



SPF-SIG STATE STRATEGIC PLAN

REVISED - JANUARY, 2011

MARYLAND ALCOHOL AND DRUG ABUSE ADMINISTRATION
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Maryland's Strategic Prevention Framework (MSPF) Plan

Introduction

In 2009, the Maryland Alcohol and Drug Abuse Administration (ADAA) was awarded funding from the Substance Abuse and Mental Health Services Administration (SAMHSA) to develop and implement the Maryland Strategic Prevention Framework (MSPF). The MSPF Advisory Committee, a committee of the Governor's State Drug and Alcohol Abuse Council (SDAAC), was convened and tasked with guiding and overseeing the development, implementation and success of the MSPF Initiative. The MSPF Advisory Committee has three active work groups: the State Epidemiology Outcomes Work Group (SEOW), Cultural Competence Work Group and Evidence Based Practices Work Group. These work groups have met regularly to develop recommendations for MSPF priorities, activities, policies, practices, and guiding principles. These recommendations were then presented to the MSPF Advisory Council for further discussion and approval. Following this approval, the priorities, activities, policies, practices, and principles were incorporated into the MSPF Strategic Plan that follows.

Principles Grounding the MSPF

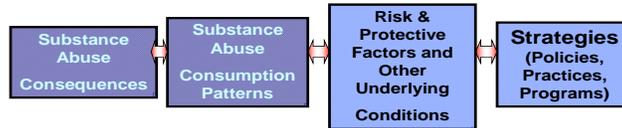
The effort to profile the impact of substance use in Maryland, described in this plan, was undertaken with the goal of facilitating a systematic, data driven approach to generating and monitoring priorities for prevention in Maryland. This novel approach to prevention for the state, advocated by the Center for Substance Abuse Prevention (CSAP), maintains that prevention should:

- be outcomes based;
- be public health-oriented; and
- use epidemiological data.

Outcomes-Based Prevention

Outcomes-based prevention (Figure 1.) emphasizes as the first step in planning: identifying the outcome or negative consequence of substance use that is to be the target of modification through prevention. Only once the consequence is established can the second step be undertaken: identifying the associated consumption patterns to be targeted. This approach expands the prevailing focus of substance abuse prevention planning, which typically targets only change in consumption, and shifts the focus to reducing the problems experienced as a result of use. In the scope of the SPF process, the first two outcome-based prevention steps pertain to this assessment. The foremost focus on the outcomes/consequences of substance use has guided every aspect of the data collection described in this plan and ultimately the prioritization process.

Figure 1. Outcomes-Based Prevention



Public Health Approach to Prevention

The public health approach encourages a focus on population-based change. Under this approach the ultimate aim of prevention efforts should be to target and measure change at the population level (i.e., among the state population as a whole or among certain sub-populations of the state sharing similar characteristics, such as 18-25 year olds in Baltimore City) rather than solely at an individual/programmatic level (i.e., among prevention program recipients). The assessment described in this Strategic Plan emphasizes a statewide population-level approach.

Use of Epidemiological Data to Inform Prevention

The use of epidemiological data to discern measurable, population-level outcomes provides a solid foundation upon which to build substance use/abuse prevention efforts. Use of data facilitates informed decision making by helping to identify areas to target based on where and how the state is experiencing the biggest impact of substance use. In addition, data can assist with determining the most effective way to allocate limited resources to elicit change and which sub-populations exhibit the greatest need so that prevention efforts might be maximized. Ultimately the use of data permits monitoring and evaluation of prevention efforts in order to track successes and highlight needed improvements.

MSPF Priority, Indicators, Logic Model, and Theory of Action:

MSPF Priority and Indicators:

The MSPF Priority is to reduce the misuse of alcohol by youth and young adults in Maryland, as measured by the following indicators:

- Reduce the number of youth, ages 12-20, reporting past month alcohol use
- Reduce the number of young persons, ages 18-25, reporting past month binge drinking
- Reduce the number of alcohol-related crashes involving youth ages 16-25

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#1U79SP015591-01

MSPF Community Logic Model

<p style="text-align: center;">Substance-Related Consequences and Use</p>	<p style="text-align: center;">Intervening Variables/ Contributing Factors (These are examples; targeted contributing factors will vary by community and be selected by each MSPF community)</p>	<p style="text-align: center;">Evidence Based Strategies, Programs, Policies & Practices (These are examples; strategies and programs will vary by community and be selected by each MSPF community)</p>
<p>High incidence of alcohol use by Maryland youth under age 21</p>	<ul style="list-style-type: none"> • Enforcement of alcohol-related laws • Commercial and social availability of alcohol to youth • Community attitudes toward alcohol use • Youth perceptions of the dangers of alcohol use • Youth perceptions of the social acceptability of use • Family use and attitudes towards alcohol use 	<ul style="list-style-type: none"> • Rigorous enforcement of MLDA and other alcohol laws • Compliance checks • Community mobilization to address community and institutional underage drinking norms and attitudes • Normative education emphasizing that most adolescents don't use ATOD • Parent programs stressing setting clear rules against drinking, enforcing those rules and monitoring child's behavior
<p>High incidence of binge drinking by youth ages 18-25</p>	<ul style="list-style-type: none"> • Enforcement of alcohol-related laws • Commercial and social availability of alcohol to youth • Community attitudes toward alcohol use • Youth perceptions of the dangers of alcohol use • Youth perceptions of the social acceptability of use • Family use and attitudes towards alcohol use • Early onset of alcohol and/or drug use 	<ul style="list-style-type: none"> • Establishment or more enforcement of underage drinking party, keg registration, adult provider and social host laws • Alcohol excise taxes to reduce economic availability • Education programs that follow social influence models and include setting norms, addressing social pressure to use, and resistance skills • Multi-component programs that involve the individual, family, school and community • Interventions that identify and provide treatment for adolescents already using
<p>High incidence of alcohol-crashes involving youth ages 16-25</p>	<ul style="list-style-type: none"> • Enforcement of drinking and driving laws • Judicial drinking and driving decisions and practices • Commercial and social availability of alcohol • Community attitudes toward drinking and driving • Perceptions of the risk of being caught and punished for drinking and driving • Availability and access to treatment in the community 	<ul style="list-style-type: none"> • Rigorous enforcement of drinking and driving laws • Awareness regarding the increased risk of being caught and punished for drinking and driving • Enforcement campaigns with sobriety check points • Court Watch • Community wide media campaigns and task forces • Police, judiciary, server, and business training • Court-ordered and enforced treatment for DUI offenders

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#1U79SP015591-01

MSPF Theory of Action:

The MSPF Theory of Action depicted in Community Logic Model proposes that by providing culturally competent, evidence based prevention strategies and programs at the community level, Maryland will impact a number of key contributing factors for underage drinking, binge drinking, and alcohol-related crashes in Maryland, and as a result prevent and reduce the incidence of these problems.

Table of Contents

Introduction	i
I Assessment	
A. Assessment of Substance use and Related Consequences	1
1. Substance use in Maryland	1
- Drug Use	1
- Alcohol Use	2
- Tobacco Use	2
- Underage Drinking	
and Alcohol Abuse in Maryland	3
- Special Population: Veterans	3
2. Related Consequences of Substance Use in Maryland	4
- Crimes	4
- Arrests	5
- HIV/AIDS	5
- Past Year Abuse or Dependence	6
- Motor Vehicle Crashes	6
- Mortality	6
- Suspensions/Expulsions from Public Schools	7
3. Data Indicators on Substance use and Substance Related Consequences	7
4. Epidemiological Dimensions on which Data Analysis was based	8
5. Policies, Procedures and Processes Considered/Utilized to select indicators	8
6. Data Regarding Risk/Protective Factors or Other Causal	

MARYLAND SPF SIG PLAN
#1U79SP015591-01

Factors	11
7. Statewide and Jurisdictional Substance Use and Substance Related Consequences Profiles	11
8. Assessing Substance use and Consequences Across the Life Span	12
9. Assessing Underage Drinking Issues	12
B. Assessment of Substance Abuse Related Systems in Maryland and its Communities	12
1. Prevention Infrastructure (personnel, resources and systems)	12
2. Significant gaps in Maryland’s current infrastructure	19
3. Maryland’s Capacity to Implement SPF at the State Level	23
4. Maryland’s Capacity to collect, analyze and report data to support data –driven decision making in each step of the SPF	26
5. Community Prevention Infrastructure in place and its effectiveness	27
6. Significant gaps in the current community level prevention system in Maryland	28
7. Community capacity to implement the SPF and to collect, analyze and report on data	29
C. Criteria and Rationale for Determining MSPF Priorities	29
D. Description of MSPF Priorities	37
II. Capacity Building	38
A. Areas needing strengthening	38
B. State and Community Level Activities	38
C. Role of the State Epidemiological Outcomes Workgroup (SEOW)	41
III. Planning	43

MARYLAND SPF SIG PLAN
#1U79SP015591-01

A. Planning Model	43
B. Allocation Approach	43
C. Implications of the Planning Model/Allocation Approach	46
D. Community-Based Activities	47
IV. Implementation	49
A. Supporting the Work of Communities	49
B. MSPF Relationship to Anti-Drug Coalitions	51
V. Evaluation	52
VI. Cross Cutting Components and Challenges	61
A. Ensuring Cultural Competence	61
B. Addressing Underage Drinking	62
C. Addressing Sustainability	62
D. Expected Challenges in applying a Data-Driven Allocation Process	63
E. Expected Challenges in the Implementation Process	63
F. Timeline and Milestones	64
Acronym List	66
List of Appendix Documents	68

I. Assessment

A. Assessment of Substance Use and Related Consequences (Epidemiological Profile)

A summary of the data on substance use and related consequences in Maryland from the most recent state profile produced in 2009 follows (See Appendix A for complete profile).

1. Substance Use (Consumption) in Maryland

The consumption data comes from four sources: 1) SAMHSA's National Survey on Drug Use and Health (NSDUH) for the years 2002 & 2003 through 2006 & 2007; 2) Maryland State Department of Education (MSDE)'s Maryland Adolescent Survey(MAS) for the school years 2002-03 through 2006-07; 3) SAMHSA's Treatment Episode Data Set (TEDS) for the years 2003 through 2007; and the Center for Disease Control(CDC)'s Behavioral Risk Factor Surveillance System Survey data for the years 2003 through 2007.

Drug Use

- According to data from the 2006-2007 NSDUH, an estimated 326,000 Marylanders aged 12 years or older used an illicit drug in the past month; an estimated 235,000 used marijuana.
- Marylanders between the ages of 18-25 reported the highest rate of past month drug use—an estimated 19.1% of 18-25 years olds used an illicit drug in the past month compared to 8.8% of those between the ages of 12 and 17 and 4.8% of those 26 years or older. A similar age pattern of use was found for past month marijuana use as well.
- According to NSDUH, estimates of past month use of illicit drugs and marijuana in Maryland was similar to those found for the nation as a whole.
- Trend data from NSDUH show that while past month use of illicit drugs and marijuana were stable between 2002-03 and 2006-07 for the population (12+ years) as a whole and the age groups 12-17 and 26 and older; use fluctuated among those aged 18-25 years.
- NSDUH data for 2006-2007 showed an estimated 198,000 Marylanders aged 12 years or older used pain relievers non-medically in the past year.
- TEDS data show that in Maryland in 2007, there were 36,634 treatment admissions in which an illicit drug was mentioned as a primary substance of abuse. Of those illicit drug treatment admissions, heroin accounted for the largest proportion with 13, 987 (38%), followed by marijuana with 9,360 primary mentions (26%), and cocaine with 8,790 primary mentions (24%).

MARYLAND SPF SIG PLAN

#1U79SP015591-01

- Compared to the nation as a whole, Maryland had higher percentages of its treatment admissions with an illicit drug problem (includes any illicit drug and specifically heroin, cocaine, marijuana, and prescription drugs).

Alcohol Use

- According to data from the 2006-2007 NSDUH, an estimated 2.5 million Marylanders aged 12 years or older consumed alcohol in the past month; an estimated 204,000 were underage (12-20 years).
- An estimated 977,000 Marylanders aged 12 years or older binged (i.e., consumed five or more drinks on the same occasion); those between the ages of 18-25 had the highest rate of past month binge alcohol use (40% compared to 9.5% among those aged 12 to 17 years and 19.5% among those aged 26 years or older).
- NSDUH data show that past month alcohol use has remained stable for all age groups between 2002-03 and 2006-07 but past month binge alcohol use has fluctuated for the age groups 12-20 years and 18-25 years.
- According to 2007 TEDS data for Maryland, there were 19,502 treatment admissions in which alcohol was mentioned as a primary substance of abuse. Maryland had a lower percentage of primary alcohol treatment admissions than the nation as a whole with approximately 35% of Maryland treatment admissions involving alcohol as a primary substance of abuse compared to 40% nationwide.

Tobacco Use

- According to data from the 2006-2007 NSDUH, an estimated 1.2 million (26% of) Marylanders aged 12 years or older used a tobacco product in the past month; an estimated 1,032,000 smoked cigarettes in the past month.
- According to NSDUH, tobacco use rates among the population as a whole (aged 12 years or older) was lower in Maryland than the nation as a whole. But Maryland's tobacco and cigarette use rates, broken down by age, were similar to those in the nation.
- Tobacco and cigarette use rates have remained stable between the survey years 2002-03 and 2006-07.
- In 2007, there were an estimated 490,000 Maryland adults (aged 18 and older) who smoked on a daily basis. However, Maryland rates are lower than the national average and show a decreasing trend over the past five years (2003-2007).

Underage Drinking and Alcohol Abuse in Maryland

- According to the 2006-2007 NSDUH, approximately 134,000 Marylanders between the ages of 12 and 25 years were classified with past year alcohol dependence or abuse. The Maryland estimates were similar to the national estimates and have been stable over the past five years (2002-03 through 2006-07).
- In 2007, there were 938 vehicle crashes involving an underage (16 to 20 years) AOD-impaired driver; the AOD-related crashes represented approximately 5% of all crashes involving underage drivers in Maryland.
- In 2007, there were 1,681 alcohol-related arrests among Maryland youth (18 and under).
- Compared to national arrest figures for juveniles, Maryland had a higher percentage of AOD-related arrests than the U.S. as a whole (16% in Maryland vs. 9% in the U.S.).
- According to the 2006-2007 NSDUH, approximately 204,000 underaged Marylanders (aged 12-20 years) consumed alcohol in the past month.
- According to the 2006-2007 NSDUH, approximately 283,000 Marylanders between the ages of 12 and 25 binge (i.e., consumed five or more drinks on the same occasion); those between the ages of 18-25 had the highest rate of past month binge alcohol use with an estimated 40% or 237,000 young adult Marylanders bingeing.

Special Population: Veterans

CSAP has encouraged Veterans be considered as a special population of interest. Data on veterans were assembled in a special briefing (Appendix B). Highlights are provided below. Sources include NSDUH and ADAA's SMART system.

- A significantly smaller proportion of Maryland veterans compared to similarly aged (18+) non-veteran Marylanders, engaged in past month binge drinking (15.1% vs. 22.5%) and illicit drug use (2.8% vs. 6.6%) according to annual average estimates derived from self-reports from the 2004-2008 yearly National Survey on Drug Use and Health.
- In total, an annual average of 78,000 veterans were estimated to have engaged in past month binge alcohol use and 14,000 veterans were estimated to have engaged in past month illicit drug use.
- According to the 2004-2008 National Survey on Drug Use and Health, in the past year similar proportions of veterans and non-veterans in Maryland aged 18 years and older were dependent or abused substances (8.7% vs. 8.4%), alcohol (7.5% vs. 6.9%), and illicit drugs (1.7% vs. 2.4%) based on DSM-IV criteria.

MARYLAND SPF SIG PLAN

#1U79SP015591-01

- In total, an annual average of 45,000 veterans were estimated to have been dependent or abused a substance in the past year.
- Among Maryland treatment admissions, a greater proportion of veteran admissions than all admissions were for primary alcohol problems from July-December 2009.
- In Maryland from July-December 2009, compared to total treatment admissions a similar proportion of veteran treatment admissions had a co-occurring psychiatric condition (38%) and was homeless (7%).

2. Related Consequences of Substance Use in Maryland

Crimes

Data on violent crimes and property crimes in Maryland were taken from the Maryland State Police, Uniform Crime Reporting Program's *Crime in Maryland, 2003-2007*. National data was taken from the U.S. Department of Justice, Federal Bureau of Investigation's *Crime in the United States, 2006-2007*.

- In 2007, there were approximately 58,000 alcohol- and/or drug (AOD)-related crimes¹ in Maryland. The crime rate in Maryland was similar to that for the nation as

¹ Estimated Number of Crimes that are Alcohol- and Drug-Related are calculated based on nationwide estimates from The Economic Costs of Alcohol and Drug Abuse in the United States – 1992

(<http://www.nida.nih.gov/economiccosts/index.html>) that indicate that approximately 30% of murders, 23% of rapes, 3% of robberies, and 30% of aggravated assaults are attributable to alcohol and 30% of burglaries, 30% of larceny-thefts, and 7% of motor vehicle thefts are attributable to drugs. Estimates of the percentage of crimes attributable to drugs are derived primarily from self-reports of incarcerated offenders. The percentage actually attributable to drug use may vary across geographic units or subpopulations.

MARYLAND SPF SIG PLAN

#1U79SP015591-01

a whole and showed a decreasing trend over the past five years, decreasing approximately 10% between 2003 and 2007.

- Property crimes accounted for a large proportion (88%) of total AOD-related crimes in Maryland; 51,000 of the 58,000 AOD-related crimes in 2007 were estimated to be drug-related property crimes. Maryland's 2007 property crime rate (913.2 per 100,000 population) was similar to the national rate (895.5 per 100,000 population) and has decreased over the past five years; decreasing by 10% between 2003 and 2007.
- In 2007, there were approximately 7,000 alcohol-related violent crimes in Maryland. While the number of alcohol-related violent crimes decreased over the past five years (by about 10%), the violent crime rate in Maryland of 127.4 per 100,000 population is higher than the national rate (98.1 per 100,000 population).

Arrests

Data on alcohol- and drug-related arrests in Maryland were taken from the Maryland State Police, Uniform Crime Reporting Program's *Crime in Maryland, 2003-2007*. National data was taken from the U.S. Department of Justice's *Crime in the United States, 2006-2007*.

- In 2007, there were 86,511 alcohol- and drug-related arrests in Maryland representing approximately 29% of all arrests in Maryland. Compared to national arrest figures, Maryland had a higher percentage of AOD-related arrests than the U.S. as a whole (29% in Maryland vs. 27% in the U.S.).
- There were 55,408 arrests for possession and distribution of drugs in Maryland in 2007. Maryland had a higher percentage of drug-related arrests than the U.S. as a whole (19% vs. 12%) and showed an increasing trend in the percentage of arrests that were drug-related over the past five years (2003 to 2007).
- In 2007, there were 31,103 arrests for driving under the influence (DUI) and/or liquor law violations in Maryland. While the percentage of total arrests that are alcohol-related was lower in Maryland than for the nation as a whole, there was an increasing trend in the percentage of alcohol-related arrests in Maryland between 2003 and 2007.

HIV/AIDS

Data on HIV/AIDS were taken from the Centers for Disease Control and Prevention's (CDC). *HIV/AIDS Surveillance Report* for 2002-06.

MARYLAND SPF SIG PLAN

#1U79SP015591-01

- In 2006, there were an estimated 14,581 persons living with AIDS in Maryland. Maryland's 2006 AIDS case report rate of 29.0 per 100,000 population was more than double the national rate of 14.4 per 100,000 population. The percentage change in the Maryland AIDS case report rate has fluctuated over the five year period between 2002 and 2006.

Past Year Abuse or Dependence

Data on past year abuse or dependence of alcohol and/or illicit drugs were taken from the Substance Abuse and Mental Health Services Administration's (SAMHSA) National Survey on Drug Use and Health (NSDUH) for the years 2002 & 2003 through 2006 & 2007.

- According to the 2006-2007 NSDUH, approximately 430,000 Marylanders aged 12 or older were classified with dependence on or abuse of any illicit drug and/or alcohol in the past year. An estimated 357,000 was for alcohol and an estimated 137,000 was for illicit drugs.
- The Maryland estimates were similar to the national estimates and have been stable over the past five years (2002-03 through 2006-07). Breakdowns by age showed similar patterns (i.e., Maryland rates, by age, were similar to national rates and have remained stable over the past five years).

Motor Vehicle Crashes

Data on Maryland alcohol- and/or drug (AOD)-related motor vehicle crashes from 2003 to 2007 were provided by the Maryland State Highway Administration's Automated Accident Reporting System (MAARS). Comparable AOD-related motor vehicle crash data were not available for the U.S. as a whole.

- In 2007, approximately 8.5% of total motor vehicle crashes in Maryland involved an AOD-impaired driver. There were a total of 8,610 alcohol- and/or drug-related crashes; drivers aged 16-20 accounted for 11% or 938 of those crashes
- The percentage of crashes involving an AOD-impaired driver has shown an increasing trend over the past five years for both drivers aged 16-20 years and those aged 21 or older.

Mortality

Data on alcohol- and drug-induced deaths were taken from the Maryland Department of Health and Mental Hygiene's *Maryland's Vital Statistics Annual*

MARYLAND SPF SIG PLAN

#1U79SP015591-01

Reports, 2003-2007. Comparable national data on alcohol- and drug-induced deaths were not available. Data on tobacco-related disease deaths were taken from the National Center for Health Statistics' *Multiple Cause of Death, 2001-2003* data file.

- In 2007, 795 (1.8%) of all deaths in Maryland were drug-induced and 328 were alcohol-induced. In 2003, the most current year available for tobacco-related disease deaths, there were 4,914 tobacco-related deaths.
- Maryland's tobacco-related disease death rate (89.2 per 100,000 population) was lower than that for the nation as a whole (95.4 per 100,000 population).
- The five year trend from 1999 to 2003 (most current data available) for tobacco-related disease death showed a decreasing trend.
- Alcohol-induced deaths showed an increasing trend from the time period 2003 to 2007; drug-induced deaths fluctuated during the same time period.

Suspensions/Expulsions from Public Schools

The data on alcohol-, drug-, and tobacco-related suspensions was taken from the Maryland State Department of Education's *Suspensions, Expulsions, and Health-Related Exclusions, Maryland Public Schools, 2003-04 to 2007-08*. Comparable national data on AOD-related suspensions were not available. Also, trend data on tobacco-related suspensions was not available.

- During the 2007-08 school year, there were 4,130 AOD-related school suspensions in Maryland public schools. Drug-related suspensions accounted for over half of total AOD suspensions (2,113) followed by tobacco-related suspensions (1,229) and alcohol-related suspensions (788).
- While drug-related suspensions accounted for the majority of AOD-related suspensions, the percentage of drug-related suspensions had decreased over the five year period between school years 2003-04 to 2007-08.

3. Data Indicators on Substance Use and Substance Related Consequences

The indicators of substance use and associated consequences profiled by the Maryland SEOW (listed below) were identified through a careful selection process.

MARYLAND SPF SIG PLAN
 #1U79SP015591-01

Table 1. Categories of Consequences and Consumption Assessed by Maryland SEOW

	CONSEQUENCES	CONSUMPTION
Illicit Drugs	1. Property Crimes/Drug Arrests 2. HIV/AIDS 3. Past Year Abuse/Dependence 4. Drug-Induced Deaths 5. Suspensions/Expulsions	1. Illicit Drug Use 2. Treatment Admissions
Alcohol	1. Violent Crimes 2. Alcohol-Related Crashes 3. Past Year Abuse/Dependence 4. Alcohol-Induced Deaths 5. Suspensions/Expulsions	1. Alcohol Use 2. Treatment Admissions 3. Sales per Capita
Tobacco	1. Tobacco-Related Deaths 2. Suspensions/Expulsions	1. Tobacco and Cigarette Use 2. Retailer Compliance Checks

4. Epidemiological Dimensions on Which Data Analysis was Based

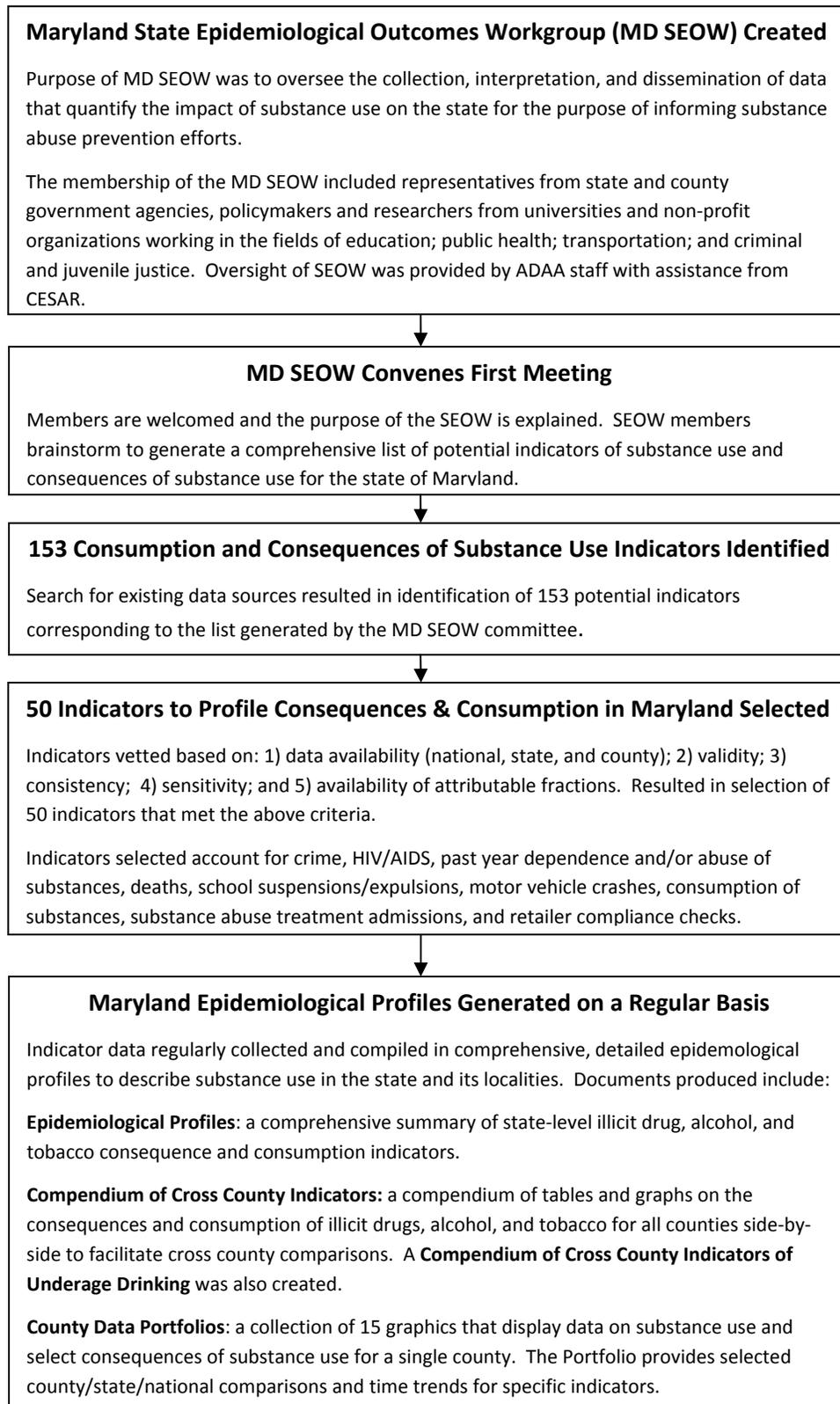
As determined by the SEOW, the Epidemiological Profile contained statewide data on the indicators to permit the assessment of the state versus the United States, the prevalence/magnitude of the problem (including demographic breakdowns where possible), trends over time (typically over 5 years) and, where possible, prevalence by jurisdiction/region.

5. Policies, Procedures and Processes Considered/Utilized to Select Indicators

The following section describes and Figure 2 illustrates how Maryland collected existing epidemiological data to describe the impact of substance use on the state for the purpose of informing outcomes-based prevention efforts.

MARYLAND SPF SIG PLAN
#1U79SP015591-01

Figure 2. Process for Creating Maryland Epidemiological Profiles



Guiding the Assessment Process:***The Maryland State Epidemiological Outcomes Workgroup (SEOW)***

The Maryland Statewide Epidemiological Outcomes Workgroup (SEOW) was created to oversee the collection, interpretation, and dissemination of data that quantify the impact of substance use on the state for the purposes of informing prevention efforts. The SEOW was formed in March 2006 with funding from the Substance Abuse and Mental Health Administration (SAMHSA) Center for Substance Abuse Prevention (CSAP) under the oversight of the Maryland Alcohol and Drug Abuse Administration (ADAA), the single state authority responsible for planning, development, and funding of services to prevent harmful involvement with alcohol and other drugs and treatment of those in need of addiction services. Assistance in coordination of the SEOW and data analysis, management, and dissemination has been provided by the University of Maryland's Center for Substance Abuse Research (CESAR). The original 34 core members of the SEOW included representatives from state and local agencies, organizations, and universities from the fields of public health, prevention, treatment, education, transportation, research, and criminal and juvenile justice. The members defined the mission of the Maryland SEOW:

The MD SEOW will monitor the use of alcohol, tobacco, and other drugs and the consequences of their use in Maryland and its localities in order to identify and prioritize the prevention needs of the state and its local jurisdictions. To achieve this end the MD SEOW will oversee the collection, interpretation, and dissemination of statewide and local data that quantify substance use and its consequences for the state.

Identifying Indicators

A careful process was implemented to identify the indicators of the substance use and associated consequences to be included in an epidemiological profile of Maryland. The process began at a meeting of the SEOW, in which the group members engaged in a brainstorming session to generate a list of potential consequences of substance use and associated consumption patterns of interest. Researching existing data sources for indicators that corresponded to the suggestions generated, resulted in the identification of 153 potential indicators.

Each potential indicator was assessed inclusion based on 6 criteria: availability, validity, consistency, sensitivity, and availability of attributable fractions. (An attributable fraction is an estimate, based on current research, of drug-related incidents in a consequence.) Availability referred to whether there were existing, usable data for the state and regional/county levels on the indicator of interest.

Validity referred to whether the indicator was believed to be an appropriately accurate measure of what it claimed to be. Consistency referred to whether the indicator was collected at various points in time, in the same manner in order to facilitate assessment of trends over time. Sensitivity referred to whether the indicator was deemed as viable to reflect/capture change over time. Availability of attributable fractions was relevant for consequences known to be associated with substance use, but for which data directly linking the consequence to substance use was not available. For those cases in order to generate an estimate of the proportion of cases attributable to substance use an estimate was necessary from the research literature. Indicators that were not appropriately classified as either a consequence or consumption pattern were excluded from review.

After a thorough assessment of each, the list of 153 indicators was reduced to fifty. Sixty-eight indicators were assessed in relation to illicit drugs. Of the 68 indicators, 22 were selected for inclusion in the epidemiological profile. Sixty-six indicators were assessed in relation to alcohol. Of the 66 alcohol-related indicators, 20 were selected for inclusion in the epidemiological profile. For tobacco, 29 indicators were assessed for inclusion; of the 29, eight were selected for inclusion in the epidemiological profile. Finally, three indicators, related to all three substances combined, were assessed and selected for inclusion. Table 1 displays the resulting categories represented by the consequence and consumption indicators identified through this process.

6. Data Regarding Risk/Protective Factors or other Causal Factors

Per our CSAP guidance: Causal/risk and protective factors should be considered only after MSPF SIG priorities have been identified. Identification of such factors is not required or encouraged in the current MSPF Plan submission as they will be identified by funded communities as they move forward with the SPF process.

7. Statewide and Jurisdictional Substance Use and Substance Related Consequences Profiles

Additional jurisdictional level data were compiled in the *Maryland Compendium of Cross County Indicators on the Consequences and Consumption of Alcohol, Illicit Drugs and Tobacco* (Appendix C). A product of the Maryland State Epidemiological Outcomes Workgroup (MD SEOW), the Compendium of Cross County Indicators compiles recent available county level data on the consequences and consumption of alcohol, drug, and tobacco use in Maryland. The data are presented in a format to facilitate state and cross county comparisons and is designed as a convenient reference for use when describing and assessing substance use and its consequences at the county level. Although this report is intended primarily as a resource for state

prevention professionals to use in local prevention planning, it should be of use to all with an interest in substance abuse in Maryland.

8. Assessing Substance Use and Consequences Across the Lifespan

Data were collected and assessed by the SEOW in order to characterize substance use and its consequences in Maryland across the lifespan, consistent with the recommendations of CSAP and the population-based approach to prevention.

9. Assessing Underage Drinking Issues

CSAP has identified underage drinking as a key priority for states. The SEOW has completed *The Maryland Compendium on Cross County Indicators on Underage Drinking* (Appendix D) which includes statewide and jurisdictional data on underage drinking and related consequences. It compiles recent available county level data on crashes, arrests, suspensions from public schools, consumption, and treatment admissions. The data are presented in a format to facilitate state and cross county comparisons. This report is intended primarily as a resource for the use of state and local prevention professionals in local prevention planning, but should be of use to all persons who have an interest in underage drinking in Maryland.

B. Assessment of Substance Abuse Related Systems in Place in Maryland and its Communities (Capacity and Infrastructure).

1. Prevention Infrastructure (personnel, resources and systems)

The Maryland Alcohol & Drug Abuse Administration (ADAA) is the single state agency responsible for the planning, development, and funding services to prevent harmful involvement with alcohol, tobacco and other drugs and for treating individuals in need of addiction services. The ADAA maintains a statewide, integrated service delivery system that promotes public health and safety of patients, families and communities. The Community Services and Quality Assurance Divisions are the lead entities for implementing ADAA's policies, programs and practices for community-based prevention services and SYNAR compliance efforts.

The ADAA has utilized a community development process for its prevention services. The model focuses on developing effective comprehensive programs that give participants a positive identity and the skills, opportunities, relationships, and experiences to develop healthy lifestyles. ADAA prevention programs are developed in cooperation with communities and are designed and implemented for all age groups with a special emphasis on evidence-based programming that demonstrates effective outcomes.

MARYLAND SPF SIG PLAN

#1U79SP015591-01

An essential component of Maryland's prevention infrastructure is the ADAA-funded county prevention coordinator system; an established, coordinated, and recognized strategy for the provision of technical assistance and program development services at the county and community level. Each jurisdiction has a designated Prevention Coordinator. The Prevention Coordinator helps plan, deliver, coordinate, and monitor prevention services that meet the needs of their particular jurisdiction. Prevention Coordinators serve as resources for the community, working closely with all elements of the community to identify needs, develop substance abuse projects, implement programs, and obtain funding.

The Maryland State Department of Education (MSDE) is a major element in Maryland's prevention infrastructure, providing drug prevention education to all of Maryland's 848,412 students, K -12, in 1,450 public schools. As part of the Maryland Comprehensive Health Program, MSDE provides drug prevention education that provides for the diversity of student needs, abilities, and interests at the early, middle, and high school learning years. The drug prevention education curriculum helps students acquire and apply knowledge of tobacco, alcohol and other drugs (ATOD) and the consequences of their non-use, use, and abuse. This includes the effects of ATOD on the body systems; the physical, psychological, social, and legal consequences of ATOD use; the stages of chemical dependence; and the development and application of ATOD resistance skills.

Another key element of Maryland's prevention infrastructure is its four University Prevention Centers. The ADAA funds four strategically located regional ATOD Prevention Centers. Frostburg University, Towson University, Bowie State University, and the University of Maryland Eastern Shore receive funding from ADAA to support on-going ATOD prevention efforts on their campuses and within the surrounding communities. A primary focus of these centers is to provide education and training for college students by creating and/or enhancing peer education networks. Each center is responsible for working with their institution to develop campus ATOD policies, establishing linkages with surrounding communities and other colleges to implement ATOD prevention services.

The Maryland Association of Prevention Professionals and Advocates (MAPPA) serves as the advocacy and certification body for Maryland's prevention system. MAPPA represents prevention experts throughout Maryland, including state and local agency and private sector professionals, consultants and community volunteers. Its purpose is to unite and empower prevention professionals within the state to promote and enhance health and wellness across the lifespan, primarily by preventing, delaying and reducing the use of alcohol, tobacco and other drugs. MAPPA provides

MARYLAND SPF SIG PLAN

#1U79SP015591-01

on-going prevention training to the community, including training leading to certification as a Certified Prevention Professional (CPP), Certified Prevention Specialist (CPS), or Associate Prevention Specialist (APS).

The nine CSAP-funded Maryland Drug Free Community (DFC) grant sites are another key element of the Maryland prevention infrastructure. Drug Free Communities grants strengthen and enable local community coalitions to prevent and reduce youth substance use. Drug Free Communities sites are located in Anne Arundel County, Baltimore City, Baltimore County, Caroline County, Charles County, Garrett County, Queen Anne's County, Talbot County, and Wicomico County.

The Governor's State Drug and Alcohol Abuse Council (SDAAC) and the 24 Local Drug and Alcohol Abuse Councils (LDAAC) are also key components of the Maryland prevention infrastructure. The State Council was established by Executive Order to prepare and annually update a two-year State strategic plan that identifies priorities for the delivery and funding of drug and alcohol abuse prevention, intervention and treatment services within the state. The local councils were also mandated by Executive Order and are also required to submit a local plan to the Governor every two years and progress updates to the ADAA every six months. Both the State and local councils incorporate input from multiple agencies and stakeholders into their planning activities. Plans are intended to guide the improvement of current services as well as document the need for new services.

Several substance abuse prevention resource assessment activities have been conducted over the past several years:

- The ADAA requires each of Maryland's 24 jurisdictions to complete, as part of its annual funding proposal, a program matrix listing their prevention programs; whether they are evidence based; which CSAP Strategy they fall under; which IOM category; which risk factors they address; target population; numbers served; goals & objectives; timeline; and amount of funding. Information from these matrices is provided below in the analysis of Maryland's infrastructure gaps.
- The Governor's State Drug and Alcohol Abuse Council conducted a survey of FY '05 federal and State resources that State agencies were allocating for prevention, intervention and treatment of tobacco and other drugs. Among its findings were:

MARYLAND SPF SIG PLAN

#1U79SP015591-01

- that all state agencies combined devoted \$252,470,454 for ATOD prevention, intervention and treatment;
 - Of these ATOD resources, \$7,785,252 (3%) were designated as *prevention* resources;
 - Of this *prevention* figure, \$4,985,017 (64%) was allocated by the Maryland Alcohol & Drug Abuse Administration (ADAA).
 - All of these ADAA prevention funds were from the federal SAPT Block Grant
 - Of the total ATOD resources, \$6,625,382 (2.6%) were designated as *intervention* resources
 - Of this *intervention* figure, \$2,322,384 (35%) was allocated by the ADAA.
 - All of these ADAA intervention funds were State General funds
 - Of the total ATOD prevention, intervention and treatment resources, State agencies allocated \$14,410,634 (5.7%) for *prevention and/or intervention*
 - Of this figure, \$7,607,401 (52.8%) was allocated by ADAA.
 - 65.5% of the ADAA prevention and intervention allocation was Federal SAPT Block Grant funds
- The August 2009 *Governor's State Drug and Alcohol Abuse Council Strategic Plan* included an assessment of prevention services in Maryland and several objectives and action steps for strengthening the prevention system and infrastructure. These recommendations included:
 - Substance abuse prevention education/training:

The Plan noted “that substance use prevention methods and technology are not widely known by the general public or even substance use professionals. Because of this, prevention services are neither adequately funded nor adequately used in Maryland’s strategy to address substance use. This lack of awareness and knowledge is not only a deficit in Maryland. Nationally, prevention services receive considerably less funding than treatment services, and best practices in prevention services are generally less known than those

MARYLAND SPF SIG PLAN

#1U79SP015591-01

in treatment. In the main, this is due to an outdated and erroneous notion that prevention strategies and interventions are not well-researched and therefore not “evidence-based.” “

To address this concern, the Strategic Plan includes an objective of *promoting the use of effective prevention strategies and interventions by informing stakeholder groups and coalitions of evidence based prevention practice, such as SAMHSA’s six core strategies: information dissemination, prevention education, alternative activities, community-based processes, problem identification, and environmental.*

- Substance Abuse Prevention Workforce Development

The Plan also noted that “there is a critical shortage of behavioral healthcare workers both entering and staying in the field of substance abuse prevention, intervention and treatment, and a critical shortage of professionals currently practicing in the field who are sufficiently trained and skilled in working with the variety of disorders presented by individuals seeking substance abuse services in Maryland.”

To address this concern, the Strategic Plan includes an objective of *ameliorating the substance abuse workforce shortage crisis through a series of on-going action steps that include the development of a structured, progressive training curricula for the entire workforce from the beginning counselor/preventionist to the seasoned program manager; development of structured workforce mentoring programs; and developing a state wide system of quality supervision, including an on-going training and preceptorship program.*

- An MSPF prevention resource assessment was conducted by the SEOW in early 2010 to develop a current list of all federal, state, local, and privately funded prevention programs in Maryland. The MSPF Recommendations Subcommittee of the MD SEOW developed an instruction sheet and matrix to be completed by all 24 county prevention coordinators (Appendix E). The instruction sheet included ADAA’s definition of prevention and a detailed description of each variable included in the matrix. Each matrix included 10 variables: Implementing entity, direct/indirect activity, key contact, program name, function/mission, target population, evidenced-based program Y/N, funding source, funding amount for FY2010, and source of program info.

MARYLAND SPF SIG PLAN

#1U79SP015591-01

In addition to the instruction sheet, CESAR staff collected all existing reports on prevention programs and generated a matrix or spreadsheet for each county. Sources for information on prevention programs included the ADAA Minimum Data Set (MDS), resource surveys developed by Local Drug and Alcohol Abuse Councils, the ADAA community coalitions list, and the Maryland Community Services Locator. Complete matrices and instructions were sent out to each prevention coordinator for review and updating. The coordinators tapped into the following additional sources: county public schools, county health departments, local management boards, drug free communities, and other state and local agencies. The types of programs counted in this process included evidence-based programs such as Second Step, Strengthening Families, Guiding Good Choices, Life Skills, and Communities Mobilizing for Change on Alcohol, and other programs such as DARE, After School Programs, Drug Free Communities, and Merchant Tobacco Education.

- Key Results of Resource Assessment
 - All 24 jurisdictions participated in the process and submitted completed matrices.
 - These matrices included 286 total prevention programs and coalitions.
 - Nearly three-quarters (approximately 71%) are identified as direct activities,
 - Approximately 35% were labeled evidence-based by county coordinators.
 - Nearly two-thirds (66%) of the programs served juveniles. The majority of the juvenile programs served students in grades K-12.
 - More than one quarter were community wide.
 - There was significant variation by county.
 - The number of programs across the counties ranged from 2 to 34
 - The percentage of evidence-based programs ranged from 9% to 100%.

MARYLAND SPF SIG PLAN

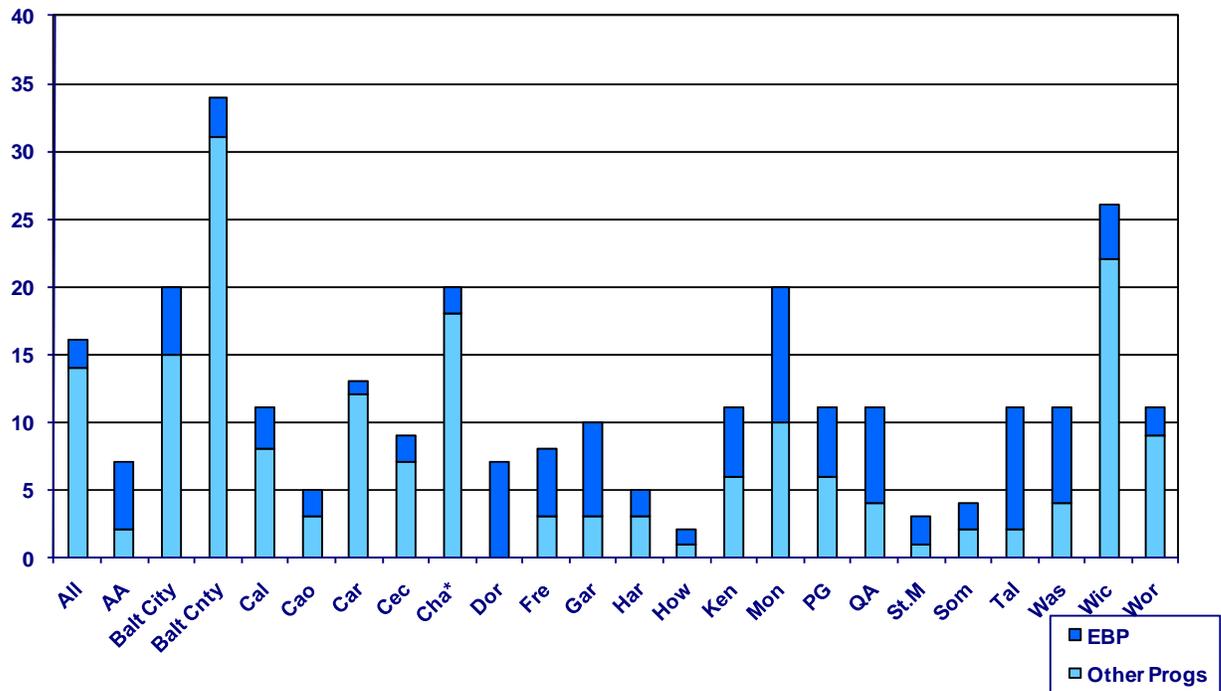
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- Seventeen jurisdictions had 11 or fewer programs.
- Evidence Based Programs Targeted to MSPF Priorities
 - Each of Maryland's 24 jurisdictions reported providing evidence-based programs designed to *decrease underage drinking and its contributing factors*. This includes such model programs as Communities Mobilizing for Change on Alcohol (in 9 jurisdictions), Strengthening Families (7 jurisdictions), Guiding Good Choices (7), Second Step – Middle School (6), Dare to be You (6), Life Skills Training (5), All Stars (4), Second Step – Preschool (4), Project Towards No Tobacco Use (3), Creating Lasting Family Connections (2), Project Alert (2), Across Ages (1), and Communities That Care (1).
 - Each of Maryland's jurisdictions reported providing evidence-based programs designed to *decrease alcohol and/or drug abuse and their contributing factors*. This includes Communities Mobilizing for Change on Alcohol (in 9 jurisdictions), Strengthening Families (7), Guiding Good Choices (7), Second Step – Middle School (6), Dare to be You (6), Life Skills Training (5), All Stars (4), Second Step – Preschool (4), Project Towards No Tobacco Use (3), Creating Lasting Family Connections (2), Project Alert (2), Across Ages (1), and Communities That Care (1).
 - Each of Maryland's jurisdictions reported providing evidence-based programs designed to *decrease binge drinking and its contributing factors*. This includes such model programs as Communities Mobilizing for Change on Alcohol (in 9 jurisdictions), Strengthening Families (7), Guiding Good Choices (7), Dare to be You (6), Life Skills Training (5), All Stars (4), Creating Lasting Family Connections (2), Project Alert (2), and Across Ages (1).
 - Nine jurisdictions are providing prevention programming which specifically targets reducing alcohol- and/or drug related crashes. In each instance, the jurisdiction is implementing the Communities Mobilizing for Change on Alcohol (CMCA) Program.

MARYLAND SPF SIG PLAN
 #1U79SP015591-01

The total number of programs and the number of evidence-based programs by County is displayed in Figure 3.

Figure 3: Number of Prevention Programs, by County



2. Significant gaps in Maryland’s current infrastructure

Based on the assessment of the substance use and related consequences, the MSPF priority and indicators, and the prevention infrastructure described above, the following gaps have been identified:

MSPF Indicator: Reducing past month alcohol use by youth ages 12-20

The Need:

According to the 2006-2007 National Survey on Drug Use and Health (MSDUH) (latest available data), approximately 204,000 underage Marylanders (aged 12-20) consumed alcohol in the past month. This is approximately 26% of the estimated 790,000 Maryland youth in this age category

MARYLAND SPF SIG PLAN
#1U79SP015591-01

Current level of ADAA funded prevention services:

The FY'2009 Maryland Alcohol & Drug Abuse Administration's Prevention Program Annual Report indicates that approximately 9,378 youth ages 12-20 participated in recurring prevention programs (programs that meet with the same group of individuals within a specified service population for a minimum of four separate occasions). The report also indicates that approximately 65,331 youth ages 12-20 received single service prevention activities (e.g., presentations, speaking engagements, community services, training services, technical assistance, and programs with the same population occurring on less than four separate occasions).

The Gap:

While Maryland has approximately 204,000 youth ages 12-20 who consumed alcohol in the past month, only 9,378 youth were regular prevention program participants and only 65,331 received single prevention services.

The gap between the number of youth ages 12-20 who have already consumed alcohol, a high risk population, and the number of prevention program participants ages 12-20 is significant. *Maryland clearly needs to expand the number, reach and effectiveness of its prevention programs and strategies in order to attain its priority of reducing and preventing underage drinking.* Since only two of the model prevention programs cited above target primarily community-level indicators, *Maryland needs additional programs designed to affect population level changes in underage drinking and its contributing factors.*

MSPF Indicator: Reducing past month binge drinking among young adults ages 18-25

The Need:

According to the 2006-2007 NSDUH, an estimated 977,000 Marylanders aged 12 years or older binged (i.e., consumed five or more drinks on the same occasion). Approximately 237,000 youth ages 18-25 report past month binge drinking. This is 43% of the estimated 546,000 Maryland youth in this age category.

Current prevention services:

The FY'2009 Maryland Alcohol & Drug Abuse Administration's Prevention Program Annual Report indicates that approximately 6,252 youth ages 18-24

MARYLAND SPF SIG PLAN

#1U79SP015591-01

participated in recurring prevention programs and that approximately 43,553 youth ages 18-24 received single service prevention activities in that year.

The Gap:

While Maryland has approximately 237,000 young people ages 18-25 that binged in the past month, only 6,252 youth in this age category were regular prevention program participants and only 43,553 received single prevention services. *Maryland clearly needs to expand the number, reach and effectiveness of its prevention programs and strategies in order to attain its priority objective of reducing and preventing binge drinking among youth ages 18 -25.*

Since only one of the previously cited model prevention programs targeting binge drinking targets primarily community-level indicators, *Maryland needs additional programs designed to affect population level changes in binge drinking and its contributing factors.* Since most existing prevention programs are school-based, *Maryland needs additional evidence-based programs and services for youth who are not in school.*

MSPF Indicator: Reducing alcohol-related crashes involving youth ages 16-25

The Need:

In 2007, approximately 8.5% of total motor vehicle crashes in Maryland involved an AOD-impaired driver. There were a total of 8,610 alcohol- and/or drug-related crashes; drivers aged 16-20 accounted for 11% or 938 of those crashes. The percentage of crashes involving an AOD-impaired driver has shown an increasing trend over the past five years for both drivers aged 16-20 years and those aged 21 or older.

Current prevention services:

The FY'2009 Maryland Alcohol & Drug Abuse Administration's Prevention Program Annual Report and the SEOW survey responses from Prevention Coordinators indicate that nine jurisdictions are providing prevention programming which specifically targets reducing alcohol-related crashes. In each instance, the jurisdiction is implementing the Communities Mobilizing for Change on Alcohol (CMCA) Program. Statewide, approximately 7,488 persons are receiving CMCA services designed to reduce alcohol access and alcohol-related crashes through changing community alcohol-related policies and practices.

MARYLAND SPF SIG PLAN
#1U79SP015591-01

The Gap:

Maryland State Highway Safety Administration data indicate that alcohol- and /or drug- related crashes are a serious problem throughout the State of Maryland, yet only nine jurisdictions are providing prevention programs specifically intended to reduce alcohol-related crashes. The fact that a significant percentage of these crashes (11%) involve drivers ages 16-20 and that the number of these crashes is trending upward make the service gap even more pronounced. *Maryland clearly needs to expand the number of initiatives addressing alcohol-related crashes, targeted to both persons 16-20 and persons beyond the legal drinking age of 21.* Since much of the evidence-based practice literature cites community-level, environmental strategies to be effective in reducing alcohol-related crashes, *Maryland would benefit from more such programs designed to affect population level changes in alcohol-related crashes.*

Infrastructure resources needed to help fill the identified gaps:

In order to address the identified gaps, expanding and enhancing the number, reach and effectiveness of its prevention programs and strategies, Maryland must strengthen its existing prevention infrastructure. To this end, ADAA will utilize its MSPF resources to:

- Provide additional ATOD prevention training at the State, jurisdictional and community levels,
- Provide technical assistance and resources to assist local communities to strengthen their ATOD awareness, needs assessment, community mobilization, active prevention coalitions, and strategic planning capabilities,
- Provide additional resources at the community level for evidence based prevention strategies and programs that specifically address local community needs and the State MSPF prevention priorities (reducing underage drinking, binge drinking, and alcohol- related crashes),
- Provide additional resources at the community level for evidence based environmental strategies that are specifically designed to affect population level changes in substance use and its consequence, and
- Provide technical assistance and resources to communities for program monitoring and evaluation.

3. Maryland's capacity to implement SPF at the State level

Existing State organizational resources devoted to implementing the MSPF

Maryland has marshaled a variety of resources to date in the development of its SIG SPF application to SAMSHA and the development of this MSPF Strategic Plan. The MSPF Advisory Committee is a work group of the Governor's State Drug and Alcohol Abuse Council (SDAAC) and guides the development and implementation of the MSPF initiative. The SDAAC provides ongoing advice and guidance to the MSPF Advisory Committee regarding issues and concerns that require higher level interventions for resolution.

The MSPF Advisory Council comprises representatives from 12 State agencies and offices; Local Drug Abuse Advisory Councils (LDAAC); local County Prevention Coordinators; the Maryland Association of Prevention Professionals and Advocates (MAPPAs); Maryland's University Prevention Resource Centers; and SAMHSA/CSAP funded Drug Free Communities; as well individuals representing their communities or having specific interest or expertise in prevention; and the CSAP Project Officer. It is co-chaired by Suzan Swanton, the Executive Director of the Governor's State Drug and Alcohol Abuse Council, and Maryland State Delegate Kirill Reznik, a member of that Council. The MSPF Advisory Council has three standing work groups that carry out the bulk of its MSPF planning activities: the State Epidemiology Outcomes Workgroup (SEOW), the Cultural Competence Work Group, and the Evidence Based Practices Work Group.

An MSPF Plan Development Team has been formed to develop the MSPF Strategic Plan. The team has developed this Plan in a methodical, inclusive manner that will maximize the likelihood of success in addressing MSPF State priorities. The Plan was reviewed and approved by the MSPF Advisory Council prior to submission.

The MSPF Plan Development Team consists of:

- the ADAA Director of the Community Services Division, who is also acting as the MSPF Project Manager;
- the Deputy Director, Center for Substance Abuse Research (CESAR), who serves as the SEOW Manager;
- the Vice President of the Maryland Association of Prevention Professionals and Advocates (MAPPAs);
- the Acting Director of ADAA Management Services; and a

MARYLAND SPF SIG PLAN
#1U79SP015591-01

- Substance Abuse Prevention Expert/ Consultant.

The MSPF Plan Development Team established a process through which it involved the MSPF Advisory Council and its various work groups in the development of all proposed MSPF activities. The SEOW, Cultural Competence and Evidence Based Practices Work Groups have met regularly to discuss and develop recommendations for MSPF priorities, activities, policies, practices, and guiding principles. These recommendations were then presented by the work groups to the Governor's State Drug and Alcohol Abuse Council's MSPF Advisory Council for further discussion and approval. Upon its approval, the priorities, activities, policies, practices, and principles were incorporated into the MSPF Strategic Plan.

Some examples of this process include:

Assessment: The State Epidemiology Outcomes Work Group has involved a wide array of prevention stakeholders who have worked diligently to conduct the MSPF assessment of substance abuse and related consequences, the assessment of our substance abuse related systems; develop the criteria and rationale for determining MSPF priorities; and facilitate the selection of MSPF priorities. The SEOW will continue to be active as described in the Capacity Building section.

Capacity Building: The SEOW, through its prevention system assessment, and the Evidence Based Practices Work Group through its Workforce Development Survey, have both been actively involved in determining the capacity building needs of our current prevention system. Both of these work groups as well as the Cultural Competence Work Group will be engaged in the planning and implementation of our training and technical assistance syllabus and calendar which will include specific training/technical assistance sessions to assist communities to infuse cultural competence in all of their activities; to select and implement evidence based programs, policies and practices; and to collect, analyze and utilize data in their SPF planning, decision-making, and evaluation activities.

Planning: The Evidence Based Practices and Cultural Competence Work Groups have been consistently engaged in our MSPF planning activities. For example, the Evidence Based Practices Work Group has reviewed and utilized CSAP Guidance documents to develop our MSPF policies regarding how MSPF funding will be used only in support of evidence based programs, policies and practices. It also was responsible for reviewing the CSAP guidance document regarding the allocation of SPF SIG resources and developing the planning model and allocation approach that we will utilize to provide funds to local communities. Similarly, the Cultural

MARYLAND SPF SIG PLAN
#1U79SP015591-01

Competence Work group has reviewed CSAP Cultural Competence guidance to craft the MSPF cultural competence policies and sub-recipient requirements. Both work groups will continue their involvement through review and approval of our specific RFP language in these areas.

Implementation: The Evidence Based Practices and Cultural Competence Work Groups will continue their MSPF responsibilities when we move into the Implementation phase of the project. For example, each work group will have representation on the MSPF proposal review panel to ensure that all sub-recipients are proposing activities that meet the MSPF cultural competence and best practices policies and requirements that they have developed. As local level prevention plans and activities are implemented, both work groups will have the opportunity to review the progress of the local implementation to ensure that the local sites are fully compliant with the MSPF cultural competence and evidence based practices that they committed to in their proposals

Evaluation: The SEOW will continue its active involvement throughout the MSPF Evaluation process. It will continue to provide its data collection, analysis and reporting expertise and guidance as the Evaluation component design is finalized, the contractual Project Evaluator selected, and the evaluation activities are implemented. Through its ongoing review and assessment of MSPF evaluation activities and recommendations to the MSPF Advisory Council, the SEOW Work Group will continue to serve as a critical MSPF resource as it has from the inception of the project.

The Maryland Alcohol & Drug Abuse Administration (ADAA) is the single state agency responsible for the planning, development, and funding services to prevent harmful involvement with alcohol, tobacco and other drugs and for treating individuals in need of addiction services. The ADAA will oversee the MSPF initiative and cooperative agreement with SAMHSA. It will hire an MSPF Project Director, Technical Assistance/Training Coordinator and Administrative Assistant to work full time on ensuring the success of the MSPF initiative. Going forward, the ADAA Research Division will convene and manage the SEOW Work Group, carry out all State-level MSPF data collection, analysis and reporting functions, provide guidance to community level organizations, and supervision to the contractual MSPF Evaluator.

State funding resources devoted to implementing the MSPF

Over the next five years, the ADAA will utilize its MSPF funding and its SAPT Block Grant prevention funding to implement the MSPF initiative. In the upcoming

MARYLAND SPF SIG PLAN

#1U79SP015591-01

year, ADAA will allocate Assessment/Planning grants to Maryland's 24 Prevention Coordinator's offices to assist them to conduct a formal jurisdictional level MSPF needs assessment; identifying their jurisdiction's substance use and consequences priorities and the targeted community for MSPF implementation. Jurisdictions will document these efforts and use them as the basis for their proposals to ADAA for MSPF implementation funds. Jurisdictions will be encouraged to use their SAPT Block Grant funding from ADAA to supplement the funding for the activities detailed in their local MSPF strategic plans. As detailed in the Sustainability Section of this strategy, at the end of the SPF SIG funding period, local jurisdictions can choose to sustain their successful MSPF activities utilizing their SAPT Block Grant funding from ADAA.

New State resources that will be developed through implementing MSPF processes and funding

In the current economic downturn no new resources from other State agencies have been committed to support the MSPF initiative. As MSPF activities are implemented and evaluated however, positive outcomes will be documented and presented to the Governor's State Drug and Alcohol Abuse Council, the Maryland State Legislature and the public to support the value of devoting additional State resources for data driven, evidence based prevention programs and strategies.

4. Maryland's capacity to collect, analyze and report data to support data-driven decision-making in each step of the SPF (surveillance data, program monitoring data, etc.)

The Maryland Alcohol & Drug Administration's Research Division will carry out all data collection, analysis and reporting functions necessary to support the data driven decision-making at each step of the MSPF process. An epidemiologist and data analysis staff will provide direct support for this initiative. In the remaining years of the MSPF grant, the Maryland SEOW will continue to monitor the use of alcohol, tobacco, and other drugs and the consequences of their use in Maryland and its localities in order to identify and prioritize the prevention needs of the state and its local jurisdictions. To achieve this end, the MD SEOW will continue to oversee the collection, interpretation, and dissemination of statewide and local data that quantify substance use and its consequences for the state.

5. Community prevention infrastructure in place (i.e., coalitions, resource centers, etc.) and its effectiveness

Each of Maryland's 24 local jurisdictions has an ADAA-funded Prevention Coordinator that is responsible for planning, delivering, coordinating, and monitoring prevention services that meet the needs of their particular jurisdiction. Each Prevention Coordinator receives ADAA funding (from the SAPT Block Grant) for its prevention activities and administration. Many of the Prevention Coordinator's offices receive additional funding from non-ADAA sources and support additional prevention staff members and activities with that funding. Most Prevention Coordinators are located in the local Health Department and, as such, work closely with other prevention (e.g., HIV/AIDS, tobacco) and health promotion personnel and can often leverage the time and resources of those staff to assist their substance abuse prevention efforts.

Additionally, each jurisdiction has a Local Drug and Alcohol Abuse Council which is responsible for developing and submitting a local plan to the Governor every two years and progress updates to the ADAA every six months. Local councils incorporate input from multiple agencies and stakeholders into their planning activities. Plans are intended to guide the improvement of current services as well as document the need for new services. These councils are required by State Executive Order and are linked to the Governor's State Drug and Alcohol Abuse Council. While several local councils currently involve their county Prevention Coordinators as active members, many do not. ADAA intends to use the MSPF process and funding as a means to enhance the active involvement of local Prevention Coordinators on every Local Drug and Alcohol Abuse Council. This will be a major boost to strengthening prevention services and better integrating them with substance abuse intervention and treatment services in each jurisdiction.

The ADAA also funds four regional University Prevention Resource Centers strategically located across the State in Western Maryland, the Eastern Shore, Southern Maryland, and the Baltimore metropolitan area. These centers provide ongoing ATOD prevention efforts on their campuses and within the surrounding communities. The centers work with the Prevention Coordinators in their home jurisdiction and in their region to coordinate campus- and community-based prevention services and activities.

Additionally, nine Maryland jurisdictions now benefit from SAMSHA-funded Drug Free Community grants to strengthen and enable local community coalitions to prevent and reduce youth substance use. ADAA will strongly encourage local

Prevention Coordinators to involve these coalitions in all MSPF needs assessment, community mobilization, planning, implementation, and evaluation activities.

6. Significant gaps in the current *community level* prevention system in Maryland

Prevention infrastructure gaps at the community level closely mirror the State prevention infrastructure gaps described in Section B.2, above. Review of the SEOW's *Maryland Compendium of Cross County Indicators on the Consequences and Consumption of Alcohol, Illicit Drugs and Tobacco* (Appendix C), and the 2009 Maryland Alcohol & Drug Abuse Administration's Prevention Program Annual Report shows that the number of persons using substances and impacted by their consequences greatly exceeds the number of prevention services and activities that the jurisdiction can currently provide with its existing level of resources.

In order to expand and enhance the number, reach and effectiveness of community-level prevention programs and strategies, each jurisdiction must strengthen its existing prevention infrastructure. To this end, MSPF resources will be used to:

- Provide additional ATOD prevention training at the jurisdiction and community levels
- Provide technical assistance and resources to assist local communities to strengthen their ATOD awareness, needs assessment, community mobilization, active prevention coalitions, and strategic planning capabilities
- Provide additional resources at the community level for evidence based prevention strategies and programs that specifically address local community needs and State prevention priorities
- Provide additional resources at the community level for evidence based environmental strategies that are specifically designed to affect population level changes in substance abuse and its consequence
- Provide technical assistance and resources to communities for program monitoring and evaluation.

7. Community capacity to implement the SPF and to collect, analyze and report on data

By utilizing its MSPF resources to support and strengthen the local prevention infrastructure described above, ADAA is very confident that all MSPF activities can be effectively implemented at the community level. The Prevention Coordinator Network, which is an established, coordinated, and recognized strategy for the provision of technical assistance and program development services at the county and community level, will serve as the hub of SPF implementation at the local level.

ADAA will encourage the participation of the local Drug Free Communities and Local Drug and Alcohol Abuse Councils in the county's SPF planning and implementation processes. With the extensive training and technical assistance to be provided to each jurisdiction local prevention infrastructure will be strengthened, expanded through additional participants, and extremely well prepared to successfully implement all SPF activities.

C. Criteria and Rationale for Determining MSPF Priorities.

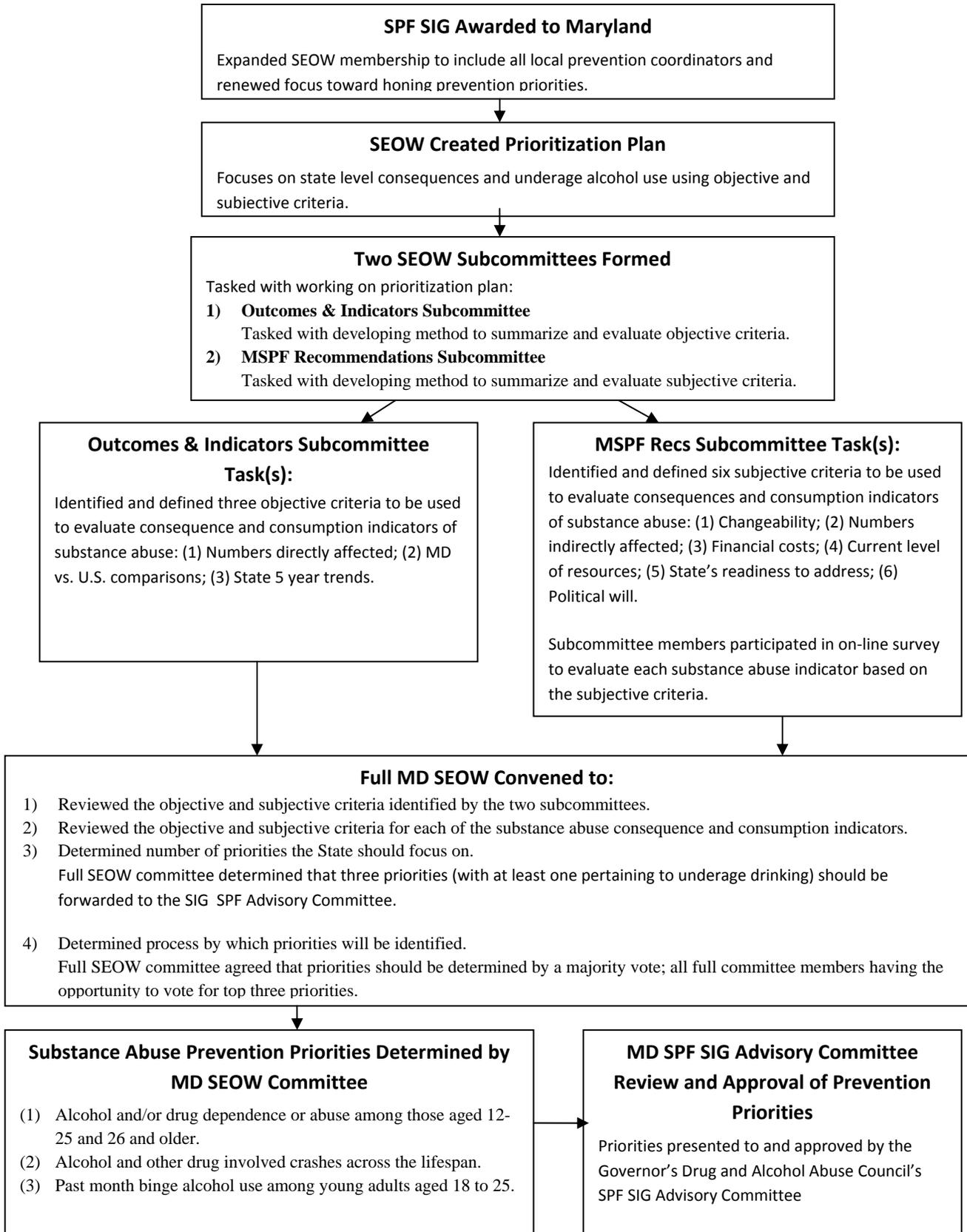
This section describes and discusses the process Maryland used in arriving at targeted priorities for the state. Beginning in 2009, the SEOW carefully designed and engaged in a systematic process for generating prevention priority recommendations for the state, as outlined in Figure 4. Upon Maryland's award of the SPF SIG in 2009, the SEOW renewed its focus toward honing prevention priorities. In so doing, the SEOW was expanded to include all local prevention coordinators to ensure that all jurisdictions in the state had the opportunity to participate in the prioritization process.

The expanded SEOW outlined a plan for prioritization to center on the evaluation of state level consequences of substance use (in keeping with the outcomes based approach to prevention) and underage alcohol use (as mandated by CSAP) using both objective and subjective criteria. To facilitate the process, two SEOW subcommittees were formed:

- (1) The Outcomes and Indicators Subcommittee to develop a method to summarize and evaluate the objective criteria, and
- (2) The Maryland Strategic Prevention Framework Recommendations Subcommittee to develop a method to summarize and evaluate the subjective criteria.

MARYLAND SPF SIG PLAN
#1U79SP015591-01

Figure 4: Prioritization Process



1. Epidemiological criteria Maryland used to define priorities or issues/areas of “critical need” based on substance related consequence and consumption data presented in the epidemiological profile (e.g., magnitude, time trends, severity, economic costs)

Method to Summarize and Evaluate the Objective Criteria

The Outcomes and Indicators Subcommittee was tasked with determining how to translate the objective data contained in the State Epidemiological Profile into an easy to use interpretive document to guide prioritization. The subcommittee agreed to consolidate the consequence and underage alcohol consumption data into table form as the Maryland Scorecard (see Appendix F) with information/assessments on three primary criteria. The Outcomes and Indicators Subcommittee approved summarizing the data based on the following objective criterion and associated definitions:

1) Magnitude or Numbers Directly Affected

To measure the size of the problem in terms of the numbers directly affected in the state it was decided this criteria would represent actual numbers for indicators based on administrative data, and estimated numbers for indicators based on survey data.

2) State vs. U.S. Comparisons

To provide an indicator of the relative size of the problem in Maryland relative it was determined that state data would be compared to national data and classified as higher, similar, or lower. Where national data were available, Maryland’s rates or percentages would be compared to the nation’s. The subcommittee approved the following rules for classifying the data for each indicator:

MD Higher than U.S.: The State figure is higher than the U.S. figure by at least 5% for administrative data or statistically higher than the U.S. for survey data.

Similar: The State figure is within $\pm 5\%$ of the national data for administrative data or has overlapping confidence intervals for survey data.

MD Lower than U.S.: The State figure is lower than the U.S. figure by at least 5% for administrative data or is statistically lower than the U.S. for survey data.

In order to classify the data into the categories above the committee agreed to a number of data source specific guidelines. For administrative data it was agreed that although all differences are actual, a rule would be applied that meaningful differences are those where Maryland’s rate/percent was at least 5% greater or less than the nation’s. For survey data, the data available for determining differences varied by survey, so different guidelines were developed for each survey. For the National Survey on Drug Use and Health (NSDUH), employing a conservative approach, differences were determined based on whether confidence/prediction intervals around the Maryland and U.S.

MARYLAND SPF SIG PLAN

#1U79SP015591-01

percentage were overlapping. For the Maryland Adolescent Survey standard errors are not available, an arbitrary rule was determined that differences of at least ± 7 percentage points are meaningfully different from the national Monitoring the Future data. For the Behavioral Risk Factor Surveillance Survey (BRFSS), each of the 50 states and Washington, DC administers their own surveys and reports their results to the CDC. The CDC reports the median of all states as the national figure. Confidence intervals are available for Maryland but not for the nation. Therefore, differences were determined if the national figure falls outside of the confidence interval surrounding Maryland's estimate.

3) State Trends

In order to classify the recent 5-year trend in an indicator the following guidelines were agreed upon:

Fluctuating: Indicates cases with no clear trend during the 5-year time period. For administrative data the data showed $\pm 5\%$ increases and decreases within the time period. For survey data the data showed both statistically significant increases and decreases during the time period.

Increasing Trend: For administrative data this indicates the most recent year's data is at least 5% higher than the data from 5 years ago and the data did not fluctuate during that 5 year time period. For Survey Data this indicates the most recent year's data was significantly higher than the data from 5 years ago and the data did not fluctuate during that 5 year time period.

Stable Trend: When the difference between the two time periods falls within $\pm 5\%$ for administrative data and are not significantly different for survey data.

Decreasing Trend: For administrative data, the most recent year's data are at least 5% lower than the data from 5 years ago and the data did not fluctuate during that 5-year time period. For survey data, the most recent year's data was significantly lower than the data from 5 years ago and the data did not fluctuate.

Method to Generate, Summarize and Evaluate the Subjective Criteria

The Maryland Strategic Prevention Framework Subcommittee was tasked with developing a method to incorporate subjective criteria or important criteria for which there are no objective data into the prioritization process. First, the subcommittee met to identify and define the subjective criteria. Through discussion the group reached a consensus on the following criteria and associated definitions:

- 1) **Changeability:** What is the likelihood that each consequence below could be improved in 3 years through SPF SIG prevention efforts in Maryland?

MARYLAND SPF SIG PLAN

#1U79SP015591-01

Consider the following in your assessment:

- \$1.8 million a year will be available to fund local prevention efforts through the SPF SIG

- Are there evidenced-based (grounded in research) strategies, programs or policies that could be implemented to affect change in this consequence/consumption?

- Can behaviors/habits/perceptions/policies associated with the consequence/consumption be changed meaningfully in three years and sustained afterward?

- Can the availability of the substances associated with the consequence/consumption be impacted?

- Can we get others to view the associated substance use as a health problem?

- Are data available to measure change in the consequence/consumption?

- 2) Numbers Indirectly Affected: Would you estimate a relatively high, moderate, or low number of people in Maryland is indirectly affected by the consequence?

Consider the following in your assessment:

- The number of people who are not directly involved in the consequence, but who may be negatively impacted by the consequence.

- The impact of the consequence on the population, community, neighborhood, family, children, peers, businesses, medical community, etc.

- It may also be helpful to refer to the numbers directly affected provided in the MD SEOW Objective Data Scorecard.

- 3) Cost: Would you estimate the financial costs to Maryland associated with this consequence to be relatively high, moderate, or low?

Consider the following in your assessment:

- Dollars associated with: lost wages, lost productivity, property damage, health care/insurance, criminal justice, school-related, lawsuits, fatality-related costs (medical examiner, years life lost and associated lost earnings), social services, and extra fees/taxes associated with covering these costs

- It may also be helpful to refer to the numbers directly affected provided in the MD SEOW Objective Data Scorecard.

- 4) Current Resources: Is the current level of resources in Maryland to address this consequence high, moderate or low?

Consider the following in your assessment:

- Current capacity: coalitions, local groups/organizations, youth coalitions, partners providing in-kind resources

MARYLAND SPF SIG PLAN

#1U79SP015591-01

- Actual strategies, programs, policies being implemented
- Funding available through Drug Free Communities, Block Grant, etc.

5) Readiness to Address: Is Maryland's level of readiness to address this consequence high, moderate, or low?

Consider the following in your assessment:

- Resources that could be drawn upon to add to those that are already in place or fill a current gap
- Potential capacity: coalitions, local groups/organizations, youth coalitions, partners to provide in-kind resources

6) Political Will: Is the current level of political will in Maryland to address this consequence high, moderate, or low?

Consider the following in your assessment:

- Involvement/interest of local politicians, LDAAC
- Involvement/interest of state level policy makers
- Existing coalitions/grassroots organizations
- Constituent interest

An online survey was created to capture the ratings of each consequence and underage drinking indicator on the subjective criteria as defined by the subcommittee. Each subcommittee member completed the survey and the results were summarized for each indicator with a mean, standard deviation, and ranking (Appendix G). There was little variance among the indicators for the subjective criterion Current Resources and Readiness to Address, thus since these criterion did little to distinguish among indicators they were removed from the results summary for the purpose of prioritization.

2. Resulting State-level priorities/areas of critical need (e.g., specific consumption patterns, consequences, populations, geographic areas). Describe how the epidemiological criteria described above were applied to substance use and substance related consequences data to determine epidemiological priorities/areas of critical need

The full SEOW was convened in January 2010 to review the objective and subjective criterion summaries (Appendices C & D) that were compiled under the guidance of the subcommittees in order to generate recommended priorities for prevention. The full SEOW determined that three priorities (with at least one pertaining to underage drinking) should be forwarded to the SPF Advisory Committee of the Governors Drug and Alcohol Advisory Council. The SEOW agreed that the priorities would be determined by a majority vote at the meeting with all full committee members having

MARYLAND SPF SIG PLAN
#1U79SP015591-01

the opportunity to vote for their top priorities. Consensus in identifying the recommended priorities was achieved in one round of voting.

Subsequently, the MSPF Plan Development Team assessed the priorities for the purpose of ranking them and developing the MSPF Priority Statement. Key criteria the team employed for this ranking process included (1) Magnitude (how significant is the problem in Maryland) and (2) Changeability (how likely it is that Maryland will reduce the problem with MSPF resources).

Priorities were ranked as follows:

- **Reducing the number of youth, ages 12-20, reporting past month alcohol use**
 - Magnitude:
 - 204,000 youth ages 12-20 report past month use. This is **26%** of the estimated 790,000 Maryland youth in this age category.
 - Changeability:
 - The Maryland SEOW ranked this priority second in changeability;
 - The MSPF Plan Development Team ranks this priority high in changeability due to the availability of evidence based strategies and programs that have demonstrated effectiveness in reducing underage drinking, as well as Maryland's ability to collect data on this population.
 - **Overall ranking - #1**
 - The magnitude of the problem, with approximately 26% of youth ages 12-20 engaging in underage drinking; the likelihood of being able to impact this indicator (changeability) with strategically allocated MSPF resources; and CSAP's emphasis on reducing underage drinking make this Maryland's #1 MSPF priority. Reducing underage drinking will also contribute to the priorities of reducing binge drinking and alcohol related crashes.

- **Reducing the number of young persons, ages 18-25, reporting past month binge drinking**
 - Magnitude:
 - 237,000 youth ages 18-25 report past month binge drinking. This is **43%** of the estimated 546,000 Maryland youth in this age category.
 - Changeability:
 - The Maryland SEOW ranked binge drinking for ages 12-20 second; binge drinking by ages 12-17 first; and binge drinking by ages 18-25 sixth in changeability;

MARYLAND SPF SIG PLAN

#1U79SP015591-01

- The MSPF Plan Development Team ranked this priority high in changeability due to the availability of evidence based strategies and programs that have demonstrated effectiveness in reducing the *amount* of alcohol consumed by underage and young adult drinkers, as well as Maryland's ability to collect data on this population.
- **Overall ranking - #2**
 - The magnitude of the problem, with approximately 43% of youth in this age group engaging in binge drinking, and the likelihood of being able to impact this indicator (changeability) with strategically allocated MSPF resources make this Maryland's #2 MSPF priority. The reduction of binge drinking will also contribute to the reduction of alcohol related crashes.
- **Reducing the number of alcohol and/or drug related crashes**
 - Magnitude:
 - There were 8,610 alcohol- and/or drug-related crashes reported in the most recent year; Maryland's numbers have been increasing for all drivers and youthful drivers over the past five years.
 - Changeability:
 - The Maryland SEOW ranked alcohol and/or drug-related crashes first in changeability;
 - The MSPF Plan Development Team ranked this priority high in changeability due to the availability of evidence based strategies and practices that have demonstrated effectiveness in reducing the incidence of youth and young adult drinking and driving, as well as Maryland's ability to collect data on this indicator.
- **Overall ranking - #3**
 - The upward trend of alcohol and/or drug related crashes for all drivers and for youthful drivers over the past five years, and the likelihood of being able to impact this indicator (changeability) with strategically allocated MSPF resources make this Maryland's #3 MSPF priority.
- **Reducing the number of Marylanders across the lifespan that report past year alcohol and/or drug dependence or abuse**
 - Magnitude:
 - 430,000 Marylanders are reported to be alcohol and/or drug dependent or abusing. This is **7.7 %** of the total Maryland population, and approximately **10%** of the population age 15 and older.
 - Changeability:

MARYLAND SPF SIG PLAN

#1U79SP015591-01

- The Maryland SEOW ranked alcohol dependence and abuse moderately high on changeability; it ranked drug dependence very low.
- The MSPF Plan Development Team ranked the priority very low on changeability due to its determination that:
 1. the priority is far too broad (in essence it means reducing *all* types of substance abuse among *all* Marylanders, which is actually not prioritizing at all); and
 2. the number and severity of alcohol and/or drug dependence or abuse are too high to be changed by the level of MSPF funding that will be available. There is little likelihood of being able to decrease the indicator over the life of the initiative.
- **Overall ranking - #4**
 - Changeability is a very important criterion for inclusion as an MSPF Priority. It is very unlikely that the amount of MSPF resources to be allocated to communities will be sufficient to move the indicators for this large, all inclusive population of AOD dependent/abusing Marylanders over the length of the grant period. Consequently, Maryland eliminated this as an MSPF Priority.

Following consultation with the CAPT Epidemiologist regarding how other SPF SIG states had worded their priority statements, a single priority focus area, reducing the misuse of alcohol by youth and young adults, with three closely related, measurable and obtainable indicators, was agreed upon.

D. Description of MSPF Priority and Indicators:

The MSPF Priority is to reduce the misuse of alcohol by youth and young adults in Maryland, as measured by the following indicators:

- Reduce the number of youth, ages 12-20, reporting past month alcohol use
- Reduce the number of young persons, ages 18-25, reporting past month binge drinking
- Reduce the number of alcohol-related crashes involving youth ages 16-25

The MSPF Priority Statement was reviewed and approved by the MSPF Advisory Committee.

II. Capacity Building

A. Areas Needing Strengthening

As discussed in the Assessment Section's comparison of Maryland's MSPF priority substance use and consequences problems and the current prevention resources available to address those problems, Maryland will utilize its MSPF resources to (1) strengthen the capacity of its prevention system and infrastructure and (2) expand and strengthen the number, reach and effectiveness of community-level prevention programs and strategies. In order to do so, MSPF resources will be used to:

Strengthen the Prevention System & Infrastructure:

- Provide additional ATOD prevention training at the State, jurisdiction and community levels
- Provide technical assistance and resources to assist local communities to strengthen their ATOD awareness, needs assessment, community mobilization, active prevention coalitions, and strategic planning capabilities
- Provide technical assistance and resources to communities for program monitoring and evaluation.

Strengthen the Number, Reach and Effectiveness of Community-level Programs and Strategies:

- Provide additional resources at the community level for evidence based prevention strategies and programs that specifically address local community needs and the State MSPF prevention priority and indicators
- Provide additional resources at the community level for evidence based environmental strategies that are specifically designed to affect population level changes in substance abuse and its consequence

B. State- and Community-level Activities:

ADAA is currently in the process of hiring an MSPF Technical Assistance Coordinator that will be responsible for identifying, providing and coordinating training and technical assistance to local communities that will assist them to (1) strengthen their needs assessment, mobilization, strategic planning, program implementation, and evaluation capacity and (2) strengthen the number, reach and effectiveness of their community-level programs and strategies.

MARYLAND SPF SIG PLAN

#1U79SP015591-01

The ADAA's Office of Education and Training for Addiction Services (OETAS) will work with the MSPF Advisory Committee and the MSPF Technical Assistance Coordinator to develop a Prevention Training Academy. ADAA will utilize OETAS' 30 years of expertise in designing and delivering addictions training to meet the varied needs of professionals and community volunteers that work with at-risk, substance abusing, and substance dependent individuals and their families to develop this new training resource. The Prevention Training Academy's initial focus will be on providing the training necessary to ensure that Maryland attains its MSPF priorities.

Based on the MSPF Advisory Committee meetings and numerous ADAA meetings, planning sessions and training events with Prevention Coordinators, MAPPA, and other prevention stakeholders, a tentative list of training topics has been developed. The topics identified include:

- Overview of the SPF and MSPF initiatives (including goals & priorities; the five step process, key SPF principles (e.g., data-driven, evidence based, culturally competent); state level activities and participants; local level activities and participants, etc.)
- Prevention 101 (an overview of current prevention science and practice, including CSAP's six primary prevention strategies, the Institute of Medicine's prevention approaches, the public health approach, and a summary of current research on best practices and model programs)
- Evidence Based Practices (a more detailed exploration of research findings on effective prevention practices and model programs, including selection and implementation of specific evidence-based programs and strategies to meet local community needs and address State MSPF priorities)
- Cultural Competence (including MSPF cultural competence definitions and requirements; and assistance on how to infuse cultural competence throughout all phases of the MSPF process (and beyond))
- Needs Assessment (including MSPF definitions and requirements; data collection, analysis and reporting skills and resources; using needs assessment to set priorities; and SEOW and MSPF technical assistance resources available to assist communities with their local needs assessment)
- Community Mobilization (including MSPF definitions and requirements; basic community mobilization skills and strategies; examples of successful prevention mobilization efforts; and specific assistance on how to mobilize the community to support prevention efforts, meet local community needs, and address State MSPF priorities)
- Strategic Planning (including MSPF definitions and requirements; basic strategic planning skills and strategies; examples of successful SPF strategic planning efforts; and specific assistance on how to develop a strategic plan that meets local community needs and addresses State MSPF priorities)

MARYLAND SPF SIG PLAN

#1U79SP015591-01

- Program Implementation (includes how to match identified community needs with evidence based practices, programs and strategies; selecting the most appropriate programs or strategies (universal, selected or indicated); issues on implementing evidence based programs with fidelity; program monitoring and oversight)
- Evaluation (includes MSPF definitions and requirements; process and outcome evaluation; selection of appropriate indicators to document the prevention community initiative's success; selection of an evaluator; and SEOW and MSPF technical assistance resources available to assist communities with their evaluation effort)
- Sustainability (includes MSPF definitions and requirements; review of successful sustainability strategies implemented elsewhere (including other SIG SPF states); provision of federal, state, local and foundation funding resource directories and websites)

A Maryland Prevention Workforce Development Survey has recently been developed by the MSPF Evidence Based Practices Work Group and disseminated to prevention professionals statewide. The results of this document will help us to further shape the content of the topics listed above, their length (i.e., ½ day, full day, 2 day, etc.), format, sequencing, etc. This survey feedback will also identify additional prevention training topics needed to increase that capacity of our prevention system practitioners and community volunteers.

The MSPF capacity-building training being developed will be provided through OETAS courses, workshops, seminars, and conferences throughout the year in commuter and residential settings. Web-based prevention training will also be developed and provided. A complete MSPF prevention training syllabus and calendar will be developed when MSPF staff is in place and disseminated widely to the substance abuse prevention, intervention, treatment communities; agencies and programs that provide supportive services to at-risk, substance abusing, and substance dependent individuals and their families; policy makers; etc.

Training will be provided at the State level for audiences such as the Governor's State Drug and Alcohol Abuse Council, the MSPF Advisory Committee, State agencies, State legislators, and other key service planners and policy makers. Training will be provided at the community level for county and local community MSPF planning group members, community coalition members, MAPPAs members, Prevention Coordinators and their staff, prevention program providers, local human services program and agency staff, and a wide variety of others interested in preventing and reducing substance use and its consequences in their community.

MARYLAND SPF SIG PLAN
#1U79SP015591-01

The proposed Prevention Training Academy will also help facilitate the development and implementation of a Substance Abuse Prevention Specialist Training track within OETAS. This training component will be developed in cooperation with MAPPAs, the prevention certification entity for Maryland.

OETAS and MSPF staff will identify a roster of training resources, focusing on utilizing the prevention expertise of the groups described in the Resource Needs Assessment section of this plan (Section I.B.1), including Prevention Coordinators, MAPPAs members, prevention program providers, and University Resource Center staff. Maryland will also utilize the training resources of CSAP's Northeast Center for the Application of Prevention Technologies (NCAPT) whenever appropriate.

The ADAA will identify additional training needs and topics, as well as any needed revisions to the training being provided through its on-going training needs assessment activities. This will include review and analysis of evaluation surveys submitted by participants in all training sessions; feedback received at local and State MSPF, LDAAC, and other prevention meetings; and ADAA MSPF staff's regular review of progress and evaluation results from the local MSPF initiatives. All prevention training sessions will have an evaluation component and all evaluation results will be documented.

The ADAA MSPF staff's regular review of progress and evaluation results from the local MSPF initiatives will also be utilized to identify the specific technical assistance needs of individual communities. The MSPF Technical Assistance Coordinator will provide the needed assistance whenever possible and will identify and secure other technical assistance resources when necessary. As with the provision of training, those technical assistance resources may include Prevention Coordinators, MAPPAs members, prevention program providers, University Resource Center staff, and NCAPT resources. SEOW and ADAA Research Division resources will also be available to provide technical assistance to local communities regarding data collection, analysis and reporting and program evaluation.

C. Role of the State Epidemiological Outcomes Workgroup (SEOW)

In the remaining years of the MSPF grant, the Maryland SEOW will continue to monitor the use of alcohol, tobacco, and other drugs and the consequences of their use in Maryland and its localities in order to identify and prioritize the prevention needs of the state and its local jurisdictions. To achieve this end, the MD SEOW will continue to oversee the collection, interpretation, and dissemination of statewide and local data that quantify substance use and its consequences for the state.

MARYLAND SPF SIG PLAN

#1U79SP015591-01

Since 2006, ADAA has contracted with the University of Maryland's Center for Substance Abuse Research (CESAR) to convene and manage the Maryland SEOW. CESAR has successfully managed the SEOW process through the completion of the MSPF Assessment which serves as Section I of this Maryland SIG SPF Plan. In an effort to increase the efficiency and cost effectiveness of the SEOW process and activities in the future as the MSPF process moves from planning to implementation, ADAA is undertaking a reorganization through which the SEOW will be managed by the ADAA Research Division beginning July 1, 2010.

The Maryland Alcohol & Drug Administration's Research Division will carry out all data collection, analysis and reporting functions necessary to support the data driven decision-making at each step of the MSPF process. An epidemiologist and data analysis staff will provide direct support for this initiative. SEOW related activities to support its data collection, analysis and reporting functions will include:

- Convening regular SEOW meetings, including setting agendas, compiling minutes and submitting workgroup reports to the MSPF Advisory Committee
- Compiling state and local data into reports such as *Maryland Epidemiological Profiles* and *Maryland Compendiums of Cross County Indicators* that serve to provide information such as the most current indicator data on the nature and extent of substance use and consequences, cross jurisdictional comparisons, emerging problems, and trends over time to help inform prevention planning and decision-making.
- Providing briefings and presentations to the Governor's State Drug and Alcohol Abuse Council, the MSPF Advisory Committee, Local Drug and Alcohol Abuse Councils, and other substance abuse policy and planning bodies to help inform their decision-making
- Identifying and developing data sources that will enable local MSPF communities to establish appropriate outcome indicators and track their progress over time
- Provide on-going feedback reports to local MSPF communities regarding changes in substance use and consequences indicators, emerging problems, trends, etc. to inform their planning and decision-making
- In collaboration with the MSPF Program Manager, supervise the efforts of the ADAA's contractual State MSPF Evaluator
- Guide and coordinate the efforts of the local communities' contractual MSPF Evaluators

III. Planning

A. Planning Model:

On the *jurisdictional* level, Maryland's MSPF funds will be allocated following the Equity Resource-Allocation Model described in the SIG SPF Guidance for States. Each of Maryland's 24 jurisdictions will receive MSPF funding upon its meeting criteria established by the ADAA, including the submission and approval of its MSPF Jurisdictional Assessment and Planning Final Report which (1) documents the nature and extent of youth and young adult alcohol misuse, contributing factors, and prevention resources in the jurisdiction, and (2) identifies and describes a community to receive MSPF funding based upon the data-driven needs assessment.

At the *community* level, MSPF Community Implementation funds will be allocated to a high need community in each jurisdiction that shows evidence of (1) having the highest number of youth and young adults misusing alcohol (greatest contributor) and/or (2) having the highest rates of alcohol misuse by youth and young adults (greatest need) in the jurisdiction. This allocation approach will result in MSPF funding going to 24 highest need communities across the State following the submission and approval of their comprehensive local MSPF Strategic Plans and budgets.

B. Allocation Approach:

Jurisdictional Assessment/Planning Grants:

The first step of the MSPF allocation approach is to provide small (\$10,000) Assessment/Planning grants to each of Maryland's 24 jurisdictions. These grants will enable the jurisdiction to begin MSPF planning. The grants will be made to the Prevention Coordinator's Office within each local Health Department. That office will:

1. Receive and administer the MSPF Assessment/Planning awards
2. Convene local policy makers, stakeholders, community, and organization leaders to conduct a data-driven jurisdiction-wide needs assessment process to:
 - Assess and document the nature and extent of alcohol misuse by youth and young adults, contributing factors, and prevention resources in the jurisdiction, and by community.
 - Identify a local community for MSPF funding and technical assistance resources with:
 - a. The highest prevalence numbers and/or prevalence rates of underage drinking, youth binge drinking and alcohol-related crashes involving youth in the jurisdiction, and

MARYLAND SPF SIG PLAN

#1U79SP015591-01

- b. a reasonable level of readiness and capacity to address their youth alcohol issues through MSPF planning and the implementation of culturally competent and evidence based prevention programs
3. Complete and submit a comprehensive report/proposal to ADAA, within the required time frame, describing:
 - The completed needs assessment process; the nature and extent of alcohol misuse by youth and young adults in the jurisdiction; contributing factors; community prevention resources; and the community selected for MSPF funding based upon its data-driven needs assessment.
 - Their proposed methods to assist the selected community to (1) implement effective programs utilizing the five step MSPF process and (2) incorporate cultural competence, sustainability and evidence based practice throughout the MSPF process.

An MSPF Review Panel comprising ADAA staff, members of the MSPF Advisory Committee and other knowledgeable experts will review the submissions provided by the local jurisdictions to assess:

1. The quality and completeness of the jurisdiction's assessment activities and process;
2. Documentation that the selected local community is a community of greatest need, based on its prevalence numbers and/or rates;
3. Documentation of the community's readiness and capacity to implement culturally competent and evidence based prevention strategies and programs; and
4. The description of how the local Prevention Office will assist the selected community to:
 - implement effective programs utilizing the five step SPF process;
 - incorporate cultural competence, sustainability and evidence based practice throughout the local MSPF process; and
 - track and measure program activities and outcomes

The review will identify areas in which the Final Report is deficient or needs improvement and provide specific information and technical assistance to the jurisdiction regarding what additional information or corrections are needed for approval and funding. The review and feedback process will continue until the Final Report is approved.

MARYLAND SPF SIG PLAN
#1U79SP015591-01

Community Implementation Grants:

Upon the approval of a jurisdiction's Assessment and Planning Final Report, ADAA will award the jurisdiction MSPF Community Implementation grant funding. The 24 selected communities will receive MSPF funding, averaging approximately \$75,000 per year, through their local Health Departments. MSPF Community Implementation Grants will support the implementation of the 5-step MSPF process in the approved high-need MSPF communities. 15% of the award may be immediately released to the selected community's MSPF Planning Team to complete MSPF steps 1-3. Upon approval of the community's MSPF Strategic Plan (as described below), the remaining 85% of the award will be released to the community for MSPF steps 4 and 5 (implementation and evaluation).

Intensive training and technical assistance will be provided to the selected local MSPF communities to help them (1) better understand the MSPF, its purpose, processes and key prevention principles (e.g., data guided planning and programs; evidence based programs and practices; cultural competence infused in all SPF phases) (2) successfully implement their local plans and funded programs, and (3) collect data, track outcomes and evaluate their efforts.

This will include the provision of (1) specific guidance documents for completing their MSPF Strategic Plans and for selecting and implementing evidence based strategies, programs and practices that will address their specific youth alcohol needs and contributing factors, (2) the prevention training topics cited above in the Capacity Building Section of this plan and (3) the provision of technical assistance by the MSPF Technical Assistance Coordinator, the local Prevention Coordinator, CAPT, CADCA, and the other resources as described above.

Upon completion of the local MSPF Strategic Plan, the Prevention Office will submit the plan to ADAA for review and approval. ADAA will again convene an MSPF Review Panel comprising ADAA staff, members of the MSPF Advisory Committee and other knowledgeable experts to review the submitted local community MSPF Strategic Plans. The panel will review the plans to ensure that they contain all the required components and processes included in the MSPF Strategic Plan guidance document. The panel will identify areas in which the Strategic Plan is deficient or needs improvement and provide specific information and technical assistance to the jurisdiction regarding what additional information or corrections are needed for approval and funding. The review and feedback process will continue until the Strategic Plan is approved.

MARYLAND SPF SIG PLAN

#1U79SP015591-01

The remaining 85% of Community Implementation Grant funds will then be released to the community by the Health Department for the implementation and evaluation of culturally competent, evidence based prevention strategies and programs specifically designed to reduce the prevalence of underage drinking, youth binge drinking and/or alcohol-related crashes in the community.

The Health Department and its Prevention Coordinator's office will continue to be involved with the local community's MSPF Planning Team. Responsibilities will include:

- Working with the selected community to get the MSPF process started quickly and effectively
- Serving as a member of the community's MSPF governing body
- Providing or securing technical assistance and training as needed to assist the community to successfully implement MSPF activities
- Monitoring MSPF progress and contract compliance
- Contracting with an independent evaluator for the local evaluation
- Reporting regularly to ADAA and SAMHSA on MSPF activities, process and outcome evaluation progress

C. Implications of the Planning Model/Allocation Approach:

The MSPF planning model and allocation approach will result in each of Maryland's 24 jurisdictions receiving funding and technical assistance devoted specifically toward reducing the misuse of alcohol by youth and young adults in their highest need communities. This is the most likely way for MSPF funding to produce both local and statewide reductions in underage drinking, youth binge drinking, and alcohol-related crashes involving youth.

In addition to reductions in the MSPF priority indicators that will result from implementing MSPF programs and strategies in highest need communities, the MSPF Assessment/Planning Grants, MSPF Community Implementation Grants, technical assistance, and training resources that are being provided at the State and community levels will greatly strengthen our prevention system infrastructure and capacity. This will, in turn, lead to more effective prevention programs which will, over time, lead to greater reductions in all substance use and consequences in Maryland. .

The types and level of technical assistance and training to be provided through the MSPF process is well documented in the Capacity Building Section and throughout this plan. The MSPF Technical Assistance Coordinator will be well-versed in prevention science and experienced in the implementation of culturally competent, evidence based

MARYLAND SPF SIG PLAN

#1U79SP015591-01

prevention programs and strategies. This person will provide technical assistance and training, and will also marshal and coordinate other training and technical assistance resources.

ADAA's OETAS will provide 30 years experience in the development and delivery of substance abuse training courses, workshops, seminars and conferences. The ADAA Research Division and the SEOW will provide technical assistance to communities in the critical areas of data collection, analysis and reporting; tracking process and outcome measures; and program evaluation.

D. Community-based Activities:

As described above, Assessment/Planning grants will be made to all Maryland jurisdictions that will enable them to carry out jurisdiction-wide needs assessment activities, resulting in the selection of their high need community for MSPF resources. These communities will then complete the MSPF community mobilizing, strategic planning, implementation, and evaluation steps.

This will include the identification of the contributing factors in their particular community that are believed to contribute most to the misuse of alcohol by youth and young adults in their community. Each community will develop a local logic model that ties together the youth and young adult alcohol misuse they are addressing, the contributing factors present in the community, and the evidence based programs and/or strategies they will implement to address the contributing factors.

Communities will be provided MSPF technical assistance specifically intended to help them mobilize their community; develop their strategic plan; implement their evidence based programs and strategies; track the fidelity of program implementation; collect data, track outcomes and evaluate their effort.

The ADAA Implementation awards will include very specific language about requirements such as following the proscribed MSPF planning process; infusing cultural competence and inclusion in all local MSPF activities; collecting and using data to drive their decisions and activities; implementing evidence-based programs, practices and policies; evaluating program performance and outcomes; and developing sustainability strategies.

The grant monitoring provided by MSPF staff will then specifically track the compliance of the grantees in implementing these requirements. Sub-recipients that do not implement the required policies, practices and programs will receive specific technical assistance to assist them to do so, may be required to implement a corrective action plan to address the

MARYLAND SPF SIG PLAN
#1U79SP015591-01

issues, and may be subject to funding reduction or discontinuation if non-compliance issues are not adequately addressed.

The MSPF Sustainability Plan calls for transitioning funding for the MSPF administrative/infrastructure-building functions to the Substance Abuse Prevention and Treatment Block Grant (SAPT-BG) 20% Prevention Set Aside at a rate of 25% per year. By Year 5 of the SPF-SIG funding, the SAPT-BG 20 % Set Aside will accommodate SEOW funding at 100% and the 3 MSPF positions at 100% without reductions in existing Set-Aside awards to jurisdictions. All existing ADAA SAPT-BG Prevention awards will be required to implement the SPF SIG planning model as a condition of award. All jurisdictions will be encouraged to continue their successful MSPF activities utilizing their SAPT Block Grant funding from ADAA when MSPF funding ends.

IV. Implementation

A. Supporting the Work of Communities

Support during the MSPF planning process (Pre-Grant Award)

As described above in the Capacity Building and Planning sections, Maryland will build prevention system capacity and enhance the prevention infrastructure at the community level through the provision of training, technical assistance and funding resources to jurisdictional and local community SPF planning bodies. A training syllabus will be developed by MSPF planners and will be updated and revised as needed through input received from the Maryland Prevention Workforce Development Survey and additional surveys that will be developed to assess the strengths and needs of SPF planners at the jurisdictional (county needs assessment) and local community levels.

Training will begin with an MSPF Orientation Workshop that each local jurisdiction must attend in order to be eligible for an MSPF Assessment/Planning grant and then, if selected, an MSPF Implementation Grant.

This workshop will provide an overview of the SPF and MSPF initiatives including:

- MSPF goals & State priorities;
- the required five steps of the SPF process;
- key SPF principles (e.g., data-driven, evidence based, culturally competent);
- State level activities and participants
- jurisdiction level activities and participants;
- local community level activities and participants

The workshop will also detail the processes through which:

- the local jurisdiction conducts a jurisdiction-wide needs assessment to:
 - identify the nature and extent of youth and young adult alcohol misuse in the jurisdiction, and
 - identify a local community for MSPF funding
- the local jurisdiction develops and submits a comprehensive report/proposal to ADAA for MSPF funding for the selected community
- the MSPF review panel will review the report and approve local communities for MSPF funding
- ADAA will make the MSPF awards to local communities

Each jurisdiction will be required to send a team representing its prevention system to this workshop. This team will include the Prevention Coordinator, Local Drug and Alcohol Abuse Council members, Drug Free Community coalition members (where appropriate), and other community prevention advocates, providers and policy makers.

MARYLAND SPF SIG PLAN

#1U79SP015591-01

As the next step in the MSPF process, training and technical assistance will be provided to each jurisdiction's MSPF Needs Assessment team by ADAA's MSPF and Research Division personnel. An initial needs assessment skills training session will be provided that will include MSPF definitions and requirements; data collection, analysis and reporting methods and skills; using needs assessment data to select the MSPF community; and a review of technical assistance resources that will be available to assist them with their jurisdiction-wide needs assessment.

Local jurisdictions may also request, through the MSPF Technical Assistance Coordinator, additional needs assessment skills technical assistance. This may be provided by MSPF personnel, the ADAA Research Division, SEOW members, and other appropriate resources, such as the local Prevention Coordinator and CAPT. Jurisdictions may also choose to utilize a portion of their MSPF Assessment/Planning grants to contract with other resources for needs assessment technical assistance.

Support for MSPF Community Grantees

Once the local MSPF communities have been awarded their funding, an additional round of training and technical assistance will be provided. The MSPF Technical Assistance Coordinator and the local Prevention Coordinator will help the local community MSPF planning body to assess its training and technical assistance needs, utilizing methods such as surveys and focus groups. This training may include any of the 10 training topics listed in the Capacity Building section, or other training as determined by the assessment of the group's needs. Training will be provided to several groups of MSPF communities at a time, whenever possible, to increase peer to peer interaction and learning as well as to increase cost effectiveness. Training resources will include Prevention Coordinators, MAPPA members, prevention program providers, and University Resource Center staff. Maryland will also utilize the training resources of CAPT and other Prevention experts, such as CADCA, whenever appropriate.

As previously stated in the Capacity Building section, all training sessions will conclude with participant completion of evaluation surveys. The MSPF Technical Assistance Coordinator and Project Manager will regularly review the evaluation survey feedback and utilize the findings to revise and improve the training content, delivery methods, logistics, etc. on an on-going basis.

Individualized technical assistance will also be arranged or provided by the MSPF Technical Assistance Coordinator as determined by the aforementioned local community training and technical assistance assessment. Jurisdictions may also choose to utilize a portion of their MSPF Implementation grants to contract with other resources for technical assistance.

MARYLAND SPF SIG PLAN

#1U79SP015591-01

The MSPF Implementation grant monitoring process will be designed to identify problem areas as early as possible and to provide training and technical assistance to address those problems in a timely manner. Following the provision of any such training and technical assistance, subsequent grant monitoring activities will track progress in MSPF operations that resulted from the assistance. The ultimate success of the training and technical assistance provided will be reflected by the quality of local SPF strategic plans developed, and the effectiveness of local SPF evidence based prevention strategies and programs implemented.

B. MSPF Relationship to Anti-Drug Coalitions

Nine Maryland jurisdictions have SAMHSA-funded Drug Free Communities grants and coalitions. Fifteen jurisdictions report having alcohol, tobacco, and/or other drug prevention coalitions. ADAA will require as a condition of Assessment/Planning grant awards that all jurisdictions' Prevention Coordinators invite and strongly encourage the Drug Free Communities and other ATOD coalitions to participate in their jurisdiction-wide needs assessment activities. Additionally, once the local MSPF communities are selected, ADAA will require as a condition of implementation grant award that any Drug Free Community or other ATOD prevention coalitions in the selected communities be involved in the MSPF process for that community. Grant monitoring activities will track the level of such involvement and, if monitoring indicates that there is little or no involvement, technical assistance will be provided to help bring the coalitions to the table.

ADAA will emphasize at the MSPF Orientation Workshop and will require as a condition of Implementation grant award, that no MSPF Implementation grant funds can be used to support duplicative ATOD prevention coalition infrastructures or programs. On-going MSPF grant monitoring will ensure that no funding is supporting duplicative ATOD prevention infrastructures or programs.

MARYLAND SPF SIG PLAN
#1U79SP015591-01

V. Evaluation

MSPF Priority

The Maryland SEOW and MSPF Advisory Committee have conducted a comprehensive Substance Use and Consequences Needs Assessment and determined the following MSPF Priority and Indicators:

The MSPF Priority is to reduce the misuse of alcohol by youth and young adults in Maryland, as measured by the following indicators:

- Reduce the number of youth, ages 12-20, reporting past month alcohol use
- Reduce the number of young persons, ages 18-25, reporting past month binge drinking
- Reduce the number of alcohol-related crashes involving youth ages 16-25

MSPF Community Logic Model

<p>Substance-Related Consequences and Use</p>	<p>Intervening Variables/ Contributing Factors</p> <p>(Examples; targeted contributing factors will vary by community and be selected by each MSPF community)</p>	<p>Evidence Based Strategies, Programs, Policies & Practices</p> <p>(Examples, strategies and programs to be implemented will vary by community and be selected by each MSPF community)</p>
<p>High incidence of alcohol use by Maryland youth under age 21</p>	<ul style="list-style-type: none"> • Enforcement of alcohol-related laws • Commercial and social availability of alcohol to youth • Community attitudes toward alcohol use • Youth perceptions of the dangers of alcohol use • Youth perceptions of the social acceptability of use • Family use and attitudes towards alcohol use 	<ul style="list-style-type: none"> • Rigorous enforcement of MLDA and other alcohol laws • Compliance checks • Community mobilization to address community and institutional underage drinking norms and attitudes • Normative education emphasizing that most adolescents don't use ATOD • Parent programs stressing setting clear rules against drinking, enforcing those rules and monitoring child's behavior
<p>High incidence of binge drinking by youth ages 18-25</p>	<ul style="list-style-type: none"> • Enforcement of alcohol-related laws • Commercial and social availability of alcohol to youth • Community attitudes toward alcohol use • Youth perceptions of the dangers of alcohol use • Youth perceptions of the social 	<ul style="list-style-type: none"> • Establishment or more enforcement of keg registration, underage drinking parties, adult provider and social host laws • Alcohol excise taxes to reduce economic availability • Education programs that follow social influence models and include setting norms,

MARYLAND SPF SIG PLAN
#1U79SP015591-01

	<ul style="list-style-type: none"> • acceptability of use • Family use and attitudes towards alcohol use • Early onset of alcohol and/or drug use 	<ul style="list-style-type: none"> • addressing social pressure to use, and resistance skills • Multi-component programs that involve the individual, family, school and community • Interventions that identify and provide treatment for adolescents already using
High incidence of alcohol- and /or drug related crashes	<ul style="list-style-type: none"> • Enforcement of drinking and driving laws • Judicial drinking and driving decisions and practices • Commercial and social availability of alcohol • Community attitudes toward drinking and driving • Perceptions of the risk of being caught and punished for drinking and driving • Availability and access to treatment in the community 	<ul style="list-style-type: none"> • Rigorous enforcement of drinking and driving laws • Awareness regarding the increased risk of being caught and punished for drinking and driving • Enforcement campaigns with sobriety check points • Court Watch • Community wide media campaigns and task forces • Police, judiciary, server, and business training • Court-ordered and enforced treatment for DUI offenders

MSPF Theory of Action:

The MSPF Theory of Action depicted in Community Logic Model proposes that by providing data-driven, culturally competent, evidence based prevention strategies and programs at the community level, Maryland will impact a number of key contributing factors for underage drinking, binge drinking, and alcohol-related crashes in Maryland, as a result reducing the incidence of these problems.

Enhancing Maryland’s Prevention Framework:

In addition to the reducing the incidence of the State Priority substance use and consequences, a primary goal of the MSPF is to strengthen Maryland’s State and local prevention infrastructure. The following chart summarizes the MSPF approach to attaining this goal.

Goals	Strategies	Activities	Performance Measures
Build prevention capacity and infrastructure at the State level	Implement a formal State prevention framework and planning process	<ol style="list-style-type: none"> 1. Secure and sustain SPF SIG funding 2. Convene MSPF Advisory Committee (of SDAAC) to oversee 	<ul style="list-style-type: none"> • Increased State prevention funding • Increased # of State prevention planning bodies and participants

MARYLAND SPF SIG PLAN

#1U79SP015591-01

		<p>the MSPF Initiative</p> <p>3. Develop and implement the five step State MSPF planning process</p> <p>4. Develop and implement State MSPF Prevention Strategy</p> <p>5. Provide training and technical assistance to state planners and Maryland's local jurisdictions to assist them to develop and implement local SPF processes and to access MSPF funding</p> <p>6. Provide state and local level (as available) alcohol/drug use and consequence data to local jurisdictions to assist them in their SPF planning efforts</p> <p>7. Provide MSPF Assessment/ Planning funds to local jurisdictions for substance use and consequences needs assessment</p> <p>8. Provide Implementation funds to communities of greatest need to enable them to develop local SPF Strategic Plans and implement the prevention activities contained in their local plans</p> <p>9. Monitor funded programs and provide technical assistance and training as needed to ensure their success</p>	<p>Increased # of formal State prevention planning activities</p> <p>Increased # of formal State Prevention Strategies</p> <p>Increased # of State & local community prevention advocates and planners receiving formal prevention training</p> <p>Increased # of data- driven needs assessments at the jurisdictional and community levels</p> <p>Increased # of data- driven needs assessments at the jurisdictional and community levels</p> <p>-Increased # of local community prevention planning processes</p> <p>-Increased # of local prevention Strategic Plans</p> <p>-Increased # of evidence-based prevention strategies, programs, policies and practices</p> <p>Increased # of training and technical assistance sessions provided to communities implementing MSPFactivities</p>
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MARYLAND SPF SIG PLAN
#1U79SP015591-01

		<p>10. Evaluate effectiveness of funded programs and activities</p> <p>11. Secure sustained funding for MSPF activities beyond the life of the federal MSPF funding</p>	<p>Increased # of evaluations of local prevention programs and initiatives</p> <p># of MSPF strategies and programs sustained beyond their MSPF funding</p>
<p>Build prevention capacity and infrastructure at the community level</p>	<p>Implement formal prevention frameworks and planning processes in Maryland's 24 jurisdictions and communities of greatest need</p>	<p>1. Utilize MSPF Assessment/Planning grant funds to conduct jurisdiction-wide substance use and consequences needs assessment</p> <p>2. Identify the nature and extent of youth and young adult alcohol misuse in the jurisdiction</p> <p>3. Select a community of need to receive MSPF implementation funds and apply for MSPF Implementation funds on behalf of that community</p> <p>4. Upon receipt of Implementation funds, complete the 5-step MSPF process in that community</p> <p>5. Complete local community Strategic Plan and submit to ADAA for approval</p> <p>6. Implement the evidence based strategies and programs contained in the Strategic Plan</p>	<p>Increased # of jurisdiction-wide substance use and consequences needs assessments</p> <p>Increased # of jurisdictions that have documented the nature and extent of youth and young adult alcohol misuse</p> <p>Increased # of jurisdictions that have identified high incidence communities in which to focus their prevention efforts</p> <p>Increased # of local communities that implement a formal MSPF planning process</p> <p>Increased # of communities that have developed formal prevention Strategic Plans</p> <p>Increased # of evidence based prevention strategies and programs</p>

MARYLAND SPF SIG PLAN
#1U79SP015591-01

		7. Monitor program implementation, collect data, track process indicators, use data to continuously improve effectiveness, and evaluate program outcomes.	Increased # of communities that collect and utilize data to track progress, and evaluate program outcomes
		8. Evaluate the effectiveness of the local SPF process in attaining the outcomes specified in the local Strategic Plan	Increased # of communities that formally evaluate the effectiveness of their strategies
		9. Secure sustained funding for local MSPF activities beyond the life of the federal MSPF funding	# of community MSPF strategies and programs sustained beyond their MSPF funding

MSPF Evaluation Activities

ADAA will contract with a vendor with extensive evaluation and epidemiological experience to design and conduct the MSPF evaluation and provide the resources and expertise necessary to collect and report on the required performance measures. The evaluation vendor’s staff will utilize a combination of best practices and current technology to ensure that evaluations are conducted in accordance with all OMB and IRB requirements, and will result in useful and practical reports that will assist in the planning and implementation of SPF programs and strategies throughout the funding cycle.

Data will be collected in a culturally appropriate, consistent, scientifically valid manner across all program sites, and will enable the evaluator to aggregate program-level data across sites, make site comparisons, increase our ability to have adequate sample sizes to statistically test effectiveness, and will foster evaluation skills among community program staff. Evaluation goals are:

1. to determine if desired outcomes have been achieved,
2. to assess the effectiveness and quality of funded programs and strategies, and
3. to provide regular feedback to the State and local councils to ensure that appropriate technical assistance is provided throughout the MSPF process.

The evaluation will consist of both process and outcomes components and will be conducted at the State, community-, and program-levels. ADAA’s grant awards to local

MARYLAND SPF SIG PLAN

#1U79SP015591-01

MSPF communities will include conditions of award requiring all sub recipient communities to collect National Outcomes Measures (NOMS) data and submit this data to both ADAA and SAMHSA/CSAP. Performance data including both process and outcomes measures will be reported to SAMHSA in May and November as required.

While the selected MSPF Evaluator will design the specific evaluation processes, techniques and instruments to be used for the MSPF evaluation, the evaluation will be designed to answer at a minimum the following questions.

State Level Evaluation:

- Process Evaluation

Maryland's State-level *process* evaluation will address the five steps of the SPF and the MSPF goals and objectives. Data will be collected to answer the six questions required by SAMHSA and five additional questions identified by the State. Together, they are:

1. Has the SEOW been established?
2. Has the MSPF Advisory Council been established?
3. Have necessary needs assessments been completed?
4. Has a Strategic Plan been developed and submitted to SAMHSA for review?
5. Has the Strategic plan been approved by SAMHSA?
6. Have evidence-based programs, policies, and practices been implemented based on the SPF process?
7. How closely did implementation match the Strategic Plan?
8. What deviations, if any, occurred?
9. Why did these deviations occur?
10. What impact did these deviations have on the intervention and evaluation?
11. Who provided what services, to whom, in what context, at what cost?

Additionally, the State-level process evaluation will track the attainment of the performance measures listed in the Enhancing Maryland's Prevention Framework chart, specifically:

1. Has State prevention funding increased? (To what total?)
2. Has the number of State prevention planning participants increased? (To what total?)
3. Has the number of formal State prevention planning activities increased? (To what total?)
4. Has a Strategic plan been developed, submitted to, and approved by SAMHSA?
5. Has the number of State & local community prevention advocates and planners receiving formal prevention training increased? (To what total?)
6. Have the number of data- driven needs assessments at the jurisdictional and community levels increased? (To what total?)

MARYLAND SPF SIG PLAN

#1U79SP015591-01

7. Has the number of local community prevention planning processes increased? (To what total?)
8. Has the number of local community prevention Strategic Plans increased? (To what total?)
9. Has the number of evidence-based prevention strategies, programs, policies and practices increased? (To what total?)
10. Has the number of training and technical assistance sessions provided to communities implementing MSPF activities increased? (To what total?)
11. Has the number of evaluations of local prevention programs and initiatives increased? (To what total?)
12. How many MSPF strategies and programs have been sustained beyond their MSPF funding?

- Outcome Evaluation

Maryland's state-level outcome evaluation will collect data to measure changes in the MSPF Priority Indicators across the duration of the MSPF initiative

1. Were there reductions in the number of youth, ages 12-20, reporting past month alcohol use?
2. Were there reductions in the number of young persons, ages 18-25, reporting past month binge drinking?
3. Were there reductions in the number of alcohol- and/or drug-related crashes?

Data will also be collected to measure the relationship between these changes and MSPF implementation. Data will be collected to answer six questions, four identified by SAMHSA and two by the State:

1. What was the effect of MSPF on service capacity and other infrastructure objectives?
2. What was the effect of the intervention on the participants?
3. Did the MSPF project achieve its intended goals?
4. What program/contextual factors were associated with outcomes?
5. What individual factors were associated with outcomes?
6. How durable were the effects?

The evaluation will also collect data to measure changes in NOMS and the relationship between changes in NOMS and MSPF implementation.

Community Level Evaluation

- Process

The community level MSPF evaluation will track the attainment of the performance measures listed in the Enhancing Maryland's Prevention Framework chart, specifically:

MARYLAND SPF SIG PLAN

#1U79SP015591-01

1. Has the number of jurisdiction-wide substance use and consequences needs assessments increased? (To what total?)
2. Has the number of jurisdictions that have identified substance use and consequences priorities increased? (To what total?)
3. Has the number of jurisdictions that have identified high incidence/need communities in which to focus their prevention efforts increased? (To what total?)
4. Has the number of local communities that implement a formal SPF planning process increased? (To what total?)
5. Has the number of communities that have developed formal prevention Strategic Plans increased? (To what total?)
6. Has the number of evidence based prevention strategies and programs increased? (To what total?)
7. Has the number of communities that collect and utilize data to track progress, and evaluate program outcomes increased? (To what total?)
8. Has the number of communities that formally evaluate the effectiveness of their strategies increased? (To what total?)
9. How many community MSPF strategies and programs have been sustained beyond their MSPF funding?

- Outcome

Maryland's community level outcome evaluation will collect data to measure changes in the three MSPF Priority Indicators in each of MSPF communities across the duration of the MSPF initiative.

1. Were there reductions in the number of youth, ages 12-20, reporting past month alcohol use?
2. Were there reductions in the number of young persons, ages 18-25, reporting past month binge drinking?
3. Were there reductions in the number of alcohol- and/or drug-related crashes?

Data will also be collected to measure the relationship between these changes and MSPF implementation at the community level. Data will be collected to answer six questions, four identified by SAMHSA and two by the State:

1. What was the effect of MSPF on service capacity and other infrastructure objectives?
2. What was the effect of the intervention on the participants?
3. Did the MSPF project achieve its intended goals?
4. What program/contextual factors were associated with outcomes?
5. What individual factors were associated with outcomes?
6. How durable were the effects?

MARYLAND SPF SIG PLAN

#1U79SP015591-01

The evaluation will also collect data to measure changes in NOMS at the community level and the relationship between changes in NOMS and MSPF implementation.

Program Level Evaluation

At present, it is impossible to know how many evidence based prevention strategies and programs will be funded; which contributing factors they will target; what specific activities, programs and strategies will be implemented; the number and demographics of the target populations to be served; etc. Until the MSPF processes unfold, it will be impossible to describe the program level evaluation in great detail. The program level evaluation will, however, gather data to answer questions such as:

- Process:
 1. Who is the strategy or program designed to serve (number, characteristics, demographics, etc.)?
 2. What substance use and/or consequences contributing factors is the program or strategy designed to address?
 3. What type and number of prevention activities will be provided; at what dosage; over what time period; etc.?
 4. What level of resources is needed to implement the program or strategy?
 5. What are the expected program outcomes?

- Outcome:
 1. What was the effect of the intervention on the participants?
 2. Did the program achieve its intended outcomes?
 3. What program/contextual factors were associated with outcomes?
 4. What individual factors were associated with outcomes?
 5. How durable were the effects?
 6. Did program-level outcomes impact the incidence of the targeted substance use or consequence at the community level

VI. Cross Cutting Components and Challenges

A. Ensuring Cultural Competence

Ensuring cultural competence throughout the MSPF process has been a focus of ADAA and the MSPF Advisory Committee from day one of the initiative. The Cultural Competence Work Group was one of the first work groups formed and it has met regularly to review CSAP guidance materials and develop MSPF cultural competence policies and a guidance tool that will assist MSPF communities to infuse cultural competence throughout each step of the local SPF process.

The Cultural Competence Work Group will continue to be engaged in the planning and implementation of our training and technical assistance syllabus and calendar which will include specific training/technical assistance sessions to assist communities to infuse cultural competence in all of their activities. Similarly, the Cultural Competence Work group will be engaged in the development of the specific cultural competence language and requirements of the MSPF funding proposal document that local communities will submit to apply for MSPF funding.

The work group will continue its MSPF responsibilities in the Implementation phase of the project. For example, it will have representation on the MSPF grant review/selection panel to ensure that all sub-recipients are proposing activities that meet the MSPF cultural competence practices, policies and requirements that they have developed. As local level prevention plans and activities are implemented, the work group will have the opportunity to review the progress of the local implementation to ensure that the local sites are fully compliant with the MSPF cultural competence practices that they committed to in their proposals

ADAA will include very specific cultural competence language and conditions in its MSPF funding proposal document, in its Assessment/Planning grant contracts with local Health Departments, and in its Implementation grant contracts with local communities. The grant monitoring to be conducted by MSPF staff will include a strong focus on tracking the local communities' progress in implementing the cultural competence policies, practices and procedures developed by the Cultural Competence Work Group and clearly specified in ADAA's grant proposal and grant award documents.

As stated in previous sections, Cultural Competence training and technical assistance will be available to all jurisdiction-wide needs assessment groups and to all local community SPF planning bodies. A variety of skilled technical assistance providers will be identified and utilized for this assistance to local communities.

B. Addressing Underage Drinking

Addressing underage drinking is one of the MSPF State Priority Indicators as determined by the Maryland SEOW's data-driven needs assessment process. Reducing underage drinking will not only directly attain one of Maryland's priority indicators, it will also contribute to attaining its other indicators; reducing binge drinking and reducing alcohol-related crashes involving youth. The ADAA's MSPF Orientation Workshop, its funding proposal documents and its contracts with local communities will emphasize the importance of reducing underage drinking as an end in its self and as a means to reduce the incidence of the other State Priority Indicators.

The need to prioritize underage drinking was strongly supported by epidemiological data at the state and local jurisdictional levels as documented in the *Maryland Compendium of Cross County Indicators on Underage Drinking*, the *Maryland Compendium of Cross County Indicators on the Consequences and Consumption of Alcohol, Illicit Drugs and Tobacco*, and the *Maryland Epidemiological Profile* documents. Survey responses from Maryland's 24 local Prevention Coordinators indicate that each jurisdiction currently provides evidence-based programs designed to decrease underage drinking, its contributing factors and consequences; another indication of the importance that our prevention system places on reducing underage drinking.

Evidence based programs, practices and strategies for reducing underage drinking will be featured prominently in the training and technical assistance to be provided to local communities, since it is such a high priority and there is a significant amount of solid research in this area. Environmental strategies for affecting community-level reductions in underage drinking will also be heavily emphasized in the training and technical assistance to be provided to local communities.

C. Addressing Sustainability

At the State level, The MSPF Sustainability Plan calls for transitioning funding for the MSPF administrative/infrastructure-building functions to the Substance Abuse Prevention and Treatment Block Grant (SAPT-BG) 20% Prevention Set Aside at a rate of 25% per year. By Year 5 of the SPF-SIG funding, the SAPT-BG 20 % Set Aside will accommodate SEOW funding at 100% and the 3 MSPF positions at 100% without reductions in existing Set- Aside awards to Jurisdictions. All existing ADAA SAPT-BG Prevention awards will be required to implement the SPF SIG planning model as a condition of award.

At the local level, each community receiving MSPF Implementation funds will be required to include a sustainability strategy as part of its MSPF Strategic Plan submitted

to ADAA. This will ensure that communities begin thinking about sustaining their efforts from the very beginning of their planning processes. Sustainability training is included in our training syllabus and technical assistance will be provided to communities upon their request or if program monitoring identifies such a need. *All jurisdictions receiving Implementation grants will be encouraged to continue their successful MSPF activities utilizing their SAPT Block Grant funding from ADAA when MSPF funding ends.*

D. Expected Challenges in Applying a Data-Driven “Need-Based” Allocation Process

All communities are eligible to receive \$10,000 Assessment/Planning grants as phase-one of the MSPF process. This will enable each jurisdiction to conduct a jurisdiction-wide needs assessment; document the nature and extent of youth and young adult alcohol misuse in the jurisdiction; select their local community of need; and initiate the complete MSPF planning process in that community.

Beyond that point however, MSPF resources will be allocated to 24 communities statewide based on need. It is expected that even when utilizing an objective data-driven process for allocating MSPF resources, there will be disappointment and dissatisfaction from communities not selected for MSPF funding. ADAA will be able to alleviate some of this dissatisfaction by encouraging jurisdictions to utilize their SAPT Block Grant funds to implement culturally competent, evidence based prevention activities in local communities not selected for MSPF funding.

Additionally, as MSPF activities are implemented and evaluated, positive outcomes will be documented and presented to the Governor’s State Drug and Alcohol Abuse Council and the Maryland State Legislature to support the value of devoting additional State resources in support of MSPF and other data driven, evidence based prevention programs and strategies. This may offer hope to communities that were not selected for MSPF funding through the initial “needs-based” process.

E. Expected Challenges in the Implementation Process

One major challenge is that Maryland’s primary survey of adolescent drug and alcohol use, consequences, and contributors has been discontinued. Due to budget constraints, the Maryland Adolescent Survey (MAS) will no longer be conducted by the Maryland State Department of Education. This biennial survey of middle and high school students provided both State-wide and jurisdiction-wide data that has been essential to substance abuse prevention and treatment planners. This survey was to be one of the primary means to collect student data on the MSPF priorities of underage drinking, binge drinking, and alcohol-related crashes involving youth.

MARYLAND SPF SIG PLAN
#1U79SP015591-01

One of the primary tasks of the ADAA Research Division as it now begins managing the Maryland SEOW is identifying a new method of surveying Maryland students to obtain county level data. The survey methodology must be administered in a manner so that useful jurisdiction level data can continue to be collected and cross jurisdictional comparisons made. The MSPF Advisory Committee’s SEOW has begun exploring the possibility of broadening the DHMH Maryland Youth Tobacco Survey (YTS) to include questions regarding adolescent drug and alcohol use, consequences, and contributors. This effort would also require some adjustments in survey methodology, sample sizes, frequency, etc., so there are still a number of challenges ahead in utilizing this survey to attain the much-needed ATOD data previously attained through the MAS. In addition to developing an alternative student survey, other community focused surveys will be considered to track substance abuse consumption and consequences across the life span.

F. Timeline and Milestones

Activity	Responsible ADAA Staff (& Content Experts)	Completion Month
Hire MSPF Staff	<ul style="list-style-type: none"> • ADAA Director of Community Services 	August 2010
MSPF Strategic Plan Approval by CSAP	<ul style="list-style-type: none"> • ADAA Director of Community Services 	September 2010
MSPF Orientation Workshop(s)	<ul style="list-style-type: none"> • MSPF Manager; • MSPF Technical Assistance Coordinator; • ADAA Director of Research/SEOW; • ADAA OETAS Director 	October 2010
Assessment/Planning grants awarded to local Health Departments/Prevention Coordinators	<ul style="list-style-type: none"> • MSPF Manager; • ADAA Director of Management Services 	November 2010
Needs Assessment technical assistance training provided to jurisdictions	<ul style="list-style-type: none"> • MSPF Technical Assistance Coordinator; • ADAA Director of Research/SEOW; • ADAA OETAS Director; • MAPPA members 	November 2010 – March 2011

MARYLAND SPF SIG PLAN
#1U79SP015591-01

Jurisdictions' completed needs assessment reports and funding proposals submitted to ADAA	<ul style="list-style-type: none"> • MSPF Manager 	April 2011
Proposals rated; MSPF communities selected	<ul style="list-style-type: none"> • MSPF Manager; • MSPF Advisory Committee and Work Group members 	April 2011
Selected MSPF communities notified	<ul style="list-style-type: none"> • MSPF Manager 	May 2011
Awards made to MSPF communities	<ul style="list-style-type: none"> • MSPF Manager; • ADAA Director of Management Services 	June 2011
SPF process begins in funded MSPF communities	<ul style="list-style-type: none"> • MSPF Manager • MSPF Technical Assistance Coordinator 	July 2011
Training and technical assistance provided to local community planning groups	<ul style="list-style-type: none"> • MSPF Technical Assistance Coordinator; • ADAA Director of Research/ SEOW; • ADAA OETAS Director; • MAPPA members; • Local Prevention Coordinators 	July 2011 to project conclusion
Community MSPF Strategic Plan development	<ul style="list-style-type: none"> • MSPF Technical Assistance Coordinator • MSPF Manager 	July – October 2011
Local MSPF communities submit their Strategic Plans to ADAA for approval to begin implementation	<ul style="list-style-type: none"> • MSPF Manager 	November 2011
Local MSPF strategies and programs begin	<ul style="list-style-type: none"> • MSPF Manager • MSPF Technical Assistance Coordinator 	January 2012

Acronyms

ADAA- Maryland State's Alcohol and Drug Abuse Administration

AOD- Alcohol and / or Drugs

APS- Associate Prevention Specialist

ATOD- Alcohol Tobacco and Other Drugs

CDC- Center for Disease Control

CESAR- Center for Substance Abuse Research

CMCA- Communities Mobilizing for Change on Alcohol

CPP- Certified Prevention Professional

CPS- Certified Prevention Specialist

CSAP- Center for Substance Abuse Prevention

DFC- Drug Free Communities

DHMH- Maryland State's Department of Health and Mental Hygiene

DUI- Driving Under the Influence

EBPP- Evidence Based Programs and Practices

EP- Epidemiological Profile

LDAAC- Local Drug and Alcohol Abuse Councils

MAARS- Maryland State Highway Administration's Automated Accident Reporting System

MAPPA- Maryland Association of Prevention Professionals and Advocates

MAS- Maryland Adolescent Survey

MD SEOW- Maryland State Epidemiological Workgroup

MDS- Minimum Data Set

MSDE- Maryland State Department of Education

MSPF- Maryland Strategic Prevention Framework

NCAP- Northeast Center for the Application of Prevention Technologies

NSDUH- National Survey on Drug Use and Health

MARYLAND SPF SIG PLAN
#1U79SP015591-01

OETAS- Office of Education and Training for Addiction Services

SAMHSA- Substance Abuse and Mental Health Services Administration

SAPT- BG- Substance Abuse Prevention and Treatment Block Grant

SDAAC- State Drug and Alcohol Abuse Council

SEOW- State Epidemiological Workgroup

SPF- Strategic Prevention Framework

SPF SIG- Strategic Prevention Framework State Incentive Grant

TEDS- Treatment Episode Data Set

YTS- Maryland Youth Tobacco Survey

List of Appendix Documents

APPENDIX A: MARYLAND EPIDEMIOLOGICAL PROFILE: CONSEQUENCES OF ILLICIT DRUG USE, ALCOHOL ABUSE, AND SMOKING, 2009

APPENDIX B: MARYLAND SEOW BRIEFING, SPECIAL POPULATIONS IN MARYLAND: VETERANS, 2010

APPENDIX C: MARYLAND COMPENDIUM OF CROSS COUNTY INDICATORS ON THE CONSEQUENCES AND CONSUMPTION OF ALCOHOL, ILLICIT DRUGS, AND TOBACCO, DECEMBER, 2008

APPENDIX D: MARYLAND COMPENDIUM OF CROSS COUNTY INDICATORS ON UNDERAGE DRINKING, NOVEMBER 2008

APPENDIX E: RESOURCE ASSESSMENT SAMPLE MATRIX, 2009

APPENDIX F: MARYLAND SCORECARD, 2009

APPENDIX G: RANKING OF SUBJECTIVE CRITERIA OF CONSEQUENCES CONSUMPTION OF SUBSTANCE USE IN MARYLAND, 2010