

2011

# Evaluation of Maine's Strategic Prevention Framework

## Final Report 2005 - 2010



Office of Substance Abuse  
An Office of the  
Department of Health and Human Services

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**Evaluation of Maine's  
Strategic Prevention Framework  
Final Report 2005–2010**

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## Executive Summary

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In 2004, Maine was selected through a competitive process to be among the first cohort of states to receive a Strategic Prevention Framework State Incentive Grant (SPF SIG) from the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA). The grant funded the State's effort to develop its substance abuse prevention infrastructure and to implement evidence-based approaches to prevention reflecting needs and resources, and involving a comprehensive strategic plan at the state and local levels.

### *Infrastructure Summary*

One of the primary goals of the SPF SIG project was to build Maine's Infrastructure and Prevention capacity. Before receiving its SPF SIG funding, Maine's Office of Substance Abuse characterized the state's prevention infrastructure as one facing underserved areas, inconsistent and limited funding, and a lack of coordinated efforts across the various prevention funding sources (state, federal and private). These challenges resulted in both gaps and duplication of prevention efforts across the state.

To meet the goals of reducing substance use and its related consequences, Maine recognized that it was essential to develop a strengthened, more systematic prevention infrastructure. The original proposal identified six goals for infrastructure and capacity development that would be achieved through the SPF SIG:

- Conduct a statewide epidemiological analysis to identify high-need areas/subpopulations;
- Develop local needs assessments and strategic plans;
- Create a consistent cross-disciplinary prevention infrastructure at the local and regional levels;
- Increase the number of communities that coordinate funding from multiple state programs;
- Increase the number of communities that implement evidence-based prevention programs; and
- Develop and implement a cross-disciplinary Prevention Workforce Development Plan.<sup>1</sup>

The primary evaluation question, then, is "What was the effect of the Strategic Prevention Framework on service capacity and other infrastructure objectives?" To answer this question, the evaluators, Hornby Zeller Associates, Inc. (HZA) administered the Community Infrastructure Assessment (CIA) at three points throughout the SPF SIG process, capturing critical information about eight infrastructure domains identified by the national cross-site team. HZA also reviewed meeting minutes, conducted interviews with key informants in 2006 and 2010, and held site visits with all grantees to supplement the findings of the CIA. As can be seen in the table below, Maine made great strides over the course of the SPF SIG in regard to its prevention infrastructure.

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<sup>1</sup> Office of the Governor, Application for Federal Assistance, Strategic Prevention Framework SIG, June 30, 2004.

**Table 1. Accomplishments of Maine’s SPF SIG: Infrastructure**

Domain	Score*			Major Achievements
	2006	2008	2010	
<b>Organizational Structure</b>	2.08	2.29	2.46	Established and sustained Prevention Advisory Board  Substance Abuse included in statewide Public Health Infrastructure
<b>Data and Data Systems</b>	2.03	1.67	2.13	Completed a Statewide Epidemiological Profile  Communities drafted 16 Local Needs Assessments  Established and sustained State Epidemiological Outcomes Workgroup (SEOW)
<b>Planning</b>	2.20	2.36	2.53	Created State of Maine Strategic Plan; updated in 2010  Communities drafted 16 Local Strategic Plans
<b>Workforce Development</b>	1.58	1.97	2.31	Supported Workforce Development for Prevention Survey  Established Prevention Calendar  Expanded opportunities for technical assistance and training
<b>Evidence-Based Practices</b>	2.19	2.19	2.25	Created Evidence-based Strategy List  Established method for determining “Acceptable Evidence” for emerging strategies  Focused on Environmental Strategies
<b>Cultural Competence</b>	1.35	1.31	1.67	Completed studies of six Cultural Subpopulations  Enhanced collaboration with Maine Tribes  Supported Cultural Competence at the local level
<b>Evaluation and Monitoring</b>	2.00	2.07	2.36	Created single reporting system for Public Health Infrastructure  Released how-to guides for communities (Assessment and Evaluation)  Created Logic Models for local implementation efforts
<b>Sustainability</b>	2.06	1.96	2.45	Established partnerships with other state agencies involved in prevention  Included language in most recent RFP to allow for future funding to be braided in

**Source: Community Infrastructure Assessment (CIA), 2006, 2008 and 2010.**

\*Scores represent the average capacity and infrastructure that exists for substance abuse prevention within the Healthy Maine Partnership organizations across the state. In this case, 1 equals low, 2 equals moderate, and 3 equals high-capacity or infrastructure.

## *Implementation Summary*

Through an intense, year-long process of needs assessment and strategic planning occurring at the state level, Maine chose to focus on three priority consumption areas and their related consequences. This decision was supported through consultation with Maine's Federal SPF SIG Project Officer. In 2007, Maine funded 28 communities to implement evidence-based environmental approaches to address the following priority areas:

- 1) Underage drinking;
- 2) High risk drinking among young adults (18 to 25); and
- 3) Young adult (18 to 25) prescription drug misuse.

OSA further broke these priorities into 16 objectives and identified approved strategies to address each. Of the objectives, five were required of SPF SIG grantees meaning all grantees had to select at least one strategy that was identified for each of the required objectives.

To increase the effectiveness of local underage drinking law enforcement policies and practices, OSA asked grantees to work with local police departments to: develop a departmental policy around underage drinking; work to enhance their existing policy; provide training to officers on best practices; and support departments as they implemented Party Patrols and compliance checks. All districts reported that they built stronger relationships with their local police departments and cited this as one of the great successes of the SPF SIG; in fact, they reported working with about 100 departments across the state each year.<sup>2</sup> Over the course of the SPF SIG, the proportion of high school students reporting that they thought they would be caught by the police for drinking alcohol had increased from 11 percent in 2006 to 12 percent in 2008.

To increase the effectiveness retailer policies and practices, and to decrease pricing specials and alcohol promotions, grantees could: offer Responsible Beverage Service (RBS) Trainings; help retailers incorporate the best practices; educate retailers on the importance of prioritizing underage access to alcohol; implement the Card ME program; educate merchants about the negative impacts of low pricing and promotions; work with them to limit promotions; and to implement activities to inform customers of the penalties for furnishing alcohol to minors. RBS Trainings were offered in every public health district, and coalition estimates suggest that staff from more than 600 Maine retailers participated over the course of the SPF SIG, making these trainings the most commonly implemented strategy to address retail access to alcohol. All SPF SIG grantees reported great success with this particular strategy and by 2008, 63 percent of high school students thought it was easy to obtain alcohol, compared to 66 percent in 2006.

To increase use of recommended parental monitoring practices for underage drinking, SPF SIG grantees could use the OSA Parent Media Campaign materials to build a social marketing campaign, hold educational meetings for parents or work with agencies,

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<sup>2</sup> Because coalitions may work with the same departments in each work plan year on different components, an annual count is provided here.

organizations and worksites to educate parents. Coalitions in all Public Health Districts used a variety of media to try to get their message across to the general community. In total, coalitions estimated that the messages about parental monitoring and modeling were distributed across more than 1,300 channels (examples of which include media outlets, doctors' offices, stores, community bulletin boards, public transportation, movie theaters, and restaurants), and resulted in more than 1.2 million media exposures between 2006 and 2009. While the social marketing campaign was implemented with relative success, coalitions reported that parents were especially difficult to reach and there was often wide variance in terms of attendance at parent meetings. In 2008, 85 percent of high school students reported that their parents thought alcohol use was wrong, compared to 83 percent in 2006, and 42 percent thought they would be caught by their parents (up from 39 percent in 2006).

To increase young adults' knowledge of the health risks associated with risky drinking behaviors, OSA developed a Drug-Free workplace component to be incorporated into the HMP Worksite Framework. Coalitions could distribute information about available assessment and self-help materials; help employers provide information to their employees; help develop a substance abuse policy; and help employers learn how to consistently enforce that policy. Although some coalitions reported modest success with worksites, this was one of the less successful initiatives undertaken by the SPF SIG. The primary barrier was one of access, with coalitions finding that many businesses were simply unwilling to work with them in regards to employee use of alcohol and drugs.

OSA also identified strategies for coalitions to use in partnership with colleges and universities that mirrored the strategies for worksites. These strategies included distributing information about available assessment and feedback services and developing appropriate substance abuse policies and procedures. Coalitions reported limited success with these strategies in large part because they overlapped with the work that many colleges and universities had been engaged in through Maine's Higher Education Alcohol Prevention Partnership (HEAPP) prior to the SPF SIG. In some cases, this overlap created a barrier for coalitions in developing relationships with their local colleges and universities as the institutions felt they were already implementing the strategies.

### ***Outcomes Summary***

One of Maine's great achievements during the SPF SIG was a 6.6 percentage point decrease in the rate of underage drinking in the past month among high school students between 2004 and 2008; from 41.6 percent in 2004 to 35 percent in 2008 (see the table below). The observed decline between 2006 and 2008, the first two years of SPF SIG implementation at the local level, marked the first decrease of this magnitude since 1998.

**Table 2. Critical Prevention Factors for Maine High School Students: 2004, 2006 and 2008**

	2004	2006	2008
Past-Month Alcohol Use	41.6%	40.3%	35.0%
Binge-Drinking (past two weeks)	23.0%	21.6%	18.2%
Caught by Parents	37.6%	39.1%	41.5%
Caught by Police	10.5%	11.1%	12.1%
Clear Rules	79.8%	80.6%	81.2%
Easy Access	69.2%	66.3%	63.4%
Parents Think Use Wrong	82.3%	83.1%	84.9%
Perception of Harm (1-2 per day)	65.0%	66.5%	68.4%
<i>Source: Maine Youth Drug and Alcohol Use Survey, grades 9-12</i>			

Maine’s original SPF SIG grant laid out 16 measures where the state hoped to see improvements as a result. During the course of the needs assessment and strategic planning process, these measures were narrowed based upon the review of epidemiological data. The remaining relevant benchmarks included:

- Increase proportion of youth who report no 30-day use of alcohol by five percent;
- Reduce two-week binge-drinking among youth by five percent;
- Decrease perceived access to alcohol among youth by 10 percent;
- Increase perceived consistency of underage drinking enforcement by 10 percent;
- Reduce the proportion of 9<sup>th</sup>-12<sup>th</sup> graders who start drinking before age 14 by 10 percent;
- Increase proportion of 9<sup>th</sup>-12<sup>th</sup> graders who report no 30-day use of any substances by five percent;
- Increase proportion of 9<sup>th</sup>-12<sup>th</sup> graders who report no lifetime use of any substances by five percent; and
- Reduce binge-drinking among 18-24 year olds by five percent.

Maine’s ability to meet these benchmarks during the implementation SPF SIG is illustrated in the following table which uses data from the Maine Youth Drug and Alcohol Use Survey (MYDAUS) and the Behavioral Risk Factor Surveillance Survey (BRFSS) to calculate the rates of change. For youth, data from 2004 serve as a baseline for calculating a rate of change from 2008 estimates. For young adults, BRFSS 2006 and 2009 data are used. Although Maine did observe decreases in prescription drug use, no benchmark was established at the outset of the grant against which to gauge success.

**Table 3. Accomplishments of Maine’s SPF SIG: Outcome Benchmarks**

Indicator	Target	Actual	Status
Increase proportion of youth who report no 30-day use of alcohol	+5%	+11.3% <sup>3</sup>	✓
Reduce 2-week binge-drinking among youth	-10%	-20.8%	✓
Decrease perceived ease of access to alcohol among youth	-10%	-8.3%	Not met
Increase perceived consistency of underage drinking enforcement	+10%	+15.1%	✓
Reduce the proportion of 9 <sup>th</sup> -12 <sup>th</sup> graders who start drinking before age 14	-10%	-8.2%	Not met
Increase proportion of 9 <sup>th</sup> -12 <sup>th</sup> graders who report no 30-day use of any substances	+5%	+49.3%	✓
Increase proportion of 9 <sup>th</sup> -12 <sup>th</sup> graders who report no lifetime use of any substances	+5%	+22.2%	✓
Reduce binge-drinking among 18-24 year olds by 5 percent	-5%	-17.1%	✓

Data results from the 2009 Maine Youth Integrated Health Survey (MIYHS) are somewhat more challenging to interpret. Direct comparisons between the 2008 MYDAUS and the new 2009 MIYHS data are not possible due in large part to changes in the format and administration methodology of the survey.<sup>4</sup> For this reason, the data findings should be used as a baseline against which to gauge future progress, rather than a final measure by which to determine previous successes.

Nonetheless, the statewide 2009 survey data do suggest that positive outcomes continue. As demonstrated in Table 4 on the following page, the past-month use of alcohol among high school students remained stable statewide between 2008 and 2009 (35% and 34.7%, respectively). However, binge-drinking within the past two weeks increased slightly from 18 to 20 percent.

<sup>3</sup> Using YRBSS data, the rate of change between 2005 and 2009 is 19 percent (from 57% in 2005 to 68% in 2009).

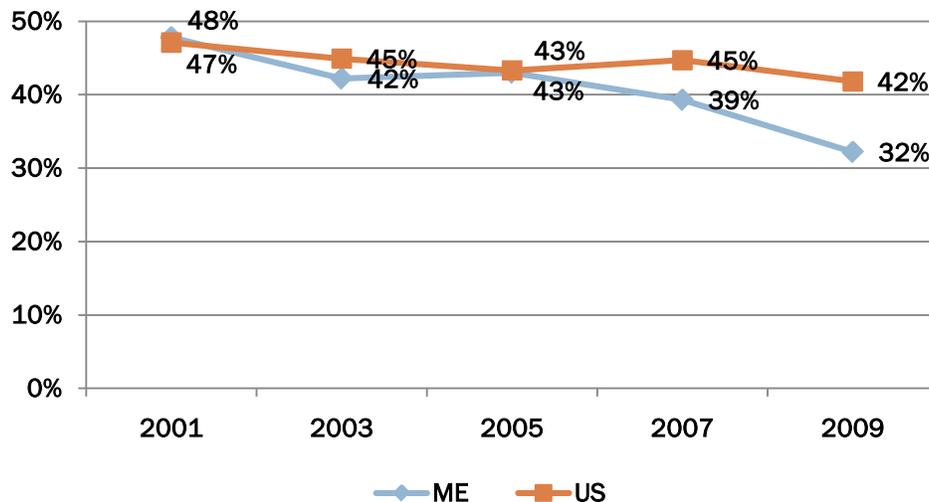
<sup>4</sup> For more information on the 2009 survey, please see: <http://www.maine.gov/youthhealthsurvey/main.cgi>

Table 4. Critical Prevention Factors for Maine High School Students: 2008 and 2009			
	2008		2009
Past-Month Use of Alcohol	35.0%		34.7%
Binge-Drinking (past two weeks)	18.2%		20.1%
Caught by Parents	41.5%		42.1%
Caught by Police	12.1%		15.6%
Clear Rules	81.2%		85.2%
Easy Access	63.4%		67.5%
Parents Think Use Wrong	84.9%		82.7%
Perception of Harm	68.4%		59.9%

*Source: 2008 Maine Youth Drug and Alcohol Use Survey, grades 9-12; 2009 Maine Integrated Youth Health Survey, grades 9-12. Trending between 2008 MYDAUS and 2009 MIYHS is not possible due to changes in the administration methodology of the survey. Data are presented together here for discussion purposes only.*

When Maine is compared to national trends using a nationally comparable source of student data, however, the downward trend continues in 2009. As demonstrated by the graphic below, Maine’s rate of past-month alcohol use among high school students declined from 43 percent in 2005 (the first year of the SPF) to 32 percent in 2009. Moreover, these declines are far greater than the current national trends in underage alcohol use, where rates actually increased in 2007 to 45 percent before decreasing slightly to 42 percent in 2009.

**Figure 1. Previous 30-Day Use of Alcohol by High School Students in Maine and United States, 2001 to 2009**



*Source: Youth Risk Behavior Surveillance System (YRBSS), 2001 - 2009.*

As mentioned, prescription drugs were not included in the original proposal with established targets. However, misuse of prescription drugs among young adults ages 18 to 25 was

identified in Maine's SPF SIG Strategic Plan as a priority, and grantees could work on selected strategies relating to prescription drugs. According to the National Survey on Drug Use and Health (NSDUH), the past-year use of painkillers among 18 to 25 year olds has been decreasing slightly each year since 2003-04, from 13 percent in 2004-05 to 12 percent in 2007-08. Maine also conducted a community survey in 2008 ( $n = 564$ ) and 2010 ( $n = 741$ ) to obtain information about this population. Those results show a statistically significant decline in non-medical use of pain relievers in the past year, from 16 percent in 2008 to 11 percent in 2010.

### *Conclusion*

Sustainability of the SPF SIG can be thought of as the ability to integrate the newly developed SPF SIG approaches into the fabric of existing prevention programs and services. Although dedicated prevention staff and programming at the local level have not been sustained uniformly, SPF SIG principles have been fully embraced and integrated into Maine's prevention infrastructure. In particular, OSA places a strong emphasis on implementing evidence-based programs and environmental strategies, and it routinely engages in data-driven decision-making. These advances in capacity and the infrastructure developed to support them at the state level will sustain well beyond the lifetime of the SPF SIG project.

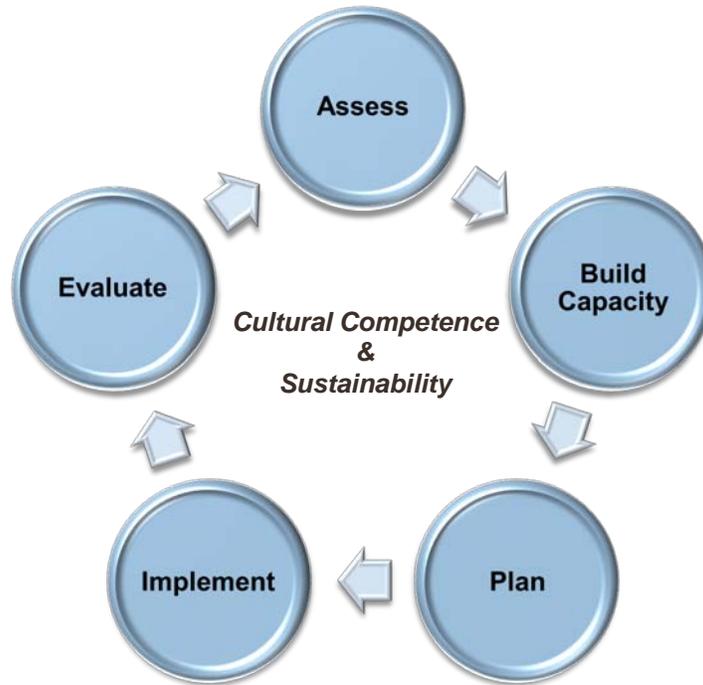
Of the five objectives required of SPF SIG grantees, strategies to engage local police, retailers and parents appear to have had the most unilateral successes across all the public health districts. Indeed, student survey data from 2006 and 2008 shows promising changes observed on measures that directly relate to these strategies. Maine saw significant reductions in the rates of underage drinking and high-risk drinking among young adults over the course of the SPF SIG. The student survey data and supplemental qualitative information strongly suggest that environmental strategies implemented statewide under the SPF SIG influenced the decline in drinking rates among high school students. The evidence is less clear about the linkage between the work completed under the SFP SIG and the decreases in binge-drinking observed among the young adult population. This is also the case for the observed decreases in the rates of prescription drug use among this age group. Nonetheless, the successes experienced in Maine show the value of statewide implementation of the SPF SIG approach using evidence-based environmental strategies.

## Chapter 1. Introduction

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### *The SPF SIG Model*

For the past five years, the Substance Abuse and Mental Health Services Administration (SAMHSA) has been promoting its Strategic Prevention Framework (SPF) as a structure within which substance abuse prevention work should occur. The Framework has five steps (shown below), with two overarching principles, sustainability and cultural competence.



The framework was built upon the outcomes-based prevention model developed in the public health arena. Outcomes-based prevention focuses on both the consumption patterns as well as related consequences to determine priority areas for prevention. The model also posits that there are factors that “cause” consumption patterns and substance-related consequences in communities. Researchers have termed these factors “intervening variables” and for prevention they include such things as availability of a substance, social norms regarding use, current enforcement practices and the promotion of substances.<sup>5</sup> By positively impacting intervening variables related to substance abuse, SPF SIG hoped to achieve population-level<sup>6</sup> changes in alcohol consumption patterns and related consequences. In this way, the framework applies a public health approach to substance-related prevention.

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<sup>5</sup> “A General Causal Model to Guide Alcohol, Tobacco and Illicit Drug Prevention: Assessing the Research Evidence.” Multi-State Technical Assistance Workshop. Washington, DC. March 16, 2006.

<sup>6</sup> “Population-level change” focuses on change among collections of individuals who have one or more personal or environmental characteristics in common. One example of a “population” under this definition is young adults between the ages of 18 and 25. Center for Substance Abuse Prevention, *SPF SIG Overview and Expectations*. New Grantee Workshop (2005).

The SPF SIG also intended to build state and local capacity to decrease substance use and abuse by using a data-driven approach to decision-making and by strengthening the existing prevention infrastructure.

### ***Implementing the SPF SIG in Maine***

In 2004, Maine was selected through a competitive process to be among the first cohort of states to receive a Strategic Prevention Framework State Incentive Grant (SPF SIG). The grant funded the State to develop its substance abuse prevention infrastructure and to implement evidence-based approaches based on needs and resources and a comprehensive strategic plan at the state and local levels. Maine outlined three primary goals in its application:

- 1) Build Maine's Infrastructure and Prevention Capacity;
- 2) Improve Outcomes on Federal Measures; and
- 3) Use Cost-effective Evidence-based Practices.

Through an intense, year-long process of needs assessment and strategic planning that occurred at the state level, Maine chose to focus on three priority consumption areas:

- Underage drinking;
- High-risk drinking among young adults (18 to 25); and
- Young adult (18 to 25) prescription drug misuse.

In 2006, 15 community coalitions across the state (one in each county<sup>7</sup>) were funded to engage in local needs assessment and strategic planning for substance abuse prevention. This was considered "Phase I" of the SPF SIG. For Phase II, Maine funded 28 communities in September 2007 to implement evidence-based environmental approaches.<sup>8</sup>

### ***Purpose of This Report***

Evaluation and monitoring is the fifth step in the Strategic Prevention Framework. The purpose of the evaluation of Maine's Strategic Prevention Framework is first and foremost to determine whether or not the substance abuse prevention work, framed by the SPF SIG, affected the factors that contribute to underage alcohol use and high-risk drinking, and thereby reduced the consumption patterns within the state.

The previous evaluation report focused on the first three years of the SPF. The purpose of this report is to examine the activities and accomplishments of the SPF SIG in Maine that were achieved during the implementation phase, the final three years, at both the state and local district levels. Hornby Zeller Associates, Inc. (HZA), evaluator for SPF SIG, is charged

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<sup>7</sup> The assessments for Piscataquis and Penobscot counties were conducted by one organization.

<sup>8</sup> Environmental approaches focus on changing public laws, policies, practices and norms to create an environment that reduces the likelihood of substance abuse. Evidence-based refers to approaches where substantial research suggests the approach is effective.

with documenting and evaluating how Maine implemented the SPF and what contributed to the success of the effort and achievement of outcomes.

The remainder of the report is broken into five parts: **Chapter 2** outlines the sources of information that are used throughout the evaluation, as well as the methodologies employed in data analysis and trending. **Chapter 3** highlights the infrastructure accomplishments that were accomplished during the SPF SIG and the direct role that the grant played in infrastructure development, including efforts to enhance cultural competence, as well as presenting what will be sustained, and how. **Chapter 4** discusses the five work plan objectives that were required of the 28 community grantees by the State. **Chapter 5** first presents the outcomes observed over the course of the SPF SIG and then examines these outcomes in terms of the original targets set by the State at the inception of the grant. Critical to the discussion is the impact that local coalition work has had on essential “intervening variable” measures. Finally, **Chapter 6** provides a summary of the evaluation findings and lessons learned, as well as providing recommendations on facing the challenges that persist as the State and communities move forward.

## Chapter 2. Methodology and Data Sources

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### *Approach*

In keeping with the outcomes-based prevention model, Maine sought a decrease in substance-related consequences in addition to reductions in the consumption patterns listed above. Because the consequences were not wholly defined in the SPF logic model in the state's plan,<sup>9</sup> the evaluation team discussed them in more detail with staff from the Office of Substance Abuse and the State Epidemiological Outcomes Workgroup (SEOW) and used the *Maine State Substance Abuse Assessment and Epidemiological Profile 2005* to select consequences that are logically linked to the priority consumption patterns.

Ultimately, an evaluation of SPF SIG should measure reductions in negative consequences and the consumption patterns that contribute to them. The following lay out the longer-term questions pertaining to Maine's key objectives.

- Is there a reduction in treatment admissions for alcohol and prescription drugs?
- Is there a reduction in hospital admissions for alcohol and prescription drug abuse or dependence?
- Do the numbers of alcohol related poisonings and opioid related poisonings decrease?
- Is there a reduction in overdose deaths due to prescription drugs?

However, it is unrealistic to expect changes by the conclusion of SPF SIG implementation in terms of longer-term consequences, such as reduced treatment admissions or overdose deaths, opposed to the consumption patterns. Moreover, for some of the data sources, the updated information is not available at the time of this report. These consequence trends must be monitored over time in order to gauge the true impact of the SPF SIG on them. Therefore, this evaluation report focuses on observed changes to the priority consumption patterns, as well as the factors that contribute to them. The one exception is car accidents, which are shown to be fairly responsive to environmental and law enforcement strategies.

- Is there a reduction in use of alcohol among youth ages 12 to 17?
- Is there a reduction in binge-drinking among youth ages 12 to 17?
- Is there a reduction in high-risk alcohol use among young adults ages 18 to 25?
- Is there a reduction in prescription drug misuse among young adults ages 18 to 25?
- Is there a reduction in deaths and non-fatal car crashes that involve alcohol?

Consumption patterns and intervening variables are also the focus of the community level outcome evaluation. It is through changes in these areas that Maine will see a reduction in its statewide priorities. For the purposes of SPF SIG, Maine defines "community" as the service areas covered by the eight Public Health Districts (discussed in more detail in the following chapter), each of which is comprised of multiple HMP coalitions. It should be noted that the work on alcohol use among youth and young adults was required of all grantees, whereas work around prescription drug misuse was optional depending on community

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<sup>9</sup> A copy of Maine's SPF SIG Logic Model can be found in Appendix A.

needs assessments and priorities. Maine has named sets of priority-intervening variables for each priority consumption pattern. The questions below reflect only those priorities and intervening variables (called objectives in the SPF SIG work plans) that were required of all communities.

- Is there a reduction in use of alcohol?
- Is there a reduction in binge-drinking?
- Is there a reduction in high-risk alcohol use?
- Is there an increase in parental monitoring around youth alcohol use?
- Is there an increase in families with clear rules around alcohol and drug use?
- Is there an increase perception that parents think alcohol use by youth is wrong?
- Is there an increase in perceived enforcement?
- Is there an increase perception of risk from alcohol use?

Developing the statewide prevention infrastructure was also a primary goal of the SPF SIG. The overarching question is “What infrastructure is in place to support substance abuse prevention pre- and post-SPF at the state and local levels?” The evaluation team broke this broad question down into several sub-parts:

- How is implementation designed and coordinated at the state level? What resources are provided to guide implementation?
- Who receives the implementation funds? Is there statewide coverage (all towns covered as intended)?
- What organizational structures are in place to support prevention?
- To what extent does the infrastructure support planning and data-driven decision-making?
- Is implementation monitored by the state?
- To what degree does the infrastructure promote cultural competence?
- What systems are established to provide training and technical assistance on implementation?
- What training and technical assistance is provided to ensure prevention activities and outcomes continue after SPF SIG?

Successful implementation and positive outcomes in the Strategic Prevention Framework are related to the assessment of needs, strategic planning to address identified needs, and the capacity-building activities to address resource and readiness issues. However, Maine experienced a transition between Step 3 (planning) and Step 4 (implementation) that is likely not found in other states. Fifteen grantees (covering 16 counties) were funded to complete county-level needs assessments and strategic plans, while SPF implementation was carried out by a new set of 28 grantees across eight Public Health Districts. This transition presents a challenge of continuity. To address this, the evaluation also examines the following questions to assess the impact of implementing SPF in two parts:

- What processes are in place to ensure there was continuity between SPEP plans and HMP implementation? What training was provided to ensure this continuity?

- What training was provided to ensure HMP grantees understand the SPF?
- Does the HMP RFP reflect the targets and priorities in the State's Strategic Plan?
- Do the HMP proposals demonstrate that the Community Strategic Planning and Environmental Programming (SPEP) strategic plans were the primary planning tool used to identify priorities and strategies?

### *Data Sources*

This report relies on a variety of data sources to draw its conclusions. A description of each source, and the primary analyses performed, can be found below. While some of the data resources described may not be explicitly cited in the subsequent report, each of them helps to inform the reasoning that forms the basis of the report's evaluative conclusions.

#### *Behavioral Risk Factor Surveillance System (BRFSS)*

The BRFSS is a national survey administered on an ongoing basis by the National Centers for Disease Control and Prevention (CDC) to adults in all 50 states and several districts and territories. The instrument collects data on adult risk behaviors, including alcohol abuse. BRFSS defines binge-drinking as males having five or more drinks on one occasion and females having four or more drinks on one occasion. The most recent data available are from 2009. Older data are also included for trending analyses, and comparisons between state and national trends are made. Rates of change over time were calculated in order to determine whether Maine successfully met the targets that were established in 2005 for the SFP SIG.

#### *Community Infrastructure Assessment*

The Community Infrastructure Assessment was developed to gauge the state and local substance abuse prevention infrastructure at a given point in time from the perspective of the funded communities. The results are not indicative of the capacity of grantees specifically, but rather are about the prevention system generally. The assessment administered during site visits at three points over the course of the SPF SIG: 2006-07, 2008 and 2010. In all cases, two evaluators were present when the infrastructure assessment was conducted, and each ranked the various responses to each question independently of the other. At the conclusion of the assessment, the evaluators discussed the results and reached consensus on how to rank each item along a continuum from low to moderate to high. The low ranking was given a score of 1, moderate was 2 and high was 3. These rankings were then averaged within each domain. A copy of the assessment can be found in Appendix B.

#### *Community Site Visits*

Evaluation site visits were conducted three times during the SPF SIG project with the local grantees in 2006, 2008 and 2010. Two evaluators attended each site visit to record notes and administer the Community Infrastructure Assessment (see above). During the site visits, evaluators reviewed federal and local evaluation announcements and requirements. Participants also spent a significant portion of the visit discussing local challenges and

successes that they experienced during implementation. A sample site visit protocol can be found in Appendix C.

### *Key Stakeholder Interviews*

In 2006 and again in 2010, HZA conducted interviews with representatives who served on various advisory boards to the SPF SIG. The purpose of the interviews was to obtain opinions and perspectives on the SPF SIG implementation throughout the state, both in terms of successes as well as challenges. Each informant was chosen to provide a different perspective, with special knowledge of a particular program, population, or region. Key informants remain confidential in this report; Appendix D contains the interview protocols.

### *KIT Solutions*

The KIT Solutions® Performance-Based Monitoring System is a web-based reporting and monitoring system that is employed by Maine Office of Substance Abuse, Maine Centers for Disease Control and the Maine Department of Education to record and monitor the activities and accomplishments of the Healthy Maine Partnerships (HMP). HMP organizations must develop and input annual work plans that include the objectives and strategies they plan to implement, as well as quarterly updates of the activities they have undertaken for each. The system runs off a database and HZA obtained a copy of the database representing the entire implementation phase of the project. For this report, HZA extracted data from the database for more in-depth analysis. In particular, HZA compiled all the quarterly reports from the back-end database and reviewed them *en masse* to gain an overall perspective and inform the evaluative conclusions. The review focused on three areas: grantee successes, barriers to implementation, and technical assistance needs. In this manner, HZA was able to identify which communities implemented particular strategies and the degree to which they were successful in doing so.

### *Maine Integrated Youth Health Survey (MIYHS).*

The MIYHS is a statewide survey that is administered biennially by the Maine state Office of Substance Abuse (OSA) to students in grades 7 through 12. The survey is a revised version of the Maine Youth Drug and Alcohol Use Survey described below and collects information on student substance use, including binge-drinking, as well as student perceptions of enforcement, social norms and family attitudes towards substance use. The first year for which data are available from this particular survey is 2009. Although many of the critical data measures remained the same across both surveys, trending between 2008 MYDAUS and 2009 MIYHS is not possible due to changes in the administration methodology. Estimates were calculated for high school students and are presented in relation to the previous years of survey data for discussion purposes only.

### *Maine Youth Drug and Alcohol Use Survey (MYDAUS).*

The MYDAUS is a statewide survey that was administered biennially by the Maine state Office of Substance Abuse (OSA) to students in grades 6 through 12. The survey collects information on student substance use, including binge-drinking, as well as student

perceptions of enforcement, social norms and family attitudes towards substance use. MYDAUS defines binge-drinking as consuming five or more drinks in a row. The final year from which data are available from this particular survey is 2008; trending data from 2004, 2006 and 2008 are included in this report. Estimates were calculated for high school students in all three years. Rates of change over time were calculated in order to determine whether Maine successfully met the targets that were established in 2005 for the SFP SIG.

#### *Strategic Plan Rating Matrix (SPRM)*

The SPRM was developed by HZA to assess the community strategic plans and extent to which they addressed nine critical components: geographic areas covered; scope of community participation; priorities identified; selection of “best fit” strategies; capacity, resources and readiness; detailed action plans for implementation; measurable outcomes; sustainability; and cultural competency. Each plan was rated separately by two SPF SIG evaluators on scale of 1 to 5 according to detailed criteria contained in the rating tool. Once the independent reviews were completed, the two evaluators discussed the ratings and reached consensus for a final score. The SPRM criteria are located in Appendix E.

#### *Youth Risk Behavior Surveillance System (YRBSS)*

The YRBSS is national survey administered biennially by the National Centers for Disease Control and Prevention (CDC) to students in grades 9 through 12. The survey collects information on youth risk behaviors, including substance use. The YRBSS defines binge-drinking as consuming five or more drinks of alcohol in a row and also asks about any alcohol consumption within 30 days prior to the survey. The most recent YRBSS data is available for 2009. This report examines data from 2005 through 2009 for trending purposes and also compares state estimates to national trends.

#### *Young Adult Drug and Alcohol Use Survey (YADAUS)*

The Young Adult Drug and Alcohol Use Survey was implemented by HZA at the local level in 2008 and again in 2010 in order to provide sub-state estimates for this population, as well as to measure changes on the intervening variables. Communities were asked to distribute at least 100 paper surveys in multiple venues, as well as to distribute a link to a web-based version of the survey, with a target response rate of at least 50 respondents per county; raffle incentives were used to increase response rates. The YADAUS findings at the state level were weighted to account for geographic differences in response rates and state-level consumption data from NSDUH and BRFSS were used to benchmark the results. However, at the local level the small samples likely do not accurately represent the local population. In these instances, weighting cannot adequately adjust the sample to create representative data; these data remain unweighted. Sub-state estimates therefore represent only the behaviors of individuals who responded to the survey. Appendix F contains a copy of the four-page instrument.

### Chapter 3. Evaluation of Statewide Infrastructure and Capacity

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One of the primary goals of the SPF SIG project was to build Maine's Infrastructure and Prevention capacity. Before receiving its SPF SIG funding, Maine's Office of Substance Abuse characterized the state's prevention infrastructure as one in which the capacity to provide prevention services was inconsistent across the state, funding was limited, and the efforts that were in place were neither coordinated nor consistently funded. These challenges resulted in both gaps in service and duplication of prevention efforts across the state.

To meet the goals of reducing substance use and its related consequences, Maine recognized that it was essential to develop a strengthened, more systematic prevention infrastructure. The original proposal identified six goals for infrastructure and capacity development that would be achieved through the SPF SIG:

- 1) Conduct a statewide epidemiological analysis to identify high need areas/subpopulations;
- 2) Develop local needs assessments and strategic plans;
- 3) Create a consistent cross-disciplinary prevention infrastructure at the local and regional levels;
- 4) Increase the number of communities that coordinate funding from multiple state programs;
- 5) Increase the number of communities that implement evidence-based prevention programs; and
- 6) Develop and implement a cross-disciplinary Prevention Workforce Development Plan.<sup>10</sup>

The primary evaluation question, then, is "What was the effect of the Strategic Prevention Framework on service capacity and other infrastructure objectives?" To answer this, HZA administered the Community Infrastructure Assessment (CIA) at three different points throughout the SPF SIG process, capturing critical information about the eight infrastructure domains identified by the national cross-site evaluation team. HZA also reviewed meeting minutes, conducted interviews with key informants in 2006 and 2010, and held site visits with all the grantees to supplement the findings of the CIA.<sup>11</sup>

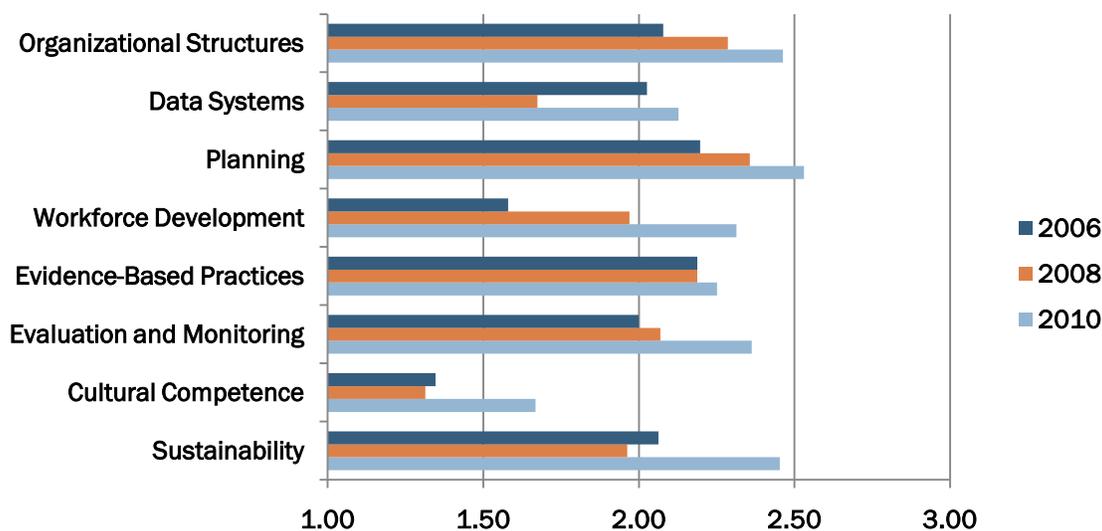
As can be seen in Figure 2 on the following page, Maine made great strides over the course of the SPF SIG with regard to enhancing its prevention infrastructure, particularly in the areas of organizational structure, workforce development, evaluation, and monitoring, sustainability and cultural competence. The remainder of this chapter discusses the specific accomplishments achieved and the challenges that remain for each of the major infrastructure domains.

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<sup>10</sup> Office of the Governor, Application for Federal Assistance, Strategic Prevention Framework SIG, June 30, 2004.

<sup>11</sup> For more information about these methods, please refer to Chapter 2. Copies of the assessment tool and the interview protocols can be found in the appendices.

Figure 2. Prevention Infrastructure In Maine:  
2006, 2008 and 2010



Cultural competence and sustainability are considered critical to the SPF SIG grant but were not explicitly articulated in Maine’s original infrastructure and capacity goals. These two goals reach across several infrastructure areas and they will be discussed throughout the remainder of this chapter as well as within their own subsections, but warrant being defined here as well. According to the Center for Applied Prevention Technology, organizational cultural competence is “a set of congruent behaviors, attitudes and policies that come together in a system, agency, or among professionals that enable that system, agency, or those professionals to work effectively in cross-cultural situations.”<sup>12</sup> Sustainability in regard to the SPF SIG should be defined in two ways. First, given that the SPF SIG was ultimately about bringing a new public health outcomes-based approach to substance abuse prevention, sustainability can be thought of as integration of the newly developed SPF SIG approaches into the fabric of existing prevention programs and services. Second, sustainability must involve a more practical application and be examined within the context of the steps that were taken to sustain the prevention infrastructure that the SPF SIG helped to build.

### ***Organizational Structures***

As previously stated, Maine wanted to create a consistent cross-disciplinary prevention infrastructure at the local and regional levels. In this area, Maine made great strides over the course of the SPF SIG in designing a statewide structure to overcome geographic gaps and duplication in prevention service delivery. In addition, many of the coordination issues have been addressed through the braided funding agreement that is a critical component of the new Healthy Maine Partnership public health infrastructure.

<sup>12</sup> “*Incorporating Culture Into Your Organization.*” Presentation to Maine SPF SIG grantees by the Northeast Center for the Application of Prevention Technologies (NE CAPT). December 18, 2008.

## Prevention Advisory Boards

When the SPF SIG first began, three formal workgroups were formed to contribute to the project. The Strategies for Healthy Youth (SHY) Workgroup was charged with advising OSA on SPF implementation and included members from the OSA Prevention Team, the Maine Drug Enforcement Administration, the Maine CDC, Maine Children’s Trust, the Department of Education, the Higher Education Alcohol Prevention Partnership, Maine Environmental Substance Abuse Programs, Maine Association of Prevention Providers and Communities for Children and Youth, as well as OSA staff. The Executive Management Team (EMT) was smaller and charged with making decisions for SPF SIG; in addition to members of the OSA Prevention Team, this group consisted of evaluators (HZA) and representatives from the Prevention Centers of Excellence. The final group, the State Epidemiological Workgroup (SEW),<sup>13</sup> will be discussed in more detail in the subsection relating to “Using Data to Drive Planning and Implementation,” but bears mentioning here as part of the organizational structures that were developed to support the SPF SIG.

After the implementation funding was disbursed to the grantees, the SHY was no longer engaging in the same level of data assessment and strategic planning, instead being updated on the status of the SPF SIG implementation at the local level and providing feedback and insights into other work occurring statewide. Given this shift in scope and that the group did not work exclusively on strategies for healthy youth as its name implied, the group renamed itself the SPF SIG Advisory Board (SPF AB) in March 2008. The Advisory Board brought together people with different perspectives about prevention to make connections, combine ideas or initiatives, prioritize, and focus on sustainability efforts going forward. In this manner, it connected substance abuse prevention efforts with other areas such as chronic disease, education, enforcement, and public health. Board members shared their viewpoints and expertise which enabled OSA’s Prevention Team to put their work, including SPF SIG, into a broader context.

“I know I’ve learned a lot just by being at the table; [being able to] understand what OSA is trying to do. It helps build relationships and potential collaborations.”

*State-Level Stakeholder*

The group also acted as a sounding board for staff to share future plans and get a sense as to whether there might be resistance from key partners, or the opportunity to collaborate. Over time, the group was able to expand its membership to include those who are not as closely affiliated with OSA and substance abuse prevention. By fall 2009, members of OSA’s Prevention Team found that many of the updates and agenda items for the SFP SIG AB overlapped with the agenda items for the EMT meetings, essentially resulting in staff attending the same meeting twice. Given these considerations, the EMT proposed to merge with the SPF AB, a move which was unanimously approved by both boards.

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The SPF SIG Advisory Board will continue to play a role in Maine; it has been renamed and will serve as the Prevention Advisory Board for OSA. However, as the SPF SIG approached its

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<sup>13</sup> As will be discussed later in the report, the SEW is now the Community Epidemiologic Surveillance Network/State Epidemiological Outcomes Workgroup, or CESN/SEOW.

conclusion, the group did not provide as much advice and guidance to specific prevention projects as a typical advisory board might. Whereas the previous groups had been extremely directive and hands-on at the beginning of the project, in the latter phases of the project the SPF SIG Advisory Board served primarily to facilitate communication between key stakeholders. Moreover, the connection between the Advisory Board and the SEW waned over time. In the coming year, the group should reconsider its primary function and how it can support OSA's Strategic Plan for Prevention.<sup>14</sup> This could include restructuring the agenda to include the opportunity for OSA to present questions and solicit feedback, thereby engaging members in a true advisory capacity. Reintroducing data trends and emerging research considerations to the Advisory Board may jumpstart the advisory process, while also serving to connect the group to the SEW.

### *Public Health Infrastructure and the Healthy Maine Partnerships*

During the same period in which the SPF SIG was being implemented, the Public Health infrastructure in Maine was undergoing major changes. A Public Health Workgroup was charged with designing a framework for Maine's comprehensive public health system, and its objectives closely aligned with the infrastructure goals set forth in Maine's SPF SIG proposal. The Office of Substance Abuse played an integral role in Maine's Public Health Workgroup and helped ensure that substance abuse was at the table. Based on the existing structure of 28 Healthy Maine Partnership (HMP) coalitions in Maine, the Public Health Workgroup crafted eight Public Health Districts, as illustrated in Figure 3 on the following page.

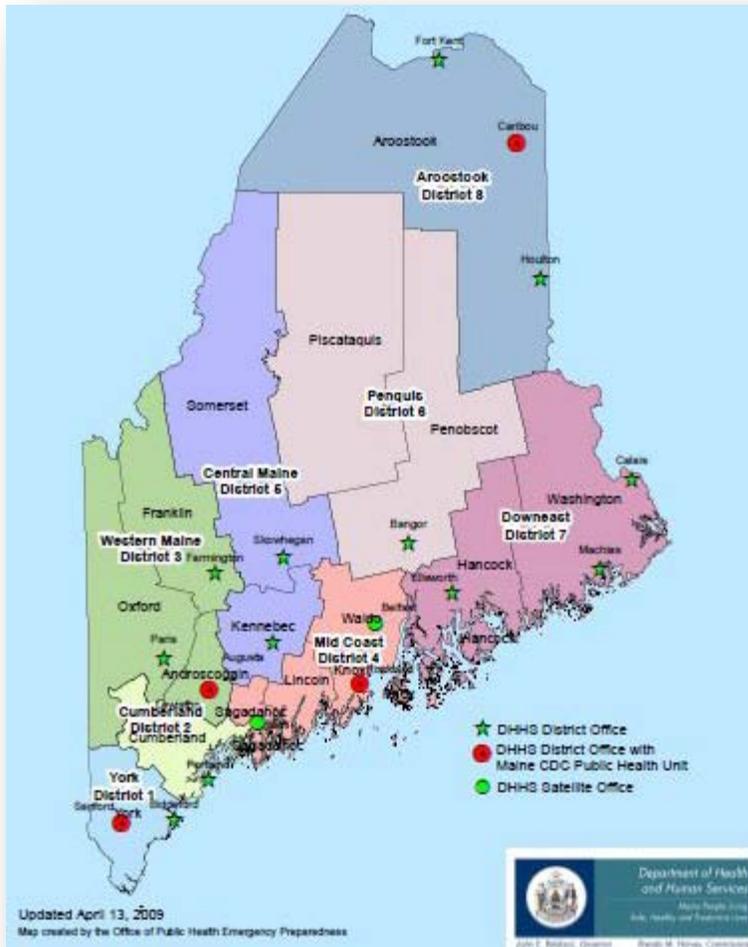
OSA's ability to participate meaningfully in the development of the emerging infrastructure was strongly supported by SPF SIG and the Unified Governance Structure study, a "participatory case study of eight very different community-based coalitions located throughout the State...to provide ideas and models to help communities in Maine develop their own infrastructure and thus strengthen Maine's prevention capacity."<sup>15</sup> The resulting report outlined the capacities needed within coalitions to implement the SPF SIG model, particularly in the areas of capacity building, environmental strategies, program development, and coalition development and maintenance. The findings of this report, available publicly on OSA's website, were shared with the Public Health Workgroup while it was considering the structure and roles of local coalitions.

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<sup>14</sup> A diverse group met in August 2010 to update OSA's Strategic Plan for Prevention. The updated plan will be discussed later in this report.

<sup>15</sup> Maine Office of Substance Abuse. (September 2006). *What coalitions can do: An examination of the Functions of Community Coalitions*.

Figure 3. Maine's Public Health Infrastructure



A major achievement of the SPF SIG was to support the role of Substance Abuse Prevention within the emerging public health infrastructure, as well as to support laying the groundwork for a wider prevention system. As the public health infrastructure was finalized, OSA, the Department of Education and the Maine Center for Disease Control (MCDC) worked on the development of a joint request for proposals (RFP) as laid out in the State Health Plan. The enhanced infrastructure and collaboration was characterized by braided funding, shared project management among state departments and offices, a common reporting system and statewide coverage. Substance abuse prevention became one of five priority prevention areas which funded HMP coalitions were required to work on; the others included tobacco, chronic disease, nutrition, and physical activity.

It was through this mechanism that SPF SIG dollars were disbursed locally for the implementation of evidence-based environmental approaches. This enabled OSA to fund prevention activities within almost all communities statewide, which was

“Bringing together...the substance abuse prevention arena with the public health and chronic disease prevention arena – each enhanced and fed the other.”  
*State-Level Stakeholder*

unprecedented. By funding 28 community coalitions to implement the SPF SIG, Maine was for the first time providing every town across the state with some level of substance abuse prevention intervention and there were dedicated substance abuse prevention staff at coalitions statewide. This also meant that there was coordinated substance abuse prevention messaging across the board.

Going forward, OSA faces the challenge of keeping substance abuse as a high priority within the HMP prevention structure. The emergent system is still primarily focused on chronic diseases and substance abuse is not always considered as much of a priority as other public health issues. This is exacerbated by the conclusion of the SPF SIG funding which has cut prevention funding in Maine by more than half, with no replacement of the same magnitude in the foreseeable future. Moreover, the end of the SPF SIG resulted in the loss of dedicated substance abuse prevention staff within the coalitions. It will be imperative to keep substance abuse prevention as an equal player, both at the state level but also within the local infrastructure. OSA should explore ways to support having a substance abuse prevention coordinator in place – if not at the HMP level, then at the public health district level – to make sure that substance abuse prevention continues to be part of the public health infrastructure.

Another critical aspect to keeping substance abuse prevention on the table locally will be engaging the support and dedication of HMP Executive Directors for substance abuse prevention. In some instances, substance abuse prevention was seen as an “add-on” and there may have less investment in the implementation of strategies. For example, in some Public Health Districts, Substance Abuse Prevention Specialist (SAPS) reported that substance abuse rarely made it onto the agenda at the HMP Coordinating Council meetings. OSA should ensure that HMP Executive Directors are invited to learning opportunities about substance abuse prevention and should consider engaging in direct “marketing” with them to help with buy-in.

At the state level, the new infrastructure meant bringing together the different offices and funding streams under a single state contracting system that was not ready for this type of consolidation. Getting the funding streams sorted out, as well as what that meant in terms of reporting requirements, impacted the implementation and may have hampered the desired streamlining. Staff at the local level found limitations on how the different funding streams could be used frustrating and often nonsensical. For example, one grantee stated that the retailers found too many retail-oriented programs (one for tobacco and one for alcohol) “confusing,” while another noted that the lack of substance abuse content included in “Healthy Maine Works” led to the duplication of effort with businesses.

SPF SIG played a critical role in building and supporting the emergent Public Health infrastructure as well as ensuring that substance abuse prevention played a significant role. The question facing OSA and its partners now will be whether all the players can sustain and grow the infrastructure, particularly given the lower levels of funding.

## *Using Data to Drive Planning and Implementation*

Through the SPF SIG, Maine has been able to greatly increase its capacity to use data in its regular operations and decision-making. When asked, key informants overwhelmingly attributed the great strides made for data driven decision-making for substance abuse prevention in Maine to the SPF SIG. Some of this was a culture shift in that the requirements of the SPF SIG encouraged OSA to change the way it operated and used data. They are now regularly using data to support decision-making and to evaluate the impact of their efforts. However, OSA has had difficulty retaining an Epidemiologist to undertake this important work; instead, HZA stepped in to provide the necessary data collection, analysis and support.

### *State and County Epidemiological Profiles*

The purpose of the initial SPF SIG needs and resource assessment was to prioritize Maine's substance abuse prevention investments and activities based on epidemiological and other data. The *State Epidemiological Profile* was finalized in August 2006 and represented the first time such an extensive examination of substance abuse data had been conducted in Maine. The profile included data from the following sources:

- Fatality Analysis Reporting System (FARS);
- National Center for Health Statistics (NCHS);
- National Survey of Drug Use and Health (NSDUH);
- Behavior and Risk Factor Surveillance System (BRFSS);
- Maine Household Survey;
- Youth Risk Behavior Surveillance System (YRBSS);
- Maine Youth Drug and Alcohol Use Survey (MYDAUS); and
- Prescription Monitoring Program (PMP).<sup>16</sup>

At the outset, the epidemiological profile was critical to help provide data and synthesize the data in an understandable way. The state-level analysis clearly indicated the importance of focusing the SPF SIG on youth and young adults and on high-risk drinking, marijuana use and the abuse of prescription medication.<sup>17</sup> The profile also established the priorities that were identified in the State's Strategic Plan, as well as the specific objectives that were required during the implementation phase. That the young adult population became a priority in Maine represents an entirely data-driven decision. Prior to SPF SIG, OSA tended to focus on prevention within the K-12 population. Through the SPF, and particularly the epidemiological profile, the young adult population emerged from the data as a target

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<sup>16</sup> Maine Office of Substance Abuse, Maine State Substance Abuse Assessment and Epidemiological Profile, August 31, 2006. The data sources were selected based on the following criteria: the data source is valid, reliable, unbiased and representative of the statewide population; the data are collected periodically; adequate sample sizes are available to generate stable estimates at the state level; and the indicator reflects the underlying substance abuse needs of the population.

<sup>17</sup> As discussed elsewhere in this report, OSA narrowed the scope of work for implementation funding to three areas: underage drinking, high-risk drinking among young adults and prescription drug use among young adults. This was done to ensure that the project would produce statewide reductions in consumption rates.

population. In response to these findings, Maine expanded its prevention scope to include that age group in its statewide efforts as well as for community-level providers.

At the onset of the SPF SIG, all but one community described the extent of epidemiological data sharing between the state and local grantees as “not routine” or non-existent. Using the same data sources that were included in the State Epidemiological Profile, HZA also created 16 county profiles to supplement the needs assessment work at the local level, which is described in more detail below. These profiles included county-level consumption estimates for students and adults, as well as consequence data such as traffic fatalities, crime statistics and treatment admissions. The *County Profile Supplements* represented the first time OSA had provided sub-state data directly to locally funded coalitions that went beyond the scope of the detailed student survey reports. The county profiles were updated in 2009 and can be accessed from OSA’s SPF SIG website.<sup>18</sup> Communities now indicate that there is increased sharing of data across the state, but they continue to feel that little guidance is available on how to interpret and use the data.

### *Local Needs Assessments*

In September 2006, Maine funded its first set of communities to begin the implementation of the Strategic Prevention Framework at the local level. This funding, known as the Community Strategic Planning and Environmental Programming (SPEP) grants, supported 15 coalitions (covering 16 counties) over the course of one year to conduct a county-level needs and capacity assessment and to develop a strategic plan.<sup>19</sup>

All of the SPEP communities engaged in county-level needs assessment by examining substance use rates and consequences, factors contributing to substance use, community partnerships, and community readiness. To complete the local needs assessments, communities relied on many different data sources, in particular student survey and law enforcement data. When local data were lacking (particularly around some intervening variables), grantees employed qualitative methods to supplement their findings, such as interviews, community surveys and public meetings. In addition to the County Profile Supplements, the state and HZA provided a detailed Guide to Assessment and Planning as well as regional training and as-needed technical assistance to support these local efforts.

As was the case with the State’s Epidemiological profile, the majority of SPEP assessments identified underage alcohol consumption and the related consequences, along with prescription drug misuse and marijuana as the highest priorities, although not always in that order. However, where the local findings tended to differ from one another was in the local factors contributing to the identified problems. For example, one community found that alcohol was readily available to young people in the “downtown” district and focused a lot of energy on retail and enforcement strategies. In another, the needs assessment showed that underage access was primarily through parents who were uninformed about proper

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<sup>18</sup> OSA’s SPF SIG site can be found at the following web address:

<http://www.maine.gov/dhhs/osa/prevention/community/spfsig/plansdata/epiprofile.htm>

<sup>19</sup> No entity from either Piscataquis or Penobscot counties applied for SPEP funding. The Prevention Center of Excellence at University of Maine in Orono worked to identify a coalition to engage in the SPEP work for this area, and Bangor Health and Welfare ultimately completed the work in both counties.

monitoring and the repercussions of furnishing alcohol; that community emphasized parental strategies in its strategic plan. In this manner the SPEG assessments helped inform the specific strategies that coalitions implemented in the second Phase of the SPF SIG.

By funding at least one entity in each county, OSA ensured that needs were assessed across all areas of the state and represented a serious investment in developing the statewide prevention infrastructure. The investment also represented an important step in building the local capacity to engage in data-driven decision-making. However, the extent to which similar needs assessment activities will be regularly repeated in the future is unknown, and there is likely to be variation across the communities in terms of sustaining needs assessment activities and data-driven work in an ongoing manner. What is clear is that it would be unrealistic to expect local coalitions to undertake a similar level of effort again without additional funding expressly for that purpose.

### *Studies of Cultural Subpopulations*

Through SPF SIG, ME OSA was able to examine cultural populations within the state in terms of substance abuse. Early in the project, the state funded studies of six cultural subpopulations that were identified by the SEOW. The results of the studies were featured at a 2006 prevention event, and fact sheets and reports are available on OSA's website and include materials about the following groups:

- Young adults (18 to 25), primarily not in college;
- Young adult members of the LGBTQ community (18 to 29);
- Young adult females (18-24 year old), in colleges;
- Elderly (age 65 and older) in two counties (Hancock and Knox); and
- Sudanese and Cambodian refugee population in Portland.

The studies represented the first time that such in-depth explorations of specific cultures had been undertaken in Maine for prevention purposes, and they particularly highlighted the significant resources and efforts necessary to reach these populations in Maine. However, the extent to which the studies were used to develop a prevention infrastructure that considers and ensures cultural competence remains unclear; next steps were not articulated, nor does it appear that the results of the studies were consistently acted upon in a deliberate manner. However, OSA has relied on the results of these SPF SIG supported cultural studies when considering and prioritizing funding or planning for statewide prevention efforts such as media campaigns.

### *State Epidemiological Outcomes Workgroup (SEOW)*

As previously described, the *Statewide Epidemiology Profile* provided OSA with its first comprehensive view of substance abuse trends across the state. Once that work was completed, however, the role of the State Epidemiological Outcomes Workgroup (SEOW) became less clear. To enhance and sustain these efforts, OSA merged the SEOW with its Community Epidemiology Surveillance Network (CESN) in 2008 to streamline the agency's infrastructure in place to support data-driven decision making. The current SEOW/CESN brings together a diverse group of individuals with knowledge about substance abuse data

to monitor the trends, provide context and supplemental information and to drive the data process for OSA. In addition to Maine OSA, the current membership represents the following organizations:

- Maine Center for Disease Control and Prevention
- Maine Department of Public Safety
- Maine Health and Environmental Testing Laboratory
- Maine Office of the Attorney General
- Maine Office of Chief Medical Examiner
- Maine Opiate Treatment Providers Association
- Margaret Chase Smith Center for Public Policy, University of Maine
- Northern New England Poison Center
- Portland Department of Public Health
- Maine Department of Transportation
- New England Drug Enforcement Agency

Through the SEOW/CESN, Maine has been able to assemble a diverse but related group of people and foster regular conversations about what is available for data and how the data should be disseminated and communicated. Moreover, the group produces a biannual report that encompasses all the information and perspectives that are represented by its membership and updates the original Epidemiological profile on a regular basis. This report has been tailored to meet the goals of both the SPF SIG and the CESN in that it contains an examination of trends over time, as well as comparisons to national trends and more in-depth study of key populations that have been consistently of concern (e.g., young adult population).<sup>20</sup> In this manner, the SEOW/CESN provides OSA with ongoing and up-to-date information on the most recent and emerging substance abuse trends.

As a result, OSA staff now use data regularly during the course of work. Indeed, the fact that data are now regularly updated and referenced by Maine OSA is a major achievement that is fully attributable to the SPF SIG grant, and merging with the CESN sustains the efforts of the original SEOW well into the future. As was seen with the Prevention Advisory Board, however, the challenge the group now faces is to move participants towards pursuing a more active role in identifying emerging populations as well as trends. The group needs more actively to provide analysis and recommendations that are relevant to the priorities Maine has chosen to work on.

For example, in the past, the SEOW identified consequences that have some relationship to substance abuse and wrote a series of “white papers” on each topic to explore the relationship in more depth (e.g., child maltreatment, crime, traffic injury). The SEOW had planned to take what was learned from the papers and prioritize areas to be included in OSA’s Data Improvement Plan; that work was never completed. Examples of advisory actions that could be taken by the group would be to commission additional white papers, or tackle a new Data Improvement Plan.

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<sup>20</sup> *Substance Abuse Trends in Maine*. (2010). Maine Office of Substance Abuse. Reports can be accessed from the following website: <http://www.maine.gov/dhhs/osa/data/cesn/index.htm>

Moreover, the group has primarily been focused on state-level data, and less so on examining sub-state trends. In the future, OSA should consider using the SEOW/CESN to update community profiles related to substance abuse. This endeavor should be incorporated into the Public Health District Profiles produced by the Maine CDC whenever possible. Finally, OSA should provide more opportunities for cross-pollination between the Prevention Advisory Board and the SEOW/CESN. For example, a standing agenda item for each work group could be regular updates from the other, followed by a discussion of the implications those updates might have for substance abuse prevention in Maine in terms of research, policy and program development.

“I think it’s a good collaboration, but I’m not always clear how much this group influences the use of data.”

*State-Level Stakeholder*

### ***Strategic Planning***

#### *State of Maine Strategic Plan*

Based on its needs assessment and *State Epidemiology Profile*, OSA developed Maine’s *Substance Abuse Prevention Strategic Prevention Framework Plan Summary: 2006–2010*, which was approved by the Center for Substance Abuse Prevention in 2006.<sup>21</sup> Maine’s strategic planning process resulted in the identification of five priorities:

- 1) Reduce high-risk drinking among youth (12-17).
- 2) Reduce high-risk drinking among young adults (18-25).
- 3) Reduce marijuana use, abuse of prescription medications and use of other drugs among youth (12-17).
- 4) Reduce marijuana use, abuse of prescription medications and use of other drugs among young adults (18-25).
- 5) Slow the spread and reduce the use of methamphetamines.<sup>22</sup>

After reviewing Maine’s Strategic Plan, the Center for Substance Abuse Prevention (CSAP) encouraged OSA to revisit the plan with the intent of identifying fewer priorities to be addressed through the implementation of strategies. CSAP’s concern was that trying to address so many priorities simultaneously might diffuse the impact of the SPF SIG in terms of seeing statewide changes in consumption rates and consequences, particularly given that Maine was using an equity model to fund prevention work across the state. In the early part of 2007, Maine made the decision to utilize SPF SIG funds for a smaller set of priorities, namely to:

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<sup>21</sup> The original SPF SIG Strategic Plan can be accessed from Maine’s SPF SIG website: <http://www.maine.gov/dhhs/osa/prevention/community/spfsig/plansdata/strategicplan.htm>

<sup>22</sup> *Maine Substance Abuse Prevention Strategic Prevention Framework Plan Summary: 2006–2010*, 2006.

- Reduce alcohol use among youth (with a primary focus on high-school aged youth);
- Reduce high-risk drinking among adults (with a primary focus on 18-25 year olds); and
- Reduce prescription drug abuse among young adults (18-25).

While the plan was never formally updated to reflect these changes, the narrowed priorities were laid out in the Healthy Maine Partnership RFP and served as a guide for local funding distribution.<sup>23</sup>

In August of 2010, OSA hosted a strategic planning retreat to update its Strategic Plan for Prevention in the face of reduced prevention funds and the end of the SPF SIG. The two-day retreat was led by an experienced Strategic Planning facilitator, who was provided to Maine through a request placed with the Northeast Regional Expert Team (NE RET). The retreat was well-attended by state-level representatives from law enforcement, liquor licensing, education, juvenile justice, adult mental health, child and family services, and substance abuse treatment.

Participants were first provided with a broad overview of the current trends in prevention and the national outlook according to the Centers for Substance Abuse Prevention (CSAP) in order to provide a big-picture context for the remainder of the retreat. They were also given a summary of the most current trends for substance abuse in Maine, which showed that the primary areas of concern remained youth alcohol use and high-risk drinking among young adults, as well as misuse of prescription drugs. Throughout the retreat, strengths, weaknesses opportunities and threats were identified and prioritized, as were tentative goals for OSA in terms of collaboration and infrastructure.

Some of the primary findings involved OSA's needed to more closely collaborate with agencies outside of the HMP infrastructure, many of whom indicated that they were unclear about OSA's broad array of prevention initiatives and resources (as opposed to treatment which OSA also supports). Participants also articulated other goals for policy and procedures, as well as citing a continuing need to improve the quality of data. The results of the strategic planning session will form the basis of OSA's revised Strategic Plan for Prevention for the next five years, which was being drafted at the time of this report.

### *Local Strategic Planning*

Strategic plans were completed for each county in Maine as part of the Community Strategic Planning and Environmental Programming (SPEP) grants. All 15 strategic plans indicated that key community partners were included in the planning process, particularly schools and law enforcement agencies, and all 15 plans demonstrated at least some evidence of being data-driven. Indeed, all grantees identified specific priority consumption patterns and target populations, most commonly underage drinking, high-risk drinking among young adults and prescription drug misuse. However, this warrants further explanation to understand the context in which communities were operating.

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<sup>23</sup> RFP #G107192 Healthy Maine Partnership, 2007.

The Healthy Maine Partnership Request for Proposals, a portion of which contained the Phase 2 funding for SPF SIG implementation, was released during the time that the Phase 1 SPEP grantees were finishing their needs assessments and strategic plans. This RFP reflected the fact that OSA had narrowed the state's substance abuse priorities for the reasons discussed above; in short, to move the needle in the areas of highest concern to the State, Maine picked its three top priorities to be supported by SPF SIG implementation funding.

The review of strategic plans clearly indicated that the RFP influenced the planning process locally. OSA advised grantees that the narrowed scope of the SPF SIG work plans for the implementation phase should not diminish the scope of their SPEP strategic plans. However, getting the coalitions to fully understand the intent of the SPF SIG strategic plan, as opposed to the narrower purpose of the SPF SIG implementation work plan, was a barrier that was only partially overcome. The situation was complicated by the fact that the same funding stream (SPF SIG) was supporting each effort. Grantees knew that they needed to be responsive to the RFP as they identified consumption patterns and intervening variables. In some local strategic plans, the needs identified by the local assessment were trumped by the RFP's priorities, which resulted in coalitions feeling that the State chose their objectives.

In terms of infrastructure, however, engaging the local coalitions in assessing needs and making data-driven decisions was critical to building the local capacity to implement substance abuse prevention planning across the state. Many coalitions had only engaged in a limited cycle of assessment, data collection, and strategic planning prior to the SPF SIG. Moreover, SPF SIG enabled Maine to provide a tremendous influx of support – both financially and also in terms of resources – that had never before been available to communities throughout the state.

### ***Technical Assistance and Workforce Development***

In 2005, the statewide workforce for prevention was lacking trained and qualified program coordinators. Another goal of the SPF SIG grant was to enhance the cross-disciplinary prevention workforce and develop a plan for providing learning opportunities to this workforce. To accomplish this goal, Maine invested in three endeavors: creating the Prevention Centers of Excellence, supporting a Workforce Development for Prevention survey, and expanding Technical Assistance and Training opportunities in Maine.

#### ***Prevention Centers of Excellence***

One of the major SPF SIG infrastructure investments OSA made at the outset of the project was to establish two Prevention Centers of Excellence, one at the University of Southern Maine in Portland and one at the University of Maine in Orono. The hope was that these centers could serve a number of purposes: provide technical assistance and support for coalitions; help with the needs assessments and strategic plans in underserved areas; engage in workforce development initiatives for prevention; conduct academic research on substance abuse and prevention; and develop diverse funding streams for future sustainability.

The Prevention Centers successfully engaged two low-capacity areas in Maine during the needs assessment and planning phase, which helped them to complete SPF steps 1-3. They also began to develop a metric for measuring capacity and infrastructure for prevention throughout the state. Finally, the Prevention Centers successfully administered a survey of the statewide prevention workforce (more details can be found in the next section). Unfortunately, the Prevention Centers were unsuccessful in attempts to garner additional funding to sustain their work. Once OSA moved into funding the implementation of environmental strategies at the local level, the Prevention Centers of Excellence evaporated.

OSA was able to fulfill many of the SPF SIG technical assistance and workforce needs through its relationships with other organizations such as Maine's Environmental Substance Abuse Prevention Center (MESAP) and AdCare Educational Institute of Maine. However, one role that remains unfilled in the absence of the Prevention Centers is the capacity to conduct academic research on substance abuse, prevention and inter-related issues in Maine. This represents a vital aspect of prevention infrastructure that was unable to be supported or sustained through the SPF. Maine OSA should continue exploring potential academic and research partnerships in the future, particularly given the breadth and depth of Maine's student survey data.

### *Workforce Development for Prevention Survey*

To identify the workforce needs for prevention, OSA commissioned a survey of the prevention workforce to be conducted by the Prevention Center of Excellence at University of Southern Maine. The 30-question survey was completed by 91 prevention staff across the state, representing 60 percent of the individuals who were invited to complete the survey. The questions addressed core competencies for prevention that were defined with the input of the SPF SIG advisory committees and included such areas as: community organization, communication, cultural competency, strategy implementation, assessment and evaluation, financial planning and leadership. The survey also asked about education level, staff training and current professional development opportunities.

The final survey report was released in 2008 and found that many staff were new to the field of substance abuse prevention, having been involved for less than two years, and that

“OSA took great effort to provide true support, not just oversight, to coalitions.”

*SPF SIG Grantee*

the education levels across the respondents varied widely.<sup>24</sup> The report made three basic recommendations: create a categorized inventory of current trainings; develop a comprehensive training plan; and work with providers to “rate” trainings according to competencies and skill levels (e.g., core, advanced, specialty). The following sections describe the subsequent activities that OSA undertook to address these recommendations.

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<sup>24</sup> Hartley, David et al. (September 2008). “Barriers and Opportunities for Transitioning Maine’s Substance Abuse Prevention Workforce toward a Population-Based Service Delivery Model.” University of Southern Maine, Edmund S. Muskie School of Public Service. A copy of the full report can be accessed at: <http://www.maine.gov/dhhs/osa/prevention/provider/workdev.htm>

## Technical Assistance and Training

Once the implementation funding was distributed to the coalitions, OSA staff supported substance abuse prevention in the field as project officers through the HMP structure. Among the other standard project officer duties, OSA supported the coalitions through the following actions:

- helping coalitions choose strategies that were feasible given their capacity,
- connecting coalitions to share ideas with one another,
- articulating what would and would not be appropriate when implementing a given strategy, and
- helping coalitions understand the best ways they could accomplish their work plan.

OSA also developed published guidelines to help local staff select appropriate SPF SIG strategies and develop their work plans.<sup>25</sup> In this manner, project officers were visible and entrenched in the community and represented a real presence for the Substance Abuse Prevention Specialists (SAPS). They consistently reported that, when unsure about a how to implement a strategy or deal with a situation they faced, they could call their OSA project officer for support. Despite the conclusion of SPF SIG funding, OSA continues to maintain this level of support for its grantees.

Maine also undertook a number of activities to develop the core competencies of the prevention workforce, based in part on the findings of the workforce survey described above. The Northeast Center for Application of Prevention Technologies (NE CAPT)<sup>26</sup> and Maine's Environmental Substance Abuse Prevention Center (MESAP) held two learning communities in early 2007 which were attended by all of the SPEG grantees. The sessions focused on the Strategic Prevention Framework model, evidence-based and environmental strategies, and how to ensure that selected strategies "fit" an identified need. OSA staff, along with MESAP, also facilitated a series of conference calls for SPF SIG grantees to address areas of need that were identified during site visits and by requests from the field, such as local evaluation, using student survey data, and success stories.

Additionally, Maine solicited the assistance of the NE CAPT to develop a webinar about cultural competence for prevention providers that was available to all SPF SIG grantees. Lastly, OSA enhanced (and will sustain) the Prevention Provider Day, which is hosted by OSA with help from AdCare Educational Institute. The Provider Day offers a low-cost training opportunity for new and continuing prevention professionals across the state. The topics have included presentations on best practices, emerging research, local successes, evaluation and monitoring, working with law enforcement and other

"It was difficult finding people, and making sure they were supported with professional development opportunities."

*State-Level Stakeholder*

<sup>25</sup> All these resources are available on Maine's SPF SIG website: <http://www.maine.gov/dhhs/osa/prevention/community/spfsig/index.htm>

<sup>26</sup> Now known as the Northeast Regional Experts Team (NE RET).

cross-disciplinary collaborations. However, some long-term prevention workers continue to report that they feel challenged to find and access more advanced training opportunities for their field.

The online Prevention Calendar brings together all the training and technical assistance opportunities available across the state and represents a collaboration among OSA, the Maine Departments of Education, Juvenile Justice, Centers for Disease Control and Communities for Children and Youth. The calendar is free to search and contains a list of upcoming prevention-related trainings and events across the various disciplines, with the intent of both sharing information and resources and coordinating event schedules at the state and local levels. With support from the SPF SIG, OSA worked with the partners to develop an online form so that anyone could submit an event to OSA for posting. Adding this function to the Calendar helped ensure that the list contained the most current and complete listing of upcoming prevention trainings across the state.

A strong statewide workforce for prevention was not present at the outset of the SPF SIG; OSA and its grantee coalitions had difficulty finding people to do the work and making sure those individuals were supported with professional development opportunities. The challenge was exacerbated by staff turnover and the constant need to bring new prevention providers up to speed. In large part through the SPF SIG, Maine has been able to make great strides in determining where its prevention workforce is lacking and providing ongoing opportunities to address those needs.

### ***Evidence-Based Practices and Environmental Strategies***

Another goal articulated in the original SPF SIG grant was to “increase the number of communities that implement evidence-based prevention programs.” While the results of the Community Infrastructure Assessment (cited at the beginning of this chapter) suggested only moderate growth in the capacity to engage in evidence-based prevention work over the course of SPF SIG, the capacity and infrastructure was relatively high to begin with; some coalitions were at a much higher capacity than others. This was largely due to the accomplishments of the One ME State Incentive Grant, in which 23 coalitions across the state implemented SAMHSA-identified model programs in advance of SPF. By implementing the SPF SIG through the HMP infrastructure and ensuring statewide coverage, Maine was able to greatly enhance the *statewide* delivery of evidence-based programming.

### ***Evidence-based Strategy List and “Acceptable Evidence”***

“We’re going to fund communities to support programming, but also ask them to implement policy and environmental change strategies.”

*State-Level Stakeholder*

OSA successfully supported and grew the infrastructure needed to sustain evidence-based and environmental programming through two major endeavors: the creation of a list of acceptable evidence-based and environmental strategies, and the development of the panel by which to determine the appropriateness of new and emerging strategies. In July 2007, the Office of Substance Abuse released its SPF SIG Strategy Approval Guide which contained a comprehensive list of evidence-based

strategies that could be used to address each of the objectives contained in the Healthy Maine Partnership RFP. The guide included such strategies as *Communities Mobilizing for Change on Alcohol*, *Responsible Beverage Server Training*, *Parents Who Host Lose the Most*, OSA's Parent Media Campaign and the Maine's Police Chief's Model Policy; the list was based on an extensive review of the literature surrounding environmental and evidence-based strategies. In this manner, every single SPF SIG work plan that was funded for implementation contained strategies with demonstrated evidence of effectiveness.

At the federal level, the definitions of evidence-based strategies are fairly clear: a strategy that can be found on a national registry such as NREPP, or a strategy that has been shown to be effective through research that has been published in a peer-reviewed journal. Recognizing innovation in the field, a third category for determining "documented effectiveness" was established as follows:

- **Guideline 1:** The intervention is based on a solid theory or theoretical perspective that has been validated by research;
- **Guideline 2:** The intervention is supported by a documented body of knowledge – a converging accumulation of empirical evidence of effectiveness – generated from similar or related interventions that indicate effectiveness; and
- **Guideline 3:** The intervention is judged by a consensus among informed experts to be effective based on a combination of theory, research, and practice experience. Informed experts may include key community prevention leaders, and elders or other respected leaders within indigenous cultures.<sup>27</sup>

In 2007, OSA took this federal guidance one step further and developed the "Evidence-Based Approval Process," a mechanism through which coalitions could submit for approval a strategy to address one of the required work plan objectives. This consisted of guidelines for convening a panel of evidence base-informed experts to review and determine whether a strategy submitted by a grantee meets the "evidence-based" definition per the federally established guidelines. The final process is outlined in a document that articulates who serves on the panel, the voting process, and the panel review template/criteria. It also includes templates for a grantee to use to submit a proposed strategy (including the necessary documentation) and a sample logic model.<sup>28</sup> To date, one local strategy, the Boomerang Program, has successfully undergone this review process.

The two state-level accomplishments described above will continue to support the capacity of Maine's communities to select appropriate evidence-based and environmental prevention strategies to be implemented. In particular, this approval process allows OSA the flexibility to

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<sup>27</sup> *Identifying and Selecting Evidence-Based Interventions: Guidance Document for the Strategic Prevention Framework State Incentive Grant Program*. U.S. Department of Health and Human Services. Substance Abuse and Mental Health Administration. Center for Substance Abuse Prevention. Washington, DC. January 2007.

<sup>28</sup> A complete copy can be found at:

<http://www.maine.gov/dhhs/osa/prevention/community/spfsig/documents/Reviewer%20Manual%20approval%20process11-13-07.pdf>

fund promising practices without diminishing the intensity of its support for strategies that have proven to be effective. However, by the conclusion of the SPF, grantees still felt that the resources available to help them implement and *adapt* the approved strategies were limited. As previously mentioned, SAPS often called their OSA project officer when they were unsure about a strategy or a proposed variation; however, that was the only resource they consistently mentioned. OSA should explore expanding its guidelines to include acceptable adaptations and variations for approved strategies (e.g., placing parent media campaign flyers on pizza boxes), holding group trouble-shooting sessions, or creating tip sheets based on best practices from around the state.

Another challenge expressed by locals was the need to balance evidence-based practice with programs and practices that excite members of the coalition and keep them engaged. Some SAPS report that events like the mock car crash are very exciting to community members and it is difficult to refocus that energy towards strategies founded in research. This reality faced by community coalitions should not be minimized. It could be worthwhile for OSA to expend some effort to identify acceptable research-based alternatives to the exciting but less effective strategies that frequently arise.

### *Focus on Environmental Strategies*

The capacity of local coalitions to implement environmental strategies based on evidence of effectiveness, as opposed to individual-based curricula, also represented a major change in the focus of local prevention in Maine. Indeed, at the start of SPF SIG, not all of the grantees were implementing environmental based strategies. Some grantees initially had a hard time making the switch to environmental and indirect activities, and OSA invested time in getting people to understand the purpose and effectiveness of environmental work. Moreover, the emphasis placed by OSA on collaboration across coalitions helped facilitate this shift. Local prevention coalitions now recognize the importance of focusing on evidence-based work, and have seen the immediate impact that environmental strategies can have. The broad acceptance of these types of strategies across the prevention infrastructure in Maine is almost entirely the result of the SPF SIG.<sup>29</sup>

### *Evaluation and Monitoring*

#### *Monitoring Strategy Implementation*

The development and use of common monitoring tools, including reporting requirements, was one of the state's SPF SIG goals. All grantees activities were monitored by the state, primarily through the use of KIT Solutions®. The KIT system streamlined reporting requirements by serving as a single reporting system across all the priority areas that HMPs were addressing (not just substance abuse); this was a major accomplishment that meant grantees were not being asked to report specific prevention activities in different systems according to the primary funding source. In addition, the entire system attempted to collect

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<sup>29</sup> Some prevention strategies for enforcement that address environmental factors, such as Party Patrols and compliance checks, were supported by the Enforcing Underage Drinking Laws (EUDL) grants prior to the SPF SIG and continued throughout the grant.

strategy-level process data that encompassed measures for the reach and scope of each strategy at the HMP level through a module called the “Strategy Tracker.”

By the conclusion of the grant, most grantees felt that the KIT system had successfully streamlined reporting requirements, particularly the quarterly reports, but many were surprised by the detailed requirements contained in the strategy tracker and felt it was unsuccessful for many reasons. First, the required counts were not always feasible for coalitions to collect or depended on the data collection capacity of community partners, such as police departments. Second, there was little guidance provided that defined each count, what it meant and how to collect it. Although OSA readily provided answers to specific questions about specific counts, some grantees felt overwhelmed by the task and did not even ask for guidance. Third, simply finding the Strategy Tracker on the KIT system was difficult and at the outset many grantees did not know where it was. Those who did collect and enter the information felt that it “fell into a void,” which was frustrating given the time and effort they spent to report it.

Although OSA expended considerable effort to create reporting features on the KIT system, many grantees stated that the reports were difficult to interpret and were of limited use. In addition, most SAPS were quick to highlight that other reporting requirements still existed (notably, the Community Level Instrument required by SAMHSA, but also the Drug-Free Communities reporting requirements) that were not aligned with the OSA KIT system. In those cases, they could not extract the information they entered into the system in a manner that would help them to comply with other non-Maine reporting requirements. Indeed, making changes to the KIT system and its reports was so onerous in part because the system lacked the ability to respond accurately and quickly to changing federal requirements, OSA’s shifting needs, or local priorities.

OSA has already embarked on efforts to streamline and simplify the KIT reporting system for prevention grantees. This work should remain a priority, as should making the system useful and worthwhile to the grantees, which will in turn greatly enhance compliance and accuracy. Nonetheless, it is worthwhile to note that the entire prevention system in Maine is now using the same monitoring system. This progress along the infrastructure development spectrum was greatly supported by the SPF SIG.

### *Developing Evaluation Capacity*

To develop the capacity of local coalitions to evaluate themselves, OSA and HZA routinely released evaluation products throughout the course of the SPF SIG, including:

- technical assistance and training opportunities specific to evaluation;
- step-by-step guidance documents for assessment and evaluation that provided examples and language specific to the SPF SIG in Maine; and
- local logic models based on the HMP work plans.

When planning each Prevention Provider Day, OSA made a point to include workshops about evaluation. These sessions were often hosted by HZA staff, as well as by local communities sharing their own evaluation results and best practices. The focus was usually on feasible

ways to use data that coalitions already have, methods for collecting data, and the interpretation and presentation of data to key stakeholders. To supplement these yearly opportunities, OSA and HZA also organized conference calls and webinars relating to evaluation and data collection. Indeed, coalition staff were integral to collecting valuable information about the young adult population for the SPF SIG evaluation by distributing surveys within their communities.

Through SPF SIG, OSA and HZA were able to create highly specific guidance documents that walked the local coalitions through the assessment and planning process and later, creating and implementing various types of evaluation. According to the grantees, the *SPF Guide to Assessment and Planning* and the *Guide to Evaluation and Planning*<sup>30</sup> were particularly useful because they contained language that was specific to the strategies, resources and structures that were being used to implement the SPF SIG. Moreover, the guides contained templates for analyzing available data that mirrored the county profiles and provided instructions for how to collect original evaluation data through focus groups, observation and brief survey techniques. Lastly, to accompany the evaluation guide, each coalition was provided with a SPF SIG logic model that contained the specific strategies included in its HMP work plans, as well as short-term and longer-term outcome measures from available data sources.<sup>31</sup> More than one grantee indicated that it used those logic models when applying for funding outside of the SPF SIG.

Through these activities, most coalitions reported moderate to high access to evaluation expertise such as academic institutions or private research organizations by the conclusion of the grant. However, only three districts reported having access to an evaluator either on staff or through a contractual agreement. Similarly, the extent to which coalitions use data for evaluation purposes varies widely. Most grantees reported using data to drive strategy selection, to craft their work plans, and for use in media activities such as editorials and press releases. Some also collected process evaluation data in a systematic way and made adjustments to how a specific training or education session was implemented. Others mentioned using data to gain support from coalition members to justify their activities when applying for funding. Across all the coalitions, however, an explicit focus on routine evaluation and benchmarking seemed to be somewhat of an afterthought, rather than planned for at the outset. OSA may want to consider asking grantees to include measures of success, or even benchmarks, as part of their yearly work plans. Certainly, continuing to provide technical assistance and guidance around evaluation is warranted.

### ***Infrastructure to Promote Cultural Competence***

As previously mentioned, cultural competency has been defined in the SPF as “a set of congruent behaviors, attitudes and policies that come together in a system, agency, or among professionals that enable that system, agency, or those professionals to work effectively in cross-cultural situations.”<sup>32</sup> The following section explores the extent to which

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<sup>30</sup> The guides can be accessed through OSA’s SPF SIF website.

<sup>31</sup> An example of these logic models can be found in Appendix G.

<sup>32</sup> “*Incorporating Culture Into your Organization.*” Presentation to Maine SPF SIG grantees by the Northeast Center for the Application of Prevention Technologies (NE CAPT). December 18, 2008.

the SPF SIG was able to move Maine towards a culturally competent substance abuse prevention system.

### *Enhanced Collaboration with Maine Tribes*

In large part through the SPF SIG, Maine OSA is beginning to build stronger relationships with the state's tribal communities particularly in the area of substance abuse prevention. In 2009, OSA staff attended a Quarterly Tribal Health Directors meeting to discuss areas where OSA could collaborate with the tribes. As a result of this meeting, the tribes appointed an official representative to serve on the current SPF-SIG Advisory Board and the Community Epidemiology Surveillance Network (CESN). OSA also dedicated some SPF funding to support a tribal public health survey, of which substance abuse will be part (at the time of this report, the survey is still in development). Moreover, a member of the Prevention Team was identified to serve as the primary contact for the tribes and to work with the Office of Minority Health to identify areas where collaboration can occur.

Challenges persist, however. The tribal health survey has been delayed and the primary tribal representative who attended both the SPF SIG Advisory Board and the SEOW/CESN has left the position. Once a new tribal liaison is appointed, OSA should continue to build relationships with other tribal members so that the representation of Maine's tribes in substance abuse prevention does not rely on a single point of contact within the tribal community. OSA should also continue to encourage a tribal representative to participate in the Prevention Advisory Board and the SEOW/CESN Committee.

### *Cultural Competence in Local Prevention*

The SPF SIG ushered in a shift in substance abuse prevention in Maine to look at special cultural populations and to work with coalitions across the state. The subpopulation studies and cultural competence trainings (via conference call and webinar) strove to make information available to state staff as well as to prevention providers. OSA also considered cultural competencies when designing the service delivery and workforce development materials and trainings.

Despite these many efforts by OSA, including seeking technical assistance from the Northeast CAPT (now known as the Northeast Regional Expert Team), key informant interviews and site visits revealed that cultural competence at the community level is still an area requiring more work in Maine. Adequately training field staff on culturally competent service delivery continues to be a challenge; many still struggle to recognize that special populations encompass more than just ethnic and racial heritage, and can also include socio-economic status, education levels or even professional affiliation (e.g., construction workers). Moreover, when staff do recognize the diversity within their community, they are not always taking that information to the next step and incorporating it into coalition functioning, planning or marketing.

In addition, limited funding in some cases prevented grantees from being able to produce documents or social media messaging that were culturally specific or were translated into the many foreign languages that exist within certain communities in Maine. Some of the

more recent populations speak languages that are primarily oral and grantees lacked the resources necessary to employ a bilingual individual to provide information or administer a survey in person. Indeed, some coalitions that cover extremely diverse areas feel less supported in this area and report that they are “figuring it out on our own.”

Going forward, OSA should continue to push coalitions to identify the relevant cultural communities within their areas and provide guidance on what constitutes “culture.” OSA should also continue to encourage coalitions to think creatively about how to reach these populations (e.g., partnering with local refugee agencies or adult literacy programs). Helping grantees to craft a statement of support for cultural competency in prevention that is reflective of the local community or requiring them to include at least one prevention activity relevant to a cultural subpopulation in future prevention work plans could also help increase capacity in this area.

### ***Infrastructure to Promote Sustainability***

As previously mentioned, another overarching goal of the SPF SIG project was sustainability. This section focuses on the infrastructure enhancements that will help to sustain the accomplishments of the SPF SIG. This chapter has demonstrated the extent to which the SPF SIG enabled OSA to establish strong partnerships with other state agencies involved in prevention that had not previously been routine partners in its prevention efforts. These relationships persist, as demonstrated by the cross-agency representation on the Prevention Advisory Board and the SEOW/CESN. OSA is continuing to pursue opportunities with its state-level partners and successfully worked with the Department of Education to obtain a one-year grant to plan for substance abuse and violence prevention in the schools in the face of the defunding of the Safe and Drug Free Schools program.

OSA also undertook specific actions to sustain as many of the SPF SIG activities as possible at the local level. For example, OSA shifted a larger proportion of the block grant funding to the HMPs to sustain work that they did under SPF SIG. In doing so, OSA reduced the number of strategies that will be funded to focus on the most effective ones and continues to support staff at the local level. Additionally, OSA staff ensured that language was included in most recent HMP RFP that will allow future funding to be braided into the HMP work should it become available. However, OSA is challenged to figure out how to sustain these efforts without a dedicated funding stream. Without financial support, it is difficult to sustain the same level of quality efforts, and the prevention programs established under the SPF SIG may deteriorate or disappear over time.

At the local level, SPF SIG supported sustainable prevention in large part by funding coalitions to establish relationships that increased their capacity for prevention. Moreover, many of the changes to policy and practice that were implemented by coalitions with community partners (such as police departments, retailers and schools) will continue to support good practice.<sup>33</sup> However, when the funding went away, coalitions felt a great deal of frustration; the expectations and desire for partnerships remain, but the resources available to build and sustain those relationships were significantly diminished. The other

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<sup>33</sup> More discussion about the sustainability of specific strategies can be found in the following chapter.

issue was that the funded SPF SIG work greatly raised expectations for data-sharing, needs assessment and planning. However, existing funding streams rarely support those types of activities and it is unrealistic to expect coalitions to engage in the same level of activity without financial support specifically for those purposes.

By the end of SPF SIG, all grantees reported at least moderate efforts to diversify funding streams, as well as to collaborate with other communities in their district. For example, one coalition shifted and expanded the role of their Prevention Specialist so that it could support the position with other funding sources and did not lose that individual's expertise. Other grantees used their SPF SIG experience and logic models to apply for outside funding, particularly the Drug-Free Communities grants, and many were successful. Still, not all coalitions consistently pursued sustainability efforts or developed concrete plans to overcome the identified funding obstacles. As one individual stated, "the sustainability piece of the original model fell a little short" and some coalitions clearly needed more hand-holding or guidance in this respect. At the conclusion of the project, however, when compared to the beginning, those at the local level were more likely to feel that the state, and particularly OSA, actively sought their input on matters related to sustainability.

Clearly, OSA was challenged to prepare coalitions for the inevitable end of SPF SIG funding. Although SPF SIG developed a stronger workforce and network of colleagues, many coalitions were unable to sustain full-time SAPS. It may be worthwhile in the future to require at least one sustainability activity to be included in grantee work plans, and supported by OSA's block grant dollars. It will also be critically important to provide guidance to SAPS and other coalition staff on locating funding from different sources and writing effective grants. Currently, OSA posts funding announcements to the Prevention Listserv; they may also consider hosting a website with links to relevant and available funding sources and guidance.

### ***Summary of Prevention Infrastructure and Capacity***

The first round of HMP funding, of which SPF SIG was a part, established the building blocks for an infrastructure and a culture of prevention that involved common expectations for communication, evaluation, and partnership. At the local level, this often meant bringing together a diverse set of infrastructure elements and combining them into one or consolidating existing personnel in a manner that temporarily hobbled the local capacity in some districts. However, by the conclusion of the SPF SIG grant, infrastructure and capacity at the District level was at or exceeded previous levels. Collaboration across the districts increased capacity as everyone worked together to accomplish what they needed, rather than compete against each other for limited funding. By the end of the grant, this had extended beyond the district lines as Maine saw even greater collaboration across districts; for example, Central and Penquis districts began working together on social media campaigns, pooling resources and sharing connections in order to accomplish their work.

For both the State and for the local coalitions, the development of relationships between key stakeholders and partners was a huge accomplishment of the SPF SIG that will sustain many of the inroads made in terms of infrastructure and capacity. At the state level, the collaboration between OSA, the Department of Education, and the Centers for Disease

Control is now part of the public health infrastructure. Moreover, OSA has recognized that law enforcement is a critical partner in substance abuse prevention efforts and is collaborating with them more frequently than it did prior to the SPF. Locally, SPF SIG funded coalitions made connections with schools, law enforcement, medical professionals, educators and legislators, many of whom were not previously engaged in substance abuse prevention efforts. Integrating substance abuse prevention within the HMP structure placed the work into a more stable system that can sustain some of the progress made with the SPF SIG.

Due in large part to the successes that Maine has observed over the duration of the SPF SIG project, OSA has fully embraced key components of the SPF SIG model into its developing infrastructure. In particular, OSA places a strong emphasis on implementing evidence-based programs and environmental strategies, and it routinely engages in data-driven decision-making. These advances in capacity and the infrastructure developed to support them will sustain SPF SIG principles in Maine well beyond the lifetime of the SPF SIG project.

## Chapter 4. Implementing Strategies for the SPF SIG

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The evaluation report thus far has reviewed the actions undertaken by Maine to enhance its prevention infrastructure and capacity as part of the SPF SIF project. The report has provided evaluative comments and recommendations to help further these efforts. This chapter focuses on Step 4 of the SPF SIG process, namely the implementation of environmental and evidence-based strategies at the local level. To accurately gauge the success of these endeavors, one must first understand the context in which they are implemented; that experience will be explored in the first section. The section covering strategy implementation details the most common approaches that each of the coalitions took in response to the five objectives that OSA required of all SPF SIG grantees.

### *Context of SPF SIG Strategy Implementation*

Unlike most other states implementing the SPF, Maine experienced an abrupt shift between Steps 1, 2 and 3 (assessment, mobilization and planning) and Step 4 (implementation). In 2006, OSA issued SPF SIG funds to local grantees to carry out SPF steps 1 (assessment), 2 (mobilization) and 3 (strategic planning). An “equity model” was used to distribute funding, whereby each grantee received the same amount to ensure that each locale received the same resources to assess and develop the local prevention infrastructure. The model also reflected that there was not enough evidence to distinguish one county from another with regard to risk and need.

The initial round of SPF SIG local funding was allocated to 15 grantees that covered Maine’s 16 counties. They were charged with conducting needs assessments and developing strategic plans. This decision was made while the new public health infrastructure, into which substance abuse prevention was being integrated, was still being finalized. At the same time that the 15 grantees were completing their SPF SIG needs assessments and strategic plans, the Public Health Workgroup decided upon a structure that incorporated the Healthy Maine Partnerships (HMPs) into eight Public Health Districts, which generally followed county lines by combining some counties into one district (e.g., Penquis consists of Piscataquis and Penobscot).

In this emerging infrastructure, the 28 HMP coalitions were the primary recipients of prevention funding, including SPF SIG dollars. However, in some areas, those organizations were not the same grantees that had been funded by OSA to complete the first three steps of the SPF. This meant that the SPF was essentially implemented in two parts and, in some areas, by different organizations, which posed a challenge to continuity. It also threatened to undermine the role of the locally drafted strategic plans in the implementation of strategies and thereby weaken the impact of the SPF SIG model at the local level.

To minimize the potential negative impacts of a two-phase SPF, Maine OSA undertook several actions. First, it required each HMP to address the state’s priority areas in its SPF SIG work plan, and required coalitions to work on five objectives (additional objectives were listed but were optional depending on the needs and capacity for each organization). Second, OSA identified between five and seven strategies for each objective that could be selected by the coalition, requiring HMPs to work on at least one and link it to the original

strategic plan. In this manner, OSA ensured that the work contained in the HMP proposals reflected the State's SPF SIG Strategic Plan and that the local strategic plans were the primary planning tool used to identify priorities and strategies.

Throughout the project, Maine also took every opportunity to reiterate the SPF SIG model, its intent and the implications of the model for local grantees. A brief overview of the model was included in all guidance documents, discussed during site visits and conference calls, reviewed at training workshops, and reiterated by OSA project officers regularly during one-on-one conversations with grantees. In Year 3 of implementation, OSA also provided detailed instructions for crafting the SPF SIG work plans and specifically directed grantees to refer to the SPEP strategic plans and needs assessments that were developed during Phase I, in addition to any other substance abuse data that the grantee may have collected. This represented yet another effort by OSA to ensure that the communities used their local strategic plans to determine the priority needs and strategies to be implemented with SPF SIG, and to overcome the disruption of the SPF SIG model at the local level experienced between Steps 1-3 and Step 4.

### ***Strategy Implementation Highlights***

SFP SIG grantees were able to select any number of strategies from the approved strategy list to include in their work plans. However, as described above, they had to include at least one strategy<sup>34</sup> to address each of the five priority objectives required by OSA which were as follows:

- Increase effectiveness of local underage drinking law enforcement policies and practices;
- Increase use of recommended parental monitoring practices for underage drinking;
- Increase effectiveness of retailers policies and practices that restrict access to alcohol by underage youth;
- Reduce appeal of high risk drinking by increasing knowledge of the health risks; and
- Decrease promotions and pricing that encourage high risk drinking among young adults.

Over the course of the project, grantees experienced a number of successes and challenges as they implemented their SPF SIG/HMP work plans. This section will present the highlights from the most frequently implemented strategies and discuss the implications that local experiences should have on statewide prevention initiatives in the future.

### ***Working with Law Enforcement***

To increase the effectiveness of local underage drinking law enforcement policies and practices, OSA asked grantees to work with local police departments in a number of ways. These included: developing a departmental policy around underage drinking, furnishing,

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<sup>34</sup> During contract negotiations, OSA encouraged grantees to work on at least two strategies per objective.

zero-tolerance and hosting laws; working with them to enhance their existing policy; providing training to officers on best practices and the implications of the policy; and supporting departments as they implemented Party Patrols and compliance checks.

In cases where there was not an existing policy, grantees appreciated having the model policy (developed by the Maine Sheriff's Association) as a starting point and the fact it was developed by other law enforcement professionals made it easier for local departments to accept. Some coalitions stated that helping to implement the Party Patrols, where a team of trained officers patrols specifically to locate and prevent parties, was a good way to build relationships with police departments they had previously been unable to reach. However, coalitions in the rural areas had less success with this strategy and were more likely to report that forming a local enforcement Task Force had the most important effect in their community in terms of enforcement. In fact, by the conclusion of the SPF, four districts had at least one law enforcement task force and most SAPS expected the task forces to sustain without direct support from the coalition.

Many coalitions also reported a positive, albeit unintended result, from working with the local law enforcement. They found that the police officers became important partners on some of the other prevention strategies that the coalition was engaged in, notably in disseminating information about the Responsible Beverage Server trainings that were being offered to retail establishments, and at least one district mentioned that the local police chief sent an officer to coalition-sponsored meetings to talk to parents.

However many SAPS reported that they were still finding some area police departments hard to reach. The prevailing obstacle was a lack of resources, both in terms of funding and in terms of staff time, in the police departments; indeed, small departments with only a handful of staff were sometimes the most difficult for coalitions to engage in more in-depth prevention strategies. Two districts specifically stated that they struggled because area police departments did not have the extra resources they needed to do prevention, specifically staff. One district also stated that departments were nervous that working together would show that they did not need five police departments and they would end up being consolidated. SAPS were quick to note that changes in leadership dramatically affected their partnerships with law enforcement, however. In at least two districts, new police chiefs allowed staff to begin working with a previously unreachable department. In other areas, new leadership led to reprioritizations of resources which limited the ability of those departments to participate in the coalitions or to work on underage drinking priorities.

Through these efforts, all districts reported that they built stronger relationships with their local police departments and cited this as one of the great successes of the SPF SIG; in fact, they reported working with around 100 departments across the state each year.<sup>35</sup> By the end of the SPF SIG, the proportion of students reporting that they thought they would be caught by the police for drinking alcohol had increased from 11 percent in 2006 to 12 percent in 2008; more importantly the rates increased in each public health district.

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<sup>35</sup> Because coalitions may work with the same departments in each work plan year on different components, an annual count is provided here.

## *Working with Retailers*

To increase the effectiveness of retailer policies and practices that restrict access to alcohol by underage youth, and to decrease pricing specials and alcohol promotions, OSA identified many strategies that coalitions could implement, such as: help organize compliance checks; offer Responsible Beverage Service (RBS) Trainings for local merchants; help retailers incorporate the best practices from RBS into policy and procedure; educate retailers on the importance of prioritizing underage access to alcohol; implement the Card ME program with retailers (a comprehensive program developed by OSA that guides how coalitions work with retailers on policies and practices to reduce underage access to alcohol); educate merchants about the negative impacts of low pricing and promotions; work with them to limit promotions; and to implement activities such as Sticker Shock to inform customers of the penalties for furnishing alcohol to minors.

The extent to which strategies like organizing compliance checks and Card Me were implemented varied across the coalitions. RBS Trainings, on the other hand, were offered in every single public health district and coalition estimates suggest that staff from more than 600 Maine retailers participated over the course of the SPF SIG, making them the most commonly implemented strategy to address retail access to alcohol. The trainings were intended to educate owners, managers and staff at retail alcohol outlets and were tailored to meet the different laws governing on-premise versus off premise sales. They covered such learning components as how to identify and confiscate a fake ID, how to recognize when an adult may be purchasing alcohol for minors, and how to refuse sales to minors, potential furnishers or intoxicated customers.

All SPF SIG grantees reported great success with this particular strategy which likely affected the consistent and widespread implementation of the trainings. In two districts, staff advertised all upcoming RBS trainings so that retailers could attend whichever one best suited their schedules. In some areas, the police partners in the community approached retailers to discuss compliance issues and offer information about the trainings; in these cases what was important was that information about the trainings was not given in response to an alcohol violation, but rather as a community-wide outreach on behalf of the police (but offered by the coalition). Coalition staff also reported that law enforcement officers appreciated having something positive to offer retailers to address underage drinking, opposed to writing citations. One district noted that many people who work for retailers are also parents and so they were using the RBS trainings as an opportunity to engage in parent outreach as well.

By 2008, 63 percent of high school students thought it was easy to obtain alcohol, compared to 66 percent in 2006; across the public health districts, this ranged from a decrease of 1.5 percentage points to a decrease of 5.3 percentage points. Given that managers and staff in retail outlets frequently change, RBS trainings need to continue in order to maintain educated merchants and a compliant retail environment in Maine. However, the success of this strategy should not overshadow the fact that more and more young people report that they access their alcohol through social, rather than retail, networks. Modifying the focus of retail strategies to emphasize the role played by retailers in

preventing the purchase of alcohol by adults who are providing it to minors, not just sales to minors, is the logical next step.

### *Reaching Parents*

To increase use of recommended parental monitoring practices for underage drinking, SPF SIG grantees could use the OSA Parent Media Campaign materials to build a social marketing campaign, hold educational meetings for parents or work with agencies, organizations and worksites to educate parents. Grantees could also use other parent media materials (such as *Parents Who Host, Lose the Most*) in these efforts, as well as help schools to adopt a parental notification policy regarding substance abuse.

The efforts undertaken by the HMPs mostly entailed using OSA's Parent Media Campaign and holding educational meetings for parents. Coalitions in all Public Health Districts used a variety of different media to try to get their message out to the general community. Newspapers were most commonly used, with several coalitions reporting good relationship with local reporters, and many sent out press releases when underage drinking events occurred such as busted parties or traffic accidents. Many also ran public service announcements on the local radio stations using the media campaign materials provided by OSA. One of the most common methods to reach parents was through sporting events. For example, during the basketball season coalitions distributed materials through rally cards, free coffee and mugs, displays at school events and ads in the basketball programs. Social media networks were also a very popular method by which to engage in outreach for these messages, including Facebook and MySpace pages, Twitter accounts, email lists, and interactive coalition websites. In total, coalitions estimated that the messages about parental monitoring and modeling were distributed across more than 1,300 channels (examples of which include media outlets, doctor offices, stores, community bulletin boards, public transportation, movie theaters, and restaurants) and resulted in more than 1.2 million media exposures during the two years spanning 2007-08 and 2008-09.

While the social marketing campaign was implemented with relative success, SAPS reported that parents were especially hard to reach. As one individual stated, "you cannot expect parents to come to you, you have to reach out to them where they are." Coalitions were extremely creative in their attempts to reach parents, using listservs, newsletters, fliers (in both paper form and online), and even posting information about parent meetings directly to school websites. Even so, there was often wide variance in attendance at parent meetings with some having as many as 100 attendees and others having fewer than 10.

Given these challenges, some coalitions employed unique strategies to reach out to parents. For example, some SAPS found success by collaborating with student athletics; in one district the coalition was able to work with local schools to hold mandatory athlete meetings which students had to attend with at least one parent in order to play sports during that semester; substance use and monitoring was then discussed at the meeting. Prevention staff in another district were able reach parents through worksite trainings and at treatment centers, where they appealed to participants as parents.

OSA has already incorporated the experiences outlined above into its new parent outreach strategy, called “Table Talks,” which asks coalitions to recruit a parent who is already engaged with the coalition to host a discussion evening with other parents in the community. The coalition provides materials, suggested topics and other support. The idea of this shift is to capitalize on existing parental networks in a way that is less formal or public than an event that is held at the school or hosted by the coalition, and therefore may be more appealing to parents.

In 2008, 85 percent of high school students reported that their parents thought alcohol use was wrong, compared to 83 percent in 2006, and 42 percent thought they would be caught by their parents (up from 39 percent in 2006). As with the previous strategies, these positive trends were observed across all the public health districts. However, given that three out of five high school students in Maine reported in 2008 that they thought it was easy to access alcohol, continuing to work on these parental outreach strategies is of utmost importance to preventing underage alcohol use in Maine. In the future, OSA may want to review the Parent Media Campaign and Table Talk materials to make sure there is sufficient emphasis on parental attitudes towards furnishing alcohol and educating them about the legal repercussions of doing so.

### *Working with Employers*

To increase young adults’ knowledge of the health risks associated with risky drinking behaviors, OSA developed a Drug-Free Policy component to be incorporated into the HMP Worksite Framework. To meet this objective, the Worksite Framework could be used in numerous ways, including: to distribute information about available assessment and feedback services, educational programs and self-help materials; to help employers provide information to their workers about their Drug-Free Workplace policy and the implications of that policy; to help employers develop a substance abuse program that incorporates personal assessments and evidence-based education courses; and to help employers learn how to consistently enforce their Drug-Free Workplace policy.

The Drug-Free Policy component of the Worksite Framework turned out to be more difficult to implement than other SPF SIG initiatives. The primary barrier was one of access. Coalitions found that many businesses were simply unwilling to work with them in regard to employee use of alcohol and drugs. The resistance was two-fold: one, the prevailing attitude was that what employees chose to do in their free time was not a concern to the employer; second, some businesses were unwilling to address alcohol and drug use for fear of liability concerns, that is, that staff who participated in wellness initiatives or disclosed alcohol/drug use might hold them liable if they were fired later. Many SAPS who reported success in this area stated that they often approached a business about an alcohol policy to address on-site use. Others reported higher levels of success when the coalition worked first with worksites on tobacco, which was an easier topic to address since the prevailing attitudes about second-hand smoke and workplace health are well accepted.

Once the relationship with the coalition had developed, the SAPS were more easily able to broach the subject of alcohol and other drugs. One coalition found that giving the worksite trainings a positive and compelling title (for example, “Sometimes Difficult, But Always Worth

It”) made a huge difference in willingness to participate. Similarly, some SAPS found that they were more successful if they approached the training from the perspective of employees as parents and community members and educated them about alcohol use (and prescription drugs) more generally.

Given these findings, a more successful approach for OSA to advocate in the future might first consist of education or training for business leaders that address prevailing attitudes and concerns, followed by assistance and guidance towards adopting rigorous worksite policies. OSA has recently created a new worksite website that links to the U.S. Department of Labor policy-builder. Complementing the website with a local-level information campaign focused on educating employers about the importance of a comprehensive substance abuse program which includes alcohol could be an excellent way to increase the number of worksite policies for alcohol and drugs across the state and would perhaps be more feasible for coalitions.

### *Partnerships with Colleges and Universities*

OSA also identified strategies for coalitions to use in partnership with colleges and universities to increase young adults’ knowledge of the harm associated with risky drinking behaviors. These mirrored the strategies for worksites and included distributing information about available assessment and feedback services, including web-based services such as e-CHUG, and developing appropriate substance abuse policies that contain components such as personalized assessments for students, requiring students to take an evidence-based course as part of orientation, and requiring those who violate the policy to engage in a personalized assessment.

The work of the coalitions overlapped to a degree with the work that colleges and universities were engaging in through the Higher Education Alcohol Prevention Project (HEAPP). In some cases, this overlap prevented coalitions from developing relationships with the local higher education institutions in the area. For example, one District said it had been unable to make much headway with the local university who specifically cited its work with HEAPP as evidence that it was dealing with the problem of high-risk drinking among students. Coalitions had more success in building partnerships with local institutions of higher education when they invited someone from the college to be part of their coalition, rather than to approach the colleges to propose policy changes or programming to reach the students directly.

Going forward, OSA should support policy and programming changes to impact young adult knowledge of the harm of high-risk drinking through HEAPP, and focus grantee prevention efforts primarily on environmental strategies in the community (e.g., server trainings, retail pricing strategies or work with law enforcement) that impact the young adult community more broadly. OSA should also encourage each grantee to invite a representative from its local institution(s) to serve on the coalition in order to better coordinate coalition initiatives with campus activities, policies and programs. It would not be worthwhile, however, to invite a college or university representative to attend meetings or join a coalition that is primarily focused on K-12 strategies.

### *Summary of Implementation*

Of the five objectives required of SPF SIG grantees, strategies to engage the police, retailers and parents appear to have had the most successes across all the public health districts. Indeed, student survey data from 2006 and 2008 shows promising changes observed on measures that directly relate to these strategies, and additional outcome findings will be presented in the following chapter. What is important here is the finding that strategies to address underage drinking were generally more successful than strategies to address high-risk drinking among the 18 to 25 year old population.

This is likely impacted by two considerations. First, most coalitions had been working with community members, schools and parents to address underage drinking prior to the SPF SIG and they had a high level of capacity to continue this work, albeit with a focus on environmental and evidence-based strategies. Conversely, working to address adult consumption, even young adults ages 18 to 25, was new territory for many coalitions. Likewise, collaborating with institutions of higher education and employers requires a different approach that was unfamiliar to many in the prevention field. Therefore, the learning curve for local staff to address these two objectives effectively was steep and the existing capacity was low. In addition to the specific suggestions made above, OSA should address this topic in future prevention workforce development opportunities if these types of strategies continue to be a priority.

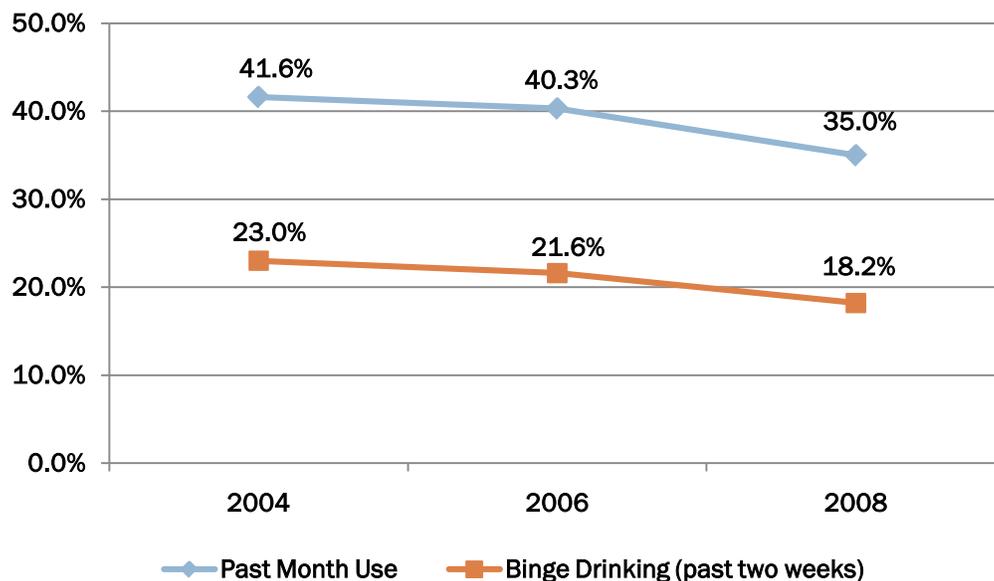
## Chapter 5. State-Level Outcomes of the SPF SIG

As the previous two chapters have demonstrated, the SPF SIG project enabled Maine to greatly enhance its capacity and infrastructure for substance abuse prevention, as well implement a number of evidence-based environmental strategies across the entire state. This chapter examines the outcomes of those efforts in terms of observed changes in consumption patterns and the behaviors and attitudes which contribute to those patterns.

### *Youth Alcohol Use Since 2004*

One of Maine's great achievements during the SPF SIG was a 6.6 percentage point decrease in the rate of underage drinking in the past month among high school students between 2004 and 2008; falling from 42 percent in 2004 to 35 percent in 2008 (see Figure 4). The observed decrease between 2006 and 2008, the first two years of SPF SIG implementation, marked the first decrease of this magnitude (14%) since 1998. Rates of binge-drinking in the past two weeks (defined as five or more drinks in one sitting) also declined from 23 percent in 2004 to 18 percent in 2008.

**Figure 4. Previous 30-Day Use of Alcohol by High School Students in Maine, by Year: 2004, 2006 and 2008**



*Source: MYDAUS, grades 9-12, 2004, 2006 and 2008.*

The same results held true for each of the Public Health Districts as well, where the changes in past-month use of alcohol between 2006 and 2008 ranged from a nine percent decrease in Downeast to a 20 percent decrease in the Penquis district, as demonstrated on the following page in Table 5.

**Table 5. Past-Month Alcohol Use Among High School Students, By Public Health District**

	2004	2006	2008	Pct Change (06 to 08)
Maine	41.6%	40.3%	35.0%	-13.0%
Aroostook	40.5%	37.3%	33.7%	-9.6%
Central	38.3%	36.7%	32.5%	-11.6%
Cumberland	42.1%	41.6%	37.8%	-9.1%
Downeast	39.2%	38.0%	34.7%	-8.8%
Mid-Coast	46.0%	43.9%	38.0%	-13.4%
Penquis	42.3%	40.7%	32.5%	-20.1%
Western	41.1%	39.2%	34.5%	-11.9%
York	41.3%	42.3%	34.9%	-17.5%

*SOURCE: MYDAUS, 2004, 2006 and 2008, grades 9-12.*

Data results from the 2009 Maine Youth Integrated Health Survey are somewhat more challenging to interpret. Continuing to trend the data using the new 2009 data is not possible due in large part to changes in the format and administration of the survey.<sup>36</sup> Additionally, some of the coalitions were successful in engaging schools that had not previously participated in the school-based survey, while other schools chose not to participate in back-to-back years (the previous administration was in 2008). These types of data considerations likely impacted the survey findings for the 2009 year, particularly at the local level. For these reasons, the data findings should be used as a baseline against which to gauge future progress, rather than a final measure by which to determine previous successes.

Nonetheless, the statewide 2009 survey data do suggest that positive outcomes sustained, despite some changes in the rates of consumption at the state level. As demonstrated by Table 6 below, past-month use of alcohol remained stable statewide between 2008 and 2009 (at 34.7%, compared to 35%). Rates of binge-drinking within the past two weeks regressed slightly, increasing to 20 percent (from 18%).

**Table 6. Underage Drinking Rates in Maine, 2008 and 2009**

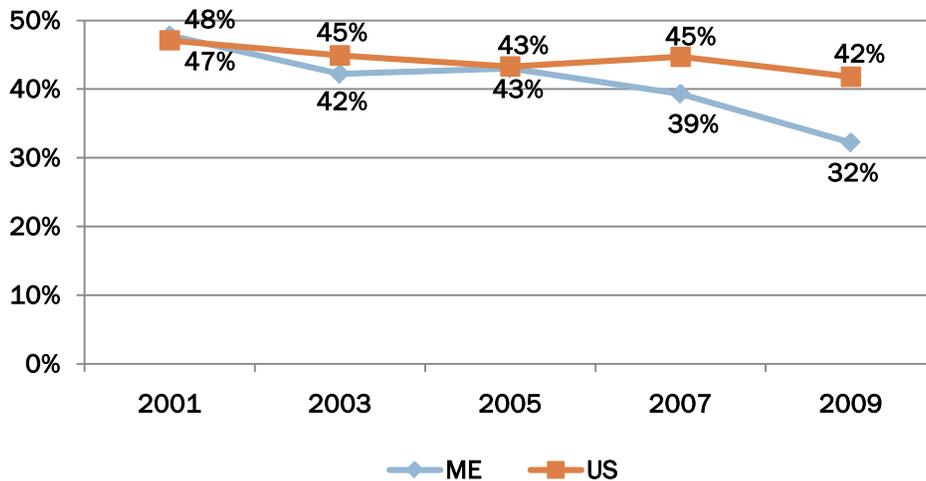
	2008	2009
Past-Month Use	35.0%	34.7%
Binge-Drinking (past two weeks)	18.2%	20.1%

*Source: 2008 MYDAUS, grades 9-12; 2009 MIYHS, grades 9-12. Trending between 2008 MYDAUS and 2009 MIYHS is not possible due to changes in the administration methodology of the survey. Data are presented together here for discussion purposes only.*

<sup>36</sup> For more information on the new Maine Integrated Youth Health Survey and its methodology, please visit <http://www.maine.gov/youthhealthsurvey/main.cgi>

When Maine is compared to national trends using a nationally comparable source of student data, however, a clear downward trend continues in 2009. As demonstrated by Figure 5, Maine’s rate of past-month alcohol use since 2005 (the first year of the SPF) declined from 43 percent in 2005 to 32 percent in 2009. Moreover, these declines are far greater than the current national trends in underage alcohol use, where rates actually increased in 2007 to 45 percent before decreasing slightly in 2009 to 42 percent.

**Figure 5. Previous 30-Day Use of Alcohol by High School Students in Maine and United States, 2001 to 2009**



*Source: YRBSS, 2001 – 2009.*

### ***Youth Perceptions and Attitudes<sup>37</sup>***

As outlined in the first chapter of this report, there are measures, or “intervening” variables, that directly relate to the strategies that were required by Maine to be implemented in communities statewide. These include:

- Perception of being caught (by parents or police),
- Ease of access (social and retail), and
- Social norms (family, youth and community perceptions).

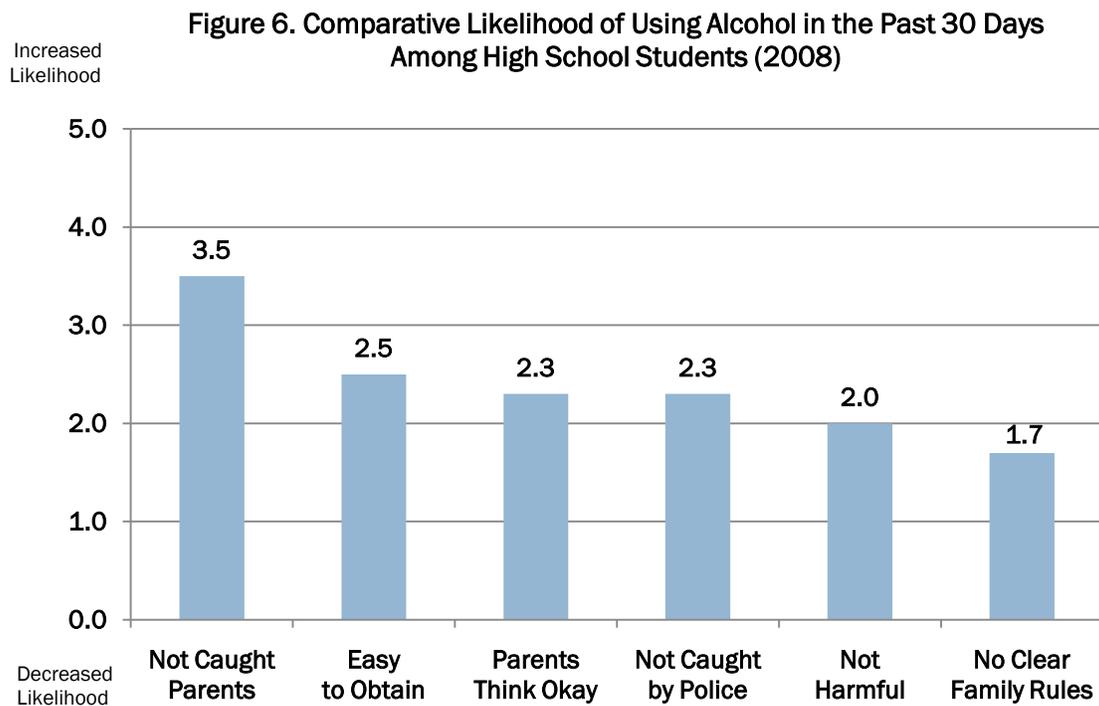
Each of these variables can be measured using the student survey data, where students are asked a series of questions that directly relate to these areas. For example, students are asked to report on the likelihood that they would be caught by their parents if they drank alcohol. Examining the indicators for these intervening variables is critical to understanding the impact of the SPF SIG on Maine, since they directly correlate to the work being done by the HMP coalitions. As Table 7 on the following page reveals, all the measures that directly relate to the required prevention objectives exhibited some degree of change in the desired direction. For example, the perception of being caught by police increased by nine percent statewide between 2006 and 2008, and the perception of being caught by parents increased by a factor of six percent. During this same period, local coalitions worked with

<sup>37</sup> A crosswalk between each indicator and the specific question(s) can be found in Appendix H.

police and sheriff departments across the state to enhance local policies and procedures as well as to publicize police activities around underage drinking. Coalitions held parent information sessions and disseminated information about monitoring children in regard to alcohol, modeling good behaviors and talking about alcohol with your child through a broad array of channels, including local festivals, media and school events.

<b>Table 7. Critical Prevention Factors for Maine High School Students: 2004, 2006 and 2008</b>				
	2004	2006	2008	Pct Change (06 to 08)
Caught by Parents	37.6%	39.1%	41.5%	+6.1%
Caught by Police	10.5%	11.1%	12.1%	+9.0%
Clear Rules	79.8%	80.6%	81.2%	+0.7%
Easy Access	69.2%	66.3%	63.4%	-4.4%
Parents Think Use Wrong	82.3%	83.1%	84.9%	+2.2%
Perception of Harm (1-2 per day)	64.8%	66.5%	68.4%	+2.9%
<i>SOURCE: MYDAUS, 2004, 2006 and 2008, grades 9-12.</i>				

Moreover, the student survey data from 2008 showed that young people who did not think that they would be caught by their parents were 3.5 times as likely to have drunk in the past month, and those who felt it was easy to obtain alcohol were 2.5 times as likely to have consumed it within the past month. This relationship exists across all the key factors and is demonstrated in Figure 6, below.



*Source: MYDAUS, grades 9-12, 2008.*

These data findings strongly suggest a correlation between SPF SIG activities implemented in communities across the state of Maine to address these factors and the observed results over the same period. Even more compelling is that the statewide findings hold true for each of the public health districts with only minor exceptions (see Table 8). For both the indicators where exceptions occurred at the local level (family rules and perceptions of parental attitudes), the baseline estimates in 2006 were quite high to begin with.

<b>Table 8. Percent Change in Critical Factors Between 2006 and 2008: Statewide and by Public Health District</b>						
	Caught by Parents	Caught by Police	Clear Rules	Easy Access	Parents Think Use Wrong	Perception of Harm
Aroostook	+9.3%	+3.4%	+4.1%	-4.5%	+3.1%	+2.9%
Central	+4.9%	+14.8%	+0.8%	-6.0%	+2.3%	+1.2%
Cumberland	+3.1%	+0.8%	+0.6%	-3.7%	<b>-0.7%</b>	+4.1%
Downeast	+7.0%	+28.7%	<b>-1.3%</b>	-7.8%	+1.4%	+3.4%
Midcoast	+8.0%	+21.0%	<b>-0.5%</b>	-6.8%	+2.3%	+2.0%
Penquis	+9.8%	+6.3%	+0.8%	-4.2%	+5.1%	+4.5%
Western	+5.9%	+1.2%	+0.7%	-3.2%	+2.4%	+2.3%
York	+6.3%	+13.2%	+1.7%	-2.2%	+3.9%	+3.6%

*SOURCE: MYDAUS, 2006 and 2008, grades 9-12.*

As was seen with the rates of underage alcohol use, when one examines the 2009 survey data for these selected indicators, the outlook is inconclusive. Table 9 suggests that more students reported that they would be caught by police and their parents for drinking, and that their family had clear family rules about alcohol and drug use. For example, the perception of being caught by police changed from 12 percent in 2008 to 16 percent in 2009. In other cases, the 2009 data are less positive; for example, the perceived easy access to alcohol appears to have increased during this timeframe, while perceptions of harm appears to have decreased. Time will tell whether any of these trends continue, particularly given the absence of SPF funding.

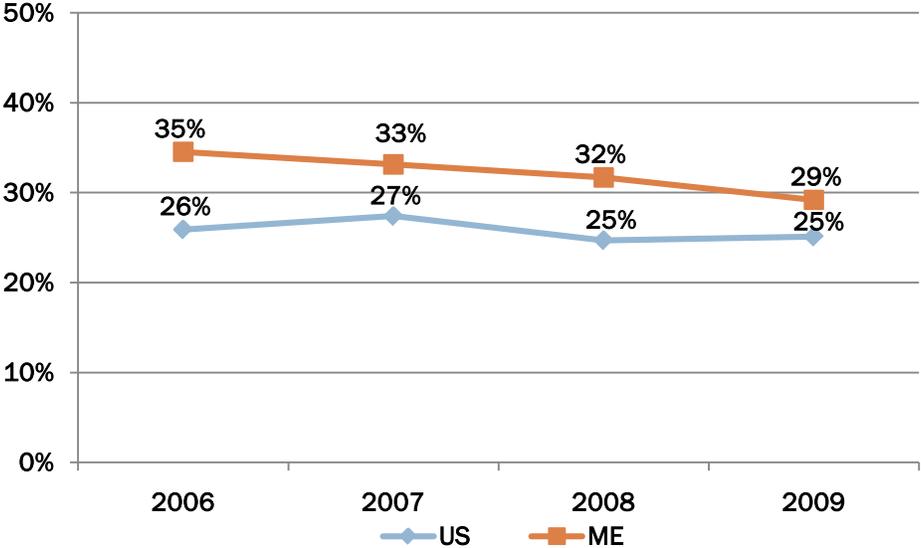
<b>Table 9. Critical Prevention Factors for Maine High School Students: 2008 and 2009</b>			
	2008		2009
Caught by Parents	41.5%		42.1%
Caught by Police	12.1%		15.6%
Clear Rules	81.2%		85.2%
Easy Access	63.4%		67.5%
Parents Think Use Wrong	84.9%		82.7%
Perception of Harm	68.4%		59.9%

*Source: 2008 MYDAUS, grades 9-12; 2009 MIYHS, grades 9-12. Trending between 2008 MYDAUS and 2009 MIYHS is not possible due to changes in the administration methodology of the survey. Data are presented together here for discussion purposes only.*

**High-Risk Alcohol Use Among Young Adults**

High-risk drinking among the young adult population has been a concern in Maine and young adults were identified by the State Epidemiological Profile as a target population for the SPF SIG. At present, statewide information is available from the Behavioral Risk Factor Surveillance Survey (BRFSS) on the rate of high-risk drinking among 18 to 24 year olds. This is defined as five or more drinks on one occasion for males and four or more drinks on one occasion for females. Consistent with the work of HEAPP and SPF SIG, there has been a steady decline on this measure for each of the past four years. Overall, there is a 17 percent decline between 2006 and 2009, as demonstrated in Figure 7 below.

**Figure 7. Percentage of 18-24 Year Olds Reporting Binge Drinking: Maine and United States, 2006 to 2009**



*Source: BRFSS, 2006-2009.*

As described in the previous chapter, SPF SIG grantees undertook many efforts to address the emerging problem of high-risk alcohol use among young adults and encountered many challenges to implementing some of the strategies targeting this population. At the same time, HEAPP (also supported by Maine OSA) was undertaking work directly with Maine’s colleges and universities to address the issue of high-risk drinking among college students. Moreover, in 2009, Maine OSA implemented a statewide social media campaign, “Party Smarter” which targeted 21 to 25 year olds with messages about responsible drinking. While the strategies employed by the SPF SIG grantees differ from the two other initiatives, it is difficult at this time to determine which initiative has had the most impact on the outcomes seen here or indeed if there was a synergistic effect. In particular, the Responsible Beverage Server Training for on-premise facilities coupled with the statewide “Party Smarter” messaging may have impacted drinking behaviors among this age group.

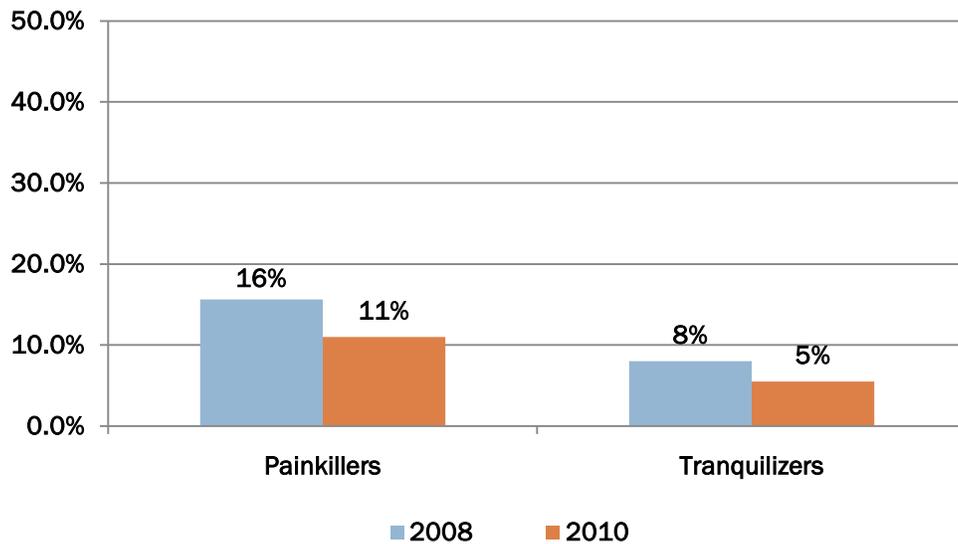
One interesting finding among a survey of Maine’s college students was that Maine residents tend to drink less than out-of-state students. While in-state students and out-of-state students consumed any alcohol at comparable rates, in-state students were less likely

to report high-risk drinking in the past month (35%) and in the past year (51%) when compared to out-of-state students (41% and 56%, respectively).<sup>38</sup> This suggests that the work being done to address underage drinking in Maine may be having longer-term effects as high school students move into the 18 to 25 year old population. What is clear is that the SPF SIG brought to the forefront the consequences of high-risk drinking among the 18 to 25 year old population, which has now become the target of concerted substance abuse prevention efforts in Maine.

### ***Prescription Drug Use Among Young Adults***

Prescription drugs were not included in the original SPF SIG proposal with established targets. However, misuse of prescription drugs among young adults ages 18 to 25 was identified in the Maine’s SPF SIG Strategic Plan as a priority. According to the National Survey on Drug Use and Health (NSDUH), the past year use of painkillers among 18 to 25 year olds has been decreasing slightly each year since 2003-04, from 13 percent in 2004-05 to 12 percent in 2007-08. Maine also conducted a community survey in 2008 (*n* = 564) and 2010 (*n* = 741) to obtain information about this population. Those results show a statistically significant decline in non-medical use of pain relievers in the past year, from 16 percent in 2008 to 11 percent in 2010, as demonstrated in Figure 8 below. The observed decrease in prescription tranquilizer use was not statistically significant. The survey results also suggest that more young adults thought prescription medications were difficult to obtain in 2010 compared to 2008 (30% in 2010 compared to 23% in 2008).

**Figure 8. Past Year Non-Medical Use of Prescription Painkillers and Tranquilizers Among 18 to 25 Year Olds: 2008 and 2010**



*Source: YADAUS 2008, 2010.*

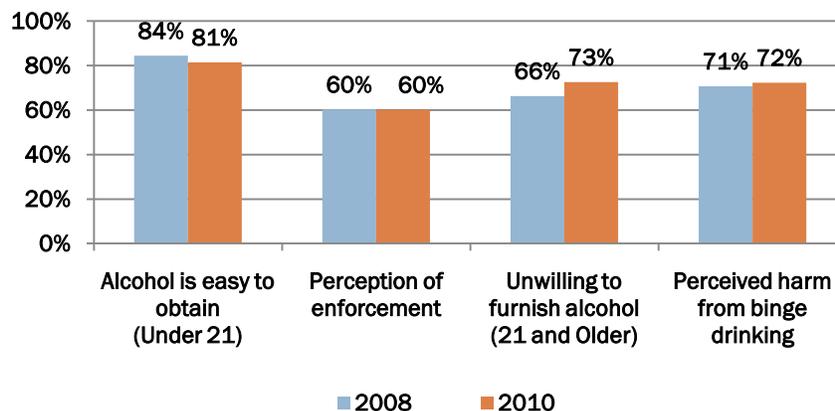
<sup>38</sup> Maine College Student Substance Abuse and Health Survey, 2008. For more information, please contact the Higher Education Alcohol Prevention Partnership (HEAPP).

Although the SPF SIG did support some activities in Maine to decrease access to prescription drugs, many other initiatives were being undertaken at the same time. At the federal level, national research reports and media attention regarding the rise in prescription drug abuse prompted the creation of federal standards for prescription drug disposal and focused national attention on the issue. In Maine, multiple take-back efforts to address the concern of easy access to extra prescriptions were hosted across the state with funding other than SPF SIG, although HMP coalitions were often involved in helping to organize the events. Some SPF SIG grantees worked to increase the participation of medical professionals in their communities who were using Maine’s Prescription Monitoring Program to monitor patient prescriptions; however, grantees reported only limited success in their own efforts, although the program was growing over this same period. When taking these activities into consideration, coupled with the fact that prescription drug strategies were not implemented statewide, it becomes difficult to determine the degree to which the SPF played a role in the observed decreases.

### *Young Adult Perceptions and Attitudes*

In addition to prescription drug information, the survey of Young Adults in Maine attempted to collect more in-depth information about alcohol consumption among this target population, particularly the factors that contribute to high-risk alcohol use and related consequences. As Figure 9 demonstrates, there were some changes in these factors over the period of the SPF SIG. For example, the proportion of young adults over the age of 21 who were unwilling to furnish alcohol to minors increased from 66 percent in 2008 to 73 percent in 2010. Similarly, those who were under the age of 21 were slightly less likely to report that alcohol was easy to obtain, although four out of five still feel it is relatively easy to get.

**Figure 9. Young Adult Perceptions and Attitudes Towards Alcohol: 2008 and 2010**



*Source: YADAUS 2008, 2010.*

In both 2008 and 2010, the primary source of alcohol for those surveyed between the ages of 18 and 20 years old was through older friends and social networks. However, the source of alcohol was less likely to be through parents or relatives in 2010 compared to 2008 as demonstrated in Table 10 on the following page. This finding is encouraging given the effort

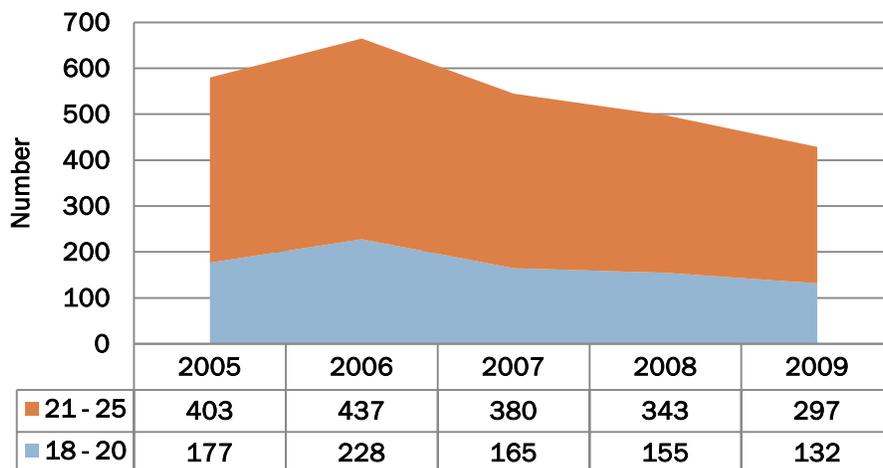
expended by SPF SIG coalitions to publicize within their respective communities the repercussions of furnishing alcohol to minors and how to monitor alcohol in the home.

Table 10. Source of Alcohol for 18-20 Year Olds: 2008 and 2010		
	2008	2010
Purchased (store)	7.5%	5.0%
Purchased (bar/restaurant)	2.7%	3.3%
Older friend purchased it	38.8%	39.0%
<b>Parent/relative purchased it</b>	<b>9.8%</b>	<b>6.7%</b>
Stolen (store)	1.2%	2.0%
<b>Stolen (parents/relative)</b>	<b>18.4%</b>	<b>12.8%</b>
Party	18.0%	26.6%
Other	3.6%	4.6%
<i>Source: YADUAS 2008, 2010.</i>		

### Motor Vehicle Crashes Among Young Adults

Chapter 2 of this report outlined the rationale for excluding some longer-term consequence data from this evaluation report, such as overdose deaths due to drugs and alcohol, given the low likelihood that any impact of the initiatives undertaken during SPF would show up in current data trends. The one exception to this is the consequence of motor vehicle crashes which is considered very responsive to environmental strategies. It appears that alcohol-related car crashes among young adults have been declining since 2006, the first year of the SPF SIG. In fact, the number of alcohol-related crashes among 21 to 25 year olds declined from 437 in 2006 to 297 in 2009, a decrease of 32 percent, as demonstrated in Figure 10 on the following page. There were marked decreases among 18 to 20 year olds as well, from 228 to 132, a 42 percent decrease over the same time period.

Figure 10. Alcohol-Related Crashes, Ages 18-25:  
2005-2009



Source: Maine Department of Transportation, 2005 - 2009.

## *Outcomes Summary*

As the data presented in this section have demonstrated, Maine made great strides in reducing underage drinking during the course of the SPF SIG, while the impact of the SPF SIG on the 18-25 population is mixed. The successes experienced in Maine have shown the value of environmental strategies and the SPF SIG approach.

Maine's original SPF SIG grant laid out 16 measures where the state hoped to see improvements. During the course of the needs assessment and strategic planning process, these were revised to reflect the narrowed scope of Maine's priorities for the SPF. The remaining relevant benchmarks for youth include:

- Increase proportion of youth who report no 30-day use of alcohol by five percent
- Reduce two-week binge-drinking among youth by five percent
- Decrease perceived access to alcohol among youth by 10 percent;
- Increase perceived consistency of underage drinking enforcement by 10 percent;
- Reduce the proportion of 9-12th graders who start drinking before age 14 by 10 percent;
- Increase proportion of 9-12th graders who report no 30-day use of any substances by five percent;
- Increase proportion of 9-12th graders who report no lifetime use of any substances by five percent; and
- Reduce binge-drinking among 18-24 year olds by five percent.

Maine's ability to meet these benchmarks during the implementation SPF SIG is illustrated in the following table, which uses 2004 MYDAUS data as a baseline for calculating a rate of change from 2008 estimates.<sup>39</sup> For young adults, BRFSS 2006 and 2009 data are used. Although Maine did observe decreases in prescription drug use, no benchmark was established at the outset of the grant against which to gauge success.

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<sup>39</sup> Although using 2009 data here would seem more appropriate on the surface, the comparability of the youth survey data over time is compromised due to changes in the survey administration. Therefore, 2008 estimates are used for the purpose of determining whether the benchmarks were met. For more information on the 2009 survey, please see <http://www.maine.gov/youthhealthsurvey/main.cgi>

**Table 11. Accomplishment of Maine’s SPF SIG: Benchmarks**

Indicator	Target	Actual	Status
Increase proportion of youth who report no 30-day use of alcohol	+5%	+11.3% <sup>40</sup>	✓
Reduce 2-week binge-drinking among youth	-10%	-20.8%	✓
Decrease perceived ease of access to alcohol among youth	-10%	-8.3%	Not met
Increase perceived consistency of underage drinking enforcement	+10%	+15.1%	✓
Reduce the proportion of 9 <sup>th</sup> -12 <sup>th</sup> graders who start drinking before age 14	-10%	-8.2%	Not met
Increase proportion of 9 <sup>th</sup> -12 <sup>th</sup> graders who report no 30-day use of any substances	+5%	+49.3%	✓
Increase proportion of 9 <sup>th</sup> -12 <sup>th</sup> graders who report no lifetime use of any substances	+5%	+22.2%	✓
Reduce binge-drinking among 18-24 year olds by 5 percent.	-5%	-17.1%	✓

In sum, Maine saw significant reductions in the rates of underage drinking and high-risk drinking among young adults over the course of the SPF SIG. The student survey data and supplemental qualitative information strongly suggest that environmental strategies implemented statewide under the SPF SIG influenced the decline in drinking rates among high school students; the evidence is less clear about the linkage between the work completed under the SFP SIG and the decreases in binge-drinking observed among the young adult population given the other initiatives. This is also the case for the observed decreases in the rates of prescription drug use among this age group. Nonetheless, the successes experienced in Maine show the value of statewide implementation of the SPF SIG approach and evidence-based environmental strategies.

<sup>40</sup> Using YRBSS data, the rate of change between 2005 and 2009 is 19 percent (from 57% in 2005 to 68% in 2009).



## Chapter 6. Where Do We Go From Here?

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Since its inception, the SPF SIG project ushered in many important changes to the face of substance abuse prevention in Maine. Important lessons can be gleaned from the analysis of infrastructure, implementation and outcomes that will inform future prevention efforts.

### *Lessons Learned and Recommendations*

The recommendations reflect the SPF experience at both the state and local levels and serve to pinpoint areas where Maine can enhance and strengthen its prevention infrastructure and support the prevention interventions being implemented. They have been organized into four broad themes: **infrastructure**, **technical assistance**, **monitoring** and **strategy modifications**.

#### *Infrastructure*

By coordinating with other state initiatives and agencies doing prevention work with community coalitions (both programmatically and fiscally), OSA has stimulated a much broader reach of prevention dollars than what would have been possible without the collaboration. Employing a statewide model that ensured that prevention dollars reached the far corners of Maine, not just those with the highest populations or greatest capacity, produced strong statewide decreases in the targeted outcomes, namely underage drinking, that had not been observed previously. Moreover, the results remained stable at the sub-state levels, suggesting that the deliberate goal to provide environmental strategies uniformly across the state undoubtedly contributed to the statewide results. To ensure that substance abuse prevention remains a strong part of Maine's statewide public health HMP **infrastructure**, Maine should consider the following:

- Pursue the possibility of establishing substance abuse prevention coordinators at the sub-state level.
- Invite HMP Executive Directors to technical assistance and learning opportunities about substance abuse prevention and how it can best be incorporated into their HMP work.
- Work with Partnership for Tobacco Free Maine to agree upon reasonable levels of collaborative efforts for the coalitions to engage in that still respect the requirements of each program.

#### *Technical Assistance*

Identifying pre-approved strategies to target the intervening variables that were identified across the State helped ensure that all communities used appropriate strategies and likely influenced the positive results observed. The strategies for which the State provided the most support and/or tools were implemented most often and with the greatest fidelity. To support coalitions as they implement environmental and evidence-based strategies for substance abuse prevention and to address areas still needing more work, Maine should consider the following **technical assistance** and workforce development approaches:

- Expand existing guidelines to include acceptable adaptations and variations to approved strategies.
- Create tip sheets based on best practices from around the state.
- Identify acceptable research-based alternatives to the exciting but less effective strategies that frequently arise (e.g., mock car crashes).
- Offer training on ways to incorporate cultural competence into substance abuse prevention and reaching identified cultural populations.
- Provide guidance on locating funding and writing effective grants.
- Host a website with links to relevant and available funding sources and guidance.

### *Monitoring*

Using data to drive decisions about where to spend prevention dollars helps ensure that they are used more efficiently and contributes to the impressive results experienced in Maine between 2004 and 2010. Indeed, this aspect of the SPF SIG approach informed many other prevention efforts and changed the way Maine pursues, oversees and allocates other funding streams in Maine, such as the Block Grant and EUDL. As Maine moves forward to develop better practices in **monitoring** future substance abuse prevention work plans, the following recommendations should be considered:

- Facilitate a higher level of cross-pollination between its two primary advisory boards, the Prevention Advisory Board and the SEOW/CESN.
- Streamline and simplify the KIT reporting system, with consideration of how to make the system useful to grantees.
- Restructure the work plans to include measures of success (e.g., benchmarks) and at least one activity related to a cultural competency and/or sustainability.

### *Strategy Modifications*

Of the five objectives required of SPF SIG grantees, strategies to engage local police, retailers and parents appear to have had the most unilateral success across all the public health districts. Indeed, student survey data from 2006 and 2008 shows promising changes observed on measures that directly relate to these strategies. Maine also saw significant reductions in the rates of underage drinking and high-risk drinking among young adults over the course of the SPF SIG. Coalitions had more success with some strategies compared to others. To enhance the **effectiveness of strategies** being implemented across the state of Maine, OSA should consider the modifications listed below:

- Emphasize the important role played by retailers in preventing the purchase of alcohol by adults who are providing it to minors in all the strategies that work with retailers.
- Continue to capitalize on existing parental networks by supporting and strengthening the Table Talks format, and ensure there is sufficient emphasis on parental attitudes towards furnishing alcohol.

- Modify the OSA worksite strategy to include a two-phase worksite information campaign that first educates employers on concerns and attitudes around substance use more generally, followed by information stressing the importance of a comprehensive substance abuse prevention program.
- Focus grantee prevention efforts for 18 to 25 year olds primarily on environmental strategies in the community (e.g., server trainings, retail pricing strategies and working with law enforcement) rather than working directly with institutions.
- Encourage grantees to invite a representative from local institution(s) to serve on the coalition to ensure that environmental strategies in the community complement campus activities, practices and policies.

### *Conclusion*

Sustainability of the SPF SIG can be thought of as the ability to integrate the newly developed SPF SIG approaches into the fabric of existing prevention programs and services. Although dedicated prevention staff and programming at the local level have not been sustained uniformly, SPF SIG principles have been fully embraced and integrated into Maine's prevention infrastructure. In particular, OSA places a strong emphasis on implementing evidence-based programs and environmental strategies, and it routinely engages in data-driven decision-making. These advances in capacity and the infrastructure developed to support them at the state level will sustain well beyond the lifetime of the SPF SIG project.

The critical role of the SPF SIG in enhancing data driven decision-making in Maine cannot be overstated. The fact that data are now routinely collected from state partners, analyzed and used for prevention planning will not fade after the conclusion of the SPF project. For example, OSA carefully drafted the 2010 work plan objectives for its block grant funding to ensure that progress on the objectives could be adequately measured using data collected from the student survey.

The data infrastructure that was developed by the SPF has allowed the state to pursue additional funding opportunities as well. For example, Maine was successfully able to secure funding from the Substance Abuse and Mental Health Administration (SAMHSA) to further support its SEOW/CESN activities. The data infrastructure also supported OSA in its application to the Office of Juvenile Justice and Delinquency (OJJDP) to implement an in-depth needs assessment and strategic plan for its Enforcement of Underage Drinking Laws (EUDL); Maine was one of only three states that were funded.

The student survey data and supplemental qualitative information strongly suggest that environmental strategies implemented statewide under the SPF SIG influenced the decline in drinking rates among high school students. The evidence is less clear about the linkage between the work completed under the SFP SIG and the decreases in binge-drinking observed among the young adult population. This is also the case for the observed decreases in the rates of prescription drug use among this age group. Nonetheless, the successes experienced in Maine show the value of statewide implementation of the SPF SIG approach using evidence-based environmental strategies.



## **Appendices**

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**Appendix A:** Statewide Logic Model

**Appendix B:** Community Infrastructure Assessment

**Appendix C:** Community Site Visits

**Appendix D:** Key Stakeholder Interviews

**Appendix E:** Strategic Plan Rating Matrix (SPRM)

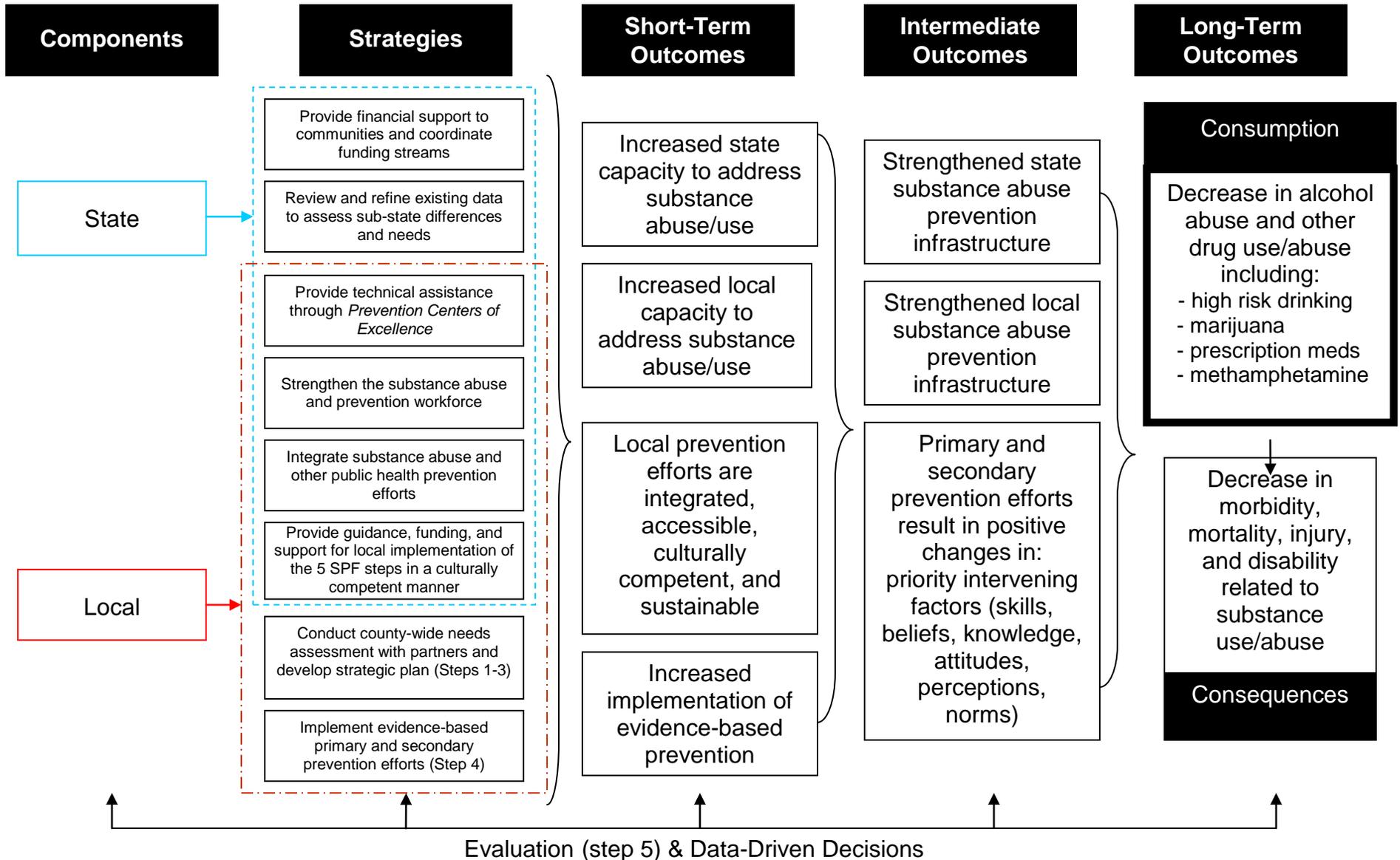
**Appendix F:** Young Adult Drug and Alcohol Use Survey (YADAUS)

**Appendix G:** Local Logic Models

**Appendix H:** Crosswalk of Indicators



## Appendix A. Maine Strategic Prevention Framework (SPF) Logic Model





**Appendix B. Community Infrastructure Assessment<sup>41</sup>**  
**Maine Strategic Prevention Framework State Incentive Grant**

- 1 County/District:
- 2 Date:
- 3 Interviewees:

**Organizational Structure**

4 Does a group of county/district level decision makers convene to integrate ATOD prevention efforts?

- Yes (Specify: \_\_\_\_\_ )  
 No (if no, skip to Question 7)

5 How often does this group convene?

- Monthly  
 Quarterly  
 Annually  
 Other:

6 How often do members of this group:

a Share information

- not at all       sometimes       routinely or always

b Engage in broad based strategic planning

- not at all       sometimes       routinely or always

c Plan for specific prevention activities

- not at all       sometimes       routinely or always

d Combine existing funding sources for prevention activities

- not at all       sometimes       routinely or always

e Seek prevention resources jointly

- not at all       sometimes       routinely or always

7 Do you have written guidelines for decision making?

- Yes  No

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<sup>41</sup> Adapted from the Infrastructure Index Scoring Guide – DRAFT 8.4 – 9/13/06

8 To what extent do you incorporate input from community stakeholders when making major substance abuse prevention-related decisions (e.g., setting priorities, allocating resources)?

<input type="checkbox"/> Low	<input type="checkbox"/> Moderate	<input type="checkbox"/> High
There is little to no incorporation of input	Incorporation of input takes place but is inconsistent or modest	Input is used consistently

Notes:

9 To what extent do you involve or solicit state-level input for major prevention-related decisions?

<input type="checkbox"/> Low	<input type="checkbox"/> Moderate	<input type="checkbox"/> High
There is little to no incorporation of input	Incorporation of input takes place but is inconsistent or modest	Input is used consistently

Notes:

### **Planning**

10 Is there a county/district-wide mission and vision for substance abuse prevention?

Yes     No

Notes:

11 Describe the mission and vision.

Notes:

12 To what extent was there input from community stakeholders in the development of the mission and vision?

<input type="checkbox"/> Low	<input type="checkbox"/> Moderate	<input type="checkbox"/> High
Little input	Some	A lot

Notes:

13 How would you characterize the current level of support for a county/districtwide strategic plan among the various stakeholders?

<input type="checkbox"/> Low	<input type="checkbox"/> Moderate	<input type="checkbox"/> High
Little support (stakeholders do not appear to support a county/districtwide plan)	Many stakeholders support a county/districtwide plan, but some withhold full support	All or nearly all appear to support a county/districtwide plan

Notes:

14 How has the strategic plan influenced prevention practices? (will not be applicable at first site visit)

<input type="checkbox"/> Low	<input type="checkbox"/> Moderate	<input type="checkbox"/> High
Little evidence that the plan influenced practices	Some evidence that the plan influenced practices	Substantial evidence that the plan influenced practices

Notes:

15 How has your county/district strategic plan influenced the allocation of prevention funding locally?

<input type="checkbox"/> Low	<input type="checkbox"/> Moderate	<input type="checkbox"/> High
Little evidence that the plan was used in funding allocation	Some evidence that the plan was used in funding allocation	Substantial evidence that the plan was used in funding allocation

Notes:

16 How often are data used to identify target populations and needs?

- Annually
- Every 2 years
- Every 3 years
- Every 4-5 years
- Other:

17 Other than SPF SIG funding, what other resources are available specifically for strategic planning?

Notes:

18 Is staff time allocated for substance abuse prevention planning? (answer will be yes at first 2 site visits; goal is to have planning become a permanent part of prevention work)

- Yes     No

19 Is outside technical assistance available for planning if needed?

- Yes     No

Notes:

20 Describe the mechanisms for linking state and county/district planning efforts.

<input type="checkbox"/> Low	<input type="checkbox"/> Moderate	<input type="checkbox"/> High
Does not appear to be a mechanism	Some linkage but no mechanism	Mechanism for linking state and county/district planning which is routinely used

Notes:

**Data Systems**

21 How would you describe your capacity to maintain data systems (e.g., KIT Solutions; access databases; COMET)?

<input type="checkbox"/> Low	<input type="checkbox"/> Moderate	<input type="checkbox"/> High
No staff with data systems expertise	At least one staff with data system expertise, but greater need	Staffing is adequate for all data system needs

Notes:

22 How would you characterize funding available for building data system capacity relative to your need?

<input type="checkbox"/> Low	<input type="checkbox"/> Moderate	<input type="checkbox"/> High
No funds allocated specifically for data systems expertise	Funds have been allocated for data system maintenance, but there is greater need	Funds allocated are adequate for all data system needs

Notes:

23 Please describe the degree to which the State and local grantees share epidemiological data.

<input type="checkbox"/> Low	<input type="checkbox"/> Moderate	<input type="checkbox"/> High
No evidence of epi data sharing	At least one activity or product has been shared, but data sharing is not routine	Epi data are routinely shared

Notes:

24 What guidance is provided by the State on how to interpret epi data?

<input type="checkbox"/> Low	<input type="checkbox"/> Moderate	<input type="checkbox"/> High
State does not play a role in providing epi guidance	Evidence that State has engaged in some activities to provide guidance	State provides substantial and continuing guidance on how to interpret epi data

Notes:

**Workforce Development**

25 Do you have a formal written professional development plan or policy?

Yes  No

a If yes, for whom?

26 Does the State offer sufficient workforce development opportunities?

<input type="checkbox"/> Low	<input type="checkbox"/> Moderate	<input type="checkbox"/> High
Too few opportunities	Some opportunities are available, but there should be more	A lot of opportunities

Notes:

27 Are the workforce development opportunities accessible?

<input type="checkbox"/> Low	<input type="checkbox"/> Moderate	<input type="checkbox"/> High
They are not accessible	Some opportunities are accessible, but there are barriers to attendance	In general, most opportunities are accessible

Notes:

28 In the past year, what types of professional development opportunities have you or other key staff participated in?

Notes:

29 What workforce development opportunities would you like to see made available which have not been provided?

Notes:

**Evidence-based Programs, Policies and Practices**

30 Are the criteria for defining evidence-based programs, policies and practices consistent across state and local prevention entities?

<input type="checkbox"/> Low	<input type="checkbox"/> Moderate	<input type="checkbox"/> High
No criteria that is consistently used	Criteria are inconsistent	Most criteria for defining EPBs are consistent across state and substate

Notes:

31 Describe resources available (e.g., training, TA, materials) to assist program providers in the selection of evidence-based practices.

<input type="checkbox"/> Low	<input type="checkbox"/> Moderate	<input type="checkbox"/> High
Resources and TA unavailable	Some resources and TA are available, but are limited	Substantial resources and TA available

Notes:

32 Describe resources available (e.g., training, TA, materials) to assist program providers in the implementation of evidence-based practices.

<input type="checkbox"/> Low	<input type="checkbox"/> Moderate	<input type="checkbox"/> High
Resources and TA unavailable	Some resources and TA are available, but are limited	Substantial resources and TA available

Notes:

33 Describe resources available (e.g., training, TA, materials) to assist program providers in the adaptation of evidence-based practices.

<input type="checkbox"/> Low	<input type="checkbox"/> Moderate	<input type="checkbox"/> High
Resources and TA unavailable	Some resources and TA are available, but are limited	Substantial resources and TA available

Notes:

**Cultural Competence**

34 Does the State provide guidance on what cultural competence means within the context of substance abuse prevention?

<input type="checkbox"/> Low	<input type="checkbox"/> Moderate	<input type="checkbox"/> High
No guidance provided	Some guidance provided but more is needed	Substantial guidance provided

Notes:

35 Describe the degree to which the State supports the selection and implementation of culturally appropriate prevention practices.

<input type="checkbox"/> Low	<input type="checkbox"/> Moderate	<input type="checkbox"/> High
There is no evidence of State support (funding, policies, TA)	Some evidence of state level support, but more is needed	Substantial support for culturally competent strategies

Notes:

36 Has anyone in the county/district developed written formal policies on how to ensure cultural competence in substance abuse prevention efforts?

Yes     No

Notes:

37 Is there a process in place in your county/district to assess and monitor cultural competence in prevention planning and practices?

Yes     No

Notes:

**Evaluation and Monitoring**

38 How would you characterize the availability of evaluation expertise (e.g., academic institutions, private research organizations) to your coalition?

<input type="checkbox"/> Low	<input type="checkbox"/> Moderate	<input type="checkbox"/> High
No expertise has been identified as available	Some expertise has been identified as available, but there is a greater need for resources	Identified evaluation expertise is adequate to meet needs

Notes:

39 Do you have an evaluator on staff or through a contract who provides evaluation services and technical assistance?

Yes     No

Notes:

40 How do you use evaluation data (process, outcome, fidelity)?

<input type="checkbox"/> Low	<input type="checkbox"/> Moderate	<input type="checkbox"/> High
No evidence that evaluation data is used	There have been some occasions on which evaluation data have been used, but use is not routine	Evaluation data are used regularly/periodically

Notes:

41 In what ways does the State monitor your activities and performance? Is feedback provided to you?

<input type="checkbox"/> Low	<input type="checkbox"/> Moderate	<input type="checkbox"/> High
Little monitoring occurs	Some monitoring occurs, but results are not regularly fed back	Regular monitoring occurs and feedback is provided as a result

Notes:

42 To what extent are State reporting requirements streamlined?

<input type="checkbox"/> Low	<input type="checkbox"/> Moderate	<input type="checkbox"/> High
Not at all, different requirements for each funding source	Two to three programs use the same reporting requirements	Substantial streamlining of reporting requirements

Notes:

**Sustainability**

43 Describe any efforts in the past six months to diversify funding streams to sustain prevention work.

<input type="checkbox"/> Low	<input type="checkbox"/> Moderate	<input type="checkbox"/> High
Prevention efforts are supported by a single source	Prevention efforts supported by two or three sources but are not coordinated	Prevention efforts are supported multiple sources which are coordinated

Notes:

44 Please describe the extent of involvement in prevention efforts of the different communities in your county/district.

<input type="checkbox"/> Low	<input type="checkbox"/> Moderate	<input type="checkbox"/> High
Few to none	Some	Almost all or all

Notes:

45 How, if at all, are prevention sustainability efforts reviewed?

Notes:

46 How often are the sustainability efforts reviewed?

- Annually
- Every 2 years
- Every 3 years
- Every 4-5 years
- Other:

47 What are some obstacles, if any, that have been identified during these reviews and how did you identify them?

Notes:

48 When obstacles are identified, how are plans made to address them?

<input type="checkbox"/> Low	<input type="checkbox"/> Moderate	<input type="checkbox"/> High
Obstacles are not identified or not addressed	Potential obstacles are identified but do not receive detailed analysis and/or detailed plan to address them	Obstacles receive a thorough analysis and a detailed plan to address them

Notes:

49 Describe the process the State uses to solicit your input on prevention sustainability.

<input type="checkbox"/> Low	<input type="checkbox"/> Moderate	<input type="checkbox"/> High
Input is not sought	Input is minimal	Input is substantial; shared responsibility exists

Notes:

**External Events**

50 In the past 12 months, what external events or incidents have taken place that may have an impact on ATOD prevention activities in your county/district (e.g., legislation, funding, administrative changes, local events)?

Notes:



**Appendix C. Community Site Visit Protocol  
Maine's Strategic Prevention Framework State Incentive Grant**

**Agenda**

- Overview and Introductions (5 min)
- Evaluation Update & Activities (20 min)
- Young Adult Drug and Alcohol Use Survey (15 min)
- Local Implementation: Updates and Report Out (SPF Step 4) (35 min)
- Community Infrastructure Assessment – Round 3 (50 min)

**Discussion Questions for Implementation (SPF SIG Step 4)**

1. Who have you involved in implementing your strategies? How has this changed since the previous site visit?
2. What have been your biggest accomplishments to date?
3. What has been the most difficult thing to overcome in the past year? How did you approach this?
4. What challenges do you face going forward?
5. How has being involved in the SPF SIG grant affected or impacted your coalition?



## Appendix D: Key Stakeholder Interviews

### SPF SIG State-level Evaluation 2006 Interview Questions

Name:

Date:

Hornby Zeller Associates, Inc. is conducting interviews with members of the committees which have guided the SPF SIG project thus far. The information you provide will be reported so that your responses will not be personally identified. We appreciate your willingness to participate.

1. Which of the following groups do you serve on?
  - Executive Management Team
  - SHY (Strategies for Health Youth)
  - SEW (State Epidemiological Work Group)

The SPF SIG Project has engaged in the first three stages of the Strategic Prevention Framework thus far: needs assessment, capacity assessment, and planning. We would like your opinion about each of these, and how well the project is progressing.

#### a. Needs Assessment

The needs assessment consisted of activities such as: epidemiological analysis; collection of National Outcome Measure baseline data, key informant interviews; and cultural sub-population grants.

2. Did this needs assessment process result in the identification of prevention needs?
3. What would you say were the strengths of the needs assessment?
4. What aspects would you like to have seen done better?
5. Do you have any advice for ongoing needs assessment activities?

#### b. Capacity Assessment

The capacity assessment consisted of activities such as: a study of Unified Governance Structures; development of Prevention Centers of Excellence; GIS Mapping; a system capacity workshop sponsored by SHY to assess prevention and health promotion for youth; and a data inventory.

6. Did this process result in a thorough assessment of resources and capacity?  
(Follow-up) Why or why not?

The national evaluators for SPF identified nine components of infrastructure. The next set of questions asks you to rate the degree to which Maine’s capacity assessment addressed each of those components.

7. First, using a scale of 1 to 5, (1 being low), how well did the capacity assessment examine the state prevention structure?
8. Using the same scale, to what extent was planning capacity addressed in the assessment?
9. Again using the same scale, to what extent were data systems assessed?
10. What about workforce development?
11. To what degree was the cultural competence of the current prevention structure assessed?
12. ... the statewide capacity for monitoring and evaluation?
13. ... the use of evidence-based practices around the State?
14. To what extent were financial resources for prevention examined?
15. Lastly, to what extent did the project assess the sustainability of the current prevention system?
16. What would you say were the greatest strengths of the capacity assessment?
17. What aspects would you like to have seen done better?
18. Moving forward, what advice do you have for ongoing capacity assessment?

### **c. Planning**

The Planning process resulted in a draft State Strategic Prevention Plan and a Request for Proposals for assessment and planning as well as the implementation of environmental strategies at the local level.

19. Do you think that the Strategic Plan incorporates the findings of the statewide needs and capacity assessments? Why or why not?
20. What would you say are the strengths of the plan?
21. What aspects would you like to have seen done better?
22. How well do you think the RFP reflects the goals laid out in the strategic plan?

**d. Summary**

23. Given all that we've discussed, what is working well in the SPF SIG project thus far?

24. Going forward, what recommendations do you have for the project?

25. Is there anything else you'd like to add?

*Thank you very much for your time.*

*The information that you shared will not be reported in a way in which you can be identified.*

## SPF SIG State-level Evaluation 2010 Interview Questions

### State Level Implementation

*The following questions ask your opinions about the state level implementation of SPF SIG.*

1. What has been your role in the SPF SIG project? For how long have you been involved? In what capacity?
2. Over the course of the SPF SIG (since 2005), what do you feel have been the most critical accomplishments in Maine's **infrastructure and capacity** to deliver prevention programming? (For example, improvements in organizational structures, planning and data capacity or sustainability.)
  - a. What were the most challenging aspects?
  - b. What barriers did Maine face?
  - c. What about delivering prevention programming to special cultural populations?
3. What **other accomplishments** were achieved through the SPF SIG initiative?
4. What **accomplishments are being sustained**? To what degree do you think those will sustain in the future? Why do you say this?
5. Do you feel that Substance Abuse Prevention & Planning at the state level is more **data driven** now than it was 6 years ago when SPF began? Why do you say this?
  - a. What has been the role of the State Epidemiological Outcomes Workgroup (SEOW) and Community Epidemiology Surveillance Network (CESN) in this work?
6. What has been the role of the SPF SIG Advisory Board in the overall project? Has this changed over time? In what way(s)?
7. At the state level (not including Project Officer work – we will ask about that later), please describe how the Office of Substance Abuse (OSA) **supported coalitions** in their work. Are there any areas where you feel Substance Abuse Specialists (SAPs) could have been supported differently?

### Local-level implementation: Project Officers

*The following questions ask about your observations as a Project Officer during SPF SIG Implementation.*

8. What districts did you oversee as a project officer? Please describe your role as project officer.
9. To what degree do you feel the SPF SIG enhanced **capacity** at the local level to conduct substance abuse prevention work?
  - a. Did the communities you oversaw follow the five-step SPF model (Assess, Mobilize, Plan, Implement, Evaluate)? Why or why not?
  - b. To what extent was the work driven by the community needs assessment and strategic plan?
10. As project officer, what do you think were the most successful aspects/accomplishments of the SPF SIG at the **local level**? (For example, collaborations, implementing new strategies or using data/media).
  - a. What were the most challenging aspects?
  - b. What barriers did communities face?
  - c. What do you think will be sustained?
11. On a scale of 1 to 5, with one being not at all and 5 being very much, how involved would say the Healthy Maine Partnership (HMP) Executive Director was in Substance Abuse Prevention in the districts you oversaw? Why do you say this?
  - a. In what ways do you think this level of involvement affected Substance Abuse prevention work in the district?

### Overall Wrap Up

12. Given everything we have talked about at both the state and local levels, to what degree do you feel that the implementation of SPF SIG in Maine reached its intended **outcomes**? Why or why not?
  - a. Is there anything you wish had been accomplished during this grant that was not?
  - b. Why do you think this is important and why do you think it was not accomplished?
13. Knowing what you know now, what would you do differently over these past 5 years and why?
14. Is there anything else you would like to tell me about the SPF SIG initiative either at the state or local levels?

*Those are all of the questions I have for you today. Thank you for your time!*



## Appendix E: Strategic Plan Rating Matrix (SPRM)

**Purpose:** This document will be used by Hornby Zeller Associates, Inc., SPF SIG evaluator, as one means of assessing the Phase 1 grantees of Maine’s SPF SIG project. HZA will assess the Strategic Plans submitted by the grantees in partial fulfillment of their Phase 1 grants in relation to the criteria described herein, most of which has been discussed in the Guide to Assessment and Planning as well as the Learning Communities. Each component will be ranked from 1, low to 5, high. Grantees who receive less than a 3 may work with OSA during contracting to specify and refine that section of the plan.

Component	Criteria	Rank (1 low, 5 high)	Comments
Geographic Areas Covered	Overall plan covers countywide population (demonstrated by towns/communities in which current prevention activities are conducted, or in which activities are planned over the next 3-5 years)		
	Planning includes key partners, organizations, institutions, individuals, and population groups (e.g. parents, youth, general public).		
Scope of Community Participation	Implementation plan involves key partners, organizations, institutions, and individuals.		
	Identifies specific priorities		
Priorities Identified (next 3 to 5 years)	Identifies priority target populations		
	Priorities are consistent with needs identified in Assessment Report (data driven)		

### Explanation of Rating Scale

**1:** No evidence that criteria are met  
**2:** Little evidence that criteria are met

**3:** Some evidence that criteria are met  
**4:** Criteria are adequately addressed  
**5:** Criteria are met in an exemplary way

Component	Criteria	Rank (1 low, 5 high)	Comments
Selection of “Best Fit” Strategies	Demonstrate conceptual fit (relevant to needs and target populations)		
	Demonstrate practical fit (consistent with community readiness)		
	Demonstrate evidence of effectiveness (evidence-based)		
Comprehensive Approach	Plan demonstrates an understanding of comprehensive strategies		
Capacity, Resources and Readiness	Includes plans to build relevant resources and capacity where needed.		
	Prioritization and strategy selection demonstrate consideration of readiness.		
Detailed Action Plan for Implementation	Action plan is specific, gives timeframes and responsible parties for each strategy or activity.		
	Planned activities aim to reach sufficient portion of target audience		
	Planned activities consider dosage and saturation toward population-level impact		
Measurable Outcomes	Plan includes preliminary benchmarks against which progress can be monitored.		
Sustainability (next 3 to 5 years)	Plan shows how group will obtain the funding and other resources needed to implement the priorities		
	Plan includes mechanisms for continuing the collaborative planning process		
Cultural Competency	Plan considers cultural competency issues		

**Explanation of Rating Scale**

- 1: No evidence that criteria are met
- 2: Little evidence that criteria are met

- 3: Some evidence that criteria are met
- 4: Criteria are adequately addressed
- 5: Criteria are met in an exemplary way



6. How often, if ever, have you used the following substances in the past 30 days? (Note: One serving of alcohol equals 12 oz beer, 4 oz wine or 1 oz liquor.)

	Once or twice per month	Once per week	A few days per week	Every day	Not in last 30 days	Never used
Alcohol (1-2 servings)	<input type="checkbox"/>					
Alcohol (3-4 servings)	<input type="checkbox"/>					
Alcohol (5+ servings)	<input type="checkbox"/>					
Painkillers (OxyContin, Vicodin, Demerol, Dilaudid, Morphine, Percocet) <i>in order to get high.</i>	<input type="checkbox"/>					
Tranquilizers/sedatives (Xanax, Valium, and Seconal) <i>in order to get high.</i>	<input type="checkbox"/>					
Marijuana (pot, hash, weed)	<input type="checkbox"/>					

7. If you wanted the following substances, how hard would it be for you to get some?

	Very Hard	Sort of Hard	Sort of Easy	Very Easy	Unsure
Alcohol (beer, wine and/or hard liquor if under age)	<input type="checkbox"/>				
Prescription drugs	<input type="checkbox"/>				
Marijuana	<input type="checkbox"/>				

8. If you have used alcohol during the past 30 days, where did you get it? (Check all that apply)

- |   |  |
|---|--|
| <input type="checkbox"/> I have not consumed alcohol        | <input type="checkbox"/> I stole it from a store             |
| <input type="checkbox"/> I bought it at a store             | <input type="checkbox"/> I stole it from my parents/relative |
| <input type="checkbox"/> I bought it at a bar/restaurant    | <input type="checkbox"/> It was at a party that I attended   |
| <input type="checkbox"/> An older friend bought it for me   | <input type="checkbox"/> Other (Please describe):            |
| <input type="checkbox"/> A parent/relative bought it for me | _____  |

9. If you have taken a prescription drug in the last 30 days in order to get high, where did you get it? (Check all that apply)

- |  |  |
|--|--|
| <input type="checkbox"/> I have not taken a prescription drug in order to get high | <input type="checkbox"/> Given to me by friend/family member |
| <input type="checkbox"/> Prescribed to me by a doctor                              | <input type="checkbox"/> Bought from dealer or other person  |
| <input type="checkbox"/> Stolen from friend/family member                          | <input type="checkbox"/> Other (Please describe):            |
| <input type="checkbox"/> Stolen from someone I don't know                          | _____  |

10. If you have used marijuana in the last 30 days, where did you get it? (Check all that apply)

- |  |   |
|--|---|
| <input type="checkbox"/> I have not used marijuana           | <input type="checkbox"/> Bought from dealer or other person |
| <input type="checkbox"/> Stolen from friend/family member    | <input type="checkbox"/> Other (Please describe):           |
| <input type="checkbox"/> Stolen from someone I don't know    | _____   |
| <input type="checkbox"/> Given to me by friend/family member |   |

**11. On average, how much alcohol do you drink during the following times of the week? (Note: One serving of alcohol equals 12 oz beer, 4 oz wine or 1 oz liquor.)**

I do not drink alcohol

	None	1 -2 drinks	5 or more drinks
Weekdays	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weeknights	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weekends	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (please specify): _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**12. Do the bars, taverns and/or restaurants near you offer specials on alcohol?**

- |  |  |
|--|--|
| <input type="checkbox"/> Yes, all the time | <input type="checkbox"/> No, not usually |
| <input type="checkbox"/> Yes, sometimes    | <input type="checkbox"/> No, never       |
| <input type="checkbox"/> Neutral           | <input type="checkbox"/> I don't know    |

**13. How often do you go to one of these establishments because of their drink specials?**

- |   |   |
|---|---|
| <input type="checkbox"/> Never                        | <input type="checkbox"/> About once per week  |
| <input type="checkbox"/> Less than one time per month | <input type="checkbox"/> A few times per week |
| <input type="checkbox"/> On average once per month    | <input type="checkbox"/> Daily                |
| <input type="checkbox"/> A few times per month        |   |

**14. Do you believe your local police department enforces alcohol laws and policies?**

- |  |  |
|--|--|
| <input type="checkbox"/> Yes, always           | <input type="checkbox"/> No, not regularly |
| <input type="checkbox"/> Yes, most of the time | <input type="checkbox"/> No, never         |
| <input type="checkbox"/> Neutral               | <input type="checkbox"/> Unsure            |

**15. How willing are you to provide alcohol to someone under 21 years of age?**

- |   |   |
|---|---|
| <input type="checkbox"/> Very willing     | <input type="checkbox"/> Somewhat unwilling |
| <input type="checkbox"/> Somewhat willing | <input type="checkbox"/> Very unwilling     |
| <input type="checkbox"/> Neutral          |   |

**16. How likely do you think it is that someone from your town would face legal consequences if he or she served or provided alcohol to someone under the age of 21?**

- |  |  |
|--|--|
| <input type="checkbox"/> Highly likely   | <input type="checkbox"/> Somewhat unlikely |
| <input type="checkbox"/> Somewhat likely | <input type="checkbox"/> Highly unlikely   |
| <input type="checkbox"/> Neutral         |  |

**17. How harmful do you think the following are to your health? (Note: One serving of alcohol equals 12 oz beer, 4 oz wine or 1 oz liquor.)**

	Very Harmful	Somewhat Harmful	A Little Harmful	Not Harmful	Unsure
Drinking 1-2 alcoholic drinks a few times a week	<input type="checkbox"/>				
Drinking 5 or more alcoholic drinks in one sitting	<input type="checkbox"/>				
Using prescription drugs <i>in order to get high</i>	<input type="checkbox"/>				
Trying marijuana once or twice	<input type="checkbox"/>				
Smoking marijuana regularly	<input type="checkbox"/>				

**18. Are you currently employed?**

- Yes, full-time
- Yes, part-time
- Yes, day labor/seasonal/irregular
- Not employed

**19. During the past year, have any of the following affected your professional career/employment and if so, how? (Check all that apply)**

	No, did not affect employment	Yes, I missed a day of work	Yes, I missed more than 1 day of work	Yes, I was in significant trouble at work	Yes, I lost my job	Have not used in the past year
Alcohol Use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prescription Drug Use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Marijuana Use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other Drug Use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**20. To your knowledge, does your employer have an alcohol and/or drug policy?**

- Yes
- No
- I don't know
- I am not employed

**21. Which of the following best describes your gender?**

- Male
- Female
- Transgender
- Other

**22. Do you consider yourself to be:**

- Heterosexual or straight
- Gay or lesbian
- Bisexual
- Other (please describe): \_\_\_\_\_

**23. Which of the following best describes your race and ethnicity? (Check all that apply)**

- White non-Hispanic
- Black non-Hispanic
- Hispanic or Latino/a?
- Asian
- Native Hawaiian or other Pacific Islander
- American Indian or Alaskan Native
- Other

**24. What is your monthly income?**

- Less than \$500
- \$500-\$1,000
- \$1,001-\$2,000
- \$2,001-\$3,000
- \$3,001 or more

**Appendix G: SPF SIG Local Logic Model Sample**



**SPF SIG LOCAL LOGIC MODEL**

Problem Statement (SPF Steps 1-2)			Strategies (SPF Step 3)	Activities (SPF Step 4)	Outcomes (SPF Step 5)		
Problem	But why? (Intervening Variables)	But why here? (Contributing Factors)	What are we doing to address the contributing factors?	What are we doing to do implement the strategy?	Short-Term	Intermediate	Long-Term <sup>42</sup>
					How are we implementing the strategy?	What behaviors will we change?	Are we meeting our long-term goals?
<b>Underage Drinking</b>	Youth do not think they will be caught by police		Work with PDs to: enhance enforcement of underage drinking, zero tolerance, furnishing and hosting laws; adopt model policy; implement party patrols (3.1a, 3.1b, 3.1c, 3.1g) Use media to publicize incidents and penalties (3.1e)		Select indicators from KIT	Perceptions of getting caught (MYDAUS)  Willingness to furnish (YADAUS, HEAPP)	<b>Measure: Rate of Past Month Alcohol Use by Youth (MYDAUS)</b>
	Youth do not think they will be caught by parents		Build social marketing campaign with OSA Parent Media Kit; education parents on modeling; educate organizations on how to use Parent Media materials (3.2a, 3.2b, 3.2c)		Select indicators from KIT	Perceptions of getting caught (MYDAUS)  Family has clear rules (MYDAUS)	
	Youth think alcohol is easy to obtain		Organize RBS training, implement public awareness campaign; help retailers develop policy; implement awareness campaign; implement sticker shock (3.3b, 3.3c, 3.3e, 3.3i)		Select indicators from KIT	Perceptions that alcohol is easy to obtain (MYDAUS)  Willingness to furnish (YADAUS, HEAPP)	
	Youth do not think they will be caught by school		Help schools communicate substance abuse policy to community (3.5a, 3.5c)		Select indicators from KIT	Been drunk or high at school (MYDAUS)	
	Parent/adult role models		Educate parents about effects of modeling behaviors (3.7b)		Select indicators from KIT	Parents think use is wrong (MYDAUS)	

<sup>42</sup> The long-term outcomes are affected not by any single strategy but by ALL of the strategies and activities. BRFSS and YADAUS are available at the District level only; HEAPP available at the state level only.

**SPF SIG LOCAL LOGIC MODEL**

Problem Statement (SPF Steps 1-2)			Strategies (SPF Step 3)	Activities (SPF Step 4)	Outcomes (SPF Step 5)		
Problem	But why? (Intervening Variables)	But why here? (Contributing Factors)	What are we doing to address the contributing factors?	What are we doing to do implement the strategy?	Short-Term	Intermediate	Long-Term <sup>43</sup>
					How are we implementing the strategy?	What behaviors will we change?	Are we meeting our long-term goals?
Young Adult High Risk Drinking	High risk drinking is not seen as harmful		Through the Worksite Framework: distribute information about assessment, programs and/or “self-help”; help employers provide information regarding Drug-Free Workplace policy (3.10a, 3.16c)  Work with college and university student health centers to implement AUDIT (3.12p)		Select indicators from KIT	Perception that binge drinking is risky (YADAUS, HEAPP)  Employer has an alcohol and/or drug policy (YADAUS)	Measure: Rate of Past Month High Risk Alcohol Use (YADAUS, BRFSS, HEAPP)
	Promotions and pricing encourage high risk drinking		Help colleges develop/ plan policies and strategies (3.11e)		Select indicators from KIT	Young adults responding to specials (YADAUS, HEAPP)  Perception that binge drinking is risky (YADAUS, HEAPP)	

<sup>43</sup> The long-term outcomes are affected not by any single strategy but by ALL of the strategies and activities. BRFSS and YADAUS are available at the District level only; HEAPP available at the state level only.

**SPF SIG LOCAL LOGIC MODEL**

Problem Statement (SPF Steps 1-2)			Strategies (SPF Step 3)	Activities (SPF Step 4)	Outcomes (SPF Step 5)		
Problem	But why? (Intervening Variables)	But why here? (Contributing Factors)	What are we doing to address the contributing factors?	What are we doing to do implement the strategy?	Short-Term	Intermediate	Long-Term <sup>44</sup>
					How are we implementing the strategy?	What behaviors will we change?	Are we meeting our long-term goals?
<b>Prescription Drug Misuse</b>	Prescription drugs are not perceived as risky		Help employers provide information regarding Drug-Free Workplace policy (3.16c)		Select indicators from KIT	Perception that using prescription drugs to get high is risky (YADAUS)  Employer has an alcohol and/or drug policy (YADAUS)	<b>Measure: Rate of Past Month Misuse of Prescription Drugs (YADAUS, HEAPP)</b>

<sup>44</sup> The long-term outcomes are affected not by any single strategy but by ALL of the strategies and activities. BRFSS and YADAUS are available at the District level only; HEAPP available at the state level only.



## Appendix H: Crosswalk of Indicators

HIGH SCHOOL STUDENTS		
Indicator	Source	Question
Past month use of alcohol	MYDAUS/ MIYHS	During the past 30 days, on how many days did you have at least one drink of alcohol?
Binge drinking in the past two weeks	MYDAUS/ MIYHS	Think back over the last two weeks. How many times have you had five or more alcoholic drinks in a row?
Perception that they will be caught by parents	MYDAUS/ MIYHS	If you drank some alcohol without your parents' permission, would you be caught by your parents?
Perception that they will be caught by police	MYDAUS/ MIYHS	If a kid drank some alcohol in your neighborhood, would he or she be caught by the police?
Family has clear rules around alcohol and drugs	MYDAUS/ MIYHS	Do you agree or disagree with the following statement: "My family has clear rules about alcohol and drug use."?
Perception that alcohol is easy to obtain	MYDAUS/ MIYHS	If you wanted to get some alcohol, how easy would it be for you to get some?
Perception that parents think alcohol use is wrong	MYDAUS/ MIYHS	How wrong do your parents feel it would be for you to drink alcohol regularly?
Perception that regular use of alcohol is harmful	MYDAUS/ MIYHS	How much do you think people risk harming themselves (physically or in other ways) if they take one or two drinks of alcohol nearly every day?
Drinking before age 14 (age of onset)	MYDAUS/ MIYHS	How old were you when you had your first drink of alcohol other than a few sips?

YOUNG ADULTS		
Indicator	Source	Question
Binge drinking among 18-24 year olds	BRFSS	Considering all types of alcoholic beverages, how many times during the past 30 days did you have (5 or more drinks for men or 4 or more drinks for women) on an occasion?
Prescription drug use among 18-24 year olds	YADAUS	When was the most recent time that you used the following: Painkillers (OxyContin, Vicodin, Demerol, Dilaudid, Morphine, Percocet) or Tranquilizers/Sedatives (Xanax, Valium, and Seconal) <i>in order to get high</i> .
Perception that alcohol is easy to obtain	YADAUS	If you wanted the following substances, how hard would it be for you to get some: Alcohol
Willingness to furnish alcohol to minors	YADAUS	How willing are you to provide alcohol to someone under 21 years of age?
Perceived risk of harm from binge drinking	YADAUS	How harmful do you think the following are to your health: Drinking 5 or more alcoholic drinks in one sitting
Source of alcohol	YADAUS	If you have used alcohol during the past 30 days, where did you get it?



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