

II: Planning Steps

Step 1: Assess the strengths and needs of the service system to address the specific populations

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Narrative Question:

Provide an overview of the State's behavioral health prevention, early identification, treatment, and recovery support systems. Describe how the public behavioral health system is currently organized at the State, intermediate and local levels differentiating between child and adult systems. This description should include a discussion of the roles of the SSA, the SMHA and other State agencies with respect to the delivery of behavioral health services. States should also include a description of regional, county, and local entities that provide behavioral health services or contribute resources that assist in providing the services. The description should also include how these systems address the needs of diverse racial, ethnic and sexual gender minorities as well as youth who are often underserved.

Footnotes:

Identify and analyze strengths, needs, and priorities of the States behavioral health system?

What of these will the state take into consideration with the specific populations that are the current focus of the Block Grants, the changing healthcare environment and SAMHSA's strategic initiatives?

Various public and private organizations in Maine have projects underway that focus on implementing primary and behavioral health care integration. Many FQHC's and some primary care practices are already implementing this model. Maine also has a pilot project focused on Medical Homes. Our Co-Occurring State Integration Initiative (COSII) project has initiated a Task Force that will develop a report on barriers and opportunities along with recommended policies, procedures and strategies for implementing bi-directional integration. This report will be presented to the State Advisory Council on Health Systems Development in response to a goal in the 2010-2012 State Health Plan. On November 18th, Maine Primary Care Association along with HRSA, SAMHSA, and others will hold a kick off meeting on Behavioral Health Care Integration in Maine that will be attended by OSA. We expect to have an ongoing involvement with this three year initiative. Finally, OSA is actively involved on all committees of the Managed Care initiative, which is heavily focused on health care integration in Maine Care (Medicaid) services.

Maine's Medicaid system is working to develop managed care through a value-based purchasing project. At present, the most prevalent model that has come forward is the creation of Health Homes as the preferred model of primary care and behavioral health integration.

Maine has a team of "content experts" that are working together to address behavioral health integration. Because of the limitations (staff capacity) to have one person delegated to this, we are utilizing the teams' strengths in particular areas and communicating on a regular basis. Additionally, the SSA contributed to the State's Health Plan and is working with the COSII Task Force to implement integration on a larger scale. This task force is comprised of state staff, provider organizations, clients/consumers, and other various stakeholders within behavioral health and primary care.

The Office of Substance Abuse (OSA) contracts all funding to community providers across the state. OSA works with these providers and the provider association to encourage communication with primary care and discussion about the benefits of working in collaboration. With the passing of the Affordable Care Act, OSA believes that these conversations will turn into action.
http://www.saasnet.org/PDF/Implementing_Healthcare_Reform-First_Steps.pdf

Maine continues to move toward greater collaboration to integrate substance abuse (SA) and mental health (MH). Efforts include a combined set of standards and regulatory language, the use of a universal screening tool, and greater collaboration between the two areas of expertise to coordinate care. The COSII initiative has promoted significant changes and works between the two disciplines at the State level and has worked with over 30 agencies as pilot sites to help them implement integrated care. We have developed co-occurring Clinical Guidelines that are available to both SA and MH agencies, and now require co-occurring competency of all providers statewide.

At minimum, address the following populations: Statutory: IVDU, Adolescents, Children and Youth at risk for MH SA etc., Women who are pregnant, parents with SA who have dependent children, Military and families, American Indians/Alaska Natives.

IVDU:

The OSA Treatment Data System (TDS) reports 3,186 admissions for IVDU by providers who receive State and federal funding for SA treatment. Males were 1.5 times more likely to be treated for IVDU than females. Two public health districts, Cumberland and Downeast had much higher rates of admissions when compared to the percentage of the population living in those districts. (Cumberland has 21.2% of Maine's population, but 29.63% of those treated live in Cumberland; for Downeast it was 6.6%

and 8.66%, respectively). Almost 43% of all treated IVDUers in Maine live in Cumberland or Central districts. The 2009 MIYHS shows that 7.3 % of males and 3.8% of females in high school have used drugs intravenously. 5.4% of 12th graders, 7% of 11th graders, 5% of 10th graders, and 4.2% of 9th graders reported they used drugs intravenously at some point in their life. From the Maine HIV program strategic prevention plan, they reported that 7% of new HIV diagnoses were identified as IVDU. Per the Maine Infectious Disease program, the rate of TB in 2009 was .7 cases per 100,000 population (9 cases for the entire state). Of the 9 TB cases, 1 was an IVDU, 2 used non-injected drugs, and 3 used alcohol excessively.

Pregnant Women:

TDS reports 238 women were pregnant at admission. 93.6% were white, 4.2% Black, 1.3% American Indian, and 2.9% Hispanic (2010 census shows 95.2% of Maine's population are white; 1.2% are Black; .6% are American Indian; and 1.3% Hispanic). Behavioral Risk Factor Surveillance Survey (BRFSS) reported that between '06-'09, the percent of pregnant women who drank in the past 30 days (month) ranged from a low of 4.8% to a high of 17.5%. In '09, pregnant women were noticeably less likely to have ever been told by a doctor that they have an anxiety or depressive disorder.

The Pregnancy Risk Assessment Monitoring System (PRAMS) reported stable percentages of women who drank in the last trimester of pregnancy between '96-'08. PRAMS also indicated that between '04-'08, women who were older or who made in excess of \$50k had noticeably higher percentages of having used alcohol in the last trimester of pregnancy.

The TDS reported that between '05-'10 the percent of pregnant women being treated for a primary substance of synthetic opioids and methadone/buprenorphine has increased sharply.

Adults in Treatment with Dependent Children:

5,425 admissions to treatment in SFY 2011 were parents with dependent children.

The Maine State Office of Child and Family Services reported that between January 1, 2010 and December 31, 2010 there were 572 reports of drug affected babies. Also during this same time frame, of the child protective assessments conducted where there was evidence of abuse, 78.9% found substance abuse to be a risk factor.

Behavioral Risk Factor Surveillance System (BRFSS) reports that in '09, adults who have children were more likely to have ever been told by a doctor that they have an anxiety or depressive disorder than those w/out children. From '06-'09, adults with children were more likely to have drunk in the past 30 days (month) than those w/out children. In '09, adults with children were more likely to have drunk in the past 30 days (month) and have ever been told by a doctor that they have an anxiety or depressive disorder than those w/out children.

Children/Youth:

TDS reports that there were 637 clients under 18 who were admitted to treatment for SA in SFY 2011 (this is a decrease of 65 clients from SFY 2010). Over 36% are from western district; and over 52% are from western and Midcoast districts). Early initiation and use of alcohol drugs has been shown to be a risk factor for future substance abuse disorders. The 2009 Maine Integrated Youth Health Survey (MIYHS) reported 30-day substance use rates in high school youth: 21.3% binge drank; 34.7% drank alcohol; 23.7% smoked marijuana; 19.7% smoked cigarettes; 11.3% used a prescription drug without a prescription. The majority of High School (HS) students who ever drank or smoked marijuana did so between the ages of 13-16.

The Maine Youth Drug and Alcohol Use Survey (MYDAUS) reported that between '04-'08 the % of HS students saying it's easy to get marijuana or alcohol is easy has averaged about 2/3rds. The percentage of HS students who perceive great risk from heavy drinking, binge drinking, and smoking marijuana regularly has remained stable. HS students report a noticeably higher likelihood of being caught by their parents than by police for drinking alcohol. HS students also report a noticeably higher

likelihood that they think parents rather than neighborhood adults feel it would be wrong to drink or smoke marijuana regularly.

The National Survey on Drug Use and Health (NSDUH) reported that between '02-'09 the percent of Mainers ages 12-25 who drank, binge drank, misused Rx drugs, have ever used cocaine (ages 18-25 only), or smoked marijuana in the past 30 days (month) has remained stable. The % of Mainers ages 18-25 who perceive great risk from binge drinking has remained stable. % of 12-25 year-olds who perceive great risk from smoking marijuana regularly has also remained stable. Between '02-'09, 18-25 year-olds had noticeably higher %'s than 26+ year-olds re: those experiencing serious psychological distress in past year; rates have also slightly increased for the former age group. For 17-25 age group, percentages have been stable regarding those experiencing at least 1 major depressive episode.

Per Department of Public Safety - Uniform Crime Report (DPS-UCR) and the U.S. Census, the rates per 10k of alcohol- and drug-related arrests by juveniles (17 or younger) in Maine have remained stable between '05-'09. Juvenile rates have been approximately ½ that of the adult (18+) rates.

Per Maine Department of Transportation (MDOT), alcohol-related motor vehicle crash rate for 16-20 year-olds went up sharply between '08-'09 and surpassed '07 levels.

Per National Vital Statistics System (NVSS), substance abuse + overdose deaths per 100k for 12-20 year-olds increased sharply between '08-'09.

Native Americans:

In the 2009 MIYHS survey of 9th-12th grade students, those identifying themselves as Native American reported higher rates of use than their peers for the following 4 substances/patterns (30 day):

Binge drinking 26.8%; Alcohol use 40.3%; Marijuana 30.2%; Cigarettes 27.8%; and Prescription drugs 16.2%.

The BRFSS reported that between 2001-2008, the percent of Native Americans in Maine has remained stable at about 1.1% of the population. Between '06-'09, the percent of Native Americans who drank in the past 30 days decreased from 54.3% to 32.2%, the last 3 years being noticeably lower than non- Native Americans.

Military/Veterans:

According to a contact at the Maine Army National Guard station, there are approximately 4,300 reservist (all branches), national guardsmen, and coast guard in Maine. In SFY 2011, approximately 6.4% of admissions to Substance Abuse Treatment in Maine were Veterans. We hope to partner and share information with the Veterans Administration (VA) in Maine around substance abuse treatment. Currently we do not know how many veterans are treated through the VA for substance abuse services. In the past couple of years the VA in Augusta Maine has agreed to allow their prescribers to register and use the States PMP to run reports on patients.

The BRFSS reported from 2003 through 2008, the percent of veterans in Maine has decreased from 17.7% to 14.6%. From 2006 through 2009, the percent of veterans who drank in the past 30 days was similar non-veterans. During that same time period, a vast majority of veterans reported being male (average of 93.1%).

Can address targets: Homeless, rural SA individuals, underserved racial/ethnic minorities and LGBTQ, persons with disabilities

LGBTQ:

The BRFSS reports that the percentage of heterosexual/straight individuals in Maine has remained consistent between 2004 and 2009 at an average of 97.2%. During this same time period, those who reported being homosexual, gay, or lesbian increased from 1.3% to 1.6% and those reporting to be bisexual increased from 0.6% to 1.1%. Those reporting to be of "Other" orientation decreased from 0.5% to 0.3%. Between 2006 and 2009, those identifying as LGBTQ had lower percentages with respect to having consumed alcohol in the past 30 days than those identifying as heterosexual/straight.

The MIYHS 2009 survey for high school students (grades 9-12) showed much higher rates of binge drinking, 30 day drinking, marijuana use, prescription drug misuse, and cigarette smoking in the Gay, Lesbian, Bisexual, and Questioning students than those who identified themselves as straight. 45.6% of students identifying as Gay/Lesbian compared to 19.4% of students identifying as straight reported binge drinking in the 30 days prior to the survey (in other words, GL students were 2.3 times as likely to have binge drank than straight students). Those identifying as Gay/Lesbian were 4 times as likely to have misused Prescription drugs, 2.3 times as likely to have used marijuana, and 3 times more likely to have smoked cigarettes than those identifying as straight.

Prevention Targets: Community populations for environmental prevention activities, including policy changing activities, and behavior change activities to community, school, family, and business norms through laws, policy and guidelines enforcement.

The assessment process for 2011 prevention planning identified two priorities for prevention in Maine: Underage population – alcohol use, marijuana use, prescription drug misuse and inhalant abuse. 18-25 year old population – binge/high-risk alcohol use, prescription drug misuse, and marijuana use.

The SAPT block grant supports environmental strategies statewide through grants to the Healthy Maine Partnerships in coordination with the Enforcing Underage Drinking Laws-funded initiatives working on environmental strategies through local law enforcement.

Current strategies work to address community norms through working with local retailers (RBS trainings and responsible server initiatives); local law enforcement (increased enforcement and communication with adults in the community); local businesses (Healthy Maine works online assessment tool with resources and assistance to implement strategies in businesses); local schools (school healthy coordinators work to implement a comprehensive substance abuse policy in their school district, as well as other prevention programming). Prevention providers across the state also engage with the Maine Alliance to Prevent Substance Abuse to educate the public about state-wide laws and policy initiatives.

Prevention Targets: Community settings for universal, selective and indicated prevention interventions, including hard-to-reach communities and “late” adopters of prevention strategies.

Maine’s current level of resources for individual strategies is limited, therefore targets are limited.

SAPT BG supports a handful of evidence-based prevention strategies in schools and local agencies across Maine. These were awarded based on successful application showing need in their area and viability of selected program to meet their local needs. Programs funded included use of Project Success, LifeSkills, Project Alert, CAST, and Lions Quest. OSA also supports 4 grantees who are implementing Student Intervention and Reintegration Program (SIRP), which is an evidence-based intervention for students referred to the program. This diversion program is based on Prime for Life curriculum.

For this coming year, OSA will determine next steps in universal, indicated and selected prevention strategies across the state, since the current competitive grant cycle will end June, 2012.

Within the State of Maine’s Medicaid system (Maine Care) coverage for individuals who would thus be eligible in 2014 category already exists and will continue to be utilized. Maine would continue to obligate federal funding to those populations who would continue not to be eligible for Medicaid or other commercial insurances.

Recovery services have not been covered for the SA population in Maine as a “clinical” service under Medicaid. Most of Maine’s providers are accessing the Medicaid system and if they are not, outreach. Recovery Systems of Care (ROSC) are being developed in Maine and there are plans to develop a Recovery Services Center in Maine’s largest city, Portland with the opening of the center planned for Fall

2011.

SMHA's and SSA's work together to provide guidance and leadership with respect to a bi-directional approach of behavioral health and primary care services by OSA has been participating in discussions regarding integration policy initiatives facilitated by the Maine Health Access Foundation (MEHAF) with a variety of state level stakeholders participating, from the Maine Primary Care Association, Maine Hospital Association, to Adult Mental Health to name a few. MEHAF has funded a few behavioral / primary care integration pilots in the state. OSA has begun the work to create connections with the primary care system. Work is underway to better screen for the presence of a SA disorder and create a process of access to appropriate resources whether they are in the facility or by referral. The provision of recovery support services for individuals with mental health or substance use disorders by The SAPTBG funding will be considered when developing adequate infrastructure to support Recovery Oriented is being conducted by the provider association in partnership with the Office of Substance Abuse.

Planning Steps:

Step 1.

Maine's Behavioral Health System is under the purview of the Maine Department of Health and Human Service. It currently consists of the following offices; Office of Substance Abuse, Office of Adult Mental Health, Office of Child and Family Services, Office of Adults with Cognitive and Physical Disabilities, Office of Elder Services, Office of Family Independence, The Maine Centers for Disease Control, and the Office of Maine Care Services.

The role of the SSA is to provide leadership in the realm of the prevention, intervention, treatment and recovery of individuals with addiction, their families and communities. The Office of Substance Abuse collaborates with all state agencies and community partners, develops, monitors and improves the lives of those affected by addiction across the lifespan. Prevention services include environmental strategies through the Health Maine Partnerships within each of the 8 public health districts across the state, with most recently a 9th Tribal Public Health District added in Maine legislation; Student Intervention and Reintegration Program and a handful of model curriculum supported in schools throughout the state. Intervention Services include Maine Driver Evaluation and Education Program. Treatment Services include ASAM - PPC2 Levels of Care as listed in the following Detoxification Management, Residential Care, Intensive Out Patient, Out Patient, Co-Occurring Treatment and Medication Assisted Treatment.

The Office of Substance Abuse is centralized in the capital of the state, contracts with providers statewide to administer necessary services. Through these contracts OSA contributes resources at the public health district level, though unlike other offices, do not have staff located at the public health district level OSA staff are responsible for the contract monitoring, providing technical assistance and site visits to ensure quality of services being provided. The Prevention system is currently supported at the state level with a variety of funding streams supporting a variety of initiatives.

Existing funders:

State of Maine General Fund

Fund for Healthy Maine (Tobacco Settlement Funds)

SAMHSA's Substance Abuse Prevention and Treatment Block Grant

U.S. Department of Education (via MOU with Maine Department of Education (DOE)

Safe and Drug Free Schools and Communities Act (close out September 30, 2011)

Building State Capacities Grant (close out September 30, 2011)

State Epidemiological Outcomes Workgroup grant (11/1/2011 - 10/30/2014)

Office of Juvenile Justice and Delinquency Prevention, Enforcing Underage Drinking Laws - Block Grant and Discretionary Grant

A combination of funding streams support initiatives that support the prevention

work in the community, such as the OSA Prevention media campaigns: MaineParents.net; PartySmarter; and WorkAlert. Enforcing Underage Drinking Laws supports alcohol compliance checks statewide, law enforcement mini grants, and the higher education alcohol prevention partnership.

From the drafted 2011 Office of Substance Abuse State Prevention Plan, gaps identified in Maine's prevention system were:
Need for funding via the HMP infrastructure (consistent and adequate funding) (gap: end of SAMHSA Strategic Prevention Framework – State Incentive Grant).
Need for statewide consistent prevention messaging – media.
Need for support of primary prevention in the schools (gap: loss of SDFS funding and minimal other funding).
Need for clear education/messaging that increases understanding of perception of harm and costs associated with use.

Maine's behavioral health shortage areas are Medication Assisted Treatment; comprehensive behavioral health services statewide – residential services for adolescent abusers with co-occurring disorders.

Maine has struggled with an aging workforce and little recruitment in the field of addiction services. We have been attempting to work with higher education to infuse addictions related coursework as a requirement in counseling and social work programs, but have repeatedly run up against the college's accreditation processes and licensing boards (Social workers, clinical counseling). Currently, we have one university that has taken this on in their community mental health program (Southern New Hampshire University). The COSII Initiative has sponsored a Committee focused on workforce issues that has met with Licensing Boards and has partnered with academic and training programs to offer and require more integrated course work. The initiative has developed a Certificate program, has authored a curriculum on integrated care, and has offered statewide trainings on integration. With the movement in the Substance Abuse arena to a proposed national scope of practice and career ladder, Maine will need at least five to ten years to meet the criteria as it stands now. Additionally, more collaboration is needed with Dept of Labor, whose efforts at workforce development tend to inadvertently neglect the behavioral health workforce issues and focus exclusively on physical health care workers. Progress with Licensing Boards and Academic programs will continue to be spotty and slow until changes occur at the national level in terms of accreditation standards and licensing requirements.

Maine contracts with an intermediary to provide behavioral health workforce development and are in regular communication about what needs training and follow up is necessary to get providers ready for changes and entice others to enter the field. Some resources that would be helpful are: effective approaches to engage higher education in offering curriculum/programming that ready the existing workforce and encourage new people to enter it. The lack of legitimacy of the field has held down salary and wages so much that it is not a sustainable profession to be part of, so market analysis of the behavioral health field in terms of adequate/appropriate average salary could be beneficial in getting people interested in the this work.

Include a description of how these systems address the needs of diverse racial, ethnic and sexual gender minorities. These systems work in tandem to address the needs of diversity in the following ways: Provision within contracts that states there is "no wrong door" when accessing services, assurance of cultural considerations with regard to race, gender and ethnicity via non-discrimination clause in regulatory and contract language, provision of education and training to increase awareness and appropriate service matching.

II: Planning Steps

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

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Narrative Question:

This step should identify the data sources used to identify the needs and gaps of the populations relevant to each Block Grant within the State's behavioral health care system, especially for those required populations described in this document and other populations identified by the State as a priority.

The State's priorities and goals must be supported by a data driven process. This could include data and information that are available through the State's unique data system (including community level data) as well as SAMHSA's data set including, but not limited to, the National Survey on Drug Use and Health, the Treatment Episode Data Set, and the National Facilities Surveys on Drug Abuse and Mental Health Services. Those States that have a State Epidemiological Outcomes Workgroup (SEOW) must describe its composition and contribution to the process for primary prevention and treatment planning. States should also continue to use the prevalence formulas for adults with serious mental illness and children with serious emotional disturbances that have been historically reported. States should use the prevalence estimates, epidemiological analyses and profiles to establish substance abuse prevention, mental health promotion, and substance abuse treatment goals at the State level. In addition, States should obtain and include in their data sources information from other State agencies that provide or purchase behavioral health services. This will allow States to have a more comprehensive approach to identifying the number of individuals that are receiving behavioral health services and the services they are receiving.

In addition to in-state data, SAMHSA has identified several other data sets that are available by State through various Federal agencies such as the Center for Medicaid and Medicare Services or the Agency for Health Research and Quality. States should use these data when developing their needs assessment. If the State needs assistance with data sources or other planning information, please contact planningdata@samhsa.hhs.gov.

Footnotes:

Main data sources reviewed include:
TDS, NSDUH, BRFSS, MIYHS, YRBSS, UCR

Maine's rates of persons who needed treatment but did not receive treatment has improved slightly, although not significantly, in age groups under 26. From the 2007-2008 and the 2008-2009 NSDUH reports for Maine rates went from, 5.02% to 4.13% of 12-17 year olds, 17.03% to 16.68% of 18-25 year olds, and 5.2% to 5.23% of 26+ year olds "needed but did not receive treatment for alcohol use". During this same time frame, those who needed but did not receive treatment for illicit drug use went from, 4.31% to 4.15% of 12-17 year olds, 9.29% to 8.92% of 18-25 year olds, and 1.61% to 1.7% of those 26 years old or older. <http://oas.samhsa.gov/2k8State/stateTabs.htm>

wait list data: During the first 8 months of SFY 2011 there were 2,175 people on the waiting list to enter treatment. During June 2011 there were 285 people on a waiting list to enter treatment at OSA contracted agencies.

Nationally, as in Maine, alcohol is the drug of choice for both youth and adults. Youth Risk Behavior Surveillance System (YRBSS) data cannot be compared to the MIYHS so in order to compare Maine data to national data, YRBSS is used. In the 2009 data, 42% of high school students across the nation have had at least one drink in the 30 days prior to the survey compared to 32% of Maine high school students. No comparison data is available for binge drinking and the percentage of high school students having used marijuana in the 30 days prior to the survey is very similar at 20.8% nationally and 20.5% in Maine.

2009 YRBSS Grades 9-12	Maine	National
30 Day Alcohol Use	32.2%	41.8%
30 Day Binge Drinking	--	24.2%
30 Day Marijuana Use	20.5%	20.8%

Behavioral Risk Factor Surveillance System (BRFSS) data shows that Maine is close to the national average when it comes to 30 day alcohol use for ages 18 to 24 at 49% and 49.8%, respectively. Maine has a higher percentage of binge drinking (males having five or more drinks on one occasion, females having four or more drinks on one occasion) than the nation, 29.2% versus 25.1%. The same holds true for heavy drinking (adult men having more than two drinks per day and adult women having more than one drink per day) with Maine's percentage of 18 to 24 year olds at 7.4% and the United States at 6.2%.

2009 BRFSS Ages 18-24	Maine	National
30 Day Alcohol Use	49%	49.8%
Binge Drinking (Alcohol)		29.2% 25.1%
Heavy Use (Alcohol)	7.4%	6.2%

In 2004 the State of Maine, Office of Substance Abuse, was awarded a Strategic Planning Framework State Incentive Grant which allowed for the creation and support of a statewide prevention/health promotion infrastructure that:

- ensured every community in Maine had the opportunity to participate in strategic prevention planning;
- cultivated a skilled prevention workforce;
- implemented a prevention plan;
- implemented evidence-based and culturally competent prevention programs, policies, and practices; and
- evaluated results.

When the grant ended in 2010, there was movement in a positive direction that resulted in key data that can be used in further program planning at the State level. That data included ensuring the work that is being implemented statewide is focused and prescriptive that allows for the combination of strategies, yet flexible enough to meet community needs, making decisions both funding and programming, based on the available data, investing in workforce and systems development is the key to sustainability, and to evaluate the programming to ensure it is an effective and efficient use of funds.

As stated before, alcohol is the drug of choice in Maine. The 2009 MIYHS survey

results show that 34.7% of Maine high school students had used alcohol in the 30 days prior to the survey. Approximately 21% had consumed five or more alcoholic drinks in one setting. Beginning in ninth grade about half the students who reported having drunk in the past 30 days also report having binge drank. Approximately 59% of tenth graders and 63% of eleventh and twelfth graders who reported having drunk in the past 30 days also report binge drinking. The 2009 MIYHS data also reveals that substance use in all three categories (30 day alcohol, binge drinking, and 30 day marijuana us) increases the most between eighth and ninth grade.

Source: MIYHS, 2009.

According to the 2008 BRFSS survey, 59% of young adults in Maine over the age of 18 consumed at least one alcoholic drink in the past 30 days, 16% binge drank (five drinks in one occasion), and 7% heavily used alcohol (more than one or two alcoholic drinks per day).

II: Planning Steps

Table 2 Step 3: Prioritize State Planning Activities

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Start Year:

2012

End Year:

2013

Number	State Priority Title	State Priority Detailed Description
1	Youth and Young Adults at risk for Substance Use/Abuse	Youths under 18 and young adults 18 - 25.
2	Pregnant Women with Substance Use Disorders	Women of child bearing years engaged in high risk use.
3	IVDU'ers	Persons with present or past history of drug use.
4	Persons in Need of Intervention/Treatment (Targeted population groups)	Criminal Justice and homeless Youth Native American TB/HIV

Footnotes:

II: Planning Steps

Table 3 Step 4: Develop Objectives, Strategies and Performance Indicators

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Start Year:

2012

End Year:

2013

Priority	Goal	Strategy	Performance Indicator	Description of Collecting and Measuring Changes in Performance Indicator
Youth and Young Adults at risk for Substance Use/Abuse	Reduce the misuse of alcohol, prescription drugs, and marijuana among 18-25 year olds by 6/30/2013.	<ol style="list-style-type: none"> 1. Engage the Healthy Maine Partnership coalition public health infrastructure to implement evidence-based environmental strategies in their district to reduce misuse of alcohol. 2. Create statewide messages and material for use by prevention providers on high risk alcohol use. 3. Support the enforcing underage drinking laws environmental strategies statewide. 4. Provide evidence-based programming opportunities to institutes of higher education throughout the state based on data and evidence of effectiveness. 5. Support the PMP 	30 day alcohol, marijuana, prescription drug use (NSDUH)	Description of Collecting and Measuring Changes in Performance Indicator: Will use the Federal Survey, National Survey on Drug Use and Health (NSDUH) as pre-populated in the NOMS to report State level changes in rates. At sub-state levels where broken down by age groups we will use the States Behavioral Risk Factor Surveillance Survey (BRFSS) to assess sub-state changes, and the Maine Higher Education Alcohol Prevention Partnership (HEAPP) higher education survey to assess higher education student changes.

promotion project with resources to educate the public about the dangers of misusing prescription medications.
6.Support the PMP with resources to educate health care providers about evidence based responsible prescribing practices

1.Engage the Healthy Maine Partnership coalition public health infrastructure to implement evidence-based environmental strategies in their district to reduce use and misuse of alcohol.
2.Support the PMP promotion project with resources to educate health care providers and the public about the misuse of prescription medications.
3.Support the PMP with resources to educate health care providers about evidence based responsible prescribing practices.
4.Create statewide messages and material for use by prevention providers on alcohol, marijuana and prescription medications.
5.Support the

30 day alcohol use, binge drinking, marijuana, and psychotherapeutics (NSDUH)

Will use the Federal Survey, National Survey on Drug Use and Health (NSDUH) as pre-populated in the NOMS to report State level changes in rates. At substate levels where broken down by age groups we will use the Maine Integrated Youth Health Survey (MIYHS) a population based school health survey.

Youth and Young Adults at risk for Substance Use/Abuse

Reduce the use, misuse, and abuse of alcohol, marijuana and prescription medications among youth.

enforcing underage drinking laws environmental strategies statewide. 6. Provide evidence-based universal, indicated and selected population prevention programming throughout the state based on data and evidence of effectiveness.

Pregnant Women with Substance Use Disorders

IVDU Pregnant Women - To reduce morbidity for IVDU pregnant women in the state of Maine by 6/30/13.

1. Monitoring access and retention measures per contract with providers
 2. Monitoring wait list reporting to ensure this population is being served within required time frames.
 3. Use of Motivational Interviewing and Cognitive-Behavioral Treatment Strategies
 4. Discussion of unmet needs begin resolved through care coordination
 5. Competency training for providers on gender-responsive care
 6. Post-treatment contacts at 3, 6, 9, and 12 months completed by providers

Changes in TDS data points and disposition on wait list.

1. Treatment Data System (TDS) can give OSA data relative to Wait Lists, A/R measures, completion of treatment, GAF improvement and services provided/referrals. Baseline data can be extracted to show changes over the next 18 months with the implementation of the above strategies. 2. Annual site visits conducted with each Block Grant provider will include a review of client charts and staff professional development plans, and a report on the providers tracking of post treatment contacts with individual's services by the agency.

Pregnant Women with Substance Use Disorders	Retention and Social Connectedness: Increase access to prevention messages and opportunities for families communicating about drug use by 6/30/13.	1. Provide information and Technical Assistance to Block Grant providers about the role of prevention and its impact on families 2. Provide adequate resources (media messages, pamphlets, access to coalitions) to providers	Changes in TDS data points and disposition on wait list.	1. Annual Site Visits: a modification will be made to the template form to ensure this is monitored annually by OSA staff.
Pregnant Women with Substance Use Disorders	To reduce morbidity for pregnant women in the state of Maine by 6/30/13.	1. Monitoring access and retention measures per contract with providers 2. Monitoring wait list reporting to ensure this population is being served within required time frames. 3. Use of Motivational Interviewing and Cognitive-Behavioral Treatment Strategies 4. Discussion of unmet needs begin resolved through care coordination 5. Competency training for providers on gender-responsive care 6. Post-treatment contacts at 3, 6, 9, and 12 months completed by providers	Changes in TDS data points and disposition on wait list.	1. Treatment Data System (TDS) can give OSA data relative to Wait Lists, A/R measures, completion of treatment, GAF improvement and services provided/referrals. Baseline data can be extracted to show changes over the next 18 months with the implementation of the above strategies. 2. Annual site visits conducted with each Block Grant provider will include a review of client charts and staff professional development plans, and a report on the providers tracking of post treatment contacts with individual's services by the agency.

IVDU'ers	Retention and Social Connectedness: Increase access to prevention messages and opportunities for family communicating about drug use by 6/30/13.	1. Provide information and Technical Assistance to Block Grant providers about the role of prevention and its impact on families 2. Provide adequate resources (media messages, pamphlets, access to coalitions) to providers	Changes in TDS data points and disposition on wait list.	1. Annual Site Visits: a modification will be made to the template form to ensure this is monitored annually by OSA staff.
IVDU'ers	To reduce morbidity and increase use of evidence-based practice for IVUDU in the state of Maine by 6/30/13.	1. Ensure access to services for individuals or appropriate referrals to those who have capacity. 2. Monitoring wait list reporting to ensure this population is being served within required time frames. 3. Provide education about various evidence-based treatment modalities including Medication Assisted Treatment 4. Participation in workforce development trainings sponsored by OSA and Workforce Development contracted provider 5. Provide education and implement training related to core competencies for practitioners utilizing Medication Assisted Treatment 6. Monitoring access and retention measures per contract	Changes in TDS data points and disposition on wait list.	1. Treatment Data System/Wait list (TDS) can give OSA data relative to Wait Lists, A/R measures, completion of treatment, GAF improvement and services provided/referrals. Baseline data can be extracted to show changes over the next 18 months with the implementation of the above strategies. 2. Annual site visits conducted with each Block Grant provider will include a review of client charts and staff professional development plans to ensure competencies have been communicated and supported by administration.

with providers

Persons in Need of Intervention/Treatment (Targeted population groups)	Criminal Justice and/or Homeless – Increase Access/Capacity and Stability in housing to this population by 6/30/13.	1. Employ NIATx process improvement aims at both provider and systems level	Changes in TDS data points and disposition on wait list.	1. Treatment Data System/Wait list (TDS) can give OSA data relative to Wait Lists, A/R measures, completion of treatment and living arrangements. 2. Annual site visits conducted with each Block Grant provider will include a review of client charts and staff professional development plans to include NIATx Process and a report on the providers tracking of post treatment contacts with individual's services by the agency. Improvement exposure/training
Persons in Need of Intervention/Treatment (Targeted population groups)	Native Americans – Reduce Morbidity – decrease use of substances of abuse and mental illness symptomatology	1. Increase awareness/knowledge of cultural competency by asking the 5 tribes in Maine to assist in workforce development 2. Increase collaboration with tribes to assure appropriate interventions are used with this population	Changes in TDS data points and disposition on wait list.	1. Treatment Data System/Wait list (TDS) can give OSA data relative to A/R measures, completion of treatment, services provided and referrals. 2. Annual site visits conducted with each Block Grant provider will include a review of client charts and staff professional development plans to include education/training for working with American Indians and a report on the providers tracking of post treatment contacts with individual's services by the agency.
Persons in Need of Intervention/Treatment (Targeted population groups)	Retention and Social Connectedness: Increase access to prevention messages and opportunities for family communicating about drug use by 6/30/13.	1. Provide information and Technical Assistance to Block Grant providers about the role of prevention and its impact on families 2. Provide adequate resources (media messages, pamphlets, access to coalitions) to providers.	Changes in TDS data points and disposition on wait list.	1. Treatment Data System/Wait list (TDS)
Persons in Need of Intervention/Treatment (Targeted population groups)	TB/HIV – Reduce Morbidity in this population by 6/30/13.	1. Collaborate and blend funding with the Maine Centers for Disease control to screen, test, and treat	Changes in TDS data points and disposition on wait list.	1. Treatment Data System/Wait list (TDS) can give OSA data relative to Wait Lists, A/R measures, completion of treatment, and referrals for medical interventions

this population.

Persons in Need of Intervention/Treatment (Targeted population groups)	Youth – Reduce Morbidity – decrease use of substances of abuse by 6/30/13.	1.Expanded use of technology with youth 2.Education/training on youth development and proven strategies that work with this population 3.Access to recovery supports in the community	Changes in TDS data points and disposition on wait list.	1.Treatment Data System/Wait list (TDS) can give OSA data relative to A/R measures, completion of treatment, services provided and referrals. 2.Annual site visits conducted with each Block Grant provider will include a review of client charts and staff professional development plans to include education/training for working with youth and a report on the providers tracking of post treatment contacts with individual's services by the agency.
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Footnotes: