary prevention needs assessment process? (check all that apply)

   a) Yes ☐ ☐ No
   b) Yes ☐ ☐ No
   c) Yes ☐ ☐ No
   d) Yes ☐ ☐ No

3. Does your state collect needs assessment data that include analysis of primary prevention needs for the following population groups? (check all that apply)

   ✔ Children (under age 12)
   ✔ Youth (ages 12-17)
   ✔ Young adults/college age (ages 18-26)
   ✔ Adults (ages 27-54)
   ✔ Older adults (age 55 and above)
   ✔ Cultural/ethnic minorities
   ✔ Sexual/gender minorities
   ✔ Rural communities
   ✔ Others (please list)

4. Does your state use data from the following sources in its Primary prevention needs assessment? (check all that apply)
Archival indicators (Please list)

- National survey on Drug Use and Health (NSDUH)
- Behavioral Risk Factor Surveillance System (BRFSS)
- Youth Risk Behavioral Surveillance System (YRBS)
- Monitoring the Future
- Communities that Care
- State - developed survey instrument
- Others (please list)

5. Does your state use assessment data to make decisions about the allocation of SABG primary prevention funds?

   If yes, (please explain)
   
   Data is reviewed by both state and community providers and strategies are selected based on trends and needs identified at the state and community levels. Community providers are required to utilize the Strategic Prevention Framework (SPF) in order to make decisions about interventions that will be implemented. State level staff review data and also follow the SPF model to make decisions about what programming is necessary to impact change across the state.

   If no, (please explain) how SABG funds are allocated:
SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. **Information Dissemination** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals, families, and communities;

2. **Education** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;

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5. **Community-based Process** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and

6. **Environmental Strategies** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

### Capacity Building

1. **Does your state have a statewide licensing or certification program for the substance use disorder prevention workforce?**

   If yes, please describe

   The state has the Maine Prevention Certification Board and any providers receiving funding from the state must carry this credential. For more information visit: [https://mainepreventioncertification.org/](https://mainepreventioncertification.org/)

2. **Does your state have a formal mechanism to provide training and technical assistance to the substance use disorder prevention workforce?**

   If yes, please describe mechanism used

   The state contracts with AdCare Educational Institute to provide training to prevention specialists across Maine. The state also provides a statewide conference for prevention specialists to provide the most up to date trends and best practice in order to enhance workforce skills. With that, in the current prevention structure (Maine Prevention Services) Domain (contract) leads oversee sub-recipient contracts and provide training and technical assistance to community partners.

3. **Does your state have a formal mechanism to assess community readiness to implement prevention strategies?**

   If yes, please describe mechanism used

   The Department requires community partners receiving funding from the state to complete the Strategic Prevention Framework model in order to assess for community needs and readiness utilizing a guide that was created for community providers to assist with this process. To view, visit: [http://www.maine.gov/dhhs/mecdc/population-health/prevention/provider/index.htm](http://www.maine.gov/dhhs/mecdc/population-health/prevention/provider/index.htm)
SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

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In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

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### Planning

1. Does your state have a strategic plan that addresses substance use disorder prevention that was developed within the last five years?  
   - Yes  
   - No  

   If yes, please attach the plan in BGAS by going to the [Attachments Page](#) and upload the plan.

   The most recent strategic plan expired at the end of 2018 and the Department is in the process of developing a current and up to date strategic plan. Data has been reviewed with problem statements developed and the most recent data (2019) is going to be reviewed once released and a final plan will be developed. Strategic plan link:


2. Does your state use the strategic plan to make decisions about use of the primary prevention set-aside of the SABG? (N/A - no prevention strategic plan)  
   - Yes  
   - No  
   - N/A

3. Does your state’s prevention strategic plan include the following components? (check all that apply):

   - a) [ ] Based on needs assessment datasets the priorities that guide the allocation of SABG primary prevention funds
   - b) [ ] Timelines
   - c) [ ] Roles and responsibilities
   - d) [ ] Process indicators
   - e) [ ] Outcome indicators
   - f) [ ] Cultural competence component
   - g) [ ] Sustainability component
   - h) [ ] Other (please list):

   These were components of the existing plan and will be included in the newly developed plan.

   - i) [ ] Not applicable/no prevention strategic plan

4. Does your state have an Advisory Council that provides input into decisions about the use of SABG primary prevention funds?  
   - Yes  
   - No

5. Does your state have an active Evidence-Based Workgroup that makes decisions about appropriate strategies to be implemented with SABG primary prevention funds?  
   - Yes  
   - No

   If yes, please describe the criteria the Evidence-Based Workgroup uses to determine which programs, policies, and strategies are evidence based.

   The current Evidence Based Workgroup exists but has not convened due to the lack of proposals for review. A protocol and application materials have been developed for proposals to be submitted but there have been no such proposals in the recent past.
SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

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In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

### Implementation

1. States distribute SABG primary prevention funds in a variety of different ways. Please check all that apply to your state:

   a) SSA staff directly implements primary prevention programs and strategies.
   b) The SSA has statewide contracts (e.g. statewide needs assessment contract, statewide workforce training contract, statewide media campaign contract).
   c) The SSA funds regional entities that are autonomous in that they issue and manage their own sub-contracts.
   d) The SSA funds regional entities that provide training and technical assistance.
   e) The SSA funds regional entities to provide prevention services.
   f) The SSA funds county, city, or tribal governments to provide prevention services.
   g) The SSA funds community coalitions to provide prevention services.
   h) The SSA funds individual programs that are not part of a larger community effort.
   i) The SSA directly funds other state agency prevention programs.
   j) Other (please describe)

   The State of Maine funds one vendor (University of New England) to implement substance use prevention strategies across the state through distribution of the funding to community prevention coalitions. These coalitions then implement approved strategies through a workplan approved by the Department.

2. Please list the specific primary prevention programs, practices, and strategies that are funded with SABG primary prevention dollars in each of the six prevention strategies. Please see the introduction above for definitions of the six strategies:

   a) **Information Dissemination:**
      Public Service announcements, community presentations, brochures/printed materials, media campaigns, social media, and implementation of the Maine Prevention Store which houses/distributes materials across the state.
      (www.mainepreventionstore.org)
   b) **Education:**
      Implementation of the Prime for Life curriculum, online education programs, classroom education, education sessions for groups including parents, teachers, youth serving organizations, and school administrators.
   c) **Alternatives:**
      Youth engagement and empowerment services, youth councils/advisory groups, and youth policy boards.
   d) **Problem Identification and Referral:**
      Student Intervention and Reintegration Program, student/employee assistance programs, screening for prevention programming.
e) Community-Based Processes:
Strategic planning, resource sharing, multi-agency collaboration, community training, community building and readiness activities.

f) Environmental:
Prescription drug take back events, safe storage and disposal of medications, PMP promotion, public policy efforts, retailer education, pricing/promotion, social norms campaigns, school policies.

3. Does your state have a process in place to ensure that SABG dollars are used only to fund primary prevention services not funded through other means?  
   ☐ Yes ☐ No

If yes, please describe
The Tobacco and Substance Use Prevention and Control Program with the Maine CDC manages all state and federal prevention services throughout the state of Maine with the exception of DFC funded communities. Strategies that are implemented at the community level are reviewed and approved by state staff to ensure that they are primary prevention focused.
SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

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In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

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**Evaluation**

1. Does your state have an evaluation plan for substance use disorder prevention that was developed within the last five years?  
   - **Yes**  - **No**  
   If yes, please attach the plan in BGAS by going to the Attachments Page and upload the plan.

2. Does your state’s prevention evaluation plan include the following components? (check all that apply):
   - [ ] Establishes methods for monitoring progress towards outcomes, such as targeted benchmarks
   - [ ] Includes evaluation information from sub-recipients
   - [ ] Includes SAMHSA National Outcome Measurement (NOMs) requirements
   - [ ] Establishes a process for providing timely evaluation information to stakeholders
   - [ ] Formalizes processes for incorporating evaluation findings into resource allocation and decision-making
   - [ ] Other (please list):
     - We do not have a formal plan for evaluation of statewide services but discretionary grants have an informal plan established for evaluation of the specific grants.
   - [ ] Not applicable/no prevention evaluation plan

3. Please check those process measures listed below that your state collects on its SABG funded prevention services:
   - [ ] Numbers served
   - [ ] Implementation fidelity
   - [ ] Participant satisfaction
   - [ ] Number of evidence based programs/practices/policies implemented
   - [ ] Attendance
   - [ ] Demographic information
   - [ ] Other (please describe):

4. Please check those outcome measures listed below that your state collects on its SABG funded prevention services:
   - [ ] 30-day use of alcohol, tobacco, prescription drugs, etc
   - [ ] Heavy use
   - [ ] Binge use
c) Perception of harm

d) Disapproval of use

e) Consequences of substance use (e.g. alcohol-related motor vehicle crashes, drug-related mortality)

Other (please describe):
Prevention Team Vision

A public untouched by substance abuse.

Mission Statement

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

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

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

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

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

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

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

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

Priorities
OSA’s prevention work is data drive, and OSA uses key data sources such as the Maine Youth Drug and Alcohol Use Survey, the Maine Integrated Youth Health Survey, Community
Epidemiology Surveillance Network, the Treatment Data System, the Higher Education Alcohol Prevention Partnership, National Survey on Drug Use and Health, Behavioral Risk Factor Surveillance System, and the Youth Risk Behavior Surveillance System. OSA selects evidence based interventions, and uses its resources efficiently to implement a limited number of interventions statewide to provide consistency across the state.

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

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

**Goals**

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

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

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

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

- Reduce use of marijuana among Mainers, with emphasis on teens and young adults.
- Reduce use of prescription drugs among Mainers, with emphasis on teens and young adults.
- Reduce underage drinking and binge drinking among Mainers, with emphasis on teens and young adults.
OSA recognizes the importance of embedding cultural competency throughout the agency and its programs, and understands the need to increase capacity in Maine in this area. OSA’s goal around cultural competency is:

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

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

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

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

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

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

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

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

Prevention Revenue

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

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

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

Contracts and Expenditures

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

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

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

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

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

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

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

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

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

Current Grants and Programs

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

SPF SIG funds for HMP grantees began September 1, 2007 and ended July 30, 2010. As of that date, OSA funds only environmental strategies through the local HMPs.
In an ongoing effort to support the new public health infrastructure and to sustain and further the work of substance abuse prevention in Maine, OSA provides HMPs the opportunity to apply for additional funds to enhance work on OSA’s HMP Minimum Common Program (OSA HMP MCP) Objectives. OSA allocated $640,000 annually from the SAPT Block Grant to support this HMP work. This allocation was divided equally among the eight Public Health Districts ($80,000 annually per district). Each district’s allocation was then divided equally among local HMPs.

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

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

**Safe and Drug-free Schools and Communities Act grantees**

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

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

**Enforcing Underage Drinking Laws Grant**

Maine’s strategy for reducing underage drinking has focused much energy in recent years on increasing the effectiveness of enforcement of the underage drinking laws and on reducing both retail and social access to alcohol by minors. OSA has taken both a localized and statewide approach, combining grants from the Enforcing Underage Drinking Laws (EUDL) Grant to community coalitions, colleges, and county sheriff’s departments with statewide strategies such as undercover compliance checks, the Card ME Program, and Project Sticker Shock. The results demonstrate a substantial increase in enforcement efforts where grant funds have been available at the local level. In addition, data show a decrease statewide in how easy youth perceive it to be to obtain alcohol (50.7% of 6-12th graders who took the Maine Youth Drug and Alcohol Use Survey in 2008 said it was “very easy” or “sort of easy” compared to 52.7% in 2002).
**Compliance Checks**
OSA works closely with Department of Public Safety to ensure a cost effective means of assuring holders of liquor licenses comply with underage access laws. The Bureau of Liquor Licensing within the State Police was established when the Bureau of Liquor Enforcement was abolished, but it lacked the resources to conduct compliance inspections. OSA provides EUDL funding through a contract with the Maine Sheriff’s Association to perform these services, as well as mini grants to local law enforcement agencies.

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

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

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

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

**Student Intervention and Reintegration Program**
SIRP is an evidence based youth diversion program which is being implemented in five organizations across the state.

**Prescription Monitoring Program Promotion**
Each public health district was funded to promote the Prescription Monitoring Program. Participants met regularly to develop promotional materials and strategize about how promotion would be delivered. This initiative ended June 30, 2012.
Maine Youth Action Network
OSA contracts with the Maine Youth Action Network to develop strategies and supports oriented toward substance abuse prevention among youth.

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

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

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

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

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

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

In Maine, OSA, MCDC and the Office of the Attorney General collaborate to perform statewide tobacco vendor inspections for purposes of Synar. The MCDC contracts with law enforcement
personnel to conduct inspections of 100% of all licensed retailers open and available to youth. States and U.S. jurisdictions must report annually to SAMHSA on their retailer violation rates, which represent the percentage of inspected retail outlets that sold tobacco products to a customer under the age of 18. OSA contributes SAPT Block Grant Funding as a requirement of the Block Grant. Maine continues to keep its non-compliance rate at under 10%.

**Definition of Prevention**

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

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

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

**Prevention Categories**

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

**Universal**

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

- *Universal Indirect* provides information to a whole population who has not been identified as at risk of having or developing problems. Interventions include media activities, community policy development, posters, pamphlets, and internet activities. Interventions in this category are commonly referred to as environmental strategies.
- *Universal Direct* interventions target a group within the general public who has not been identified as having an increased risk for behavioral health issues and share a common connection to an identifiable group. Interventions include health education for all students, after school programming, staff training, parenting class, and community workshops.
**Selective**
This category of prevention interventions targets individuals or a population subgroup whose risk of developing mental or substance abuse disorders is significantly higher than average (prior to the diagnosis of the disorder). Examples of interventions include group counseling and social/emotional skills training for youth in low-income housing developments, and a clinician-facilitated group discussion that provides education and support to families with parental depression.

**Indicated**
These interventions target individuals at high risk who have minimal but detectable signs or symptoms of mental illness or substance abuse problems (prior to a DSM IV diagnosis\(^1\)). Examples include programs for high school students who are experiencing problem behaviors such as truancy, failing academic grades, juvenile depression, suicidal ideation, and early signs of substance abuse.

**Types of Environmental Strategies**
OSA utilizes effective environmental strategies delivered in multiple domains and at multiple dosages for a comprehensive prevention approach.

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

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

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

**Education Strategies**

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

**Communications Strategies**

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

**Collaboration Strategies**

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

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

**Evidence-Based Programs, Practices and Strategies**

Evidence-based (or science-based) substance abuse prevention programs are those programs that have positive evaluation results and have been reviewed by experts in the field. Science-based programs have sound research methodology and have proven that program effects were clearly linked to the program itself and not to some other causal factor. The Center for
Strategic Prevention Plan 2013-2018

Substance Abuse Prevention maintains a registry of evidence based prevention programs that can be found at [www.nrepp.samhsa.gov](http://www.nrepp.samhsa.gov).


**Guiding Principles of Substance Abuse Prevention**

1. Effective substance abuse prevention is comprehensive and incorporates multiple strategies in multiple domains over extended periods of time. The domains refer to areas where prevention work occurs. These include peer/individual, family, school, workplace, community and society settings.

2. A combination of Universal Indirect, Universal Direct, Selective, and Indicated interventions provides a comprehensive approach.

3. Prevention specialists must possess a set of core competencies and a commitment to lifelong learning, and they must stay current with the rapidly evolving knowledge and skill base in this field.

4. Substance abuse prevention shares many elements with other fields of prevention and health promotion (e.g., juvenile delinquency prevention; adolescent suicide prevention; tobacco prevention; and mental, emotional and behavioral health promotion). Collaboration and cross training across the prevention spectrum maximizes human and material resources.

5. Substance abuse prevention is an active contributing partner supporting Maine’s public health infrastructure.

6. A continuum of services that encompasses substance abuse prevention, intervention, treatment, and recovery must be available.

7. All sectors of the community, including parents and youth, are needed in successful prevention work. Members of the education, law enforcement, public health, and health care communities are critical partners in promoting mental and emotional health and preventing behavior disorders.

8. Prevention efforts must be grounded in needs assessment data, backed by current research, and evaluated for effectiveness.

9. Prevention strategies must address all people across the life span and must be relevant for each new generation.

10. Maine’s substance abuse prevention framework utilizes the risk and protective factor framework developed by Hawkins and Catalano. The youth developmental assets and resiliency research contribute to the knowledge base of the field. These disciplines are implemented through the five-step process of the Strategic Prevention Framework:
   
   a. Assess prevention needs based on epidemiological data;
b. Build prevention capacity;

c. Develop a strategic plan;

d. Implement effective prevention programs, policies and practices; and

e. Evaluate outcomes.

11. Programs and initiatives should be executed with cultural competence and inclusivity when working with populations of diverse cultures and identities.

Costs of Substance Abuse

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

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

OSA Strategic Planning Process Overview

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

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

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

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

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

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

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

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Data Analysis

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

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

<table>
<thead>
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<tbody>
<tr>
<td>30 Day Alcohol Use</td>
<td>28.7%</td>
<td>38.7%</td>
</tr>
<tr>
<td>30 Day Binge Drinking</td>
<td>16.2%</td>
<td>21.9%</td>
</tr>
<tr>
<td>30 Day Marijuana Use</td>
<td>21.2%</td>
<td>23.1%</td>
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</tbody>
</table>

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

<table>
<thead>
<tr>
<th>2010 BRFSS Ages 18-24</th>
<th>Maine</th>
<th>National</th>
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<tbody>
<tr>
<td>30 Day Alcohol Use</td>
<td>48.7%</td>
<td>48.3%</td>
</tr>
<tr>
<td>Binge Drinking (Alcohol)</td>
<td>21.9%</td>
<td>22.1%</td>
</tr>
<tr>
<td>Heavy Use (Alcohol)</td>
<td>4.7%</td>
<td>5.2%</td>
</tr>
</tbody>
</table>
Local situation and trends
As stated above, alcohol is the drug of choice in Maine. As Chart 1 below demonstrates, the 2011 MIYHS survey results show that 28% of Maine high school students had used alcohol in the 30 days prior to the survey. This is followed by 22.1% having used marijuana in the past 30 days.

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

Chart 1
Past month Substance use among grades 9-12, 2011 MIYHS

Source: MIYHS, 2011.

Chart 2
Lifetime substance use among grades 9-12
2011 MIYHS

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

![Chart 3](image)

Source: MIYHS, 2011.

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

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

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

The Prevention Team identified the following needs and gaps:

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

*Source: TDS, 2011.*
Proposed Future of Prevention, Targeted Initiatives, Programming, and Funding Needs

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

Workforce Development

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

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

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

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

**Prevention data**

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

**Interdepartmental and intergovernmental initiatives**

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

**Outreach to schools**

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

**Funding for continuation of the following priorities:**

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

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

**Priorities**

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

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

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

**Goals and Objectives**

**Program Initiatives**

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

**Objectives:**

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

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

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

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

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

Objectives:
1. Train key stakeholders (i.e., coalitions, schools, worksites, law enforcement, etc.) to use data to increase buy-in, create action, and evaluate progress.
2. Increase the number of programs evaluated.
3. Increase accountability for prevention and early identification activities through uniform reporting:
   i. Utilize KIT to track progress of OSA grantees.
4. Increase access to data sources relevant to Maine people (i.e., behavioral health, military, tribal).

**Workforce Development**

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

**Objectives:**

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

**Marijuana Use**

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

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

**Objectives:**

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

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

Prescription Drug Use/Abuse
Goal 1: Reduce use of prescription drugs among Mainers, with emphasis on teens and young adults.

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

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

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

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

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

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

Sub goal: Increase people's perceived risk of prescription drug use.
Objective:  
1. Increase the public's awareness around the dangers of prescription drug misuse.

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

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

Alcohol use/abuse: Underage and Binge Drinking

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sub goal: Improve public awareness around individual/family factors that impact underage and binge drinking and related risks.
Objectives:
1. Increase public knowledge of predisposition to alcohol issues (i.e. those with adverse childhood experiences, co-occurring, and genetics) so as to inform drinking choices.
2. Increase public knowledge of basic alcohol information (such as: knowledge of how alcohol interacts with body, risk reduction strategies, BAC, standard drink, genetic factors, etc.).

State Prevention Enhancement

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

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

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

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

• **Education.** OSA’s strategic plan aligns with DOE’s *Education Evolving: Maine’s Plan for Putting Learners First* by supporting coordinated health and wellness programs and a commitment to community and family engagement. In addition, OSA workforce development initiatives to strengthen Maine’s prevention workforce may include educators and other professionals who engage youth in schools and the community.\(^7\) There is considerable overlap in *Preventing Substance Abuse and Violence in Schools: A Strategic Plan for Maine* as well.

• **Enforcing underage drinking laws.** The planning process related to enforcing underage drinking laws resulted in *Maine’s Enforcing the Underage Drinking Laws System Assessment, Strategic Planning, and Implementation Initiative: Strategic Action Plan*. This planning process intersects with OSA’s strategic prevention planning in numerous areas, including supporting implementation of evidence based strategies and engaging HMPs and Drug Free Communities coalitions to implement enforcement strategies consistently across the state at the local level.\(^8\)

• **Workforce development.** OSA’s plan to develop a statewide certification system for prevention professionals dovetails with initiatives in Maine to ensure fidelity of program implementation and the creation of a career ladder for professionals in early care and education.\(^9\)

• **Cultural Competency.** OSA’s ongoing commitment to embedding cultural competency throughout the agency and its programs intersects with Office of Minority Health initiatives, including in particular the development of a Toolbox of Resources on cultural competency. With the Office of Minority Health in the lead, there are numerous opportunities for training across disciplines and State agencies.\(^10\)

• **Problem Gambling.** OSA’s 2011-2014 *Problem Gambling Services Strategic Plan* recognizes that problem gambling prevention, treatment and recovery share many elements with other fields of prevention, health promotion and treatment and recognizes the importance of cross training across the prevention and treatment spectrum to maximize human and material resources.

• **Teen Driver Safety.** The *Strategic Workplan of the Maine Teen Driver Safety Committee* includes an objective to decrease teen driving related crashes, injuries and fatalities due to alcohol and other drugs. The strategies identified align with OSA’s prevention initiatives related to enforcing underage drinking laws and include youth and teens as target audiences for messages related to enforcing these laws.

• **Violence in Schools.** *Preventing Substance Abuse and Violence in Schools: A Strategic Plan for Maine* was completed by a multi-agency workgroup in 2011. Many of the

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\(^7\) The plan is available at [http://www.maine.gov/doe/plan/evolving.pdf](http://www.maine.gov/doe/plan/evolving.pdf)


\(^9\) More information on Maine’s Early Care and Education Career Development Center is available at [http://muskie.usm.maine.edu/maineroads/](http://muskie.usm.maine.edu/maineroads/)

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

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

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

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

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

**Cultural Competence**
**Goal:** Develop ways to incorporate cultural competency into substance abuse prevention programming
Objectives and Milestones:

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

2. Develop standards for cultural competency trainings and identify opportunities to partner with other public health stakeholders.

Year 1
- Definition of cultural competency created.
- Outside resources (e.g., NCCC) used to develop agency self-assessment process to determine compliance with definition.
- Components essential to comprehensive cultural competency training identified.
- “OSA Standard” for cultural competency trainings developed.

Year 2
- Agency self-assessment to determine cultural competency completed: “Walk the walk.”
- Resources that provide trainings that incorporate the essential components identified in year 1 promoted (e.g., putting training opportunities on the prevention calendar).

Year 3
- Cultural competency integrated into contracts, policies, regulations and rules.
- Plan to assess and evaluate resources and training developed and implemented.

Years 4-5
- Ongoing self-assessment plan implemented; adjustments made based on identified strengths and challenges.
- Ongoing identification, assessment, evaluation and dissemination of trainings.

Prevention Specialist Certification

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

Objectives and Milestones:

1. Convene a Credentialing Committee dedicated to creating a certification process, establishing a certification board and implementing IC&RC certification in Maine.

2. Establish certification requirements and training capacity/opportunities necessary to support and sustain Prevention Certification in Maine to meet the IC&RC standard.
3. Establish a credentialing board to meet IC&RC standard.
4. Implement a Prevention Certification process in Maine using the IC&RC standard.
5. Create a long-term sustainability plan for prevention credentialing.

Year 1
- Credentialing Committee formed and meets at least monthly. Membership includes OSA (convener), Training/Workforce Development (including higher education), and Prevention workforce from the field (including non-supporters of certification and non-OSA funded professionals). Majority are representatives of the prevention workforce.
- Assessment results and recommendations submitted to the Office of Substance Abuse.
- Core competencies identified.
- Initial training offered and existing training that meets competencies identified.

Year 2
- Independent Certification Board that meets IC&RC standards authorized/sanctioned in Maine.
- Additional training/trainer capacity identified.
- Training and trainer workforce competencies identified.
- Credentialing Committee oversees, enhances and sustains the credentialing process.

Year 3
- Certification process finalized.
- Training and trainer workforce capacity fully developed.
- Independent Certification Board application approved.
- Certification process begins (applications accepted and reviewed).
- Sustainability planning begins.
- Credentialing Committee oversees, enhances and sustains the credentialing process.

Year 4
- Prevention field moving towards universal certification.
- Recertification process begins.

Year 5
- Prevention field moving towards universal certification.
- Sustainability plan completed.
- Credentialing Committee oversees, enhances and sustains the credentialing process.
Training, Technical Assistance and Sustainability
Goal: Ensure prevention providers statewide have access to credible training on evidence based programs, policies and practices, understand the need to use data and understand the value of evaluation.

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

Year 1
- Materials developed (e.g., talking points and fact sheets) and disseminated to grantees, prevention partners, the general public and higher education partners.
- Resource list of training opportunities developed and disseminated to grantees.
- Sustainability and grant writing competencies incorporated into OSA contracts.
- Current technology opportunities assessed and incorporated appropriately into practice, based on resources available.

Year 2
- Trainings on behavioral health integration assessed.
- Training in grant writing and sustainability assessed and developed.
- Current technology opportunities assessed and incorporated appropriately into practice, based on resources available.

Year 3
- Ongoing dissemination of information.
- Ongoing training.
- Current technology opportunities assessed and incorporated appropriately into practice based on resources available.

Year 4
- Materials and training are assessed to determine further needs.
- Current technology opportunities assessed and incorporated appropriately into practice, based on resources available.
Year 5

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

Data Collection, Analysis and Reporting

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

Objectives and Milestones:
1. Improve KIT reporting system.

Year 1

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

Year 2

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

Year 3

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

Year 4

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

Year 5

- Assessment and refining reporting processes continues.

2. Establish Continuous Quality Improvement (CQI) process.

Year 1

- Assessment and inventory of current CQI process for OSA prevention grantees completed.
Year 2
- Best practices in CQI to use while KIT process reporting system is being expanded/improved as outlined above identified.

Year 3
- Grantees encouraged to engage in best practice CQI processes.

Year 4
- Use of KIT as part of CQI process expanded.
- Procedures to use KIT data to link local counts to program improvement developed.
- Project officers trained in CQI.
- Local grantees trained in CQI.

Year 5
- CQI process implemented.

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

Year 1
- List counts recorded as part of performance-based contracting compiled.
- Assessment of how these counts can be used completed.
- Gaps in data collected identified.

Year 2
- Data collected for individual strategies identified.
- Determination of how OSA can collect data for individual strategies not currently collected completed.

Year 3
- Participation in calls/training in use of data required in all OSA contracts.

Years 4-5
- Additional needs surrounding local capacity to collect/use data identified.

4. Improve TA/Training data

Year 1
- Review of data collection for TA/Training to determine areas for improvement completed.

Year 2
- Development of standard counts for TA/Training that will be routinely collected and reported completed.
Year 3-5
- TA/Training data to identify strengths and challenges collected and analyzed regularly.

Goal 2: Disseminate outcomes.

Objectives and Milestones:
1. Determine where objectives of strategic plan overlap with SEOW.
   
   Year 1
   - Determination of where objectives of strategic plan overlap with SEOW completed.
   
   Year 2
   - Development of ways to effectively communicate/collaborate to encourage efficient use of funds/staff completed.
   
   Years 3-5
   - Continue above.

2. Develop interactive data dashboard of relevant outcomes measures at state/local levels for trending, sub-state analysis.
   
   Year 1
   - Assessment of options for interactive data platform completed.
   - Data added to current public health dashboard.
   - Exploration of how services and strategies counts from KIT could be incorporated into current DHHS dashboard completed.
   - Guide to using outcomes data updated.
   
   Year 2
   - Determination of which type of data dashboard OSA will use (its own, coordination with other public health entities) completed.
   
   Year 3
   - Partnerships established (e.g., with public health if that avenue is chosen, with IT if own will be developed).
   
   Year 4
   - Counts/measures will be available and which reports the dashboard will generate identified.
   
   Year 5
   - Dashboard complete.
3. Assess current data available for adult and subpopulations and explore new partnerships to obtain additional data.

Year 1

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

Year 2

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

Year 3

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

Year 4

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

Year 5

- Continue above.

**Performance Measurement and Evaluation**

**Goal:** Meet all data reporting requirements.

**Objectives and Milestones:**

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

Year 1

- Inventory of current and potential GPRA/NOMs completed.
- Funding opportunities explored to determine priority measures.
Year 2

- Capacity to comply with collecting required measures ensured.

Years 3-5

- Continue above.

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

**Objectives and Milestones:**

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

   **Year 1**
   
   - Cost savings indicators identified.
   - “Shoveling Up” report updated.\(^\text{11}\)
   - National figures identified that could be translated into cost savings (e.g., x% of violent crime related to alcohol—how much does this crime cost and what would reduction save?).
   - Cost data prioritized (e.g., DOL wages lost, DOC incarceration costs).
   - CDC’s PRISM system explored to see how they incorporate cost benefit or cost effectiveness analyses.

   **Year 2**
   
   - Methodology developed for cost savings calculations.

   **Year 3**
   
   - Capacity to collect or identify necessary data ensured.

   **Year 4**
   
   - Mechanism developed for collecting missing data.

   **Year 5**
   
   - Cost savings procedures incorporated as a regular part of evaluation.

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

   **Year 1**
   
   - Partnering with Maine Health Data Organization to get healthcare cost data (get data through DHHS agreement with MeCDC) begins.

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\(^{11}\) The National Center on Addiction and Substance Abuse at Columbia University. (2009). *Shoveling Up II: The Impact of Substance Abuse on Federal, State and Local Budgets.* Available at [www.casacolumbia.org/su2report](http://www.casacolumbia.org/su2report)
Year 2
- Insurance and Medical data reporters/coders trained to ensure correct use of eCodes that indicate alcohol/drug related injuries or medical conditions.

Year 3
- Health care/medical data analyzed to determine utility in evaluating substance abuse prevention programs.

Years 4-5
- New data sources incorporated into evaluation and cost savings reporting.

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

Objectives and Milestones:
1. Develop standard evaluation procedures and guidelines.

Year 1
- Logic Model for Prevention across funding sources/programs using the social-ecological framework articulated.
- Determination of which outcomes each program should consider when evaluating its own effectiveness completed.
- Relevant process measures, quality and source(s) identified.
- Critical outcomes measures that can be analyzed and tracked regularly identified.
- Supplemental qualitative measures identified.

Year 2
- Methodology developed to gauge the impact of prevention efforts on observed outcomes.

Year 3
- Qualitative data utilized to aid in determining the links between process measures and outcomes. Gaps filled in where counts and numbers fail to reveal a connection.
- Interviews conducted.
- Focus groups conducted.
- Fidelity assessments conducted.

Years 4-5
- Refining and implementing procedures developed during previous years continues.
Goal: Expand capacity to engage in evaluation at the state and local levels.

Objectives and Milestones:
1. Develop evaluation plan and requirements.

Years 1-5
- Funding sought for evaluation.
- Importance of data/evaluation promoted at the state level.
- OSA’s access to evaluation expertise expanded and sustained.
- Local grantees trained in evaluation.

Strategic Plan Monitoring and Review

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

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

Office of Substance Abuse Organization Chart

Office of Substance Abuse

Guy R. Cousins
Director

Data and Research
D & R Supervisor
2 Staff
1 Contracted Staff

Geoff Miller
Associate Director

Prevention/Information & Resource Center
Prevention Manager
8 Prevention Staff
1 Contracted Prevention Staff
2 Vacancies

Intervention / DEEP
DEEP Manager
Call Center Coordinator
5 Call Center Staff
2 Case Managers
1 Vacancy

Treatment/Corrections
Treatment Manager
2 Treatment Staff
3 Contracted Treatment Staff

Administrative Support Staff
T. Lewis, Admin Secretary
2 Staff
1 Vacant
Appendix B

Acronyms and Definitions

Acronyms

- BHS: Bureau of Highway Safety
- BRFSS: Behavior and Risk Factor Surveillance System
- C4CY: Communities for Children and Youth
- CDC: Centers for Disease Control and Prevention
- CESN: Community Epidemiology Surveillance Network
- CSAP: Center for Substance Abuse Prevention
- CSHP: Coordinated School Health Program
- CSHE: Coordinated School Health Education
- DCC: District Coordinating Council
- DDR: Drug Demand Reduction program (National Guard)
- DFC: Drug Free Communities
- DHHS: Department of Health and Human Services
- DOE: Department of Education
- DOL: Department of Labor
- EUDL: Enforcing the Underage Drinking Laws
- GLESN: Gay, Lesbian and Straight Education Network
- HMP: Healthy Maine Partnership
- HEAPP: Higher Education Alcohol Prevention Partnership
- IRC: Information Resource Center, Office of Substance Abuse
- JJAG: Juvenile Justice Advisory Group
- JMG: Jobs for Maine Graduates
- MAPSA: Maine Alliance to Prevent Substance Abuse
- MASAP: Maine Association of Substance Abuse Programs
- MCDC: Maine Center for Disease Control and Prevention
- MOU: Memorandum of Understanding
- MYAN: Maine Youth Action Network
- MYDAUS: Maine Youth Drug and Alcohol Use Survey
- MIYHS: Maine Integrated Youth Health Survey
- NCCC: National Center for Cultural Competency
- NE CAPT: North East Center for Application of Prevention Technologies
- NREPP: National Registry of Evidence Based Programs and Practices
- NE RET: Northeast Regional Expert Team
- OAS: Office of Applied Studies
- OJJDP: Office of Juvenile Justice and Delinquency Prevention
- OSA: Office of Substance Abuse
• ONDCP: Office of National Drug Control Policy
• RBS Training: Responsible Beverage Server/Seller Training
• RSPM: Restorative School Practices of Maine
• SAMHSA: Substance Abuse and Mental Health Services Administration
• SBHC: School Based Health Center
• SCC: State Coordinating Council
• SETU: Staff Education Training Unit
• SIRP: Student Intervention and Reintegration Program
• SPF SIG: Strategic Prevention Framework State Incentive Grant
• SYVC: Shared Youth Vision Council
• UDETF: Underage Drinking Enforcement Task Force
• YEPP: Youth Empowerment Policy Project
• YRBSS: Youth Risk Behavior Surveillance System

Definitions

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

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

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

Emerging Practices: Emerging Practices includes practices that practitioners have tried and feel are effective and new practices or programs that have not yet been researched. These include practices that are not based on research or theory and on which original data have not been collected, but for which anecdotal evidence and professional wisdom exists.
http://www.k8accesscenter.org/training_resources/reasearchapproach.asp
**Evidence-based practice:** From SAMHSA’s Center For Substance Abuse Prevention evidence-based interventions are defined in the SPF SIG Program by inclusion in one or more of the three categories: Included in Federal registries of evidence-based interventions; reported (with positive effects on the primary targeted outcome); in peer-reviewed journals; or documented effectiveness supported by other sources of information and the consensus judgment of informed experts. [http://prevention.samhsa.gov/](http://prevention.samhsa.gov/)

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

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

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

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

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

- (2nd definition option) Prevention is the active, assertive process of creating conditions that promote well-being. [www.mainecshp.com/aboutus.html](http://www.mainecshp.com/aboutus.html)

**Promising Practice:** These practices have been tested but the results are not as clear as those results in the evidenced-based research category above. Practices that fall in this category are based on some type of research – whether it is theoretical, qualitative, or quantitative – but data have yet to be collected on effectiveness. Promising practices may have been tested under different conditions and, therefore, may have a research foundation. However, the practices themselves have not been tested using the most rigorous research designs, or were tested in
different educational contexts.
http://www.k8accesscenter.org/training_resources/reasearchapproach.asp

  o (2nd definition option) Promising Programs have the appropriate components for successful prevention, but have not yet been supported by rigorous evaluations. They are made up of strategies that have been found effective in previous research.
  http://www.unf.edu/dept/fie/sdfs/strategies/

  o (3rd definition option) Clinical practices for which there is considerable evidence or expert consensus and which show promise in improving client outcomes, but which are not yet proven by the highest or strongest scientific evidence.

**Restorative Justice:** Restorative justice is a new way of looking at criminal justice that focuses on repairing the harm done by people and relationships rather than on punishing offenders. Restorative justice includes communities of care as well; with victims’ and offenders’ families and friends participating in collaborative processes called “conference” or “circles.”

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

**Substance Abuse Prevention:** OSA’s approach to substance abuse prevention uses research-based concepts, tools, skills, and strategies which reduce the risk of alcohol and other drug related problems. Substance abuse prevention means keeping the many problems related to the use and abuse of these substances from occurring.

**Sustainability:** Sustainability refers to the process through which a prevention system becomes a norm and is integrated into ongoing operations, ensuring that prevention values and processes are firmly established, that partnerships are strengthened, and that financial and other resources are secured over the long term

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

**Youth (Positive) Development:** Positive Youth Development (PYD) is a comprehensive way of thinking about the development of children and youth and the factors that facilitate or impede their individual growth and their achievement of key developmental states. The concepts of
PYD suggest that most young people can develop and flourish if they are connected to the right mix of social resources. The PYD perspective recognizes that some youth grow up in circumstances that do not equip them for the transition from childhood to adulthood. It also recognizes that some youth behave in ways that cause serious problems for themselves and their communities. Jeff Butts, Chapin Hall Center for Children: Issue Brief #105

- (2nd definition option): Positive youth development (PYD) is a comprehensive framework outlining the supports young people need in order to be successful. PYD emphasizes the importance of focusing on youths’ strengths instead of their risk factors to ensure that all youth grow up to become contributing adults. [http://www.ncsl.org/?tabid=16375](http://www.ncsl.org/?tabid=16375)

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

Principles of Effectiveness

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

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

1) Be based on an assessment of objective data regarding the incidence of violence and illegal drug use in the elementary schools and secondary schools and communities to be served, including an objective analysis of the current conditions and consequences regarding violence and illegal drug use, including delinquency and serious discipline problems, among students who attend such schools (including private school students who participate in the drug and violence prevention program) that is based on ongoing local assessment or evaluation activities;

2) Be based on an established set of performance measures aimed at ensuring that the elementary schools and secondary schools and communities to be served by the program have a safe, orderly, and drug free learning environment;

3) Be based on scientifically based research that provides evidence that the program or strategy to be used will reduce violence and illegal drug use;

4) Be based on an analysis of the data reasonably available at the time, of the prevalence of risk factors, including high or increasing rates of reported cases of child abuse and domestic violence; protective factors, buffers, assets; or other variables in schools and communities in the State identified through scientifically based research;

5) Include meaningful and ongoing consultation with and input from parents in the development of the application and administration of the program or activity; and

6) Undergo a periodic evaluation to assess its progress toward reducing violence and illegal drug use in schools to be served based on performance measures. Use of results: The results shall be used to refine, improve, and strengthen the program, and to refine the performance measures, and shall also be made available to the public upon request, with public notice of such availability provided.
Appendix D

Identifying and Selecting Evidence-based Interventions

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

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

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

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

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

*Federal Registries*—
Provide concise descriptions of the interventions.

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

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

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

Challenges

*Federal Registries*—
Include a limited number of interventions depending on how they are selected.

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

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

Federal registries include:

**SAMHSA National Registry of Evidence based Programs and Practices (NREPP)**
http://www.nrepp.samhsa.gov Provides descriptions of and rates evidence for various interventions related to substance use and abuse and mental health problems.

**OJJDP Model Programs Guide** http://www.dsgonline.com/mpg2.5/mpg_index.htm Provides descriptions of and rates evidence for youth-oriented interventions, many of which are relevant to the prevention of substance use and abuse.

**Exemplary and Promising Safe, Disciplined and Drug-Free Schools Programs Sponsored by the U.S. Department of Education**
http://www.ed.gov/admins/lead/safety/exemplary01/exemplary01.pdf Provides descriptions of and rates evidence for educational programs related to substance use.

**Guide to Clinical Preventive Services Sponsored by the Agency for Healthcare Research and Quality [AHRQ]** http://www.ahrq.gov/clinic/cps3dix.htm Provides recommendations regarding screening and counseling in clinical settings to prevent the use of tobacco, alcohol, and other substances.
B. Using Peer-Reviewed Journals
The research literature constitutes another primary resource for identifying evidence-based prevention interventions, including those not listed in Federal registries. When the literature is used to determine strength of evidence, all articles relevant to the specific intervention should be considered. In other words, it is not sufficient to garner support for an intervention from a single document selected from a larger body of work. We recommend careful review of all documents that have been published on a particular intervention to ensure that the outcomes reported comprise a consistent pattern of positive effects on the target outcomes.

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

Assessing Elements of Evidence Reported in Peer-Reviewed Journals
Listed below are key elements addressed in most peer-reviewed journal articles, along with some questions to consider.

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

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

A well-described study population that includes baseline or “pre-intervention” measurement of the study population and comparison or control groups included in the
study. Does the article describe in detail the characteristics of the study population and the comparison or control groups used? How well does the study population match your local target group?

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

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

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

**Advantages**

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

Provide authors’ contact information that facilitates further discussion about the appropriateness of the intervention to the target need.
In some cases, report and summarize meta-analyses and other types of complex analyses (e.g., core components) that examine effectiveness across interventions or intervention components. These types of analyses are potentially very useful to prevention planners.

**Challenges**

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

Describe in limited detail the activities and practical implementation issues pertinent to the use of the intervention.
C. Using Other Sources for Documenting Effectiveness

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

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

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

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

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

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

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

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

Advantages

*Other Sources for Documenting Effectiveness* —

Enable State and community planners to consider interventions that do not currently appear on a Federal list or in the peer-reviewed literature but which have the potential to address the problem targeted.
Provide opportunities for State and community planners to use locally developed or adapted interventions, provided they are supported by adequate documentation of effectiveness.

**Challenges**

*Other Sources for Documenting Effectiveness —*

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

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

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

Stakeholders

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

Facilitated Focus Group discussion, August 23, 2010:

<table>
<thead>
<tr>
<th>Name</th>
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<tbody>
<tr>
<td>Ronni Katz</td>
</tr>
<tr>
<td>Joanne Joy</td>
</tr>
<tr>
<td>Dalene Dutton</td>
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<tr>
<td>Shawn Yardley</td>
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<tr>
<td>Rene Page</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Name</th>
<th>Organization</th>
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<tbody>
<tr>
<td>Jo McCaslin</td>
<td>OSA - Prevention Manager</td>
</tr>
<tr>
<td>Anne Rogers</td>
<td>OSA - Prevention Team</td>
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<tr>
<td>Jacinda Goodwin</td>
<td>OSA - Prevention Team</td>
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<tr>
<td>Cheryl Cichowski</td>
<td>OSA - Prevention Team</td>
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<tr>
<td>Maryann Harakall</td>
<td>OSA - Prevention Team</td>
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<tr>
<td>Peter Brough</td>
<td>OSA - Prevention Team</td>
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<tr>
<td>Leanne Morin</td>
<td>OSA - Prevention Team</td>
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<tr>
<td>Melissa Boyd</td>
<td>MAPSA</td>
</tr>
<tr>
<td>Frank Lyons</td>
<td>UDETF rep</td>
</tr>
<tr>
<td>Kathryn McGloin</td>
<td>DOC</td>
</tr>
<tr>
<td>Susan Berry</td>
<td>DOE/SAVPS</td>
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<tr>
<td>Claudia Bepko</td>
<td>Adult Mental Health</td>
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<td>Claire Harrison</td>
<td>Adult Mental Health</td>
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<tr>
<td>Sarah Goan</td>
<td>HZA</td>
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<tr>
<td>Becky Ireland</td>
<td>HEAPP/SASC</td>
</tr>
<tr>
<td>Melanie Lanctot</td>
<td>OSA D&amp;R</td>
</tr>
<tr>
<td>Jeff Austin</td>
<td>Liquor Licensing</td>
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<tr>
<td>Michelle Ross</td>
<td>MCDC/PTM</td>
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</tbody>
</table>
Appendix F

SWOT Analysis

**Strengths**

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

**Weaknesses/Challenges**

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

**Opportunities**

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

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

State Prevention Enhancement
Assessment of Coordination of Services

Contents

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

Attachment 1: OSA Prevention Advisory Board Members
Introduction

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

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

Specific definitions and acronyms used in this report are in Appendix B of the Strategic Prevention Plan 2013-2018.
I. Assessment of Coordination of Services for Substance Abuse Prevention

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

Current Coordination of Services within OSA

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

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

Although CESN provides data for the entire office, the OSA Prevention Team utilizes the data to prioritize prevention service needs and then seeks opportunities to implement identified needs. The Team creates goals, objectives and activities based on data and evidence-based strategies. The assessment process for 2011 prevention planning identified two priorities for prevention.

OSA’s prevention efforts will address the specific characteristics and needs of these populations:

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

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

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

Strengths of Current Coordination of Services within OSA

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

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

Challenges of Current Coordination of Services within OSA

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

Current Coordination of Services with Other State Agencies

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

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

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

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

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

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

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

Examples of coordination of services at the state level include:

- *The Community Epidemiology Surveillance Network.* CESN serves as Maine’s State Epidemiological Outcomes Workgroup (SEOW) and is a multi-agency work group that...
studies the spread, growth and development of substance use in Maine and its communities. The CESN/SEOW meets bi-annually to assess information from the multiple sources comprising the network, draws conclusions about drug abuse and provides updated trend reports twice a year.

- **Coordinated data collection.** OSA, MCDC and DOE together fund the administration and data analysis of the common statewide school survey, the Maine Integrated Youth Health Survey. Localized program data are collected at the community level through the utilization of the web-based KIT Performance Based Prevention System.

- **Teen Driver Safety Committee.** OSA serves on the committee with other state agencies to implement teen driver safety initiatives. One initiative is working with the Bureau of Highway Safety (BHS), Department of Public Safety, to conduct Teen Driver Awareness trainings. This is a training conducted by BHS, and because the two agencies have been working together on other public safety projects, BHS has requested OSA to provide a presentation on underage drinking at those trainings. This expands OSA connections and effectiveness statewide through new trainees. Similarly, through this partnership with BHS, OSA is forming connections with the Maine State Police and other law enforcement agencies in the state.

- **Fetal Alcohol Spectrum Disorder Coordinator.** The DHHS Office of Child and Family Services has contracted with OSA to provide a Fetal Alcohol Spectrum Disorder state system coordinator. The $275,972 contract will pay for office space and supervision of the coordinator at OSA for four years, ending in 2015.

- **Worksite wellness.** MCDC and individual HMPs look to OSA for substance abuse prevention strategies to incorporate into worksite wellness programs such as Healthy Maine Works and community wellness initiatives such as Keep Me Well. Additionally, OSA is working with the Maine Department of Labor (DOL) to develop tools such as an online drug testing policy builder for employers and provide technical assistance that help employers implement comprehensive Drug-Free Workplace Programs. OSA also works with DOL and employers on Healthy Maine Works and Work Alert.

- **Professional development.** OSA and its state agency partners regularly participate in professional development opportunities. Through the Staff Education Training Unit (SETU), OSA is also able to offer a variety of substance abuse trainings needed at the state level at little to no cost.

- **Working with Youth.** OSA and MCDC contract with the Maine Youth Action Network (MYAN) to integrate youth involvement into substance abuse prevention strategies. MYAN provides trainings statewide for youth and adults as well as hosts a statewide conference each fall.

- **Shared Youth Vision Council.** This group serves as the Children’s Cabinet’s advisory collaborative-stakeholder body, through which program efficiencies, improvements, coordination, communication, and collaboration among youth-serving agencies and providers at the state, regional, and local levels are examined. OSA participates in the Shared Youth Vision Council and in the planning of the Positive Youth Development Institute where OSA is able to offer substance abuse prevention training to a variety of youth, local, and state level stakeholders.

- **Juvenile Justice Advisory Group.** OSA serves on the Maine Juvenile Justice Advisory Group (JJAG) that oversees the state’s participation in the federal juvenile justice
The purpose of the initiative is to help states craft effective responses to the problems of juvenile crime and violence. As part of this initiative, Maine receives funds to improve its juvenile justice system, which JJAG oversees and disburses.

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

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

- **Communities for Children and Youth (C4CY).** This initiative of the Governor’s Children’s Cabinet aims to measurably improve the well-being of children in every Maine community and to increase educational attainment and achievement levels of all Maine children. This has occurred by supporting 72 communities over the past twelve years. CY4C currently works with fifteen communities and supports three grant projects: Diversion to Assets, College-Community Mentoring Project and Assets Getting to Outcomes for Maine.

- **Gay, Lesbian & Straight Education Network (GLSEN).** GLSEN is a national education organization making schools safer for all students, regardless of sexual orientation or gender identity/expression. There are two GLSEN chapters in Maine: Downeast GLSEN (based in Ellsworth) and GLSEN-Southern Maine (based in Portland). Members of both chapters consult with school staff and provide resources and support for over 50 Gay Straight Alliances in Maine’s secondary schools.

- **Jobs for Maine Graduates (JMG)** is a private, non-profit organization that provides drop-out prevention and school-to-work transition services for at-risk youth. The high school program is delivered as a for-credit course in conjunction with the student’s regular course load. Project Reach is a project-oriented and adventure-based program designed to address the challenges of middle school. JMG also supports a number of other initiatives such as the Maine Mentoring Partnership; the Maine Municipal Literacy initiative; programs specifically for incarcerated youth; and Opportunity Passport, a financial literacy and matched savings program.

- **Keeping Maine’s Children Connected** is an initiative of the Maine Children's Cabinet that takes an integrated approach to help children and youth who experience school disruption due to homelessness, foster care placement, correctional facility placement and/or in-patient psychiatric care. The intent is to simplify the transitions to and from school so that these children and youth can stay connected or re-connect to their educational program as soon as possible. It is a collaborative effort among the Departments of Corrections, Education, Labor, Justice, and Health and Human Services.

- **Maine After School Network** has as its purpose to enable every child to have access to quality, inclusive, affordable after school programming that meets the needs of the child, the family and the community. The network is a collaboration of individual and organizational partners across the state that works to foster communication among
policymakers and providers, assist in securing resources to develop and/or sustain programs, and assist with training and technical assistance.

- **Maine Coalition to End Domestic Violence** aims to create and encourage a social, political, and economic environment in which domestic violence no longer exists, and to ensure that all people affected by domestic abuse and violence are supported and that batterers are held accountable. The coalition mobilizes and coordinates community action through a statewide network of domestic violence projects.

- **Maine Families Home Visiting Program** is administered by the Early Childhood Division of the Maine DHHS and provides grants to community agencies which maintain local sites within each of Maine’s sixteen counties. Through home-based appointments, home visitors help first-time parents and parents-to-be to access information and resources that can support the physical and emotional health of their baby and entire family.

- **Maine Mentoring Partnership** was established in 2001 by the Maine Children’s Cabinet and is a statewide public-private partnership of mentoring program providers and supporters. Its primary role is to increase the number of formal mentoring relationships available to Maine’s children and youth. The partnership came under the Jobs for Maine Graduates umbrella in 2006 and is a formal partner of Communities for Children and Youth.

- **Maine Youth Action Network (MYAN).** The goal of MYAN is to empower and prepare youth and adults to partner for positive change by offering them training, networking and leadership opportunities. MYAN’s work is grounded in the models and philosophies of positive youth development. Annual events include the Peer Leadership Conference.

- **Restorative School Practices Collaborative of Maine (RSPM).** In 2006, the Restorative Justice Project of Midcoast Maine began to apply the principles and practices of restorative justice in the area of education, known as Restorative School Practices. In partnership with the University of Maine Peace & Reconciliation Studies Program and the Maine Law and Civics Education Program at University of Southern Maine, RJP formed RSPM, which is a coalition of trainers that assist and support Maine educators in understanding and implementing restorative practices, values and skills, including restorative discipline, in schools throughout Maine.

- **School-Based Health Centers (SBHC)** are administered by the Family Health Division of the Maine DHHS and provide grants to partnerships between a school and a medical provider/agency in order to keep students healthy and in school. Currently Maine funds seventeen SBHCs that have over 7,000 students enrolled. SBHCs provide primary and preventive health care with mental health and oral health services integrated into most of the centers. Students are seen in a youth-friendly environment by providers experienced in serving adolescents. They are assessed for health risks such as alcohol and tobacco use, physical activity, nutrition, unintentional injuries and intentional injuries. Treatment is provided or referrals are made to community providers, as appropriate. SBHC staff receive additional training in suicide prevention and dating violence and work with their schools in developing appropriate policies and providing support to school personnel, students and their families.

- **Youth Empowerment and Policy Project (YEPP) is an active, diverse group of students from around the state of Maine trained in public speaking, facilitation, and policy issues.**
YEPP was established in 2001 with the primary goal of involving Maine's youth in the effort to decrease underage drinking. The philosophy of the project is that, because underage drinking is a problem affecting the youth population, the most effective way to analyze and improve the environment is to involve youth directly in the discussion. YEPP is coordinated by AdCare Educational Institute of Maine, Inc., a private, non-profit organization based in Augusta.

**Strengths of Coordination of Services with Other State Agencies**

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

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

**Challenges of Coordination of Services with Other State Agencies**

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

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

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

**Coordination of Services with Other Partners**

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

Primary care providers (PCPs) engage in some primary substance abuse prevention, however there is little coordination of these services. Some PCPs work to raise awareness and provide
information to parents and teens about substance abuse (including information provided by OSA), and some PCPs conduct screenings (including the screening tool made available by OSA) and brief interventions (motivational interviewing). Many PCPs across the state are developing ways to integrate behavioral health and primary care services; however to date substance abuse prevention has not been a priority in integration initiatives.

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

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

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

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

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

**Strengths of Coordination of Services with Other Partners**

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

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

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

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

**Challenges of Coordination of Services with Other Partners**

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

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

Cultural competency issues arise at the state level in working with the Native American population. There is a need for education and training in cultural competency in order to
increase awareness and understanding of the culture. Evidence-based programs are often not appropriate for tribal communities and those that are may not be impactful to the tribes here in Maine, because they were developed for tribes in the western U.S. At the state level, there is also a lack accurate data pertaining to tribal health, including data on substance abuse.

Coordination of Local Services with HMPs

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

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

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

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

OSA works with District Coordinating Councils (DCCs). Currently, about half of the nine DCCs include substance abuse prevention in their work plans. DCCs are in the early stages of development, and do not have the staff or infrastructure that HMPs have. For this reason,
district level planning and implementation also occurs through HMPs. Some of the Community Transformation Grant funds will be devoted to building regional capacity through the DCCs.

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

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

Networks currently in place for local coalition networking are:

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

• **Maine Network of Healthy Communities** is a statewide network of comprehensive community health coalitions. All HMPs are members of the Network, which is an advocacy organization that also provides trainings and informal mentoring opportunities around community coalition issues.

• **Drug Free Communities** grantees. DFC grantees have begun meeting on their own, in order to coordinate their efforts, share resources and address sustainability. OSA staff have recently been engaged in the DFC grantee network.

• **PMP Promotion.** PMP Promotion Project champions are funded in each district and are tasked with coordinating and collaborating with one another and other stakeholders in their districts and statewide to address the reduction of prescription drug misuse by promoting the PMP with consistent messaging statewide. Grantees and OSA communicate using the PMP listserv, via monthly conference calls, face-to-face meetings and email to coordinate efforts.

**Strengths of Coordination of Local Services with HMPs**

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

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

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

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

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

**Summary of Coordination of Services**

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

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

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

A complete discussion of how to address the coordination of services at all levels, including goals, objectives and milestones, can be found in the Strategic Prevention Plan 2013-2018.
Attachment 1:

OSA Prevention Advisory Board Members

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

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

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

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

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

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

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

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

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

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

Kevin Lewis. Chief Executive Officer, Maine Primary Care Association

Randall A. Liberty. Sheriff, Kennebec County

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

Kathryn McGloin. Juvenile Corrections Division, Department of Corrections


Cheryl Peavey. Director, Early Childhood Initiative.

Anne Rogers. Data and Research Team Manager, Maine Office of Substance Abuse
Paula Thomson, Central Maine Public Health District Liaison, Office of Local Public Health, Maine Center for Disease Control & Prevention

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

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

Maine Office of Substance Abuse Prevention Team

Cheryl Cichowski. Prevention Specialist
Jacinda Goodwin. Prevention Specialist
Maryann Harakall. Prevention Specialist
Leanne Morin. Information and Resource Center Coordinator and Prevention Specialist
Appendix H

State Prevention Enhancement
Assessment of Training and Technical Assistance

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III. Summary of Training and Technical Assistance
I. Introduction

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

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

Specific definitions and acronyms used in this report are in Appendix B of the Strategic Prevention Plan 2013-2018.
II. Assessment of Training and Technical Assistance for Substance Abuse Prevention

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

Career Development

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

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

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

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

The Maine Community College System has a list of programs offered throughout Maine at [http://www.mccs.me.edu/student/student.html](http://www.mccs.me.edu/student/student.html). For example, the Maine Community College System offers programs ranging from Nursing to Human Services to Mental Health to Psychology to Social Work.
**Strengths**
There is an opportunity to build a career path that allows the current prevention workforce to provide input on what information, beyond certification, would be beneficial to new professionals in the field. There are a number of substance abuse treatment and prevention providers who have worked at institutions of higher education as staff, faculty or adjunct faculty, or instructor. These providers are an untapped resource, and through a coordinated effort may be able to assist with developing a substance abuse prevention certification program or individual classes.

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

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

**Workforce Development**

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

- **Office of Juvenile Justice and Delinquency Prevention (OJJDP)** sponsors a national conference which brings juvenile justice researchers, practitioners, policy makers, law enforcement and advocates together to learn about the latest research findings and developments, and about initiatives within the Department of Justice and across the country. OJJDP also contracts with the Pacific Institute of Research (PIRE) to provide additional training and technical assistance to the Enforcing Underage Drinking Laws (EUDL) grantees. PIRE hosts monthly webinars on topics related to the enforcement of underage drinking laws. The webinars are free and open to anyone who would like to participate.

- **US Department of Education (US DOE)** provides access to a number of webinars to grantees as well as to the Office of Safe and Drug Free Schools national conference. The conference offers sessions on research based programs and best practices; new trends and approaches; and training from practitioners in the fields of mental health, health, alcohol, drug and violence prevention as well as other areas related to school and community based prevention.
• *The National Prevention Network* Prevention Research Conference provides a forum to explore the latest prevention research, application and practice to promote positive outcomes at the community, state and federal levels.

• *Community Anti-Drug Coalitions of America’s (CADCA)* National Leadership Forum provides multiple opportunities to learn the latest strategies to fight substance abuse and to hear from nationally-known experts and policymakers. Numerous Maine coalitions are Drug Free Communities grantees and typically send staff to this conference. CADCA also provides training opportunities for community coalitions in problem solving, assessment, and planning around substance abuse prevention. As a member of CADCA, OSA is eligible to take advantage of the trainings (in person and online) offered.

• *Substance Abuse and Mental Health Services Administration (SAMHSA) - Center for Substance Abuse Prevention (CSAP)* provides national leadership in the federal effort to prevent alcohol, tobacco, and other drug problems.

• *Prevention Research Institute’s* Under 21 program is used among Student Intervention and Reintegration Program (SIRP) grantees to address high risk youth. Grantee staff are eligible to become SIRP trainers, and grantees are eligible for continuing education and support for trainers.

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

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

• *AdCare Educational Institute/New England Institute of Addiction Studies (NEIAS)* provides workforce development training opportunities through the week long Prevention School. Additionally, AdCare provides a variety of workforce development opportunities statewide on topics ranging from prevention ethics to neurobiology for prevention.

• *Maine Alliance to Prevent Substance Abuse (MAPSA)* works with key stakeholders to strengthen Maine’s substance abuse prevention infrastructure by offering trainings and sharing current research, best practices and resources.

• *The Juvenile Justice Advisory Group (JJAG)* was established in response to the federal Juvenile Justice Delinquency Prevention Act of 1974 and oversees the state’s participation in the federal juvenile justice initiative. The JJAG supports programs for the improvement of juvenile justice and delinquency prevention and offers trainings and technical assistance to grantees as well as other state agencies, local partners such as...
police departments and schools. For example, JJAG has supported Collaborative Problem Solving and Undoing Racism trainings.

- **Shared Youth Vision Council's (SYVC) goal is to ensure that the public, private and nonprofit sectors work collectively and collaboratively to increase the high school graduation rate, reduce child abuse and neglect, and create economic opportunities for youth. In collaboration with a variety of state and local agencies, the Positive Youth Development Institute is held on an annual basis and addresses a variety of topics ranging from Bullying and Violence, Safe Schools and Substance Abuse Prevention.**

- **Substance Abuse and the Workplace for Substance Abuse Prevention / Treatment Providers and Coalitions.** These workshops help build an infrastructure of trained prevention and treatment providers and coalitions who can assist local businesses with the development of a Drug Free Workplace Program (DFWP). Maine businesses may wish to implement a DFWP that is as basic as a DFWP policy and education of their employees and supervisors. By knowing about the resources in their communities to refer employees to for assistance, their policies and programs will be more effective. Connecting employers with trained service providers will set up their programs, employees, and their business for success.

- **How to Use the Maine Integrated Youth Health Survey (MIYHS) to Assess Need, Choose Evidence Based Strategies, and to Seek Funding** is a training program that educates prevention professionals on MIYHS results. MIYHS was first implemented in the spring of 2009 in 80% of Maine middle and high schools, and is administered every two years. The training gives an overview of the survey results, and offers suggestion on how local data can be used. There is an emphasis on procedures and partnering with school administrators to obtain local data, accessing data via the web, and the limitations and potential of the data. The training includes a description of funding opportunities and an opportunity for participants to network.

- **OSA Prevention Provider Day** focuses on the many facets of providing substance abuse prevention strategies, programs, and practices successfully. This conference serves as a forum for substance abuse prevention providers, other state agencies and various OSA partners to exchange information, develop skills, and foster collaboration and coordination.

- **Healthy Maine Partnerships Annual Conference** is hosted by MCDC, DOE and OSA and provides an opportunity to interface with local and state partners in public health and education. The conference offers opportunities for state staff and local HMP staff to receive professional development training that pertains to the core competencies outlined for the public health infrastructure.

- **Healthy Maine Partnership Professional Development Team** identifies need and facilitates professional development of staff who are involved with the HMP initiative. Trainings address coalition development, contract objectives, and contract deliverables. Note: OSA refers to professional development as “workforce development.”

- **Teen Driver Awareness Training** is for law enforcement officers and is offered through the Bureau of Highway Safety. OSA presents some training on Maine liquor laws, specifically those that directly impact teen drivers.

- **Maine Network of Healthy Communities (MNHC)** is a statewide network and advocacy organization comprised of comprehensive community health coalitions. All HMPs are
members of the Network. MNHC provides trainings and informal mentoring opportunities around community coalition issues.

- **Maine Afterschool Network (MASN)** works to enable every child to have access to quality, inclusive, affordable after school programming that meets the needs of the child, the family and the community. MASN is a collaboration of individual and organizational partners across the state and works to foster communication among policymakers and providers to assist in securing resources to develop and/or sustain programs, and assist with training and technical assistance.

- **Communities for Children and Youth (C4CY)** is an initiative of the Governor’s Children’s Cabinet that aims to measurably improve the wellbeing of children in every Maine community and to increase educational attainment and achievement levels of all Maine children. This has occurred by supporting 72 communities over the past twelve years. C4CY and currently works with fifteen communities and supports three grant projects: Diversion to Assets, College-Community Mentoring Project and Assets Getting to Outcomes for Maine.

- **Maine Military Clinical Outreach Network** educates training organizations, agencies and providers in the subtleties of working within the military culture as well prevention and treatment best practices within that culture.

- **Responsible Beverage Server/Seller Training** is available through the Department of Public Safety, Liquor Licensing and Compliance Division. These trainings target servers and sellers of alcohol in the state and provide detailed information about laws and the legal responsibilities of servers and sellers.

- **Prescription Monitoring Program (PMP) Promotion Project** offers grantees the opportunity to participate in monthly technical assistance phone calls with the OSA project officer and the PMP state coordinator.

- **Conference calls/webinars** are provided by OSA to all organizations receiving funds to implement prevention programming. The calls are scheduled approximately every other month and address a range of topics. Examples of calls in 2012 include evidence-based programming, medical marijuana, evaluation, and integrating substance abuse into the public health system in Maine. The calls are facilitated by OSA prevention team staff and conducted by an expert on the topic (who is not necessarily OSA staff).

- **Underage Drinking Law Enforcement** trainings are available across the state to increase the enforcement of underage drinking laws. The grantees, and any other law enforcement agency in Maine, have access to training pertaining to enforcement efforts. Training topics include effective party dispersal, compliance check procedures, and Maine liquor law. OSA grantees, specifically the HMPs, have access to training topics such as “how to work with law enforcement” and “how to work with licensees about legal sale of alcohol.”

- **Maine Youth Action Network (MYAN)** provides trainings and technical assistance to the HMPs and other OSA grantees around youth strategies and initiatives to empower and prepare youth and adults to partner for positive change. MYAN's work is grounded in the models and philosophies of positive youth development. Annual events include the Peer Leadership Conference.

- **Drug Impairment Training for Education Professionals** is a program for school personnel to educate them on identifying students who have consumed drugs. This training is
available for any school in Maine by request through the Maine Criminal Justice Academy.

- **Prime for Life/Student Intervention and Reintegration Program (SIRP)** targets an indicated population of students who have engaged in alcohol and/or drug use behavior. SIRP is designed to empower youth to make healthy decisions, reduce risk for problems and focuses on two measurable behavioral prevention goals: increase abstinence for a lifetime and reduce high-risk choices. The chosen intervention is the PRIME For Life program used with young people ages 13-20. The PRIME For Life program is provided by the Prevention Research Institute, Inc. OSA grantees that are implementing SIRP have access to the PRIME For Life program training.

- **The Higher Education Alcohol Prevention Partnership (HEAPP)** offers trainings to increase statewide capacity for addressing underage and high-risk alcohol use by college students on and around campus. Trainings focus on applying environmental management strategies to campus settings, working with law enforcement on and around campuses, data-driven needs assessment and project evaluation, stakeholder engagement in coalitions and strategies, cultural competency, and implementing evidence-based prevention and intervention programs. HEAPP utilizes internal training capacity (staff and campus-based experts) as well resources from the U.S. DOE’s Higher Education Center for Alcohol and Other Drug and Violence Prevention. Coalitions can access specialized training on how to implement environmental management strategies on and around campuses, as well as receive technical assistance on prevention programming best practices and evidence-based strategies that fit the needs and culture of this population and setting.

- **Maine Inhalant Abuse Prevention Task Force.** OSA, in partnership with the New England Inhalant Abuse Prevention Coalition, formed a statewide task force to identify the nature of the inhalant problem in Maine and recommend model prevention practices designed to reduce inhalant use.

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

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

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

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

**Challenges**

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

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

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

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

The capacity to conduct academic research on substance abuse prevention and related issues does not exist in Maine. This represents a vital aspect of prevention infrastructure that could not be supported or sustained after the SPF SIG. OSA would need to partner actively with
research bodies within Maine’s institutions of higher education to move this forward; this typically requires external funding.

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

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

**Professional Development**

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

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

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

- **Staff Education and Training Unit (SETU)** of the DHHS designs, implements, monitors and evaluates a coherent and effective staff training system. Statewide, SETU offers core competency programs, specialized training and consulting services. The primary focus of the system is to meet the educational and training needs of DHHS, of foster and adoptive parents and of local provider agencies, in order to improve the quality and delivery of social services.
- **Maine Alliance to Prevent Substance Abuse (MAPSA)** works with key stakeholders to strengthen Maine’s substance abuse prevention infrastructure by offering trainings and sharing current research, best practices and resources. Members have professional development opportunities through serving on the MAPSA steering committee and/or on its various sub-committees. Planning and presenting opportunities are a possibility through the annual MAPSA Prevention Convention.
• Maine Public Health Association (MPHA) is a member based organization with 350 members from all sectors of public health. The Association aims to protect individuals, families and communities in Maine from preventable, serious health threats and strives to assure community-based health promotion and disease prevention activities. Through its e-newsletters, advocacy alerts, annual conference and networking meetings, MPHA communicates the latest public health science and practice to members, opinion leaders and the public.

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

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

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

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

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

III. Summary of Current Training and Technical Assistance for Prevention

As demonstrated through this assessment, Maine has access to many training and technical assistance opportunities at the state and national levels that encompass substance abuse prevention initiatives. These opportunities are applicable for OSA staff, OSA partners, and OSA
grantees. While there are many opportunities for professional development, some prevention specialists do not take advantage of them.

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

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

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

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

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

State Prevention Enhancement
Data Collection, Analysis and Reporting Assessment

Contents

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

Attachment 1: Inventory of Data Sources for Prevention
I. Introduction

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

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

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

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

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

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

To conduct this assessment of the data collection, analysis and reporting currently employed in Maine, the following criteria were applied (where applicable) to the various sources of data that are collected and/or tracked:
• Current capacity:
  o Are the data collection efforts consistent for trending purposes?
  o Are they consistently funded so they can be used as part of a five-year strategic plan?
  o Are data analyzed and reported for public use?
  o Are data collected regarding contributing factors, consumption and consequences of substance use and abuse?

• Data quality:
  o Is there any oversight for data collection?
  o How accurate are the data?
  o Are data collected in a standardized way?

• Frequency of data collection:
  o How often are data collected? (e.g., annually, quarterly)

• Ability to analyze at sub-state/sub-population level:
  o Can data be analyzed by demographics, such as race or gender?
  o Can data be analyzed at a sub-state geographic level, such as county or Public Health District?

**Current Status of Process Data**

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

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

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

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

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

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

HEAPP Quarterly Reports: Though financially supported by OSA, this initiative is not solely overseen or supported by the agency. As part of the contract with OSA, however, data are collected about the number of participating campuses, quantity of program materials distributed, trainings conducted and training participants. HEAPP also administers mini-grants to colleges and universities. These grantees are required to report information to HEAPP such
as enforcement of alcohol violations and incidents of vandalism; these data are aggregated before being reported to OSA. Some process data are also recorded in KIT by OSA-funded coalitions for their work with participating campuses.

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

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

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

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

**Keep ME Well Data**: Keep ME Well is an on-line health assessment. Although the web tool was not designed as a data collection tool, it can provide basic demographic information and self-reported data about the people who use the system. The assessment includes a question about past 30 day alcohol use and is being promoted by HMPs and statewide health agencies. Basic demographic data are collected, such as zip code from which respondent is accessing the site and gender. However, the data suffers selection bias and only represents people who know about the assessment. It also cannot eliminate duplicate visitors, thus affecting the accuracy of reports indicating the number of times this resource is used.
Screening, Brief Intervention, and Referral to Treatment (SBIRT): This early intervention strategy is being implemented in some health care settings, mainly in primary care practices, but also in emergency rooms and trauma centers. These brief screenings use standardized tools to screen patients to detect potentially problematic substance use, with the aim of intervening before specialized treatment is needed. Reporting and billing data obtained from sources such as the All Claims database or MaineCare could be used to monitor such interventions although the necessary code to record these activities is not currently activated in those systems. Collecting information about the frequency and prevalence of these brief screenings that occur in health care settings would allow OSA to explore the effectiveness of this screening as a prevention tool. This information would provide a valuable addition to current process counts by incorporating the work of the medical community.

Current Status of Outcomes Data

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

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

One challenge associated with data collection, analysis and reporting of factors contributing to substance abuse is that data associated with the adult population is limited. The National Survey on Drug Use and Health (NSDUH), one source that currently measures perceived risk of harm from alcohol, has a significant time delay (most recent data are from 2008-09). Moreover, access to raw data is limited, so only observational correlations can be made (but not tested). HEAPP survey data are extensive in this area but only apply to the college population; data were most recently collected in 2008. Plans are underway to re-administer the survey in 2012-
2013-2012. Data regarding parent/adult attitudes towards youth use and furnishing, monitoring and other contributing factors to substance use among youth are also limited to an annual telephone survey of parents that has been used to gauge the impact of the social media campaign. The future sustainability of that survey is uncertain. An additional challenge is that the sources listed above provide state level estimates; limited data are available to measure contributing factors at the sub-state level. NSDUH can be monitored by Public Health District only if multiple years of data are grouped and results are obtained only upon special request.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A complete discussion of how to address these areas of data collection, analysis and reporting, including goals, objectives and milestones, can be found in the Strategic Prevention Plan, 2013-2018.
### Attachment 1:
Inventory of Data Sources for Prevention

<table>
<thead>
<tr>
<th>Process Data</th>
<th>Strategy/Intervention Counts</th>
<th>Population</th>
<th>Lowest Geo Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>KIT Solutions</td>
<td>Prevention programs and strategies implemented in communities</td>
<td>HMP Grantees</td>
<td>HMP</td>
</tr>
<tr>
<td></td>
<td>• Number</td>
<td>Block Grant</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Type</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• People Reached</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No Child Left Behind Performance Reporting System – Safe Schools Supplemental Report</td>
<td>Prevention programs implemented at schools</td>
<td>Maine Schools</td>
<td>Unknown (available upon request)</td>
</tr>
<tr>
<td></td>
<td>• Type</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Number</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enforcing Underage Drinking Laws (EUDL) Quarterly Reports</td>
<td>Law enforcement-related activities</td>
<td>EUDL Grantees</td>
<td>Police Department</td>
</tr>
<tr>
<td></td>
<td>• Type</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Number</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Associated citations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Higher Education Alcohol Prevention Project (HEAPP) Reports</td>
<td>Prevention efforts at colleges and universities</td>
<td>Colleges and universities participating in HEAPP</td>
<td>State (data are aggregated)</td>
</tr>
<tr>
<td></td>
<td>• Number of participating campuses</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Number of program materials distributed</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Number of trainings conducted</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Number of Participants</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ethos Marketing Quarterly Reports</td>
<td>OSA media campaigns</td>
<td>OSA Grantees</td>
<td>Public Health District</td>
</tr>
<tr>
<td></td>
<td>• Number of media ads</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Number of materials requested</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Number of exposures</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Duration</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Page views</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TA and Training Evaluation Data</td>
<td>Type of training Training Satisfaction/Meeting of Learning Objectives</td>
<td>Attendees at OSA-sponsored trainings</td>
<td>Participant demographic data are collected (e.g., geographic origin and educational attainment)</td>
</tr>
<tr>
<td>Keep ME Well Data (note: not designed as a data collection tool)</td>
<td>Health Risk Assessments</td>
<td>Individuals concerned about their health/self-report on assessment (Selection bias)</td>
<td>County, zip code</td>
</tr>
<tr>
<td>Health Care Billing or Patient Records</td>
<td>Needed: number of people or percentage of patients being screened for potentially risky substance use.</td>
<td>Patients in primary care settings</td>
<td>Unknown</td>
</tr>
</tbody>
</table>

**Table Notes:**
- **Lowest Geo Level** indicates the geographical level at which the data is collected.
- **HMP** indicates data related to the Homelessness Prevention program.
- **Maine Schools** indicates data related to school-based programs.
- **State** indicates data aggregated at the state level.
- **Unknown (available upon request)** indicates data that may be available upon request.
- **Selection bias** indicates potential bias in the data collection process.
- **Participant demographic data** are collected for certain data sources.
Appendix J

State Prevention Enhancement
Assessment of Performance Measurement and Evaluation

Contents

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

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

Attachment 2: Center for Disease Control Evaluation Standards
I. Introduction

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

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

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

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

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

Specific definitions and acronyms used in this report are in Appendix B of the Strategic Prevention Plan 2013-2018.
II. Assessment of Performance Measurement and Evaluation for Prevention

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

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

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

Current Status of Performance Measurement and Evaluation by OSA Programs

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

Process Evaluation
The process data for these efforts are collected from local coalitions (grant recipients) through KIT Solutions. Maine compiles effort and reach counts for HMPs and other block grant recipients through this system. KIT also allows for the collection of narratives from grant recipients about their local prevention efforts that may demonstrate connections between processes and observed outcomes. OSA project officers for each grantee review content in KIT quarterly. The challenge for evaluation is that this information on effort and reach is used only to determine whether goals were met, not whether reaching these goals affected the outcome. Data recorded in KIT are rarely investigated in-depth for meaningful program enhancement. Additionally, information about efforts involving initiatives to improve mental health is not collected. Local coalitions do not have the option to record their progress in other substance abuse prevention efforts other than those funded by the block grant; that is, those strategies related to alcohol and engaging businesses in drug-free workplace programs.
Outcomes Evaluation
The efforts recorded in KIT target factors that contribute to OSA’s priority consumption patterns and related consequences. Many indicators that measure long-term outcomes are collected through data sources like the Maine Integrated Youth Health Survey (MIYHS), the Higher Education Alcohol Prevention Partnership (HEAPP) survey and the Behavioral Risk Factor Surveillance Survey (BRFSS). These indicators are compiled annually in the State Epidemiology Profile. For middle and high school students, MIYHS also contains numerous measures related to the contributing factors that grantees address (e.g., perception of being caught by parents). Similarly, the HEAPP survey contains a number of indicators related to attitudes and behaviors, although data are not available at the sub-state level and only represent individuals enrolled in post-secondary institutions. However, measures of contributing factors related to alcohol use by adults (i.e., those behaviors being addressed by grantees) are not available with the exception of perceived risk, an indicator contained in the National Survey of Drug Use and Health (NSUDH); NSDUH has limited use in evaluation beyond an indicator that can be monitored as the data are untimely and raw data are not available. Other adult data are limited at the sub-state level and workplace related data are limited or non-existent.

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

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

Process Evaluation
KIT process counts capture work being done with college campuses through OSA-funded coalitions, so there are some process measures available. However, HEAPP also receives funding from other sources. The counts collected and reported to OSA are only for activities funded by OSA and include number of participating campuses, quantity of program materials distributed, the number of trainings conducted and the number of training participants. HEAPP administers mini-grants to colleges and universities and requires them to report information such as enforcement numbers for alcohol violations. This process information is aggregated before it is reported. HEAPP does not report regularly to OSA on process counts from funded colleges/universities.
Outcomes Evaluation
The HEAPP survey of college students collects extensive outcomes measures about alcohol consumption and contributing factors. The project has plans to administer another survey in 2012. The outcomes measured in the HEAPP survey very clearly link the consumption with consequences (e.g., did you hurt yourself? Were you drunk when you hurt yourself?). An additional strength is that data collected through the HEAPP survey provides information about a population of concern (young adults enrolled in college). On the other hand, this outcomes information is reported publicly at the state level only. Because of this, OSA cannot use these data to identify college/university communities of concern, even though the HEAPP program does use data internally to do so. Nonetheless, the survey corroborates the patterns observed in other data sources for this age group and adds to knowledge about the use of other substances, such as marijuana or prescription drugs.

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

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

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

Outcomes Evaluation
Surveys such as the MIYHS collect information about the results these efforts (e.g., changing perceptions and attitudes regarding enforcement, and reducing underage drinking and binge drinking). The short-term results of EUDL efforts such as citations, adjudications and prosecution of furnishers are not recorded or accessed in a manner that allows for an evaluation of shorter-term outcomes.
Linking Process and Outcomes Data
Data linking current EUDL efforts, or examining past EUDL funded sites, are not regularly examined for trends in the number of citations for underage drinking issued, youth reporting increased enforcement or long-term reduction in youth drinking. Moreover, evaluation and data analysis have not accounted for the relationships and collaboration that occurs between HMP coalitions and the EUDL grantees (and former grantees).

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

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

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

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

Linking Process and Outcomes Data
PMP does not formally evaluate its efforts on a regular basis. It is difficult to link the efforts of expanding the program directly to the outcome of decreasing the availability of prescription
drugs, abuse of those drugs or the related consequences (e.g., referrals to treatment, unintentional drug overdose deaths).

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

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

**Process Evaluation**

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

**Outcomes Evaluation**

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

**Linking Process and Outcomes Data**

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

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

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

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

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

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

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

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

**Figure 1: Social-Ecological Model**

![Social-Ecological Model](http://www.cdc.gov/ViolencePrevention/overview/social-ecologicalmodel.html)

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

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1 Taken from the CDC website: [http://www.cdc.gov/ViolencePrevention/overview/social-ecologicalmodel.html](http://www.cdc.gov/ViolencePrevention/overview/social-ecologicalmodel.html)
Table 1: Promotion and Prevention Strategies

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

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

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

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

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

<table>
<thead>
<tr>
<th>Target of Intervention</th>
<th>Type of Prevention Strategy Used</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Universal Indirect</td>
</tr>
<tr>
<td></td>
<td>Universal Direct</td>
</tr>
<tr>
<td></td>
<td>Selective</td>
</tr>
<tr>
<td></td>
<td>Indicated</td>
</tr>
</tbody>
</table>

- **Specific Demographic? (e.g., age)**
  - [How many of these types of prevention strategies/interventions used for the “target” indicated?]

- **Specific Substance? (e.g., alcohol)**

- **Specific Audience? (e.g., parents or law enforcement)**

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

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

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

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

A second way to analyze the combination of prevention efforts is to consider whether an increased emphasis on a particular substance or population of concern (e.g., underage alcohol use or the young adult population) resulted in the desired outcomes. If the associated surveillance data did not change, the evaluation emphasis should then be placed on whether the evidence-based programs were implemented with fidelity. For example, if at the state level OSA placed an emphasis on universal indirect prevention strategies, yet attitudes remain unchanged, a closer examination of the programs implementing these strategies might reveal that they were not implemented as designed. A specific strategy may have been the one
implemented most often by local coalitions according to their quarterly reports; but closer inspection of the KIT counts may reveal that, while many organizations are implementing the strategy, they are not reaching their stated goals; alternatively, a universal indirect program may only reach a limited audience according to the KIT measures. Additionally, if the narrative accompanying the record is consulted, it may reveal that organizations are adapting programs to local conditions not implementing the program as designed and proven to be effective through research.

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

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

**Additional Gaps, Challenges or Considerations**

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

**Federal Reporting Requirements:** When OSA receives federal dollars, the Government Performance and Report Act (GPRA) requires it to report specific measures related to that funding source. Similarly, many federal grants also have National Outcome Measures (NOMs), which relate to outcomes of individuals receiving the services or programs being funded. It is imperative to sustaining federal funding for prevention that Maine be able to demonstrate the capacity to fully report on GPRA measures and NOMs as required by the associated federal funding source. In cases where there is an inability to meet federal requirements, data collection and reporting capacity should be built. Moreover, OSA should explore whether it has the capacity to report on GPRA/NOMs for funding sources that it would like to pursue (e.g., Partnerships for Success grants that require measures for young adults) and build that infrastructure to demonstrate capacity in future applications.
Other Prevention Efforts: There are numerous prevention efforts in Maine that OSA does not fund, but that should be acknowledged since they are often closely aligned with OSA’s programs. Examples include Drug Free Communities grants and school-based Grants to Reduce Alcohol Abuse. Such programs are part of community prevention efforts and, though not linked to OSA through finances or official oversight, are important to consider alongside OSA’s efforts. As these programs are not part of OSA, access to process data is limited. For example, school-based programs present challenges for evaluation because reliable school data are difficult to obtain, especially after the elimination of funding through Safe and Drug-Free Schools. Although OSA is not responsible for the administration and evaluation of these programs, efforts should be made to incorporate information about collaboration with external agencies as part of routine process data collection. Knowledge of other community prevention efforts could provide insight into effective collaboration strategies that should be implemented throughout Maine’s prevention infrastructure.

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

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

III. Summary of Performance Measurement and Evaluation

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

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

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

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

A complete discussion of how to address these areas of performance measurement and evaluation, including goals, objectives and milestones, can be found in Strategic Prevention Plan 2013-2018.
Theory of change: If you persuade parents that their children are at risk for underage drinking and provide information on how to prevent it, parents will change their modeling and monitoring behaviors which will lead to changes in youth perceptions about alcohol and ultimately reduce the rates of underage drinking.
Attachment 2:
Center for Disease Control Evaluation Standards

Evaluation Standards

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

The 30 standards are organized into the following groups:

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

**Utility Standards**

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

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

**Feasibility Standards**

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

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

**Propriety Standards**

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

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

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

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

Evaluation Accountability Standards

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

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

Supporting Document: Cultural Competency

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

Cultural Competency: Definitions of Cultural Competency

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

- DHHS, Office of Substance Abuse
- DHHS, Maine CDC, Division of Population Health
- DHHS, Adult Mental Health Services
- DHHS, Adults with Cognitive and Physical Disabilities
- DHHS, Office of Multicultural Affairs
- DHHS, Office of Child and Family Services, Child Protective Services
- DHHS, Maine CDC, Maine Public Health Data Reports

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

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

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

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

- Cultural competence emphasizes the importance of understanding people from different backgrounds, whether it be communicating with a patient in his/her native language or approaching interactions with an understanding of an individual’s customs and beliefs. This understanding leads to more appropriate and more effective care.
- Cultural competence stems from acknowledgement of and respect for differences.
- Cultural competence must be developed at all service levels of an organization.
- Definitions differ somewhat based on the “level” such as State Agency versus service provider.
- Definitions differ somewhat based on discipline (e.g., MH vs. SA vs. public health).
- Services need to be tailored to suit the needs of communities/patients; they cannot be one size fits all.

Recommendations

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

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

<table>
<thead>
<tr>
<th>Agency/Source</th>
<th>Working Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DHHS Office of Substance Abuse</strong></td>
<td>A Cultural Subpopulation is defined as any subpopulation in the state which shares a distinct set of cultural characteristics that appear to influence the substance abuse patterns and related impacts within that group. Culture is defined by the National Center on Cultural Competence, Georgetown University as “an integrated pattern of human behavior, which includes but is not limited to—thought, communication, languages, beliefs, values, practices, customs, courtesies, rituals, manners of interacting, roles, relationships and expected behaviors of a racial, ethnic, religious, social or political group; the ability to transmit the above to succeeding generations; dynamic in nature.”</td>
</tr>
<tr>
<td><strong><a href="http://www.maine.gov/dhhs/osa/prevention/community/spfsig/projects/subpops.htm">http://www.maine.gov/dhhs/osa/prevention/community/spfsig/projects/subpops.htm</a></strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>DHHS, ME CDC Division of Population Health</strong></td>
<td>Cultural and linguistic competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations. ‘Culture’ refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. ‘Competence’ implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities. <em>(Adapted from Cross, 1989)</em>.</td>
</tr>
<tr>
<td><strong>DHHS Adult Mental Health Services</strong></td>
<td>Cultural Competence: is knowledge, data and information from and about individuals and groups that is integrated and transformed into clinical standards, skills, service approaches, techniques, and marketing programs that match the individual’s culture and increase both the quality and appropriateness of health care and health outcomes. As a multidimensional construct, cultural competence can be conceptualized from provider, program, agency, and health care system levels.</td>
</tr>
<tr>
<td><strong>DHHS Adults with Cognitive and Physical Disabilities</strong></td>
<td>Cultural competence: the ability to understand, respect and effectively work with persons/groups with various cultural backgrounds including age and gender.</td>
</tr>
<tr>
<td>Agency/Source</td>
<td>Working Definition</td>
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</tbody>
</table>
(Cultural Competency relies on language competency) |
- The US Department of Health and Human Services offers these guidelines for culturally competent practice for Child Protective Caseworkers.  
- Cultural awareness. Understanding and identifying the critical cultural values important to children and the family as well as to the caseworker.  
- Knowledge acquisition. Understanding how these cultural values function as strengths in children and the family.  
- Skill development. Matching services that support the identified cultural values and then incorporating them into appropriate interventions.  
- Inductive learning. Seeking solutions that consider indigenous interventions as well as match cultural values to Western interventions.

The practice implications for CPS caseworkers include that they are asked to:  
- Respect how clients differ from them;  
- Avoid judgments and decision-making resulting from biases, myths, or stereotypes;  
- Ask the client about a practice's history and meaning if unfamiliar with it;  
- Elicit information from the client regarding strongly held family traditions, values, and beliefs, especially child rearing practices;  
- Understanding the family's cultural values, principles of child development, child caring norms, and parenting strategies;  
- Gaining clarity regarding the family's perceptions of the responsibilities of adults and children in the extended family and community network;  
- Determining the family's perceptions of the impact of child abuse or neglect.  
- Assessing each risk factor with consideration of characteristics of the cultural or ethnic group;  
- Explaining why a culturally accepted behavior in the family's homeland may be illegal here. |
<table>
<thead>
<tr>
<th>Agency/Source</th>
<th>Working Definition</th>
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<tbody>
<tr>
<td>DHHS, ME CDC Maine Public Health Data Reports</td>
<td>A set of behaviors and attitudes that enable us to understand and work effectively in cross-cultural situations. The result of cultural competency is the establishment of positive helping relationships that effectively engage people, and the significant improvement of quality of services such as public health and health care.</td>
</tr>
<tr>
<td>Maine Public Health Data Reports Glossary of Terms: <a href="http://www.maine.gov/dhhs/mecdcpndata/glossary.htm">http://www.maine.gov/dhhs/mecdcpndata/glossary.htm</a></td>
<td></td>
</tr>
<tr>
<td>Maine Human Rights Act [2005, c. 10, §1 (AMD).] §4552. Policy</td>
<td>To protect the public health, safety and welfare, it is declared to be the policy of this State to keep continually in review all practices infringing on the basic human right to a life with dignity, and the causes of these practices, so that corrective measures may, where possible, be promptly recommended and implemented, and to prevent discrimination in employment, housing or access to public accommodations on account of race, color, sex, sexual orientation, physical or mental disability, religion, ancestry or national origin;</td>
</tr>
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</table>
Current Status of Cultural Competency Trainings Available

Summary of Findings

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

Recommendations

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

<table>
<thead>
<tr>
<th>Who Conducts Training</th>
<th>Intended Audience</th>
<th>Types of training</th>
<th>SA/MH/Cultural Competence Specific Training</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fox Intercultural Consulting Services</td>
<td>Businesses, individuals, educational institutions and local communities</td>
<td>Strategies for Effective Cross-Cultural Communication, China Briefings, South Korea Briefings, America for the Non-American, Cross-Cultural Issues in Patient Care</td>
<td>Programs can be custom designed based on specific needs.</td>
<td><a href="http://www.maine.gov/dhhs/oma/MulticulturalResource/train.html">http://www.maine.gov/dhhs/oma/MulticulturalResource/train.html</a></td>
</tr>
<tr>
<td>SETU (Maine)</td>
<td>DHHS Supervisors and Managers Only</td>
<td>This four day program is designed for new supervisors in State government, specifically those working for the Department of Health and Human Services</td>
<td>The Fourth day’s agenda will include: Employee Discipline and Contract Administration; Drugs and Alcohol in the workplace; and Diversity and workplace respect. One of the trainers, Kate Carnes, is certified in Cultural Competency for Health Care providers</td>
<td>SETU training calendar MAY 3, 10, 17 &amp; 24, 2012</td>
</tr>
<tr>
<td>Who Conducts Training</td>
<td>Intended Audience</td>
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<tr>
<td><strong>UMaine Farmington Summer Course</strong></td>
<td>Professional Ethics, Cultural Competence, and Evidence-based Practices in Early Intervention and Early Childhood Special</td>
<td>Graduate level course through UMaine</td>
<td>Through the course, students engage in reflective inquiry regarding developing personal cultural competency. Students identify and use current research to increase personal knowledge and skills, applying findings to present work settings. Related to course objectives and required assignments, students spend a minimum of 20 hours working in an early intervention or early childhood special education setting.</td>
<td><a href="http://outreach.umf.maine.edu/program-information/summer-2012-courses/sed-517-professional-ethics-cultural-competence-and-evidence-based-practices-in-early-intervention-and-early-childhood-special/">http://outreach.umf.maine.edu/program-information/summer-2012-courses/sed-517-professional-ethics-cultural-competence-and-evidence-based-practices-in-early-intervention-and-early-childhood-special/</a></td>
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<tr>
<td><strong>National Center for Cultural Competence (online)</strong></td>
<td>Health professionals</td>
<td>Bridging the Cultural Divide in Health Care Settings: The Essential Role of Cultural Broker Programs</td>
<td></td>
<td><a href="http://www.culturalbroker.info/">http://www.culturalbroker.info/</a></td>
</tr>
<tr>
<td><strong>National Center for Cultural Competence (online)</strong></td>
<td>Health professionals</td>
<td>Cultural and Linguistic Competence Self-assessment for Fetal and Infant Mortality Review Programs</td>
<td></td>
<td><a href="http://nccc.georgetown.edu/Webinars.html">http://nccc.georgetown.edu/Webinars.html</a></td>
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<td>Who Conducts Training</td>
<td>Intended Audience</td>
<td>Types of training</td>
<td>SA/MH/Cultural Competence Specific Training</td>
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| National Center for Cultural Competence (online) | Division of Research, Training and Education-funded programs | Curricula Enhancement Module Series | • Cultural awareness  
• Cultural self-assessment  
• Process of inquiry -- communicating in a multicultural environment  
• Public health in a multicultural environment | http://www.nccccurricula.info/ |
<p>| National Center for Cultural Competence (online) | health care providers, policy makers, public health professionals, researchers and agency staff | Data Vignettes | personal learning and development or to augment curricula and training activities for health care providers, policy makers, public health professionals, researchers and agency staff. Each vignette contains links to additional resources related to concepts discussed and a set of questions for discussion. | <a href="http://nccc.georgetown.edu/data_vignettes/index.html">http://nccc.georgetown.edu/data_vignettes/index.html</a> |
| National Center for Cultural Competence (online) | Health promotion trainers | Infusing Cultural and Linguistic Competence into Health Promotion Training | Designed to help experienced health promotion trainers assure that their approaches with diverse populations address culture and language in an effective, appropriate and respectful manner. | <a href="http://nccc.georgetown.edu/projects/sids/dvd/index.html">http://nccc.georgetown.edu/projects/sids/dvd/index.html</a> |
| National Center for Cultural Competence (online) | Various | Self-Assessments | | <a href="http://nccc.georgetown.edu/resources/assessments.html">http://nccc.georgetown.edu/resources/assessments.html</a> |</p>
<table>
<thead>
<tr>
<th>Who Conducts Training</th>
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<th>Types of training</th>
<th>SA/MH/Cultural Competence Specific Training</th>
<th>Source</th>
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</thead>
<tbody>
<tr>
<td>National Center for Cultural Competence (online)</td>
<td>Systems of care</td>
<td>Planning for Cultural and Linguistic Competence in Systems of Care</td>
<td>Designed to assist organizations and systems of care to develop policies, structures and practices that support cultural and linguistic competence.</td>
<td><a href="http://nccc.georgetown.edu/documents/SOC_Checklist.pdf">http://nccc.georgetown.edu/documents/SOC_Checklist.pdf</a></td>
</tr>
<tr>
<td>Think Cultural Health (Office of Minority Health)</td>
<td>Health professionals</td>
<td>Continuing education programs</td>
<td>Designed to help individuals at all levels and in all disciplines promote health and health equity.</td>
<td><a href="https://www.thinkculturalhealth.hhs.gov/Content/ContinuingEd.asp?choose=other&amp;menu=Other">https://www.thinkculturalhealth.hhs.gov/Content/ContinuingEd.asp?choose=other&amp;menu=Other</a></td>
</tr>
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</table>

Strategic Prevention Plan 2013-2018
Cultural Competency: Bibliography

The following bibliography is from:
http://www.uiowa.edu/~eod/education/bibliographies/cultural-competence.html


Texas Center for Infectious Disease. Cultural Competence Assessment for Texas Center for Infectious Disease. Texas Department of Health. (n.d.)

Cultural Competency: Annotated Bibliography


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

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

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

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

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


In 2001, there were 35 million Latinos living in the United States. It is estimated that by 2050 Latinos will comprise 97 million people in the United States, or one-fourth of the U.S. population, establishing this ethnic group as the fastest growing and soon to be largest in the country (U.S. Census Bureau, 2001). These numbers highlight the need for a multicultural paradigm shift, or the inclusion of culture-specific skills and culturally responsive interventions in psychological practice. Latinos face challenges as a racial-ethnic group that the traditional Euro-American model of treatment neither addresses nor validates. Unfortunately, substance abuse serves a purposeful function for many Latinos as a means of escape from the problems related to the social, environmental, and political structures. The current article adapts the model set forth by Parham (2002) as a strength-based therapeutic framework for intervention. The following stages are outlined to serve as the basis for most therapeutic encounters with...
Latinos bring a vast and rich experience to the fabric of the United States. Latino adolescents’ unique experiences, stresses, and circumstances should be incorporated into prevention and treatment interventions (Ramirez et al., 2004; Strait, 1999). Their dynamic and diverse experiences suggest the need for developing culturally-appropriate prevention strategies and interventions to address the high-risk behaviors of Latino youth. Insight concerning stresses, as well as some evidence to support family-based interventions, provides a foundation for developing strategies that address the needs of these youth and the Latino community in general.


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

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

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

Conclusions: Managers’ culturally sensitive beliefs—considered to be influential for effective implementation of culturally competent practices—may be particularly relevant in influencing wait time and retention in OSAT organizations that treat Latinos and African American clients.
Culture and spirituality have been conceptualized as both protecting people from addiction and assisting in the recovery process. A collaborative study, utilizing focus group and survey methods, defined and examined cultural and spiritual coping in sobriety among a select sample of Alaska Natives. Results suggest that the Alaska Native worldview incorporates a circular synthesis and balance of physical, cognitive, emotional, and spiritual processes within a protective layer of family and communal/cultural beliefs and practices embedded within the larger environment. Cultural-spiritual coping in sobriety is a process of appraisal, change, and connection that leads the person toward achieving an overarching construct: a sense of coherence. Cultural and spiritual processes provide important areas for understanding the sobriety process as well as keys to the prevention of alcohol abuse and addiction.


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

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


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

Clayton Shorkey, PhD, LCSW, Liliane Cambraia Windsor, LMSW, Richard Spence, PhD,
“Assessing Culturally Competent Chemical Dependence Treatment Services for Mexican

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

Laurie M. Anderson, PhD, MPH, Susan C. Scrimshaw, PhD, Mindy T. Fullilove, MD, Jonathan E.
Fielding, MD, MPH, MBA, Jacques Normand, PhD, and the Task Force on Community Preventive
Preventive Medicine, 2003;24(3S).

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

Supporting Document: Grant Writing Competencies

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

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

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

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

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

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

Knowledge of strategies for effective program and project design and development
1. Identify methods of soliciting and incorporating meaningful substantive input and contributions by stakeholders, including client groups, beginning with the development of a new concept or program.
2. Identify methods of building partnerships and facilitating collaborations among applicants.
3. Identify strategies for educating grant applicants about financial and programmatic accountability to comply with funder requirements.
4. Identify structures, values, and applications of logic models as they relate to elements of project design.
5. Identify appropriate definitions of and interrelationships among elements of project design (e.g., project goals, objectives, activities, evaluation).
6. Identify design and development decisions that are data-based (e.g., descriptive, qualitative, environmental, statistical).
7. Identify existing community resources that aid in developing programs and projects.
8. Identify effects of accurate and defensible evaluation designs in program and project success and sustainability.

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

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

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

Knowledge of nationally recognized standards of ethical practice by grants professionals

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

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

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

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

Ability to write a convincing case for funding

1. Follow guidelines.
2. Use conventions of standard written English.
3. Organize ideas appropriately.
4. Convey ideas clearly.
5. Make a persuasive argument.
## Grant Writing Trainings and Resources

<table>
<thead>
<tr>
<th>Source</th>
<th>Description</th>
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<tr>
<td>SAMHSA</td>
<td>Developing Competitive SAMHSA Grant Applications manual was created to help grantees acquire the skills and resources needed to plan, write, and prepare a competitive grant application for SAMHSA funding.</td>
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<tr>
<td>Maine Association of Nonprofits</td>
<td>“SkillBuilder” courses for beginner and intermediate grant writers, and specialty courses in developing a grant budget, government grant writing, foundation grant writing, etc. Courses are offered throughout the year.</td>
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<tr>
<td><a href="http://www.mainenonprofit.org">www.mainenonprofit.org</a></td>
<td></td>
</tr>
<tr>
<td>University of Southern Maine</td>
<td>The Certificate Program in Grant Writing provides an intensive opportunity to acquire the knowledge and practice the skills necessary to succeed in today's competitive grant writing environment. This certificate program is composed of four courses held over five days.</td>
</tr>
<tr>
<td><a href="http://www.usm.maine.edu/pdp/certificate-program-grant-writing">www.usm.maine.edu/pdp/certificate-program-grant-writing</a></td>
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</tr>
<tr>
<td>Maine Philanthropy Center</td>
<td>Provides grant research tutorials and free access to the Directory of Maine Grantmakers Online, which provides basic information on grant-makers that fund projects and programs in Maine.</td>
</tr>
<tr>
<td><a href="http://www.mainephilanthropy.org">Directory of Maine Grantmakers</a></td>
<td></td>
</tr>
<tr>
<td><a href="http://www.mainephilanthropy.org">The Foundation Directory Online</a></td>
<td>Provides tutorials and free access to The Foundation Directory Online, which provides instant access to data on foundations, corporate donors and grantmaking public charities. The Directory of Maine Grantmakers is available for purchase as well.</td>
</tr>
<tr>
<td>Maine Health Access Foundation</td>
<td>Informational document with basic information about grantmakers that fund health care initiatives in Maine. The list is a compilation of all foundations that:</td>
</tr>
<tr>
<td><a href="http://www.mehaf.org/media/img/library/2012/03/06/other_health_funders.pdf">www.mehaf.org/media/img/library/2012/03/06/other_health_funders.pdf</a></td>
<td>- Have healthcare, health organizations, or medical research as one of their primary focuses according to the Maine Philanthropy Center database</td>
</tr>
<tr>
<td></td>
<td>- Have previously funded projects in Maine</td>
</tr>
<tr>
<td></td>
<td>- Have open applications or accept letters of inquiry (do not contribute only to pre-selected organizations)</td>
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<tr>
<td></td>
<td>- Have assets approaching or exceeding $20 million and therefore have the resources to make substantial contributions towards health projects each year</td>
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Appendix M

Supporting Document: International Certification and Reciprocity Consortium (IC&RC)
Credentialing of Prevention Professionals Is a Critical Component to Implementing National Health Care Reform

December 2010
Our Position

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

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

Surveying the Landscape

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

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

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

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

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

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

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

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

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

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⁷ Ibid, 3.

What’s At Stake

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

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

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

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The Importance of Training

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

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

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

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

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

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17 Ibid.
Acknowledgments

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

About IC&RC

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

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

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

Direct questions and comments to:

IC&RC
298 S. Progress Avenue
Harrisburg, PA 17109
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Assuring Public Safety in the Delivery of Substance Abuse Prevention Services

An IC&RC Position Paper

May 2009
Introduction

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

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

Understanding the Need for Prevention Credentialing

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

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

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

1. **Ensuring Public Safety**: The most compelling reason to certify substance abuse prevention practitioners is to ensure the public safety. Current headlines and daily television news offer countless examples of young people entrusted to adults or to adult supervised institutions that experience abuse, violence and unethical behavior. State agencies and community based organizations that adopt prevention practice standards and enforce those standards through the requirements of credentialing significantly increase their opportunity to teach practitioners appropriate and effective service delivery for young people and families. Further, it is reasonable for consumers of prevention services to expect protection in other areas of public safety such as misappropriation of funds, misrepresentation of credentials, conflicts of interest, and discrimination. Therefore, it is necessary for prevention professionals to adhere to a recognized code of professional ethics.

2. **Enhancing Public Funds Accountability**: Ethical practice demands accountability for public expenditures and accountability dictates that states and their programs utilize prevention staff who demonstrates proficiency with competency-based standards. This increases the likelihood that taxpayer funds spent in prevention service delivery will be used for programming that is research and evidence based and that offer reasonable hope of impacting the populations being served in a positive way.

3. **Providing Practitioner Benefits**: Prevention practitioners also gain significant benefits by achieving and maintaining a practice credential. Not only are they able to demonstrate practice competencies in their daily work, but they become part of an international cadre of advocates for quality prevention service delivery. Through the continuing education required for renewal of certification, practitioners are able to maintain their prevention knowledge, skills and attitudes while staying abreast of new and emerging trends in the field. Continued skill development often leads to an enhanced career standing and the potential for greater income.

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

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

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

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

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

Who Should Be Credentialed in Prevention

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

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

**IC&RC’s Competency-Based Prevention Credential**

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

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

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

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

IC&RC Prevention Specialist Written Examination

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

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

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

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

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

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

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In 2010, IC&RC announced that the number of professionals who hold its credentials has crossed the 40,000 mark. Up to half of all substance abuse professionals in the U.S. hold IC&RC certificates.
To be eligible for reciprocity to other IC&RC jurisdictions, credentials obtained through Member Boards must meet the following IC&RC minimum standards:

**Experience**

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

**Education**

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

**Supervision**

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

**Examination**

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

**Code of Ethics**

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

**Recertification**

40 hours of continuing education earned every two years.

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

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

### Prevention Specialist (PS)

### PS Domains

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

### Prevention Resources

IC&RC recently released a position paper, "Credentialing of Prevention Professionals Is a Critical Component to Implementing National Health Care Reform." This is a valuable addition to the White Paper, "Assuring Public Safety in the Delivery of Substance Abuse Prevention Services." Special issues of IC&RC Insights, our electronic newsletter, are dedicated to Prevention: February 26, June 11, September 10, and December 14.

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

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

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

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

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

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

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

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

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

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

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

Reciprocity Process

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

Frequently Asked Questions

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

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

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

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

Can I maintain my credential in more than one jurisdiction?

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

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

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

Can I be denied reciprocity into a new jurisdiction?

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

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

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

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

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

If I hold a license rather than a certification from my jurisdiction and then reciprocate, will I receive a license from my new jurisdiction?
Not necessarily. If the new jurisdiction is one that has licensure rather than certification, you would receive a license. If the new jurisdiction is one that has certification rather than licensure, you would receive a certification.

**What is the difference between certification and licensure?**

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

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

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

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

**If my credential has expired in my current jurisdiction, can I still reciprocate into a new jurisdiction?**

No, your credential must be current and valid in order to reciprocate. If your credential has lapsed, you must successfully recertify prior to applying for reciprocity. In order to avoid credentials expiring during the reciprocity process, credentials must be valid for at least 30 days at the time of application.
Reciprocity Information for Member Boards

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

Professionals must contact the board where they are currently credentialed for a Reciprocity Application, then IC&RC facilitates the reciprocity process between boards.
Become an IC&RC Member Board

IC&RC is the only organization comprised entirely of addiction and prevention credentialing boards. Only certification boards can be members of IC&RC. The information on this page applies to certification boards only, not professionals interested in credentialing.

Benefits of Membership

- Reciprocity for certified professionals,
- Access to standards and written examinations that are evidence-based, valid, reliable, and legally defensible,
- Networking with representatives from 78 member credentialing boards worldwide,
- Issuance of an international certificate to all those holding a reciprocal credential, and
- Technical assistance for a wide variety of issues related to credentialing.

Option to Grandparent

Becoming a member board of IC&RC affords your board the opportunity to grandparent your professionals into any of the IC&RC credentials you choose to offer.

IC&RC allows boards to offer a three-month grandparenting window of opportunity to addiction professionals anytime within the first two years of your board becoming a member of IC&RC.

IC&RC can only have one certification board as a member in each jurisdiction. However, if an existing Member Board chooses not to offer an IC&RC credential, another credentialing board in that same jurisdiction can become a member board of IC&RC and offer that credential.

A list of current Member Boards and the credential each offers in available at our Member Directory.

Learn More

IC&RC provides a helpful, informative packet of Materials for Prospective Members (ZIP compressed folder of Microsoft Word documents, 2.9MB).

If you are interested in your certification board becoming a member of IC&RC, please submit an inquiry. IC&RC staff or leadership will contact you.
Find a Board

IC&RC Member Jurisdictions

IC&RC U.S. Member States & Territories

IC&RC Credentials Offered

» Prevention Specialist (PS)

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Advanced search

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<td>Louisiana Association of Substance Abuse Counselors &amp; Trainers</td>
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<td>Mississippi Association of Addiction Professionals</td>
<td>Jackson MS</td>
<td>Advanced Alcohol and Drug Counselor (AADC), Alcohol and Drug Counselor (ADC), Certified Criminal Justice Addictions Professional (CCJP), Clinical Supervisor (CS), Prevention Specialist (PS)</td>
</tr>
<tr>
<td>Missouri Substance Abuse Professional Credentialing Board</td>
<td>Jefferson City MO</td>
<td>Advanced Alcohol and Drug Counselor (AADC), Alcohol and Drug Counselor (ADC), Certified Co-occurring Disorders Professional (CCDP), Certified Co-occurring Disorders Professional Diplomate (CCDPD), Certified Criminal Justice Addictions Professional (CCJP), Prevention Specialist (PS)</td>
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<tr>
<td>Nashville Area Substance Abuse Certification Board</td>
<td>Cherokee NC</td>
<td>Alcohol and Drug Counselor (ADC), Clinical Supervisor (CS), Prevention Specialist (PS)</td>
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<td>New Hampshire Prevention Certification Board</td>
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<td>Prevention Specialist (PS)</td>
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<td>New Mexico Credentialing Board for Behavioral Health Professionals</td>
<td>Albuquerque NM</td>
<td>Alcohol and Drug Counselor (ADC), Certified Criminal Justice Addictions Professional (CCJP), Clinical Supervisor (CS), Prevention Specialist (PS)</td>
</tr>
<tr>
<td>New York Office of Alcohol &amp; Substance Abuse Services</td>
<td>Albany NV</td>
<td>Alcohol and Drug Counselor (ADC), Prevention Specialist (PS)</td>
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<td>Nordic/Baltic Regional Certification Board</td>
<td>Reykjavik Iceland</td>
<td>Alcohol and Drug Counselor (ADC), Clinical Supervisor (CS), Prevention Specialist (PS)</td>
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<td>North Carolina Substance Abuse Professional Practice Board</td>
<td>Raleigh NC</td>
<td>Advanced Alcohol and Drug Counselor (AADC), Alcohol and Drug Counselor (ADC), Certified Criminal Justice Addictions Professional (CCJP), Clinical Supervisor (CS), Prevention Specialist (PS)</td>
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<tr>
<td>Ohio Chemical Dependency Professionals Board</td>
<td>Columbus OH</td>
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<td>Advanced Alcohol and Drug Counselor (AADC), Alcohol and Drug Counselor (ADC), Certified Criminal Justice Addictions Professional (CCJP), Clinical Supervisor (CS), Prevention Specialist (PS)</td>
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<td>Prevention Credentialing Consortium of Georgia</td>
<td>Lawrenceville GA</td>
<td>Prevention Specialist (PS)</td>
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<td>Prevention Specialist Certification Board of Washington</td>
<td>Spokane WA</td>
<td>Prevention Specialist (PS)</td>
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<td>Rhode Island Board for the Certification of Chemical Dependency Professionals</td>
<td>Harrisburg PA</td>
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<tr>
<td>South Carolina Association of Prevention Professionals &amp; Advocates</td>
<td>Columbia SC</td>
<td>Prevention Specialist (PS)</td>
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<td>Southwest Certification Board</td>
<td>Phoenix AZ</td>
<td>Alcohol and Drug Counselor (ADC), Certified Criminal Justice Addictions Professional (CCJP), Prevention Specialist (PS)</td>
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<td>Substance Abuse Certification Alliance of Virginia</td>
<td>Richmond VA</td>
<td>Alcohol and Drug Counselor (ADC), Certified Co-occurring Disorders Professional (CCDP), Certified Criminal Justice Addictions Professional (CCJP), Clinical Supervisor (CS), Prevention Specialist (PS)</td>
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<td>Tennessee Certification Board</td>
<td>Nashville TN</td>
<td>Prevention Specialist (PS)</td>
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<tr>
<td>Texas Certification Board of Addiction Professionals</td>
<td>Austin TX</td>
<td>Advanced Alcohol and Drug Counselor (AADC), Alcohol and Drug Counselor (ADC), Certified Criminal Justice Addictions Professional (CCJP), Clinical Supervisor (CS), Prevention Specialist (PS)</td>
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<td>United States Navy Certification Board</td>
<td>San Diego CA</td>
<td>Alcohol and Drug Counselor (ADC), Clinical Supervisor (CS), Prevention Specialist (PS)</td>
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<td>West Virginia Certification Board for Addiction &amp; Prevention Professionals</td>
<td>Dunbar WV</td>
<td>Advanced Alcohol and Drug Counselor (AADC), Alcohol and Drug Counselor (ADC), Clinical Supervisor (CS), Prevention Specialist (PS)</td>
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</tbody>
</table>
IC&RC develops and administers examinations for seven reciprocal credentials:

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

In addition, IC&RC administers the examination for the Department of Transportation's Substance Abuse Professional (SAP), developed by the Professional Training Center, Inc.

Each IC&RC Member Board offers examinations for only the credentials they carry, and exams can only be scheduled through your local board as a part of the credentialing process. Each board chooses whether to offer Computer Based Testing (CBT) or Paper & Pencil Exams and whether to administer exams during set periods or on demand.

Important Information About Pre-Testing Items

In December 2011, IC&RC began using pretest items on its exams. Pretesting allows IC&RC to streamline its exam development process, provide much needed data on questions, and increase the security of its exams.

Pretesting began in December 2011 for the Alcohol & Drug Counselor (ADC), Advanced Alcohol & Drug Counselor (AADC), and Clinical Supervisor (CS) exams. In March 2012, IC&RC implemented pretesting for the Prevention Specialist (PS), Certified Criminal Justice Addictions Professional (CCJP), and Certified Co-Occurring Disorders (CCDP) exams.

On each IC&RC exam there are 25 “unweighted” items that do not count toward candidates’ final scores. Unweighted items are also called pretest items. Pretest items are not identified on exams and appear randomly on all exam forms. All exams are 150 questions in length, including the Advanced Alcohol and Drug Counselor (AADC), which was previously 175 questions.

It is important to include pretest items on an examination, because items should go through a trail period to ensure quality before they contribute to candidates’ scores. Pretesting items provides verification that the items are relevant to competency and contribute toward measuring candidates’ proficiency in the material. The statistical data received from pretesting is analyzed to determine if an item performs within an acceptable range. For example, item statistics tell us if an item is too difficult and possibly outside the candidates’ scope of knowledge or practice, if an item is too easy and does not measure competency, or if the correct answer is misidentified. If an item exhibits acceptable statistical performance, the item can be upgraded to “weighted” status and be included on future examinations as a scored item.

In a larger context, pretesting items allows examinations to stay current with the profession. The field is constantly evolving, and it is important that examinations reflect current practice and the knowledge, skills, and abilities required of competent practitioners. Including pretest items also allows IC&RC to produce more test forms which increases the security of its examinations.

Overall, pretesting items is in the best interest of candidates as it helps to ensure the quality of future examinations. Pretest items have absolutely no effect on candidates’ scores. For example, if two candidates both answer the same number of weighted items correctly, and one answers all of the pretest items correctly and the other answers none of the pretest items correctly, they both receive the same score and pass/fail status on the exam. In fact, candidates will be protected against poorly-performing items adversely affecting their scores, while at the same time taking an examination that is current with professional trends.

Study Guides

While IC&RC does not publish or endorse any specific study guide for our exams, there are a number of study guides available. Applicants are responsible for being informed consumers and buying the study guide best suited for their needs. It is also recommended that applicants contact their local Member Board to inquire about suggested study guide materials.

Please see the notice, “Important Information Regarding IC&RC Exams.”

Exam Verification

If you have taken an IC&RC examination and need your scores verified and/or sent to an organization, submit the Exam Verification Form with payment to IC&RC.

Processing exam verifications can take up to two weeks, but supplying the exact date you took the IC&RC exam will expedite the process.

Computer Based Testing Demonstration

Candidates preparing to take a computer based IC&RC exam can preview the exam format by clicking here.
Since 2007, IC&RC has relied on Schroeder Measurement Technologies (SMT) to administer its credential examinations. SMT offers a full range of test administration services, including computer-based testing, web-based testing, paper & pencil testing, candidate processing, recertification tracking and other related services. SMT administers examinations each year in over 40 professional categories and processes over 100,000 examinations per year.

Computer-based testing is administered through a division of SMT called ISO-Quality Testing, Inc. (IQT), which provides secure, user-friendly, high-quality, reasonably-priced computerized examination delivery services to credentialing bodies at available secure and monitored locations around the world.

IC&RC Member Boards can choose to offer Computer Based Testing (CBT) or Paper & Pencil Exams. CBT can be offered On Demand by Member Boards or during four annual testing cycles, when Paper & Pencil must be offered:

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<td>March 8 &amp; 9</td>
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<tr>
<td>December 7 &amp; 8</td>
<td>December 13 &amp; 14</td>
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</tbody>
</table>

Please see the notice, "Important Information Regarding IC&RC Exams."

**Testing Management**

Member Boards can access and administer test information at the SMT Portal.

The IQT website allows Boards to locate Testing Centers around the world and apply to become an approved Testing Center.
Domain 1: Planning and Evaluation  
Number of Questions: 36

Use needs assessment strategies to gather relevant data for ATOD prevention planning.

Identify gaps and prioritize needs based on the assessment of community conditions.

Select prevention strategies, programs, and best practices to meet the identified needs of the community.

Develop an ATOD prevention plan based on research and theory that addresses community needs and desired outcomes.

Identify resources to sustain prevention activities.

Identify appropriate ATOD prevention program evaluation strategies.

Conduct evaluation activities to document program implementation and effectiveness.

Use evaluation findings to determine whether and how to adapt ATOD prevention.

Domain 2: Education and Skill Development  
Number of Questions: 42

Develop ATOD prevention education and skill development activities based on target audience analysis.

Connect prevention theory and practice to implement effective prevention education and skill development activities.

Maintain program fidelity when implementing evidence-based programs.

Assure that ATOD education and skill activities are appropriate to the culture of the community being served.

Use appropriate instructional strategies to meet the needs of the target audience.

Ensure all ATOD prevention education and skill development programs provide accurate, relevant, timely, and appropriate content information.

Identify, adapt, or develop instructor and participant materials for use when implementing ATOD prevention activities.

Provide professionals in related fields with accurate, relevant, timely, and appropriate ATOD prevention information.

Provide technical assistance to community members and organizations regarding ATOD prevention strategies and best practices.
Domain 3: Community Organization
Number of Questions: 26

Identify the community’s demographic characteristics and core values.

Identify key community leaders to ensure diverse representation in ATOD prevention programming activities.

Build community ownership of ATOD prevention programs by collaborating with key community leaders/members when planning, implementing, and evaluating prevention activities.

Provide technical assistance to community members/leaders in implementing ATOD prevention activities.

Develop capacity within the community by recruiting, training, and mentoring ATOD prevention-focused volunteers.

Assist in creating and sustaining community-based coalitions.

Domain 4: Public Policy and Environmental Change
Number of Questions: 20

Examine the community’s public policies and norms to determine environmental change needs.

Make recommendations to policy makers/stakeholders that will positively influence the community’s public policies and norms.

Provide technical assistance, training, and consultation that promote environmental change.

Participate in public policy development and enforcement initiatives to affect environmental change.

Use media strategies to enhance prevention efforts in the community.

Domain 5: Professional Growth and Responsibility
Number of Questions on Exam: 26

Maintain personal knowledge, skills, and abilities related to current ATOD prevention theory and practice.

Network with others to develop personal and professional relationships.

Adhere to all legal, professional, and ethical standards.

Build skills necessary for effectively working within the cultural context of the community.

Demonstrate self-care consistent with ATOD prevention messages.

Total number of examination questions: 150
Total time to complete the examination, Paper & Pencil: 3 ½ hours
Total time to complete the examination, Computer Based: 3 hours
For more information contact:

Office of Substance Abuse
41 Anthony Ave
11 State House Station
Augusta, ME 04333-0011
(207) 287-2595
TTY: (207) 287-4475
Fax: (207) 287-8910
www.maineosa.org
e-mail: osa.ircosa@maine.gov

In accordance with federal and state laws, The Maine Office of Substance Abuse, DHHS, does not discriminate on the basis of disability, race, color, creed, gender, age, or national origin in admission or access to treatment, services, or employment in its programs and activities.

This information is available in alternate formats upon request.
## Criterion 1

### Improving access to treatment services

1. Does your state provide:

   a) A full continuum of services
      
      | Service                          | Yes | No |
      |---------------------------------|-----|----|
      | i) Screening                     |     |    |
      | ii) Education                   |     |    |
      | iii) Brief Intervention         |     |    |
      | iv) Assessment                  |     |    |
      | v) Detox (inpatient/social)     |     |    |
      | vi) Outpatient                  |     |    |
      | vii) Intensive Outpatient       |     |    |
      | viii) Inpatient/Residential      |     |    |
      | ix) Aftercare; Recovery support |     |    |

   b) Services for special populations:
      
      | Population                        | Yes | No |
      |-----------------------------------|-----|----|
      | Targeted services for veterans?   |     |    |
      | Adolescents?                      |     |    |
      | Other Adults?                     |     |    |
      | Medication-Assisted Treatment (MAT)? |     |    |
Criterion 2: Improving Access and Addressing Primary Prevention - See Narrative 8. Primary Prevention-Required SABG.
Criterion 3

1. Does your state meet the performance requirement to establish and/or maintain new programs or expand programs to ensure treatment availability?  
   - Yes  
   - No

2. Does your state make prenatal care available to PWWDC receiving services, either directly or through an arrangement with public or private nonprofit entities?  
   - Yes  
   - No

3. Have an agreement to ensure pregnant women are given preference in admission to treatment facilities or make available interim services within 48 hours, including prenatal care?  
   - Yes  
   - No

4. Does your state have an arrangement for ensuring the provision of required supportive services?  
   - Yes  
   - No

5. Has your state identified a need for any of the following:
   a) Open assessment and intake scheduling  
      - Yes  
      - No
   b) Establishment of an electronic system to identify available treatment slots  
      - Yes  
      - No
   c) Expanded community network for supportive services and healthcare  
      - Yes  
      - No
   d) Inclusion of recovery support services  
      - Yes  
      - No
   e) Health navigators to assist clients with community linkages  
      - Yes  
      - No
   f) Expanded capability for family services, relationship restoration, and custody issues?  
      - Yes  
      - No
   g) Providing employment assistance  
      - Yes  
      - No
   h) Providing transportation to and from services  
      - Yes  
      - No
   i) Educational assistance  
      - Yes  
      - No

6. States are required to monitor program compliance related to activities and services for PWWDC. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

The Maine Women's Services Network (WSN) representative is responsible for overseeing PWWDC services and monitoring contract compliance. A comprehensive on-site review of each PWWDC program is conducted annually and includes a review of policies and procedures, compliance with contract requirements, compliance with all applicable Federal and State regulations (including SABG requirements), and a review of client records. The provider receives a summary report with corrective actions if warranted. In addition to the annual review, the WSN maintains phone and email contact with the PWWDC providers throughout the agreement period. The waitlist is monitored monthly.

SAMHS' Quality Team has been working on improving quality management of contract providers and has developed monitoring procedures with the goal of implementing these in FY18. One of the procedures that is now operational is the implementation of quarterly reporting of progress toward outcome measures. (This is in addition to the data already captured in SAMHS data system - WITS.) The reports submitted by PWWDC providers will be reviewed by the WSN and a follow-up discussion with ensue.
Persons Who Inject Drugs (PWID)

1. Does your state fulfill the:
   a) 90 percent capacity reporting requirement
   b) 14-120 day performance requirement with provision of interim services
   c) Outreach activities
   d) Syringe services programs
   e) Monitoring requirements as outlined in the authorizing statute and implementing regulation

2. Has your state identified a need for any of the following:
   a) Electronic system with alert when 90 percent capacity is reached
   b) Automatic reminder system associated with 14-120 day performance requirement
   c) Use of peer recovery supports to maintain contact and support
   d) Service expansion to specific populations (e.g., military families, veterans, adolescents, older adults)?

3. States are required to monitor program compliance related to activities and services for PWID. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

Program Managers, including the State Opioid Treatment Authority (SOTA) are responsible for overseeing and monitoring compliance of programs which provide detoxification, medication assisted treatment (MAT), opioid treatment programs (OTP), outpatient, intensive outpatient, and residential services. A comprehensive on-site review of each program is conducted annually and includes a review of policies and procedures, compliance with contract requirements, compliance with all applicable Federal and State regulations (including SABG requirements for PWID), and a review of client records. The provider receives a summary report with corrective actions if warranted. In addition to the annual review, Program Managers maintain phone and email contact with the PWWDC providers throughout the agreement period. The SOTA provides additional support the MAT and OTP programs. Waitlists are monitored monthly.

SAMHS’ Quality Team has been working on improving quality management of contract providers and has developed monitoring procedures with the goal of implementing these in FY18. One of the procedures that is now operational is the implementation of quarterly reporting of progress toward outcome measures. (This is in addition to the data already captured in SAMHS data system - WITS.) The reports submitted by PWID providers will be reviewed by Program Managers and SOTA and a follow-up discussion with ensue.

Tuberculosis (TB)

1. Does your state currently maintain an agreement, either directly or through arrangements with other public and nonprofit private entities to make available tuberculosis services to individuals receiving SUD treatment and to monitor the service delivery?

2. Has your state identified a need for any of the following:
   a) Business agreement/MOU with primary healthcare providers
   b) Cooperative agreement/MOU with public health entity for testing and treatment
   c) Established co-located SUD professionals within FQHCs

3. States are required to monitor program compliance related to tuberculosis services made available to individuals receiving SUD treatment. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

ME SAMHS updates contract deliverables annually for treatment providers which outline and prioritize substance abuse block grant treatment requirements to these populations with quarterly review and non-compliance enforcement. The State of Maine SSA currently uses block grant funding for most of its treatment provider contracts (see allocations in Step 1) in order to ensure that agreements for tuberculosis services will be made available to individuals receiving SUD treatment. Maine SSA program staff discuss the tuberculosis services requirement at least annually at site review with the treatment providers, as well as discuss any need for Training and Technical Assistance that might result at that time.
At the time of writing this block grant application, Maine SSA staff have recently met with the Maine CDC’s TB Control Officer to collaborate on the F20/21 year plan; current treatment providers were discussed at that time, as well as aligning data collection as well as prevention efforts. Additional TB Training and Technical Assistance and collaboration discussions are expected to be scheduled throughout the program year as the need arises.

**Early Intervention Services for HIV (for “Designated States” Only)**

1. Does your state currently have an agreement to provide treatment for persons with substance use disorders with an emphasis on making available within existing programs early intervention services for HIV in areas that have the greatest need for such services and monitoring the service delivery?  
   - Yes □ No □

2. Has your state identified a need for any of the following:  
   a) Establishment of EIS-HIV service hubs in rural areas  
      - Yes □ No □
   b) Establishment or expansion of tele-health and social media support services  
      - Yes □ No □
   c) Business agreement/MOU with established community agencies/organizations serving persons with HIV/AIDS  
      - Yes □ No □

**Syringe Service Programs**

1. Does your state have in place an agreement to ensure that SABG funds are NOT expended to provide individuals with hypodermic needles or syringes(42 U.S.C § 300x-31(a)(1)(F))?  
   - Yes □ No □

2. Do any of the programs serving PWID have an existing relationship with a Syringe Services (Needle Exchange) Program?  
   - Yes □ No □

3. Do any of the programs use SABG funds to support elements of a Syringe Services Program?  
   - Yes □ No □

   If yes, please provide a brief description of the elements and the arrangement.
**Criterion 8, 9&10**

**Service System Needs**

1. Does your state have in place an agreement to ensure that the state has conducted a statewide assessment of need, which defines prevention and treatment authorized services available, identified gaps in service, and outlines the state's approach for improvement
   - Yes  No

2. Has your state identified a need for any of the following:
   - Workforce development efforts to expand service access
     - Yes  No
   - Establishment of a statewide council to address gaps and formulate a strategic plan to coordinate services
     - Yes  No
   - Establish a peer recovery support network to assist in filling the gaps
     - Yes  No
   - Incorporate input from special populations (military families, service members, veterans, tribal entities, older adults, sexual and gender minorities)
     - Yes  No
   - Formulate formal business agreements with other involved entities to coordinate services to fill gaps in the system, i.e. primary healthcare, public health, VA, community organizations
     - Yes  No
   - Explore expansion of services for:
     - MAT
       - Yes  No
     - Tele-Health
       - Yes  No
     - Social Media Outreach
       - Yes  No

**Service Coordination**

1. Does your state have a current system of coordination and collaboration related to the provision of person-centered and person-directed care?
   - Yes  No

2. Has your state identified a need for any of the following:
   - Identify MOUs/Business Agreements related to coordinate care for persons receiving SUD treatment and/or recovery services
     - Yes  No
   - Establish a program to provide trauma-informed care
     - Yes  No
   - Identify current and perspective partners to be included in building a system of care, such as FQHCs, primary healthcare, recovery community organizations, juvenile justice systems, adult criminal justice systems, and education
     - Yes  No

**Charitable Choice**

1. Does your state have in place an agreement to ensure the system can comply with the services provided by nongovernment organizations (42 U.S.C.§ 300x-65, 42 CF Part 54 ($54.8(b) and §54.8(c)(4)) and 68 FR 56430-56449)?
   - Yes  No

2. Does your state provide any of the following:
   - Notice to Program Beneficiaries
     - Yes  No
   - An organized referral system to identify alternative providers?
     - Yes  No
   - A system to maintain a list of referrals made by religious organizations?
     - Yes  No

**Referrals**

1. Does your state have an agreement to improve the process for referring individuals to the treatment modality that is most appropriate for their needs?
   - Yes  No

2. Has your state identified a need for any of the following:
   - Review and update of screening and assessment instruments
     - Yes  No
   - Review of current levels of care to determine changes or additions
     - Yes  No
c) Identify workforce needs to expand service capabilities

d) Conduct cultural awareness training to ensure staff sensitivity to client cultural orientation, environment, and background

Patient Records
1. Does your state have an agreement to ensure the protection of client records?

2. Has your state identified a need for any of the following:
   a) Training staff and community partners on confidentiality requirements
   b) Training on responding to requests asking for acknowledgement of the presence of clients
   c) Updating written procedures which regulate and control access to records
   d) Review and update of the procedure by which clients are notified of the confidentiality of their records include the exceptions for disclosure

Independent Peer Review
1. Does your state have an agreement to assess and improve, through independent peer review, the quality and appropriateness of treatment services delivered by providers?

2. Section 1943(a) of Title XIX, Part B, Subpart III of the Public Health Service Act (42 U.S.C.§ 300x-52(a)) and 45 § CFR 96.136 require states to conduct independent peer review of not fewer than 5 percent of the block grant sub-recipients providing services under the program involved.

   Please provide an estimate of the number of block grant sub-recipients identified to undergo such a review during the fiscal year(s) involved.

   At least 5% of direct-service, treatment provider sub-recipients are estimated to be reviewed by independent peers in F2020 and F2021.

3. Has your state identified a need for any of the following:
   a) Development of a quality improvement plan
   b) Establishment of policies and procedures related to independent peer review
   c) Development of long-term planning for service revision and expansion to meet the needs of specific populations

4. Does your state require a block grant sub-recipient to apply for and receive accreditation from an independent accreditation organization, such as the Commission on the Accreditation of Rehabilitation Facilities (CARF), The Joint Commission, or similar organization as an eligibility criterion for block grant funds?

   If Yes, please identify the accreditation organization(s)
   i) Commission on the Accreditation of Rehabilitation Facilities
   ii) The Joint Commission
   iii) Other (please specify)
**Criterion 7&11**

**Group Homes**

1. Does your state have an agreement to provide for and encourage the development of group homes for persons in recovery through a revolving loan program?  
   - Yes ☐  No ☐

2. Has your state identified a need for any of the following:
   a) Implementing or expanding the revolving loan fund to support recovery home development as part of the expansion of recovery support service  
      - Yes ☐  No ☐
   b) Implementing MOUs to facilitate communication between block grant service providers and group homes to assist in placing clients in need of housing  
      - Yes ☐  No ☐

**Professional Development**

1. Does your state have an agreement to ensure that prevention, treatment and recovery personnel operating in the state's substance use disorder prevention, treatment and recovery systems have an opportunity to receive training on an ongoing basis, concerning:
   a) Recent trends in substance use disorders in the state  
      - Yes ☐  No ☐
   b) Improved methods and evidence-based practices for providing substance use disorder prevention and treatment services  
      - Yes ☐  No ☐
   c) Performance-based accountability  
      - Yes ☐  No ☐
   d) Data collection and reporting requirements  
      - Yes ☐  No ☐

2. Has your state identified a need for any of the following:
   a) A comprehensive review of the current training schedule and identification of additional training needs  
      - Yes ☐  No ☐
   b) Addition of training sessions designed to increase employee understanding of recovery support services  
      - Yes ☐  No ☐
   c) Collaborative training sessions for employees and community agencies' staff to coordinate and increase integrated services  
      - Yes ☐  No ☐
   d) State office staff training across departments and divisions to increase staff knowledge of programs and initiatives, which contribute to increased collaboration and decreased duplication of effort  
      - Yes ☐  No ☐

3. Has your state utilized the Regional Prevention, Treatment and/or Mental Health Training and Technical Assistance Centers (TTCs)?
   a) Prevention TTC?  
      - Yes ☐  No ☐
   b) Mental Health TTC?  
      - Yes ☐  No ☐
   c) Addiction TTC?  
      - Yes ☐  No ☐
   d) State Targeted Response TTC?  
      - Yes ☐  No ☐

**Waivers**

Upon the request of a state, the Secretary may waive the requirements of all or part of the sections 1922(c), 1923, 1924, and 1928 (42 U.S.C. § 300x-32 (f)).

1. Is your state considering requesting a waiver of any requirements related to:
   a) Allocations regarding women  
      - Yes ☐  No ☐

2. Requirements Regarding Tuberculosis Services and Human Immunodeficiency Virus:
   a) Tuberculosis  
      - Yes ☐  No ☐
   b) Early Intervention Services Regarding HIV  
      - Yes ☐  No ☐

3. Additional Agreements
   a) Improvement of Process for Appropriate Referrals for Treatment  
      - Yes ☐  No ☐
b) Professional Development

Yes ☐  ☐ No

Please provide a link to the state administrative regulations that govern the Mental Health and Substance Use Disorder Programs.

https://www1.maine.gov/sos/cec/rules/10/chaps10.htm

c) Coordination of Various Activities and Services

Yes ☐  ☐ No
Environmental Factors and Plan

11. Quality Improvement Plan- Requested

Narrative Question
In previous block grant applications, SAMHSA asked states to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures, based on valid and reliable data, consistent with the NBHQF, which will describe the health and functioning of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that they continue to reflect this evidence of effectiveness. The state’s CQI process should also track programmatic improvements using stakeholder input, including the general population and individuals in treatment and recovery and their families. In addition, the CQI plan should include a description of the process for responding to emergencies, critical incidents, complaints, and grievances.

Please respond to the following items:

1. Has your state modified its CQI plan from FFY 2018-FFY 2019?
   - [ ] Yes
   - [ ] No

   Please indicate areas of technical assistance needed related to this section.
   Since the executive level changes taking place in 2019, Maine’s Quality Improvement plan has currently under revision. A current CQI/TQM plan will be submitted as soon as it is available for release.

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Footnotes:
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12. Trauma - Requested

Narrative Question

Trauma[^57] is a widespread, harmful, and costly public health problem. It occurs because of violence, abuse, neglect, loss, disaster, war and other emotionally harmful and/or life threatening experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography, or sexual orientation. It is an almost universal experience of people with mental and substance use difficulties. The need to address trauma is increasingly viewed as an important component of effective M/SUD service delivery. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma-informed.

Individuals with experiences of trauma are found in multiple service sectors, not just in M/SUD services. People in the juvenile and criminal justice system have high rates of mental illness and substance use disorders and personal histories of trauma. Children and families in the child welfare system similarly experience high rates of trauma and associated M/SUD problems. Many patients in primary, specialty, emergency and rehabilitative health care similarly have significant trauma histories, which has an impact on their health and their responsiveness to health interventions. Schools are now recognizing that the impact of exposure to trauma and violence among their students makes it difficult to learn and meet academic goals. Communities and neighborhoods experience trauma and violence. For some these are rare events and for others these are daily events that children and families are forced to live with. These children and families remain especially vulnerable to trauma-related problems, often are in resource poor areas, and rarely seek or receive M/SUD care. States should work with these communities to identify interventions that best meet the needs of these residents.

In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often re-traumatizing, making it necessary to rethink doing business as usual. These public institutions and service settings are increasingly adopting a trauma-informed approach. A trauma-informed approach is distinct from trauma-specific assessments and treatments. Rather, trauma-informed refers to creating an organizational culture or climate that realizes the widespread impact of trauma, recognizes the signs and symptoms of trauma in clients and staff, responds by integrating knowledge about trauma into policies and procedures, and seeks to actively resist re-traumatizing clients and staff. This approach is guided by key principles that promote safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues. A trauma-informed approach may incorporate trauma-specific screening, assessment, treatment, and recovery practices or refer individuals to these appropriate services.

It is suggested that states refer to SAMHSA’s guidance for implementing the trauma-informed approach discussed in the Concept of Trauma[^58] paper.

[^57]: Definition of Trauma: Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual’s functioning and mental, physical, social, emotional, or spiritual well-being.

[^58]: Ibid

Please consider the following items as a guide when preparing the description of the state’s system:

1. Does the state have a plan or policy for M/SUD providers that guide how they will address individuals with trauma-related issues?  
   - Yes  
   - No

2. Does the state provide information on trauma-specific assessment tools and interventions for M/SUD providers?  
   - Yes  
   - No

3. Does the state have a plan to build the capacity of M/SUD providers and organizations to implement a trauma-informed approach to care?  
   - Yes  
   - No

4. Does the state encourage employment of peers with lived experience of trauma in developing trauma-informed organizations?  
   - Yes  
   - No

5. Does the state have any activities related to this section that you would like to highlight.
   
   Please indicate areas of technical assistance needed related to this section.

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Environmental Factors and Plan

13. Criminal and Juvenile Justice - Requested

Narrative Question

More than half of all prison and jail inmates meet criteria for having mental health problems, six in ten meet criteria for a substance use problem, and more than one-third meet criteria for having co-occurring mental and substance use problems. Youth in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient use of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; therefore, risk factors remain unaddressed.59

Successful diversion of adults and youth from incarceration or re-entering the community from detention is often dependent on engaging in appropriate M/SUD treatment. Some states have implemented such efforts as mental health, veteran and drug courts, Crisis Intervention Training (CIT) and re-entry programs to help reduce arrests, imprisonment and recidivism.60

A diversion program places youth in an alternative program, rather than processing them in the juvenile justice system. States should place an emphasis on screening, assessment, and services provided prior to adjudication and/or sentencing to divert persons with M/SUD from correctional settings. States should also examine specific barriers such as a lack of identification needed for enrollment Medicaid and/or the Health Insurance Marketplace; loss of eligibility for Medicaid resulting from incarceration; and care coordination for individuals with chronic health conditions, housing instability, and employment challenges. Secure custody rates decline when community agencies are present to advocate for alternatives to detention.

The MHBG and SABG may be especially valuable in supporting care coordination to promote pre-adjudication or pre-sentencing diversion, providing care during gaps in enrollment after incarceration, and supporting other efforts related to enrollment.


60 http://csgjusticecenter.org/mental-health/

Please respond to the following items

1. Does the state (SMHA and SSA) have a plan for coordinating with the criminal and juvenile justice systems on diversion of individuals with mental and/or substance use disorders from incarceration to community treatment, and for those incarcerated, a plan for re-entry into the community that includes connecting to M/SUD services?  
   Yes  No

2. Does the state have a plan for working with law enforcement to deploy emerging strategies (e.g. civil citations, mobile crisis intervention, M/SUD provider ride-along, CIT, linkage with treatment services, etc.) to reduce the number of individuals with mental and/or substance use problems in jails and emergency rooms?  
   Yes  No

3. Does the state provide cross-trainings for M/SUD providers and criminal/juvenile justice personnel to increase capacity for working with individuals with M/SUD issues involved in the justice system?  
   Yes  No

4. Does the state have an inter-agency coordinating committee or advisory board that addresses criminal and juvenile justice issues and that includes the SMHA, SSA, and other governmental and non-governmental entities to address M/SUD and other essential domains such as employment, education, and finances?  
   Yes  No

5. Does the state have any activities related to this section that you would like to highlight?

Currently in Maine, there are six Adult Drug Treatment courts, three Family Treatment Drug Courts (a person participating in this court does not need to have criminal charges/history), one Co-occurring Drug Court, and one Co-occurring Veterans Drug Court all adhering to the National Association of Drug Court Professionals best practice standards. Each court has a treatment team to include treatment providers, clinical case managers, Dept. of Corrections, attorneys, and a specialty trained judge. Prior to acceptance in the court, each client is screened and assessed. A treatment plan is developed to address substance use disorders, mental health disorders in conjunction with a service plan developed by the clinical case manager. Goals include abstinence from substances and alcohol while integrating back into the community. SAMHS will provide MAT training to Judges, attorneys, jail staff and other court officials as a best-practice practice in treating individuals involved with the criminal justice system in April 2018. The goal is to increase awareness of the effectiveness of MAT treatment in reducing relapses and recidivism.

Maine has two interagency coordinating committees that include the SMHA/SSA, the Maine Justice Assistance Council and the Maine Opiate Collaborative. SAMHS Prevention Team has a representative attend the Maine Department of Corrections Juvenile Justice Advisory Group (JJAG). The mission of the Maine Juvenile Justice Advisory Group is to advise and make
recommendations to state policy makers and to promote
SAMHS has a contract with Day One, Inc. for the provision of outpatient services at the, Long Creek Youth Detention
Center, located in South Portland, Maine. All committed youth ages 13 to 18 are located at this facility. Youthful offenders (19
through 25) as well as adults (26 and up) receive outpatient services at Mountain View Correctional Facility, located in Charleston,
Maine. The total contract amount is $810,694, $308,063 of which are SAPTBG funds. The balance of $502,630 is from State General
Funds.effective system level responses that further the goals of the Juvenile
Justice and Delinquency Prevention Act.
Please indicate areas of technical assistance needed related to this section.

Footnotes:
Environmental Factors and Plan

14. Medication Assisted Treatment - Requested (SABG only)

Narrative Question
There is a voluminous literature on the efficacy of medication-assisted treatment (MAT); the use of FDA approved medication; counseling; behavioral therapy; and social support services, in the treatment of substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based treatment for these conditions. The evidence base for MAT for SUDs is described in SAMHSA TIPs 40[1], 43[2], 45[3], and 49[4].

SAMHSA strongly encourages that the states require treatment facilities providing clinical care to those with substance use disorders demonstrate that they both have the capacity and staff expertise to use MAT or have collaborative relationships with other providers that can provide the appropriate MAT services clinically needed.

Individuals with substance use disorders who have a disorder for which there is an FDA-approved medication treatment should have access to those treatments based upon each individual patient's needs.

In addition, SAMHSA also encourages states to require the use of MAT for substance use disorders for opioid use, alcohol use, and tobacco use disorders where clinically appropriate.

SAMHSA is asking for input from states to inform SAMHSA's activities.

Please respond to the following items:

1. Has the state implemented a plan to educate and raise awareness within SUD treatment programs regarding MAT for substance use disorders?  
   ○ Yes  ○ No

2. Has the state implemented a plan to educate and raise awareness of the use of MAT within special target audiences, particularly pregnant women?  
   ○ Yes  ○ No

3. Does the state purchase any of the following medication with block grant funds?  
   ○ Yes  ○ No
   a) Methadone
   b) Buprenorphine, Buprenorphine/naloxone
   c) Disulfiram
   d) Acamprosate
   e) Naltrexone (oral, IM)
   f) Naloxone

4. Does the state have an implemented education or quality assurance program to assure that evidence-based MAT with the use of FDA-approved medications for treatment of substance abuse use disorders are used appropriately*?  
   ○ Yes  ○ No

5. Does the state have any activities related to this section that you would like to highlight?

Resources for Medication Assisted Treatment in the state of Maine are limited. Maine has experienced an increase in treatment admissions for individuals addicted to opioids since 2005, and was recently selected by SAMSHA to apply for the Medication Assisted Treatment – Targeted Capacity Expansion funding opportunity based on its rate of treatment admissions. Opioid overdoses have increased over the past 5 years. Additional funding would support the expansion of MAT and other evidenced based treatments throughout the state, specifically in rural areas. Funding would also provide supports for non-Medicaid eligible individuals who are opioid dependent and at risk of relapse.

Funding for programs that provide evidence-based MAT treatment utilizing the FDA approved medications to individuals diagnosed with opioid dependence throughout the state would ensure that affordable and sustainable treatment is available and accessible to all individuals throughout the state.

Additional funds could be used to promote education to local communities on the effectiveness of utilizing MAT treatments and the effectiveness of recovery oriented treatment services.

Funding could be utilized to provide technical assistance for local programs addressing the utilization of MAT, increase opportunities for provider training addressing safe prescribing practices, and diversion

*Appropriate use is defined as use of medication for the treatment of a substance use disorder, combining psychological treatments with approved medications, use of peer supports in the recovery process, safeguards against misuse and/or diversion of controlled substances used in treatment of substance use disorders, and advocacy with state payers.
Environmental Factors and Plan

15. Crisis Services - Requested

Narrative Question
In the on-going development of efforts to build an robust system of evidence-based care for persons diagnosed with SMI, SED and SUD and their families via a coordinated continuum of treatments, services and supports, growing attention is being paid across the country to how states and local communities identify and effectively respond to, prevent, manage and help individuals, families, and communities recover from M/SUD crises. SAMHSA has recently released a publication, Crisis Services Effectiveness, Cost Effectiveness and Funding Strategies that states may find helpful. SAMHSA has taken a leadership role in deepening the understanding of what it means to be in crisis and how to respond to a crisis experienced by people with M/SUD conditions and their families. According to SAMHSA’s publication, Practice Guidelines: Core Elements for Responding to Mental Health Crises, “Adults, children, and older adults with an SMI or emotional disorder often lead lives characterized by recurrent, significant crises. These crises are not the inevitable consequences of mental disability, but rather represent the combined impact of a host of additional factors, including lack of access to essential services and supports, poverty, unstable housing, coexisting substance use, other health problems, discrimination, and victimization.”

A crisis response system will have the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family. SAMHSA expects that states will build on the emerging and growing body of evidence for effective community-based crisis-prevention and response systems. Given the multi-system involvement of many individuals with M/SUD issues, the crisis system approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The following are an array of services and supports used to address crisis response.

Please check those that are used in your state:

1. Crisis Prevention and Early Intervention
   a) ☑ Wellness Recovery Action Plan (WRAP) Crisis Planning
   b) ☑ Psychiatric Advance Directives
   c) ☑ Family Engagement
   d) ☑ Safety Planning
   e) ☐ Peer-Operated Warm Lines
   f) ☐ Peer-Run Crisis Respite Programs
   g) ☑ Suicide Prevention

2. Crisis Intervention/Stabilization
   a) ☑ Assessment/Triage (Living Room Model)
   b) ☑ Open Dialogue
   c) ☑ Crisis Residential/Respite
   d) ☑ Crisis Intervention Team/Law Enforcement
   e) ☑ Mobile Crisis Outreach
   f) ☑ Collaboration with Hospital Emergency Departments and Urgent Care Systems

3. Post Crisis Intervention/Support
   a) ☑ Peer Support/Peer Bridgers
   b) ☑ Follow-up Outreach and Support
   c) ☐ Family-to-Family Engagement
   d) ☑ Connection to care coordination and follow-up clinical care for individuals in crisis

e) Follow-up crisis engagement with families and involved community members
f) Recovery community coaches/peer recovery coaches
g) Recovery community organization

4. Does the state have any activities related to this section that you would like to highlight?

In 2018, Maine initiated one contract for the statewide crisis toll-free hotline, after years of having each of the 8 Districts being responsible for their own hotline, triage and dispatch. It was a significant adjustment for the entire state crisis system.

In addition to the MaineCrisis Line contract for statewide toll free crisis, each of the 8 districts has one crisis provider contracted to provide both Mobile Response and Crisis Stabilization Units--for both Adults and Children.

The first point of contact for callers is the statewide Maine Crisis Line; callers are triaged and sent to the district mobile providers if their need cannot be resolved telephonically with the Maine Crisis Line.

Once the district team receives the call, the Mobile Crisis provider also attempts to resolve the call on the telephone, but if unable, they dispatch their mobile crisis worker to the community setting of the individual. Contracts are written with statewide providers to encourage them to assess individuals in the emergency room as a last resort--however people are still making their way to Emergency Departments for assessments, and the Mobile Crisis Workers will assess them wherever they are.

Mobile Crisis Workers provide on-site assistance to include de-escalation, stabilization, recovery and follow up services. If needed, Crisis Stabilization/residential services are provided to individuals who cannot safely return home, yet do not require psychiatric hospitalization. Individuals served in CSUs have experienced acute psychiatric episodes, and some are stepping-down from psychiatric hospitalization. Contracts are written to ensure that individuals do not have to pay for crisis intervention services, if their insurance does not cover Crisis Intervention, or if they are uninsured.

Please indicate areas of technical assistance needed related to this section.

Footnotes:
Environmental Factors and Plan

16. Recovery - Required

Narrative Question

The implementation of recovery supports and services are imperative for providing comprehensive, quality M/SUD care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals. Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders. Recovery is supported through the key components of: health (access to quality health and M/SUD treatment); home (housing with needed supports); purpose (education, employment, and other pursuits); and community (peer, family, and other social supports). The principles of recovery guide the approach to person-centered care that is inclusive of shared decision-making. The continuum of care for these conditions includes psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual's mental or substance use disorder. Because mental and substance use disorders are chronic conditions, systems and services are necessary to facilitate the initiation, stabilization, and management of long-term recovery.

SAMHSA has developed the following working definition of recovery from mental and/or substance use disorders:

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life to the greatest extent possible, and strive to reach their full potential.

In addition, SAMHSA identified 10 guiding principles of recovery:

- Recovery emerges from hope;
- Recovery is person-driven;
- Recovery occurs via many pathways;
- Recovery is holistic;
- Recovery is supported by peers and allies;
- Recovery is supported through relationship and social networks;
- Recovery is culturally-based and influenced;
- Recovery is supported by addressing trauma;
- Recovery involves individuals, families, community strengths, and responsibility;
- Recovery is based on respect.

Please see SAMHSA’s Working Definition of Recovery from Mental Disorders and Substance Use Disorders.

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Technical assistance and training on a variety of such services are available through the SAMHSA supported Technical Assistance and Training Centers in each region. SAMHSA strongly encourages states to take proactive steps to implement recovery support services. To accomplish this goal and support the wide-scale adoption of recovery supports in the areas of health, home, purpose, and community, SAMHSA has launched Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.

Because recovery is based on the involvement of consumers/peers/people in recovery, their family members and caregivers, SMHAs and SSAs can engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing and create resources for new consumer, family, and youth networks; recovery community organizations and peer-run organizations; and advocacy organizations to ensure a recovery orientation and expand support networks and recovery services. States are strongly encouraged to engage individuals and families in developing, implementing and monitoring the state M/SUD treatment system.

Please respond to the following:

1. Does the state support recovery through any of the following:
1. a) Training/education on recovery principles and recovery-oriented practice and systems, including the role of peers in care?
   Yes  No

b) Required peer accreditation or certification?
   Yes  No

c) Block grant funding of recovery support services.
   Yes  No

d) Involvement of persons in recovery/peers/family members in planning, implementation, or evaluation of the impact of the state’s M/SUD system?
   Yes  No

2. Does the state measure the impact of your consumer and recovery community outreach activity?
   Yes  No

3. Provide a description of recovery and recovery support services for adults with SMI and children with SED in your state.
   Operating from a recovery-oriented framework, services that emphasize support, education/training, rehabilitation, and recovery and services that include natural and community supports and systems that work together to enable consumers to live successfully in their communities. SAMHBS strongly supports the Recovery process and has designed our office to specifically include Recovery as one of our pillars. Recovery Supports available and accessible include Recovery Coaching Training and Recovery Coaching, Recovery Peer Support Centers, statewide warm line, recovery telephone support, supported employment, evidence based clubhouses, long-term vocational support, peer support in emergency departments in some hospitals, peer support at Riverview Psychiatric Center, Assertive Community Treatment (ACT) Teams, the Stability Through Engagement Program (STEP) housing program and an Intentional Peer Support Training and Certification Program. Many of these supports are designed to be low-barrier and easily accessible for individuals.

   For children with SED, the following recovery supports are available to children and their families: In home supports including Rehabilitative and Community Services, Home Community Treatment, Functional Family Treatment and Multi-Systemic Treatment; Drop In opportunities, Youth Peer Support, Family Peer Support, Warm Lines, Children’s Behavioral Health Planning Process (person centered planning), and Children’s Residential treatment is recovery focused. Both Youth and Families of youth with SED/SMI are eligible to receive Peer Support services. OCFS contracts with two different peer support providers and the services are available in varying intensities and provided statewide. Additionally, through RFP, OCFS will be contracting with homeless youth providers in Maine to ensure that homeless youth receive recovery focused services immediately when they enter the Homeless Continuum of Care.

   The Behavioral Health Home model is very focused on recovery, the peer recovery model is integrated into the team approach, and the service is available for both adults and children.

4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state.
   Through the process of MaineCare Rulemaking, the Opioid Health Home was adopted in 2017.
   The Department adopted this rule pursuant to PL 2017 Ch. 2 Part P Sec. P-1 (“Establishment of Opioid Health Home Program”). On April 11, 2017, the Department adopted an emergency rule which established the Opioid Health Home Service as a MaineCare service. The MaineCare Opioid Health Home (OHH) Services program addresses the opioid crisis in Maine. The OHH initiative is an innovative model providing comprehensive, coordinated care focused on serving the MaineCare population. In addition to providing treatment for an individual’s substance abuse dependency, the OHH integrates physical, social, and emotional supports to provide holistic care. The model provides a community-based support system focused on team-based clinical care. MaineCare members diagnosed with opioid addiction and who have a second chronic condition or are at risk for having a second chronic condition are eligible for these services. The OHH services provide a multi-faceted approach and comprehensive treatment specifically targeted to the opioid dependent population. The program will increase access to treatment options, integrate health and dependency care, and promote stable recovery results. It is expected that this newly established OHH program will not only result in more individuals receiving the substance abuse treatment they need, but will also lead to improvements in the quality of care they are receiving.

   The Department has submitted a State Plan Amendment (SPA) request to CMS for approval, and anticipates that CMS will approve the Opioid Health Home SPA. Pending CMS approval, covered services will be provided as described in this rule.

   Peer Run Recovery Centers are Recovery-oriented community services. The focus of these programs has been to primarily provide social, recreational, leisure and some skill building activities from a fixed location to people with Severe Mental Illness (SMI) and co-occurring Substance Use Disorders (SUDs).

   The Department seeks to standardize all Recovery-oriented community services by transforming them into Peer Run Recovery Centers. Peer Run Recovery Centers are evidence-based and adjunct to traditional behavioral health care treatment. Peer-run service programs have been evidenced to significantly improve Participants’ wellbeing (hope, empowerment, goal attainment and meaningful life) and to empower Participants by promoting self-efficacy, personal-accountability and self-esteem. The structure, values and provision of this service must be consistent with the Consumer-Operated Service Program (COSP) model.

5. Does the state have any activities that it would like to highlight?
   Through the State of Maine Request for Proposals (RFP), Mental Health Block Grant funds were utilized to support a Recovery Based Training Program designed to utilize the Peers in the delivery of Recovery Based training curriculum in January 2017. Sweeter is located in Brunswick and is a community based Mental Health provider. Sweeter will provide a Recovery Based Training program which also includes ensuring that all Recovery Based training’s are accessible and available Statewide, including rural and underserved areas of Maine. Trained Peers will then become facilitators, who introduce the evidenced informed recovery curriculum and ongoing skill development to other Peers employed or volunteering in Behavioral Health Setting HH services setting such as Behavioral Health homes, assertiveness community treatment programs, Club Houses and Peer run recovery centers. The curriculum provides skills to support individuals in Recovery from behavioral health issues, aligns with their efforts.
with the principals of Intentional Peer Support, and promotes evidence based or promising practices. Peers with lived experiences have critical roles in caring for themselves and each other, whether informally through self-help or more formally through Peer Support Services. Their involvement with Recovery Based Training will strengthen the program and assist in achieving desirable outcomes.

In 2017, SAMHS sponsored a training titled: "A Day of Dialogue: Peer Role on Behavioral Health Home Teams". It was facilitated by SAMHS Lead CIPSS trainer, with special keynote guest Chris Hansen, who worked in mental health user/survivor politics and peer groups in New Zealand and Internationally for ten years.

One of the missions of IPS in Maine is to influence traditional practice so that it is more consumer friendly. Peer workers can help make that change and both SAMHS and OCFS have contracts for peer support.

OCFS has dedicated their MHBG funding, as recommended by the QIC, to Peer Support for both youth and parents of youth with SED/SMI. This evidence based practice is not covered by Maine’s State Medicaid Plan, yet the results of this support are immeasurable.

Please indicate areas of technical assistance needed related to this section.

**Footnotes:**
Environmental Factors and Plan

17. Community Living and the Implementation of Olmstead - Requested

Narrative Question
The integration mandate in Title II of the Americans with Disabilities Act (ADA) and the Supreme Court’s decision in Olmstead v. L.C., 527 U.S. 581 (1999), provide legal requirements that are consistent with SAMHSA’s mission to reduce the impact of M/SUD on America’s communities. Being an active member of a community is an important part of recovery for persons with M/SUD conditions. Title II of the ADA and the regulations promulgated for its enforcement require that states provide services in the most integrated setting appropriate to the individual and prohibit needless institutionalization and segregation in work, living, and other settings. In response to the 10th anniversary of the Supreme Court’s Olmstead decision, the Coordinating Council on Community Living was created at HHS. SAMHSA has been a key member of the council and has funded a number of technical assistance opportunities to promote integrated services for people with M/SUD needs, including a policy academy to share effective practices with states.

Community living has been a priority across the federal government with recent changes to section 811 and other housing programs operated by the Department of Housing and Urban Development (HUD). HUD and HHS collaborate to support housing opportunities for persons with disabilities, including persons with behavioral illnesses. The Department of Justice (DOJ) and the HHS Office for Civil Rights (OCR) cooperate on enforcement and compliance measures. DOJ and OCR have expressed concern about some aspects of state mental health systems including use of traditional institutions and other settings that have institutional characteristics to serve persons whose needs could be better met in community settings. More recently, there has been litigation regarding certain evidence-based supported employment services such as sheltered workshops. States should ensure block grant funds are allocated to support prevention, treatment, and recovery services in community settings whenever feasible and remain committed, as SAMHSA is, to ensuring services are implemented in accordance with Olmstead and Title II of the ADA.

It is requested that the state submit their Olmstead Plan as a part of this application, or address the following when describing community living and implementation of Olmstead:

Please respond to the following items

1. Does the state's Olmstead plan include:
   - Housing services provided.
   - Home and community based services.
   - Peer support services.
   - Employment services.

2. Does the state have a plan to transition individuals from hospital to community settings?

3. What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?
   - The Mental Health Rehabilitation Technician / Community Training and Certification processes includes additional emphasis on community inclusion. This certification is required for several community-based services, including Community Integration (Case Management), Behavioral Health Homes, Mental Health Psychosocial Clubhouses, ACT, Crisis Intervention and Community Rehabilitation Services.
   - OCFS utilizes their portion of MHBG funding peer support services; DOC values peer support for the juvenile justice system, and supports it financially.

   Please indicate areas of technical assistance needed related to this section.

Footnotes:

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18. Children and Adolescents M/SUD Services - Required MHBG, Requested SABG

Narrative Question

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SABG funds are available for prevention, treatment, and recovery services for youth and young adults with substance use disorders. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious emotional disturbance that contributes to substantial impairment in their functioning at home, at school, or in the community. Most mental disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24. For youth between the ages of 10 and 24, suicide is the third leading cause of death and for children between 12 and 17, the second leading cause of death.

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21. Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children’s needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a point person for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support services.

Since 1993, SAMHSA has funded the Children’s Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with 173 grants awarded to states and communities, and every state has received at least one CMHI grant. Since then SAMHSA has awarded planning and implementation grants to states for adolescent and transition age youth SUD treatment and infrastructure development. This work has included a focus on financing, workforce development and implementing evidence-based treatments.

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or SUD and co-occurring M/SUD and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child, youth and young adult functioning in home, school, and community. The system of care approach provides individualized services, is family driven; youth guided and culturally competent; and builds on the strengths of the child, youth or young adult and their family to promote recovery and resilience. Services are delivered in the least restrictive environment possible, use evidence-based practices, and create effective cross-system collaboration including integrated management of service delivery and costs.

According to data from the 2015 Report to Congress on systems of care, services:

1. reach many children and youth typically underserved by the mental health system;
2. improve emotional and behavioral outcomes for children and youth;
3. enhance family outcomes, such as decreased caregiver stress;
4. decrease suicidal ideation and gestures;
5. expand the availability of effective supports and services; and
6. save money by reducing costs in high cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

SAMHSA expects that states will build on the well-documented, effective system of care approach to serving children and youth with serious M/SUD needs. Given the multi- system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The array of services and supports in the system of care approach includes:

• non-residential services (e.g., wraparound service planning, intensive case management, outpatient therapy, intensive home-based services, SUD intensive outpatient services, continuing care, and mobile crisis response);
• supportive services, (e.g., peer youth support, family peer support, respite services, mental health consultation, and supported education and employment); and
residential services (e.g., like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification).

68 The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.

Please respond to the following items:

1. Does the state utilize a system of care approach to support:
   a) The recovery and resilience of children and youth with SED?
   b) The recovery and resilience of children and youth with SUD?

2. Does the state have an established collaboration plan to work with other child- and youth-serving agencies in the state to address M/SUD needs:
   a) Child welfare?
   b) Juvenile justice?
   c) Education?

3. Does the state monitor its progress and effectiveness, around:
   a) Service utilization?
   b) Costs?
   c) Outcomes for children and youth services?

4. Does the state provide training in evidence-based:
   a) Substance misuse prevention, SUD treatment and recovery services for children/adolescents, and their families?
   b) Mental health treatment and recovery services for children/adolescents and their families?

5. Does the state have plans for transitioning children and youth receiving services:
   a) to the adult M/SUD system?
   b) for youth in foster care?

6. Describe how the state provide integrated services through the system of care (social services, educational services, child welfare services, juvenile justice services, law enforcement services, substance use disorders, etc.)

OCFS utilizes the system of care approach to coordinate all services provided to children and families. Behavioral Health Home and Targeted Case Management agencies work diligently to link families to community based services and try to keep youth out of residential settings, when safely possible. The system of care principles are incorporated into all behavioral health contracts, and all efforts are made to support families in their home communities when possible. In addition to treatment such as Outpatient therapy, medication management, Home and Community treatment and Rehabilitation Community Services, Maine recognizes that Youth and Family peer support are services that are critical to support families in their recovery. OCFS is in the process of requesting proposals for statewide Youth and Family peer support providers. In addition to peer support, OCFS offers behavioral health respite, crisis intervention and stabilization units, treatment foster care and will soon offer PRTF services in Maine. OCFS has maintained strong relationships with other child/young adult-serving state agencies: Department of Corrections--Juvenile Justice Services, Department of Education, Child Development Services, Office of MaineCare services, Office of Aging and Disability Services and the Office of Substance Abuse and Mental Health Services.
Active collaboration includes monthly meetings with representatives from these teams at a regional level where services are provided to youth and their families; at the policy level where leaders work together to create practice models to support one another; and also at practice level where services to vulnerable populations are shaped, evaluated and promoted, based on outcomes that will improve the well-being of families.
OCFS consists of Child Welfare and Children's Behavioral Health Services—CBHS is integrated within the Child Welfare offices, and the teams operate together very well—ensuring continuity of care for youth involved in Child Protection Services.

7. Does the state have any activities related to this section that you would like to highlight?

Maine’s Psychiatric Residential Treatment Facility (PRTF) SPA has been approved by CMS. This is a level of care that Maine has not previously had. Due to the increase in high-level behavioral presentations of youth and need for this higher level of care, we expect that having PRTF in Maine will enable us to bring youth who are currently placed out of state in PRTF back to Maine—closer to their families and communities, where they can continue to progress toward discharge to community services. There is currently one provider who has expressed interest in becoming a provider in Maine, and OCFS will be meeting with them on September 30, 2019.

General timeline for implementation is January 2020

Please indicate areas of technical assistance needed related to this section.
Environmental Factors and Plan

Advisory Council Members
For the Mental Health Block Grant, there are specific agency representation requirements for the State representatives. States MUST identify the individuals who are representing these state agencies.

State Education Agency
State Vocational Rehabilitation Agency
State Criminal Justice Agency
State Housing Agency
State Social Services Agency
State Health (MH) Agency.

Start Year: 2020  End Year: 2021

<table>
<thead>
<tr>
<th>Name</th>
<th>Type of Membership*</th>
<th>Agency or Organization Represented</th>
<th>Address, Phone, and Fax</th>
<th>Email(if available)</th>
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*Council members should be listed only once by type of membership and Agency/organization represented.

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Footnotes:
# Environmental Factors and Plan

## Advisory Council Composition by Member Type

<table>
<thead>
<tr>
<th>Type of Membership</th>
<th>Number</th>
<th>Percentage of Total Membership</th>
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<tr>
<td>Individuals in Recovery* (to include adults with SMI who are receiving, or</td>
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<td>have received, mental health services)</td>
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<tr>
<td>Family Members of Individuals in Recovery* (to include family members of</td>
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<td>adults with SMI)</td>
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<tr>
<td>Parents of children with SED/SUD*</td>
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<tr>
<td>Vacancies (Individuals and Family Members)</td>
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</tr>
<tr>
<td>Others (Advocates who are not State employees or providers)</td>
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<tr>
<td>Persons in recovery from or providing treatment for or advocating for SUD services</td>
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<tr>
<td>Representatives from Federally Recognized Tribes</td>
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<td><strong>Total Individuals in Recovery, Family Members &amp; Others</strong></td>
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<td>State Employees</td>
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<tr>
<td>Providers</td>
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<td>Vacancies</td>
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<tr>
<td><strong>Total State Employees &amp; Providers</strong></td>
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<td>Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations</td>
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<tr>
<td>Providers from Diverse Racial, Ethnic, and LGBTQ Populations</td>
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<tr>
<td>Youth/adolescent representative (or member from an organization serving young people)</td>
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</tbody>
</table>

* States are encouraged to select these representatives from state Family/Consumer organizations or include individuals with substance misuse prevention, SUD treatment, and recovery expertise in their Councils.

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### Footnotes:
Environmental Factors and Plan

22. Public Comment on the State Plan - Required

Narrative Question

Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. § 300x-51) requires, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the state block grant plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to SAMHSA.

Please respond to the following items:

1. Did the state take any of the following steps to make the public aware of the plan and allow for public comment?

   a) Public meetings or hearings?  ☒ Yes ☐ No

   b) Posting of the plan on the web for public comment?  ☐ Yes ☒ No

      If yes, provide URL:

   c) Other (e.g. public service announcements, print media)  ☐ Yes ☐ No

Footnotes:

The Maine Mental Health Quality Improvement Council (QIC) held community Forums in each region of the State to obtain feedback from the public on the State Mental Health Block Grant Plan - with an overarching focus on behavioral health as a whole. The Forums were advertised to the public and were held in community venues that were not associated with the State Agency (DHHS). The schedule was as follows: 6/18/19 Augusta (Region II); 6/19/19 Bangor (Region III); 6/27/19 Portland (Region I). A member of the QIC was present at each community forum, and an employee of DHHS attended to take minutes, which were then provided to the QIC as a whole.