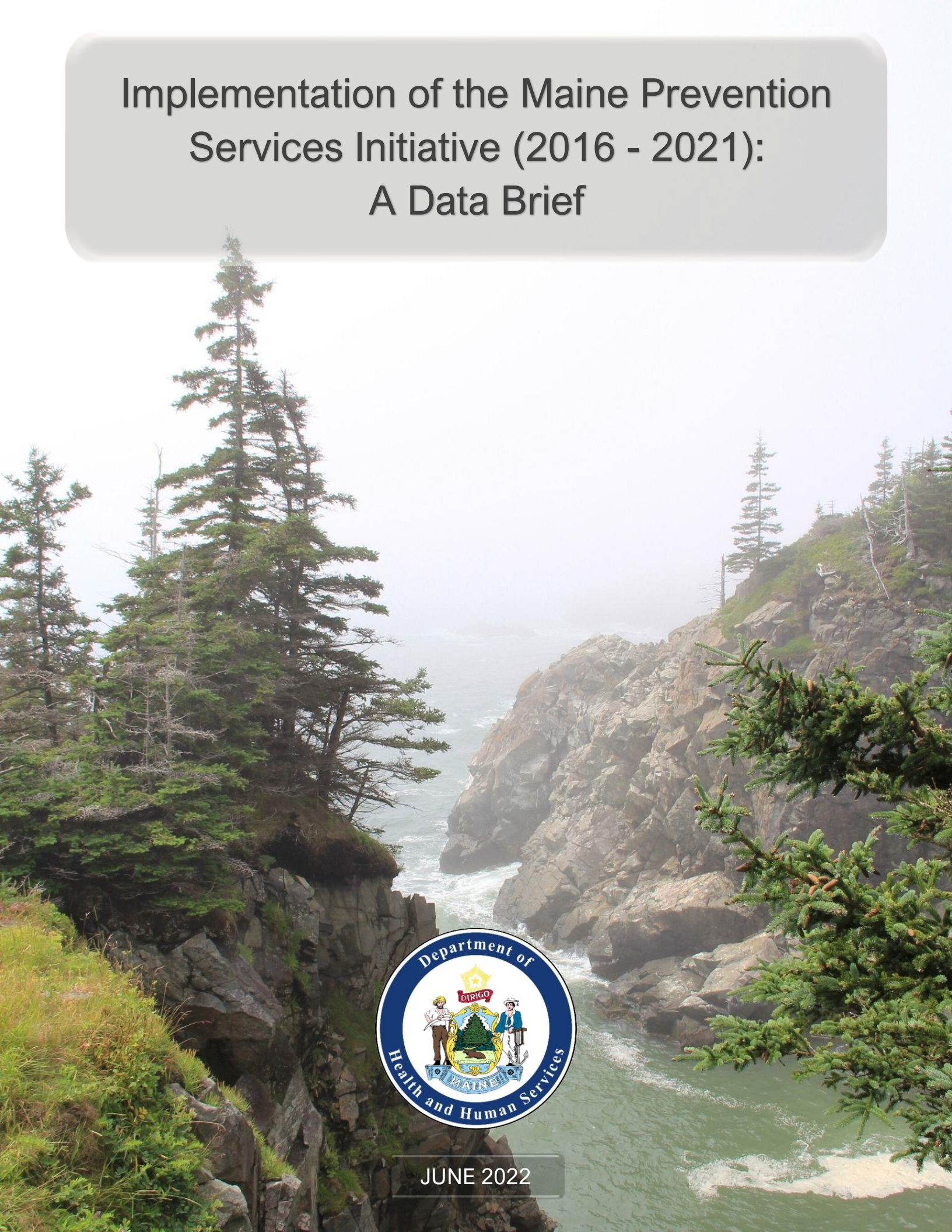
Implementation of the Maine Prevention Services Initiative (2016 - 2021): A Data Brief



JUNE 2022

ACKNOWLEDGEMENTS

The Maine Center for Disease Control and Prevention (Maine CDC), Division of Disease Prevention would like to thank the staff, partners, and contractors who continue to contribute to the successful implementation of the Maine Prevention Services (MPS) Initiative.

The MPS Initiative provides leadership, partnership, and education throughout Maine to reduce and prevent substance misuse, commercial tobacco use, and promote well-being across the lifespan. The MPS Initiative focuses state and community efforts on these key areas to:

- Stem the rising tide of opioid use and misuse and decrease the number of substance-exposed infants.
- Prevent youth from ever initiating commercial tobacco use or substance use.
- Ensure that Maine has the lowest smoking rates in the nation.
- Prevent the development and progression of chronic diseases related to or affected by tobacco use, obesity, and substance misuse.

Through the commitment and perseverance of staff, contractors, and partners, we have built healthier communities and made Maine a healthier place to live, learn, work, and play.

This report was developed by Partnerships For Health on behalf of Maine CDC. It follows the compilation of highlights (2016-2020) disseminated broadly earlier in 2022. In addition to highlighting the domain-specific work, it also highlights the strength of the MPS Initiative infrastructure to promote prevention across the state.

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CONTENTS

FOREWARD

Partnerships For Health and Public Consulting Group have been fortunate to evaluate the MPS Initiative since its inception in 2016. During this time we have designed and implemented formative, process, and outcome evaluations, many of which are published on the Maine CDC website. In addition to these program evaluations, we have worked with the Maine CDC staff and vendors to develop a system that captures effort, outputs, reach, and impact. These are published annually as Implementation Indicators Briefs.

In addition to quantifying effort, each Brief has focused on a topic such as making the case for prevention, a lifespan approach to prevention, and health disparities. This year, in our final Brief, we take a step back and look at infrastructure. In particular, we reflect on the difference between the larger, public health infrastructure and the smaller, program infrastructure which operates therein. While independent, their interconnectivity is substantial and critical for the overall health and wellbeing of Maine communities.

In the decade that I have been part of the evaluation, this is the first funding cycle that we have been able to produce annual reports on effort and reach. This achievement is the result of continual collaboration between the Maine CDC, UNE, CTI, Let's Go!, MYAN, Rinck, PCG, and ourselves. Thank you!

Michelle Mitchell
Executive Director
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INTRODUCTION AND METHODOLOGY

PUBLIC HEALTH INFRASTRUCTURE

In the early 2000s, the importance of a healthy community was in the forefront of public health. Described by the Institute of Medicine as "a place where people provide leadership in assessing their own resources and needs, where public health, social infrastructure and policies support health, and where essential public health services, including quality health care are available" (2003, p. 182), healthy communities continue to be the bedrock of prevention, treatment, and care efforts.

Serious and constantly evolving threats face the health of Americans, including chronic disease and disability; injury and illness due to occupational and environmental hazards; infectious diseases; and other preventable illnesses (Baker, 2005). Collectively, these behavior-related, environmentally caused, and deliberately imposed dangers frame the challenge to our public health infrastructure and its first line of defense: a skilled workforce, robust information system, and strong organizational capacity (ibid).

> *"Most of the advances in the health of Americans achieved over the past century are largely attributable to prevention strategies falling within the domain of the nation's public-sector, population-oriented health agencies. The vigor and effectiveness of these agencies continue to be important factors in the nation's health because some of the twentieth-century threats to health have returned or persist, and emerging threats will require similar prevention strategies of these same agencies (pg. 305)." (Baker, 2005)*

Public health infrastructure defined. The public health infrastructure is defined as the systems and structures that support the execution of the essential public health services (Baker, 2005). Originally released in 1994 and revised in 2020, the essential public health services are summarized in Figure 1. These services "actively promote policies, systems, and overall community conditions that enable optimal health for all and seek to remove systemic and structural barriers that have resulted in health inequities" (U.S. Department of Health & Human Services, 2021). Accordingly, a public health infrastructure promotes and protects the health of all individuals and communities (Institute of Medicine (US) Committee for the Study of the Future of Public Health, 1988).

10 ESSENTIAL PUBLIC HEALTH SERVICES

1. Assess and monitor population health status, factors that influence health, and community needs and assets.
2. Investigate, diagnose, and address health problems and hazards affecting the population.
3. Communicate effectively to inform and educate people about health, factors that influence it, and how to improve it.
4. Strengthen, support, and mobilize communities and partnerships to improve health.
5. Create, champion, and implement policies, plans, and laws that impact health.
6. Utilize legal and regulatory actions designed to improve and protect the public's health.
7. Assure an effective system that enables equitable access to the individual services and care needed to be healthy.
8. Build and support a diverse and skilled public health workforce.
9. Improve and innovate public health functions through ongoing evaluation, research, and continuous quality improvement.
10. Build and maintain a strong organizational infrastructure for public health.

(U.S. Department of Health & Human Services, 2021)

Components of a state public health infrastructure. The condition of the national and/or state public health infrastructure is assessed through the National Public Health Performance Standards. While useful for accreditation and improvement efforts, they also identify public health's core infrastructure elements needed to deliver each essential service (National Public Health Performance Standards Program, n.d.). These are:

- Planning and implementation
- State-local relationships
- Performance management and quality improvement
- Public health capacity and resources

The National Public Health Performance Standards Program defines a public health system as including "all public, private, and voluntary entities that contribute to the delivery of the Essential Public Health Services within a given jurisdiction (pg. 7)" (National Public Health Performance Standards Program, n.d.). Public health programs are distinct from but are an essential building block of the larger public health infrastructure (Lavinghouze S.R., 2014). While most public health programs are designed to contribute towards one or more of these essential services, their success is measured by different elements. The latter tend to vary according to the type of entity, funding resource, area of focus, geographic location, etc. Furthermore, the fact that this overall infrastructure is the sum of multiple programs is not always articulated or considered (Lavinghouze S.R., 2014).

Maine public health infrastructure. In 1999, through a Robert Wood Johnson Foundation grant, the Maine Turning Point Project was formed to reenvisage the Maine public health infrastructure (Campbell, 2005). The result was the formation of a Public Health Workgroup and the identification of 30 geographic regions that closely aligned with the hospital service areas (Maine Public Health Assocation, n.d.). The foundations of a public health infrastructure in Maine were the local health officers established in 1885. As a result of the 1918 H1N1 pandemic, Maine centralized its core public health activities through a statewide public health agency (ibid).

Today, the Maine CDC, situated within the Department of Health and Human Services, provides overall leadership and coordination of the public health infrastructure. The federally recognized tribal nations in Maine have their own independent public health entity and partner with the state and local agencies (Maine Public Health Assocation, n.d.).

Influenza in Maine: 1918 Epidemic (Digital Public Library of America, n.d.)

In 2008, public health districts were established in statute. The district system was designed to: (i) ensure consistency and equity in statewide delivery of the Essential Public Health Services; (ii) enable regional planning and coordination across public and private agencies; and (iii) build a sustainable infrastructure. The goal of this system was to enhance the effectiveness and efficiencies of public health service delivery by providing peer networking, coordination, and collaboration on a local level (Maine Center for Disease Control & Prevention, 2022). Each public health district is coordinated by a District Coordinating Council (DCC) that provides the bridge between community and state level programs and activities. Periodically, each DCC develops a District Public Health Improvement Plan based on the essential services. These Plans are implemented locally and regionally through collaboration and coordination with public health programs.

Since 2016, Maine CDC earned public health accreditation from the Public Health Accreditation Board. The accreditation recognizes the Maine CDC as successfully meeting predetermined standards and measures that are aligned with the National Public Health Performance Standards.

PUBLIC HEALTH PROGRAMMATIC INFRASTRUCTURE

While public health infrastructure and public health programs can exist independently, they each impact on the effectiveness and sustainability of each other. Similar to statewide public health infrastructure, articulating the components of a program infrastructure allows us to maximize its effectiveness and efficiencies by looking at its relationship to policy, system, and environmental changes. Clarifying this relationship is important for understanding how and under what conditions a programmatic infrastructure can maximize public health outcomes (Institute of Medicine (US) Committee on Assuring the Health of the Public in the 21st Century, 2002). It also serves to build an evidence base for the role of programmatic infrastructure within a larger public health structure. Conversely, ignoring program infrastructure can be costly and may result in greater funding needed and an overstretched workforce.

> *"The desire to realize immediate results over the need to build capacity – tends to encourage public health program administrators and evaluators to ignore infrastructure development, favoring program elements with demonstrable and direct links to outcomes (pg.3)." (Lavinghouze S.R., 2013)*

MAINE'S PUBLIC HEALTH DISTRICTS

DISTRICT	COUNTIES
Aroostook	Aroostook
Central	Somerset Kennebec
Cumberland	Cumberland
Downeast	Washington Hancock
Midcoast	Waldo Lincoln Knox Sagadahoc
Penquis	Penobscot Piscataquis
Western	Androscoggin Franklin Oxford
York	York
Tribal	Passamaquoddy Penobscot Maliseet Micmac

Models of public health program infrastructure. Two primary models exist - Lavinghouze's Ecological Model of Infrastructure (Lavinghouze S.R., 2013) which was later refined to the Component Model of Infrastructure (Lavinghouze S.R., 2014) and Frieden's six key areas/components model (Frieden, 2014). These models have formed the basis of many national programs including the Office on Smoking and Health (U.S. Centers for Disease Control and Prevention, 2017) and Substance Abuse and Mental Health Services Administration (Substance Abuse and Mental Health Services Administration, n.d.).

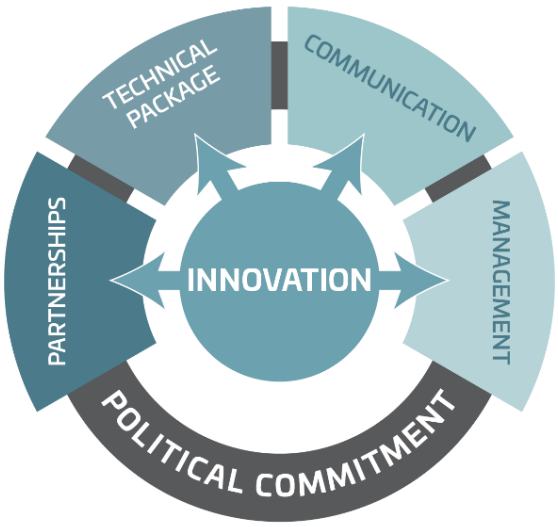
There are five foundational components to the Component Model of Infrastructure (CMI) that continuously interact and influence each other(Lavinghouze S.R., 2014). While a programmatic infrastructure is not able to function without the core components, the extent to which they are optimized is dependent on the level of strategic understanding, operations, and contextual influences (ibid). Table 1 describes each component. The dynamic interaction between the components ideally results in a synergistic effect that enables a program to effectively implement evidence-based strategies and achieve positive health outcomes (ibid).

Table 1. Components of the CMI Model (pg.18 – 20) (Lavinghouze S.R., 2014)

COMPONENT	DESCRIPTION
CORE COMPONENTS	
Multilevel Leadership	… the people and processes that make up leadership at all levels that interact with and have an impact on the program.
Managed Resources	… funding and social capital or relationships that produce social benefits.
Engaged Data	… identifying and working with data in a way that promotes action and ensures that data are used to promote public health goals.

COMPONENT	DESCRIPTION
Responsive Plans and Planning	… a dynamic process that evolves and responds to contextual influences such as changes in science, health department priorities, funding levels, and external support from the public and leadership.
Networked Partnerships	… strategic partnerships at all levels (national, state, and local), with multiple types of organizations …, content areas …, and groups …that are interconnected in such a way as to promote achievement of public health goals.
SUPPORT COMPONENTS	
Strategic Understanding	… ideas, guidance, and thinking that initiate, nurture, and sustain infrastructure. The 3 defining characteristics of strategic understanding are perceptions of the problem as a public health issue, timed visibility, and planning for sustainability.
Operations	… the day-to-day work structures, communications, and procedures used to implement the program.
Contextual Influences	… all of the other components, including outcomes, sustainability, and feedback loop to continuing support and functioning infrastructure.

Frieden's Six Key Areas For Effective Public Health Program Implementation (Frieden, 2014)



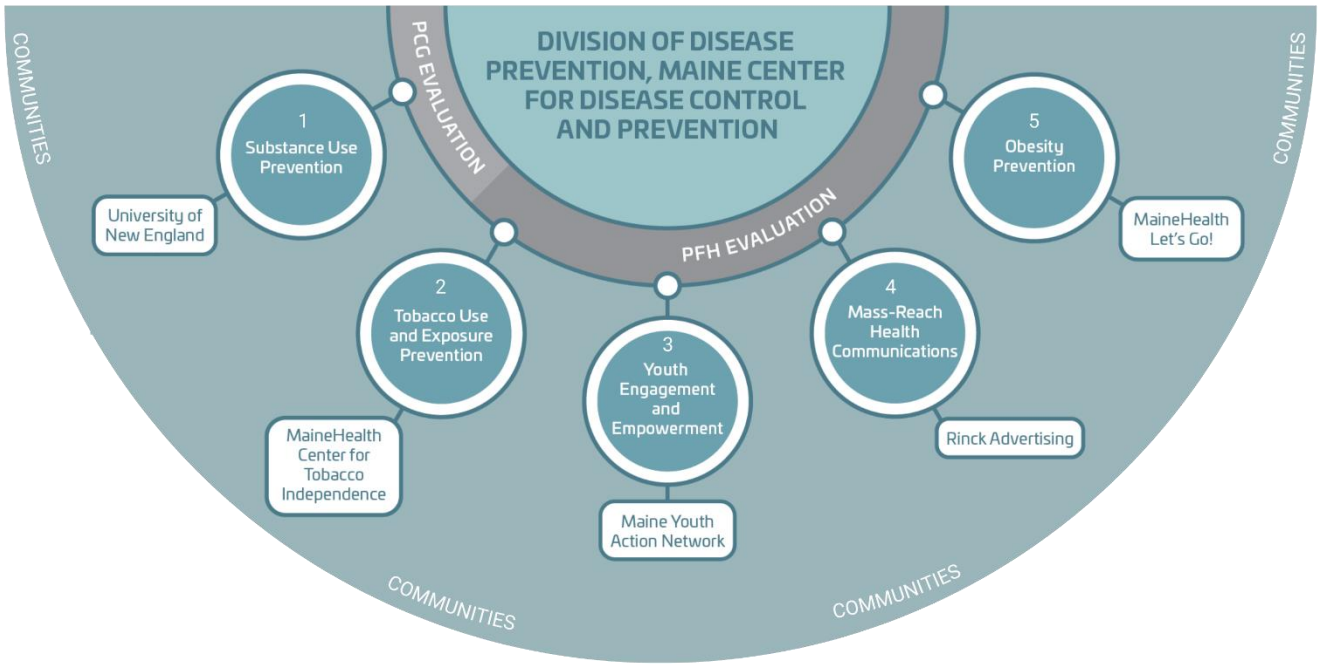
By looking at the differences between public health programs that failed and those that succeeded, six key areas that interacted with each other through innovation were identified. *Innovation* is central as it is viewed as essential to both overall program development and the development of the evidence-base needed for successful implementation (Frieden, 2014), referred to as the *technical package* (i.e., a group of evidence-based, related interventions that improve prevention efforts in a sustainable way). Technical packages identify strategies that are highly effective, scalable, and able to reach diverse populations and settings (ibid). *Management* encompasses activities around ensuring the sustainability of the program – from ongoing evaluation of the program's performance and progress, to managing human resources (ibid). *Partnerships* are key to the success of a program and refer to the cooperation and collaboration with internal and external partners (ibid). *Communication* is key to partnership, particularly the sharing of successes and benefits of the program and the public health issue it addresses (ibid). Acknowledging that all programs exist within a context, *political commitment* can be essential to a program's ability to secure resources and supports and to engage in policy changes (ibid).

MAINE PREVENTION SERVICES INITIATIVE

In 2016, Maine CDC created a new programmatic structure to deliver statewide and public health district prevention services to improve health outcomes associated with substance use, obesity, and tobacco use[1] and exposure. Tobacco, obesity, and substance use prevention - together with youth engagement and empowerment, and mass-reach health communication efforts - were organized under the rubric of the MPS Initiative. Resources were secured through multiple sources including the tobacco Master Settlement Agreement[2], as well as state and federal funding. Through a competitive process, statewide vendors were awarded for the various components of the MPS Initiative, referred to as Domains. The obesity prevention domain was awarded through a sole source process. Each Domain was supported by an independent evaluation team. Figure 1 illustrates the structure of the Initiative.

At the start of the Initiative, the statewide vendors partnered with each of the nine DCCs across Maine to identify local, community-based organizations within each public health district who were best suited to implement evidence-based interventions at the community level. This allowed for the centralization of certain activities (e.g., fiscal management) while meeting the needs of local communities in Maine.

Figure 1. MPS Initiative Structure



[1] Throughout this Brief, references to tobacco refer solely to commercial tobacco use, not the sacred and traditional tobacco used by American Indian communities.
[2] Known as the Fund For a Healthy Maine.

EVALUATION

Since its inception, the MPS Initiative has included comprehensive program evaluation. This provides the opportunity to account for work being done as well as to inform and improve program implementation and allow for adjustments moving forward. The evaluation activities serve three primary purposes:

- Monitor implementation and progress toward goals by tracking implementation indicators.
- Undertake formative, process, and outcome evaluation to quantify the impact of the MPS Initiative.
- Fulfill funder-specific reporting requirements.

The prioritization of evaluation is evident in the breadth of activities that are undertaken within and across Domains. Each vendor conducts internal evaluation activities that monitor interventions and strategies for their specific Domain across Maine. In addition, the Maine CDC appointed two independent evaluation organizations to evaluate the Domains. Public Consulting Group (PCG) is contracted to evaluate multiple funding streams for the Substance Use Prevention Domain: Partnerships for Success 2015; Strategic Prevention Framework for Prescription Drugs; various programs funded through the State Opioid Response grant and the Fund for a Healthy Maine. In addition, during Year 5 of the MPS Initiative (2020 – 2021), PCG received additional funding to conduct a retrospective evaluation of MPS Domain 1. Partnerships For Health (PFH) is contracted to assess the implementation of the other Domains.

While this Brief focuses on the annual implementation indicators reported to these external evaluators, it is important to note the synergy of evaluation activities allows for evaluation findings to be used for learning, decision making, and informing actions that are taken by the Maine CDC, vendors, partners, and stakeholders.

METHODOLOGY

The findings in this Brief represent the results of a prospective, mixed-method design with quantitative priority.

INFRASTRUCTURE

In 2019-2020 an interview protocol was developed based on Frieden's model. To better understand the programmatic infrastructure model being delivered, interviews were conducted with relevant staff members from the Domain 2, 3, and 5 vendors. These were supplemented with notes from Domain 1. Themes emerging from the interviews were expanded on through a focus group discussion with Maine CDC staff. The themes were grouped and formed the basis of an infrastructure model. Each Domain reviewed the model and provided a concrete example of a component of the model. In 2021, the Maine CDC and vendor staff reflected on the model and the way in which the MPS infrastructure had adapted to the challenges of the COVID-19 pandemic. PFH provided each vendor with a worksheet to complete regarding their challenges, successes, adaptations/innovations, and considerations. In addition, PFH facilitated a focus group with the Maine CDC staff to collect their reflections. In 2022, the emerging model (see Figure 2) was presented to the Maine CDC and vendor staff for review and reflection.

ACTIVITIES AND OUTCOMES

Implementation indicators were identified for each Domain that span the MPS funding cycle (2016 – 2021). These were recorded in vendor-specific implementation indicators monitoring systems. The data was reported according to annual funding cycles (October 1 - September 30). Starting in Contract Period 4 (2019 – 2020), Domains 2, 3, and 4 received additional funding through the tobacco Master Settlement Agreement to implement additional tobacco-related strategies. This work was tracked through additional implementation indicators, which are included in this Brief. In addition, Domain 1 received additional funding through the Fund For a Healthy Maine to implement prevention work.

Data from statewide surveillance systems are used to monitor and track changes over time. This includes the Behavioral Risk Factor Surveillance System (BRFSS) and the Maine Integrated Youth Health Survey (MIYHS)[3].

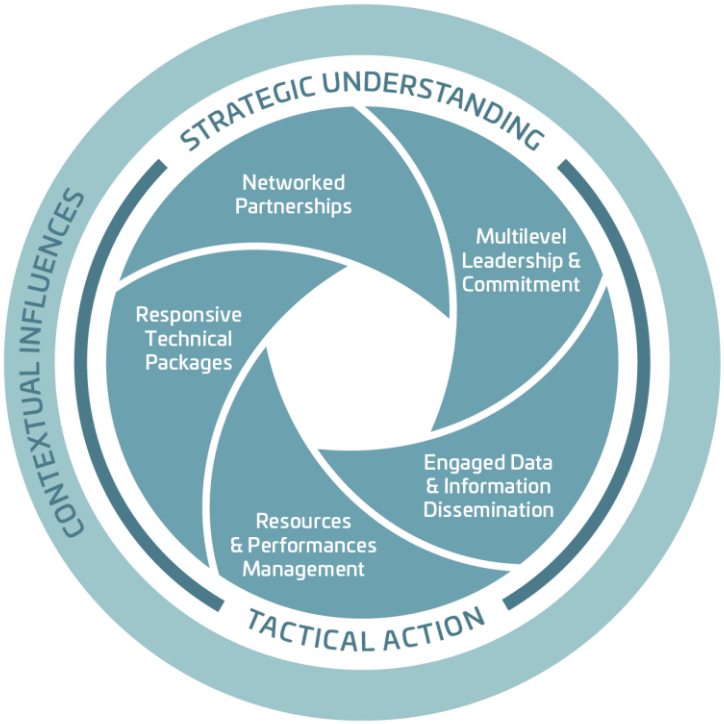
In March 2022 an interactive data walk meeting was attended by 120 people from diverse sectors. The implementation indicators and evaluation findings for each Domain were presented. Thereafter, using a Ripple Effects Mapping process (Chazdon, 2017), participants reflected on the impact of each Domain and the MPS Initiative as a whole.

[3] Due to the pandemic, current surveillance data is not available. The most recent MIYHS data available and reported in the Brief is 2019 and the most current BRFSS data is combined from the years 2013 – 2017.

MPS INFRASTRUCTURE

Informed by the literature and through natural observation and structured reflections, a model emerged as a way to talk about the MPS infrastructure (see Figure 2). Rather than static or linear, the model is dynamic with permeable and interactive layers. The outer layer includes the larger, societal public health infrastructure, as well as economic, social, and political influences. Similar to the models described in the previous chapter, no single component is more important than the other. Rather, the effectiveness of the Initiative lies in the interaction of its core components. At the center is the collective, synergistic relationship between the Maine CDC, vendors, community leaders, and individuals living in Maine. The model recognizes contextual influences and that the success of the MPS Initiative lies in its ability to master strategic understanding and maximize the effectiveness of the core elements and the efficiencies of tactical actions within a broader context.

Figure 2. MPS Infrastructure Model



CONTEXTUAL INFLUENCES

"Social change and changes in law and public health programs both influence and are influenced by each other (pg.20)" (Frieden, 2014)

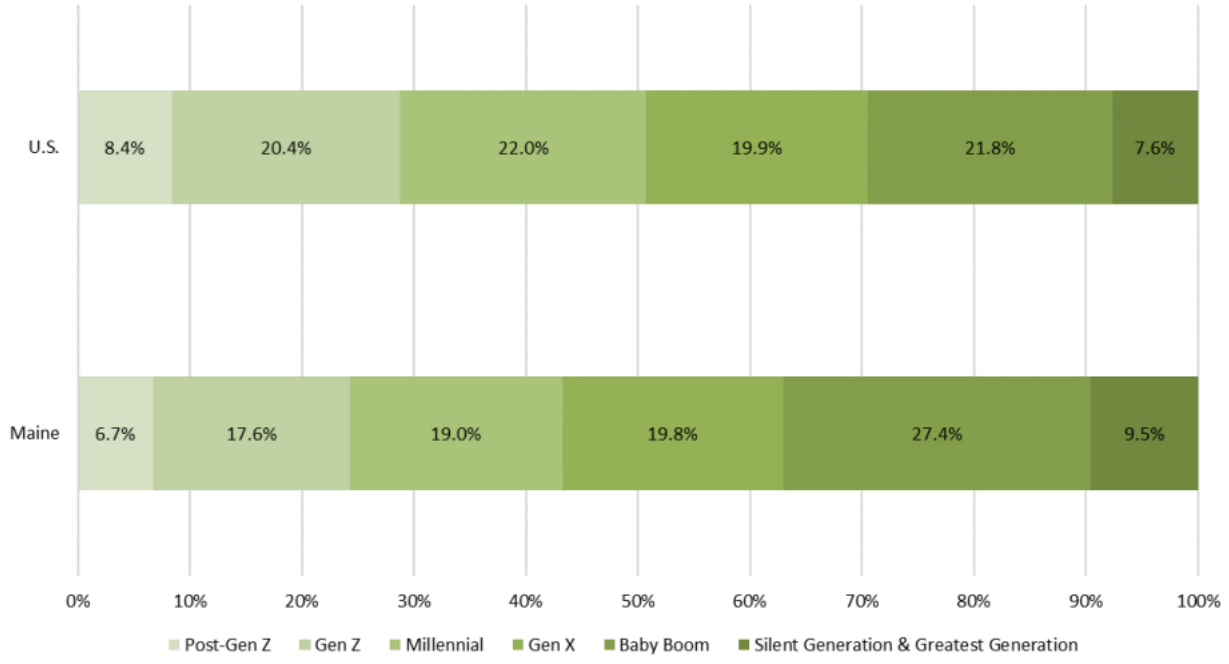
During the last 5 years, Maine has experienced many contextual changes that influence the way in which the MPS Initiative was implemented. Contextual influences include cultural values and shifting political, economic, and social priorities. These factors were often not predictable, measurable, or under the Maine CDC or vendors' control. However, in various degrees, they affect all core components of the Initiative.

Changing Maine population. Maine has a population of 1,372,247 and is nearly as large geographically as the rest of New England combined. Maine is one of the most rural states in the nation with a population density of 43.1 people per square mile (U.S. Census Bureau, n.d.). The high rurality in Maine means that many Mainers, particularly in the northern and Downeast regions, do not have easy access to health system facilities (Rural Health Information Hub, 2022).

Proportionately, Maine has the largest Baby Boomer generation in the United States (see Figure 3). In 2016, this generation ranged from 52 to 70 years old (Office of the State Economist, 2021). By 2022, many people in this generation will have aged out of the workforce, which may be accelerated by the COVID-19 pandemic. As this generation has aged, they are leaving the workforce and increasing their need for health and social supports (ibid). This is referred to as a negative old-age dependency ratio, which is the ratio of working age people for each person aged 65+ years. The implications of this include shortages of nurses and crucial health care workers; stressors on working-age children who are caregivers; and stress on pension and social security systems (ibid).

Due to the sheer size of the Baby Boomer generation, the aging of the cohort will ultimately result in natural population decline where the number of deaths each year exceed the number of births (Office of the State Economist, 2021). Despite this trend, Maine has seen a positive population growth as a result of net-migration. The latter is calculated as the number of people who have moved out of the state less the number of people who have moved into the state, both from domestic and international in-migration (ibid). Between 2010 and 2019, Maine gained approximately 16,000 people with 96.4% of these New Mainers being from non-White populations (ibid).

Figure 3. Maine Population by Generation - 2019 (Office of the State Economist, 2021)



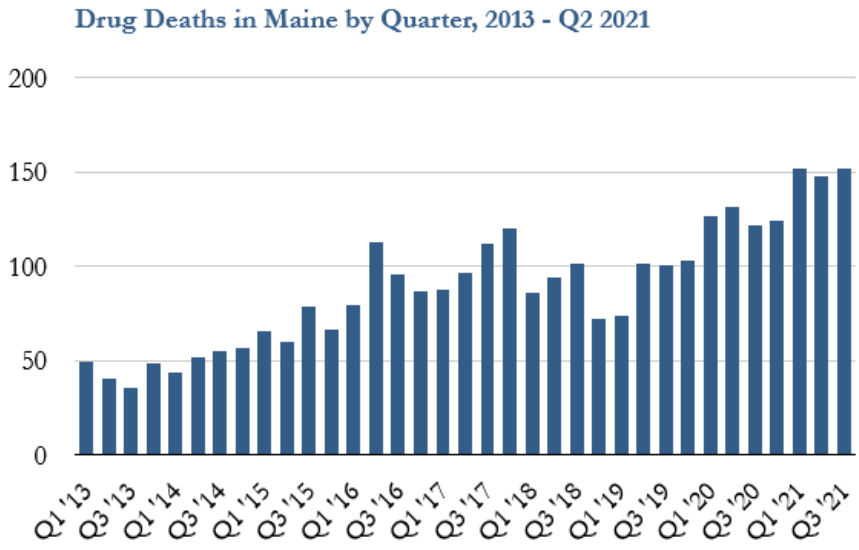
COVID-19. 2020 was a year of unprecedented upheaval for Mainers from all walks of life. Temporary closures of schools, businesses, and services, including health care, due to the COVID-19 pandemic, lead to issues that disproportionately impacted systematically disenfranchised Mainers.

A direct result of COVID is an increase in the acceptability and utilization of mobile health (mHealth) platforms. mHealth includes telehealth or telemedicine services supported by smart phones and/or tablets. Telemedicine rapidly increased during the early stage of the pandemic and was primarily used for established patients and for the delivery of psychiatric or behavioral treatments (Cortez, 2021).

COVID-19 emphasized the pervasive racial and socioeconomic inequities in healthcare access, quality, and outcomes in the US (DeSalvo, 2021). For example, the death rate from COVID-19 during the first year of the pandemic through March 2021 was 1.4 times higher among individuals who are Black, compared to White. At the same time, it has illuminated and exacerbated employment disparities (Remington, 2022). This trend is one of the contributors to the increasing rates of drug misuse and 'deaths of despair' (Case, 2020).

Both stressors and boredom were often cited reasons for the increase in tobacco use since March 2020. This increase was most apparent during the lockdown phase of 2020. One study found that 90% of the US population experienced some form of state lockdown between April and May 2020 (Columbia Mailman School of Public Health, 2021). Retail access to cigarettes and electronic nicotine delivery systems (ENDS) also changed during this period with increases in online sales (ibid). Supply delays of ENDS resulted in people smoking more readily-available cigarettes (ibid).

Figure 4. Drug Overdose Data: 2013 – 2021 (Office of the State Economist, 2021)



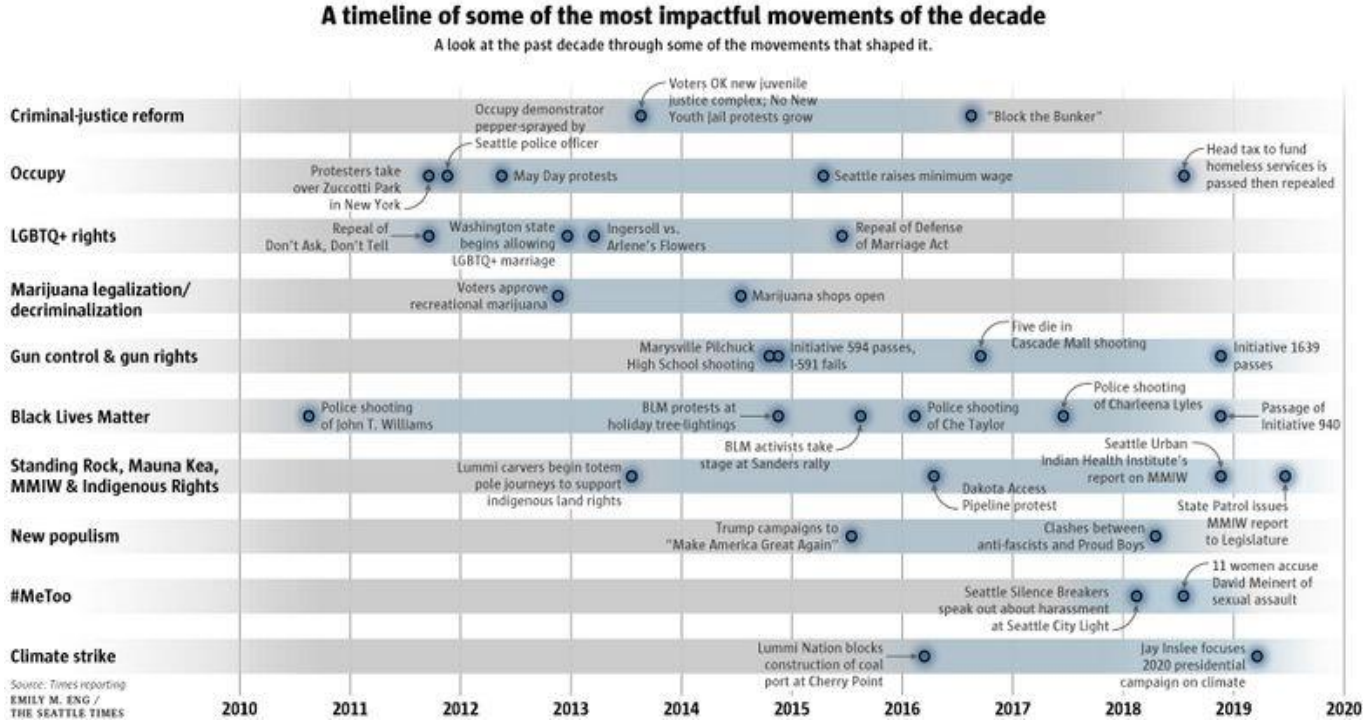
Opioid use increased while access to treatment medication (methadone and buprenorphine) decreased resulting in a significant increase in drug-related overdose deaths, as shown in Figure 4 (Becker, 2020). In Maine, drug deaths have been increasing since 2014 and had started to fall in 2019. Unfortunately, the pandemic disrupted the supply of and access to treatment and, as of December 2021, a total of 9,530 fatal and nonfatal overdoses were recorded (Sorg, 2022). In addition, due to the stay-home requirements during the pandemic, Mainers were more isolated from support networks and treatment services (Maine Public Health Association, 2021).

Nationally, communities have reported a decrease in access to affordable, healthy food options, as well as a decrease in opportunities for exercise and recreational activity during the pandemic (State of Childhood Obesity, n.d.). A 2021 U.S. CDC longitudinal trend study found that obesity increased nationally during the COVID-19 pandemic among youth between the ages of 2 and 19 (Lange, et al., 2021). Youth with moderate to severe obesity prior to the pandemic showed significantly higher increases in their BMI during the pandemic (ibid), putting these youth at higher risk for health issues and obesity-related death.

Both the immediate impacts and aftershocks of the pandemic have prioritized the need to ensure equitable and timely access to education and resources that increase prevention-related knowledge, strengthen resiliency, and build self-efficacy.

Social movements. Throughout history, social movements have promoted change. After the 2008 recession, people camped out on public lands to protest wealth inequalities. In the 2010s, much social activism stemmed from the organizing power of social media which enabled people to come together to fight for same-sex marriage and against anti-immigrant sentiments. These movements gained momentum and took on global proportions between 2016 and 2022 with the rise of the #MeToo and Black Lives Matter movements. Figure 5 summarizes the most popular movements over the last decade. These movements have resulted in policy changes and cultural shifts (Van Dyke, 2019) which are known to effect both resource allocation and community readiness to engage in topics (e.g. social determinants of health, gender and health, etc.) (Brown, 2014) (Pleyers, 2020).

Figure 5. Social Movements Between 2010 and 2020 (Paul, 2019)



Youth vulnerability. According to a 2022 U.S. CDC analysis, more than 1-in-3 high school students experienced poor mental health during the pandemic and though not directly linked to the pandemic, almost half (44%) reported persistently having feelings of sadness or hopelessness in the past year (U.S. Centers for Disease Control and Prevention, 2022). Nationally, the majority of students who are Asian (64%) and Black (55%) reported experiencing racism (ibid). School connectedness[4] serves as an important protective factor of youth who reported feeling connected to adults and peers, decreasing their feelings of sadness, hopelessness or suicidal ideation. During the pandemic, many students across the country reported feeling less connected and more isolated (ibid).[5]

In Maine in 2019, nearly one-third of high school students (32%) reported feeling so sad and hopeless that they stopped doing some of their usual activities (MIYHS, 2019). These sentiments were reflected more significantly among students who identified as gay/lesbian (58%) and bisexual (67%) (ibid). While over half of high school students (57%) reported feeling like they matter to people in their community, compared with only 43% of students who identify as gay/lesbian and 35% of bisexual students (ibid).

Cannabis legalization. In Maine, medical cannabis was legalized in 1999 and non-medical adult use in 2016. Youth use of cannabis was declining prior to legalization. In 2009, 22.0% of high school students in Maine used cannabis, compared to 19.6% in 2015, prior to the legalization of adult use of cannabis (MIYHS, 2009) (MIYHS, 2015). According to the most recent MIYHS data (2019) Maine middle and high school student use rates have increased from their lowest points in 2017. In 2019, 4.1% of middle schoolers reported using cannabis in the past 30 days, which is up from 3.6% in 2017 (MIYHS, 2017) (MIYHS, 2019). Similarly, 22.0% of high school students reported use in 2019, up from 19.2% in 2019 (ibid).

Young adult (18-25) cannabis use has also been rising. In 2011/2012, 22.7% of young adults reported using cannabis in the past month, compared with 35.1% in 2018/2019 (U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality). In the same time period, cannabis use in the past year among youth ages 12 and older has increased from its lowest rate of 14.3% to 24.8% (ibid). In addition, perception of harm among students has decreased during the same period. In 2017, 65.5% of middle schoolers and 35.1% of high schoolers perceived a moderate or great risk of harm from smoking cannabis (MIYHS, 2017). In 2019, this decreased to 61.8% of middle school students and 33.2% of high school students (MIYHS, 2019).[6]

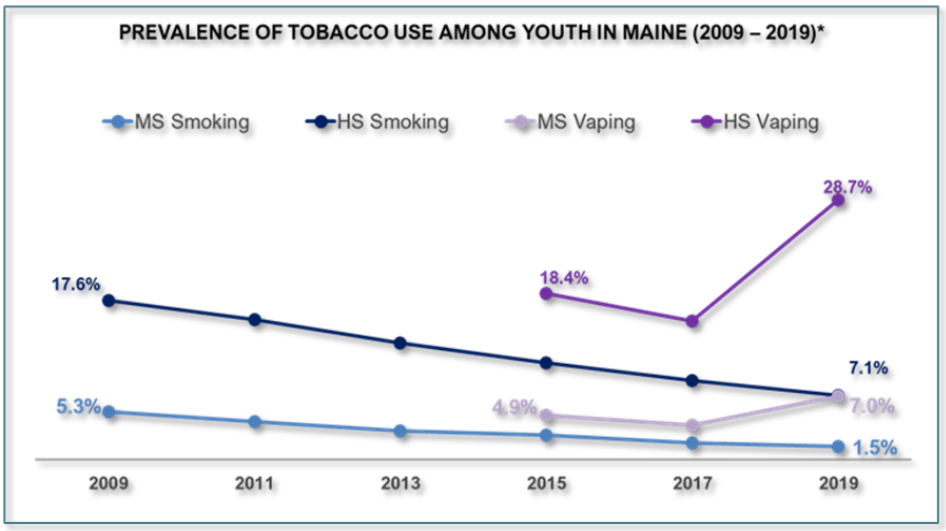
[4] School connectedness is defined as "the belief held by students that adults and peers in the school care about their learning as well as about them as individuals (American Psychological Association, 2014)

[5] Due to delays in surveillance, data on Maine youth's connectedness and isolation during the pandemic is not available.

[6] All data in this paragraph were obtained from the Maine State Epidemiological Outcomes Workgroup (SEOW) Marijuana Dashboard.

E-cigarettes. E-cigarettes, also called ENDS, vapes, or e-cigs, are battery operated non-combustible products that vaporize an 'e-liquid', almost always containing nictotine, into an aerosol form that is inhaled by the end user (U.S. Food and Drug Administration, 2022). Youth use of ENDS have increased in Maine from 18.4% of Maine high school students in 2015 (MIYHS, 2015) to 28.7% in 2019 (MIYHS, 2019). As shown in Figure 6, this increase in vaping behavior is in stark contract to the significant decrease in use of conventional and combustible tobacco products among Maine high school students over the same period of time (ibid). These trends threaten to undermine the preventive effort gains that have been made.

Figure 6. Changes in Tobacco Use Among Youth in Maine (MIYHS, 2009 - 2019)



STRATEGIC UNDERSTANDING

"Large gains in population health often come from small changes for many people rather than from large changes for fewer people (pg.21)" (Frieden, 2014)

The pandemic has served as a stark reminder that health issues are sometimes not perceived as public health concerns. Public health is, by definition, a communal (as opposed to individual) perspective and may run counter to fundamental individualism within the American culture.

> *"The exceptionalism of the United States lies in its antistatist[7] beliefs: Americans are less concerned with what government will do to benefit individuals than what government might do to control them. To the extent that Americans support collective action in the pursuit of public health or any other social good, they exhibit a strong preference for voluntary organization and participation (pg. 196)" (Oliver, 2006).*

At the core of the MPS Initiative is the belief that strides in population health will occur when the default choice is the easy choice. The interventions are primarily focused on policy and environmental changes, which would require individuals to spend significant effort to not benefit from them. For example, eliminating trans-fats in most food products results in an environment in which an individual would need to expend significant effort to locate foods with trans-fats in them, thereby positively impacting the majority of individuals.

Over the last 5 years, over 20 MPS-related evaluation reports have been published. Many of these used quasi-experimental designs to show an association between effort and policy / environmental changes. In

[7] Antistatist ideology is the belief that the state should not intervene in personal, social, or economic affairs.

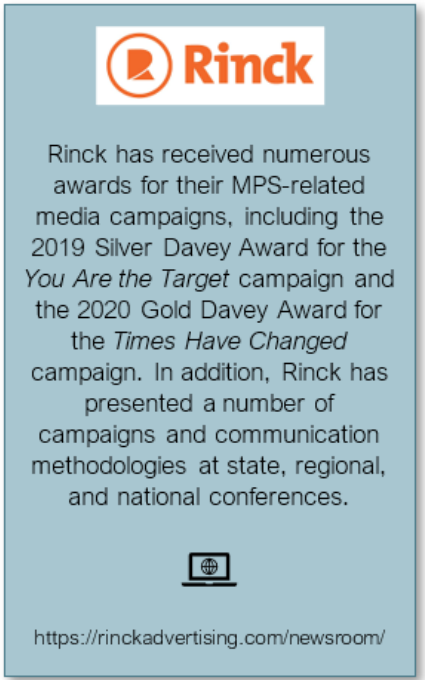
2022, an MPS Data Walk was held with over 100 professionals to showcase the effort and outcomes of the Initiative. These findings have been articulated in Domain-specific evaluation reports.

Throughout the funding cycle, mass-reach health communications have been essential to reaching the right people with the right messages to promote substance use and tobacco use behavior changes, as well as youth engagement. This included testing alternate messaging; targeting campaigns both geographically and behaviorally; and refining activities based on utilization analytics. For example Rinck Advertising developed a new alcohol campaign called 'the Sipping Point' to increase awareness of the negative impacts of alcohol misuse among adults. In addition, they created a toolkit with media assets the community sub-recipients could use in their work. This multi-level approach has shown to be effective and resource efficient (see Chapter 7: Mass-Reach Health Communications).

The Initiative included both statewide and community-level strategies. This multi-level coordinated approach leveraged the knowledge of public health professionals to identify new champions, form diverse partnerships, and tailor strategies to meet people where they are. For example, MYAN expanded its statewide reach during COVID-19 and supported an increased number of social action projects led by youth. From a strategic perspective, framing youth engagement through the lens of youth-adult partnerships during the pandemic invited real-time and meaningful conversations with those most closely impacted by isolation and loneliness caused by the pandemic.

Strategic understanding of these realities included ideas, guidelines, and thinking that initiate, nurture, and sustain infrastructure. Across the Initiative, vendors worked with local community partners who are in tune with the needs and processes of the local community. The results were twofold: it enabled a deeper understanding of the realities of disparate communities; and it allowed for locally informed adaptations to evidence-based strategies.

For example, Let's Go! worked with their community partners to modify their deliverables to better meet the needs of communities. CTI, with encouragement from their most northern local prevention partner, supported a local media campaign on tobacco cessation resources and supports available. These short ads were done in partnership with local TV station, WAGM/Channel 8. UNE worked with community partners to develop and implement specific interventions to those who faced undue burden of substance use and exposure, such people with a family history of substance use; the LGBTQ+ community; rural Mainers; and other populations throughout the state.



TACTICAL ACTION

"A strong, functional infrastructure facilitates capacity and allows programs to implement strategies effectively and efficiently" (Lavinghouze S.R., 2014).

Tactical actions are formal and informal day-to-day structures, operations, and procedures. It includes staff roles and internal and external communications with other structures, systems, and partners. Unlike other components of the model, these actions are more visible and easier to align with immediate outcomes. Each of the remaining chapters describe the domain-specific actions and the outcomes thereof.

CORE COMPONENTS

Multilevel Leadership and Commitment

Professionals involved in the MPS Initiative have both provided and received recognition for leadership and commitment. MYAN's Maine Youth Leadership Conference awards scholarships to outstanding youth leaders. Rinck has received awards from the National Conference on Tobacco and Health as well as industry recognition.

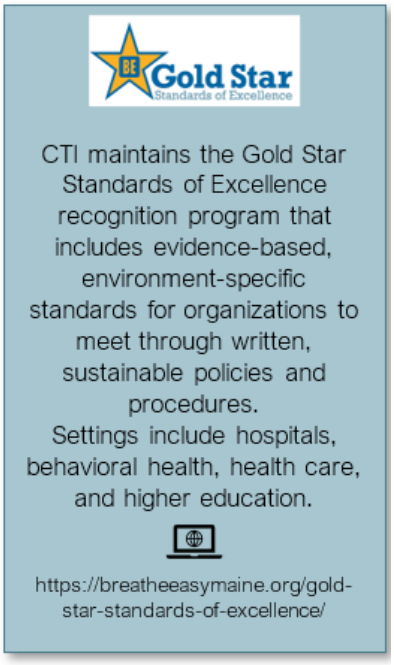
Within the MPS Initiative, organizations and community partners (i.e., schools, health care practices, etc.) are recognized by vendors based on the level at which they have engaged with the Initiative and championed strategies within specific settings. In addition, some vendors share this recognition with local-level leaders (e.g., school superintendents, health care practice leaders) to further acknowledge successes and progress.

Networked Partnerships

Partnerships occurred prior to the start of the MPS, as well as at all levels of the Initiative with diverse types of organizations, focus areas, target audiences, and approaches. These include schools, businesses, municipalities, youth-serving entities, lodgings, early care and education sites, hospitals, and more. The networks were interconnected in ways that promote health and wellbeing across Domains, ages, and settings. Collectively, these partnerships that were created and sustained throughout the MPS Initiative ensured that all activities necessary to achieve individual, community, policy, systems, and/or environmental changes are accomplished.

Vendors encouraged the inclusion of all voices in policy development through national, statewide, district-level, and community-level partnerships. Maine CDC and vendors engaged with divisions within the U.S. CDC and SAMHSA. In addition, they engaged with their colleagues from different states and participated in numerous professional bodies. Maine CDC organized and facilitated a number of statewide topic-specific committees, task forces, and advisory boards in which vendor staff co-convened. These groups are a way for Maine CDC and vendors to connect with partners, learn from each other and ensure that the work of the state and vendors supports one another. Individually and collectively, the Domains provided opportunities for sub-recipients to network with each other to share best-practice ideas and innovative strategies.

This inclusivity resulted in a continued, intentional focus on relationships at all levels of work – with youth, adults, community partners, and within the extended networks. Investment in relationships, coupled with responsive actions and supports, have been the bedrock of the MPS Initiative.



Social capital. Social capital, especially bridging[8] and linking[9] networks, are particularly significant for those sub-populations with historically low trust in government entities and their subsidiaries. Within the MPS Initiative, strengthening types of networks have been particularly important when working with people historically underserved and/or harmed by the government. Across the Domains, teams inspired to uphold the principle of *'nothing about me, without me'*. This included activities such as supporting locally informed needs assessments undertaken by communities; providing additional resources to ensure adequate staffing and support; funding innovation mini-grants to pilot new ideas; and delivering free community education / trainings.

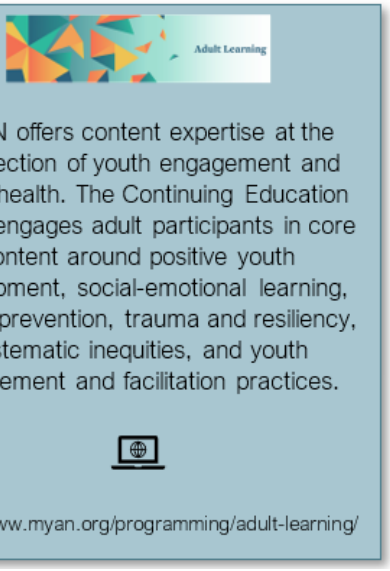
EXAMPLES OF NETWORKS

- Alcohol Prevention Stakeholders
- Cannabis Workgroup
- E-cigarette Workgroup
- Emerging Tobacco Products / Cannabis Vaping Subgroup
- LGBTQ+ SupportME Network
- Maine Obesity Advisory Committee
- Methamphetamine Task Force
- Obesity Clinical Advisory Committee
- Physical Activity and Nutrition in Early Childcare Education
- Tobacco Laws Workgroup
- Tobacco and Substance Use Prevention Advisory Board
- Tobacco Advisory Council
- Workforce Development Workgroup
- Workgroup for Alcohol Prevention

Resources and Performance Management

Workforce development. At the Maine CDC, vendor, and sub-recipient levels, the need to have the right people who are appropriately skilled has been prioritized. New hires have undergone structured onboarding and orientation processes. This helps to ensure that the principles underlying the MPS Initiative, its historical context, and Domain-specific knowledge are shared and maintained.

Maine CDC and vendor staff stayed abreast of current evidence and pursued professional development opportunities. Capacity was strengthened through the provision of professional prevention-related training, technical assistance, and resources. Both issue-specific and overall public health communities of practice have been developed to facilitate mutual learning. The result is public health professionals who are able to focus their efforts on ensuring quality and accessibility of health services; apply their knowledge of diverse bio-psycho-social models; and leverage their lived experience to build coalitions and support systemic change.



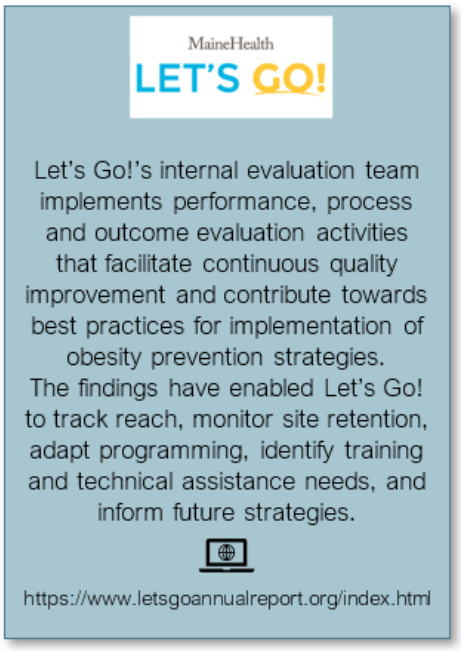
Performance management. Maine CDC staff and vendors have modified their structures to better meet the needs of the MPS Initiative at statewide, regional, and local levels. Financial and contract oversight occurred on two levels: Maine CDC staff provided contract oversight, technical assistance, and guidance to each vendor who, in turn, oversaw sub-recipient contracts. Both included activity and financial tracking and reporting. Unlike the traditional *cost settled contracts*[10] fiscal relationships between the Maine CDC and agencies implementing prevention strategies, *performance-based contracting*[11] was used between Maine CDC and vendors as well as between vendors and their sub-recipients.

[8] Bridging networks are relationships based on community norms (Scheffert, 2020).
[9] Linking networks are relationships that are determined by the trust communities have in leaders (Scheffert, 2020).
[10] Cost-settled contracts focus on the effort required to undertake the contracted activities and therefore payments are typically distributed equally across the funding cycle.
[11] Reimbursement / performance-based contracts are results-oriented and focused on outcomes rather than outputs.

Responsive Planning and Technical Packages

Extensive stakeholder-led strategic planning processes recently culminated in statewide strategic plans for both Substance Use Prevention and Tobacco Use Prevention and Control. These plans were developed to be flexible and responsive to the context, funding directives, and external support from the public and leadership, while maintaining integrity to their overall goals[12]. The strategic plans have provided direction and coordinated efforts with the vendors, who, in turn, ensured their workplans and subrecipients' activities were aligned with the statewide objectives.

Annually, each vendor conducted its own reflective processes to identify the most effective, feasible, and sustainable interventions that could be implemented locally. These processes were informed by literature, evidence-based frameworks (e.g., SAMHSA Strategic Prevention Framework), advisory councils (e.g. Clinical Advisory Committee's healthcare recommendations), and stakeholder engagement. In addition, the expert knowledge and internal capacity that has been built by vendors enables them to harness resources from within their agency to enhance the effectiveness of the Initiative.



Strategies implemented within the Initiative were primarily evidence-based and reflected best practices. They balanced standardization with customization. Vendors worked with their sub-recipients to develop a unique technical package that maintained fidelity to the statewide technical package while being responsive to local community priorities. This required agility in the creation of workplans and flexibility in strategy implementation.

All plans were viewed as living, dynamic documents able to respond to changing environments, partnerships, resources, and leadership. For example, during COVID-19 many of the activities previously planned had to be redesigned or adapted. Trainings were converted to virtual platforms; communication changed to electronic; and resources redirected to supporting local partners in their adaptation to the new realities.

Engaged Data and Information Dissemination

The Initiative has prioritized monitoring, evaluation, and learning throughout the funding cycle. This was evident in both program evaluation and performance monitoring that was used to inform decisions, facilitate continuous program improvement, and assess impact. Each vendor created a reporting system with their sub-recipients. This data was used to complete the implementation indicators system (or similar) managed by the external evaluators. In addition, vendors undertook their own formative evaluation and collated local-level success stories.

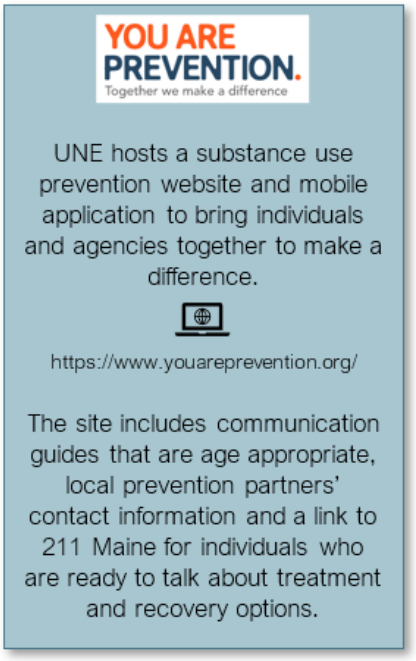
To enable the Maine CDC and vendors to fully use available data (i.e., engaging data), PFH and PCG held webinars and presented at local, regional, and national conferences. Communication and dissemination of findings were included in all program evaluation plans. This ensured that the types of data, as well as the way in which it was presented could be tailored to the needs of the audience. New apps (e.g., Menti) enabled the evaluators to maximize opportunities for interactive conversations on virtual platforms.

[12] Maine Tobacco Comprehensive Strategic and Sustainability Plan (2020 – 2025)
Maine CDC Substance Use Prevention Strategic Plan 2021 - 2024 One-Pager

Diverse, multi-directional, dynamic communication and knowledge flowed among Maine CDC staff, vendors, and local community agencies. This enabled everyone to benefit from the knowledge and experience of their peers. Communication between the Maine CDC, vendors, sub-recipients, and the public health districts took place through regular meetings and the distribution of quarterly public health district reports for the District Liaisons. In addition, at the request of legislators, the Maine CDC provided informational briefs and updates. Vendors and their sub-recipients were responsive to requests from the DCCs. Vendors and Maine CDC staff met regularly (individually and collectively) to coordinate efforts and discuss relevant or emerging cross-domain strategies. Vendors regularly reached out to their sub-recipients through electronic communications on various platforms.

COLLECTIVE IMPACT

During the 2022 MPS Data Walk, participants noted that the most significant impact of the Initiative has been the increase in collaboration between substance use prevention, tobacco use prevention, youth engagement and empowerment, and obesity prevention. They also noted the resilience of public health professionals and how partnerships continue to strengthen across the state, enabling an increase in the sharing of successful programs and lessons learned. Examples of this collective impact included an increased focus on addressing disparities and inequities, reduced duplication of effort, increased comprehensiveness of strategies, and less confusion among community stakeholders. Ultimately, they reflected that the people of Maine benefited the most from this collective impact.



DOMAIN 1: SUBSTANCE USE PREVENTION
UNIVERSITY OF NEW ENGLAND

Using a braided funding approach, the University of New England (UNE) has sub-contracted with 21 local community agencies to implement activities to prevent youth and young adult substance use and misuse. Both UNE and its sub-recipients, known as community partners, use the Substance Abuse and Mental Health Services Administration's (SAMHSA) *Strategic Prevention Framework* to address factors that cause or impact substance use that can be mitigated with intervention strategies.

GOALS

1. Prevent and reduce youth and young adult use of alcohol and marijuana.
2. Prevent and reduce youth and adult misuse of prescription drugs.

Certified Substance Use Prevention Specialists have worked in all 16 counties and the Tribal Public Health District. Together, they work closely with other community stakeholders, such as law enforcement, schools, higher education institutions, worksites, healthcare providers, and local governments to implement evidence-based, state approved, primary prevention activities.

Each sub-recipient conducts a needs assessment of their service area by using available surveillance data and collecting additional local data. They then use the results of the assessment to develop their annual workplans and identify the SAMHSA Center for Substance Abuse Prevention (CSAP) strategies and interventions they will implement. CSAP strategies cover 6 areas:

Information dissemination: Using social media, radio, print, electronic messaging, and other mass communication methods that aim to increase awareness, knowledge, and prevention-minded norms around substance use and misuse.

Education: Providing two-way interactive sessions and lessons aimed at increasing participants' knowledge and skills to take actions to prevent substance use.

Environmental factors: Establishing or changing population-based factors that influence substance use and related problem behaviors.

Problem identification and referral: Identifying and referring individuals who have illegally used or misused substances but have not been diagnosed with a substance use disorder.

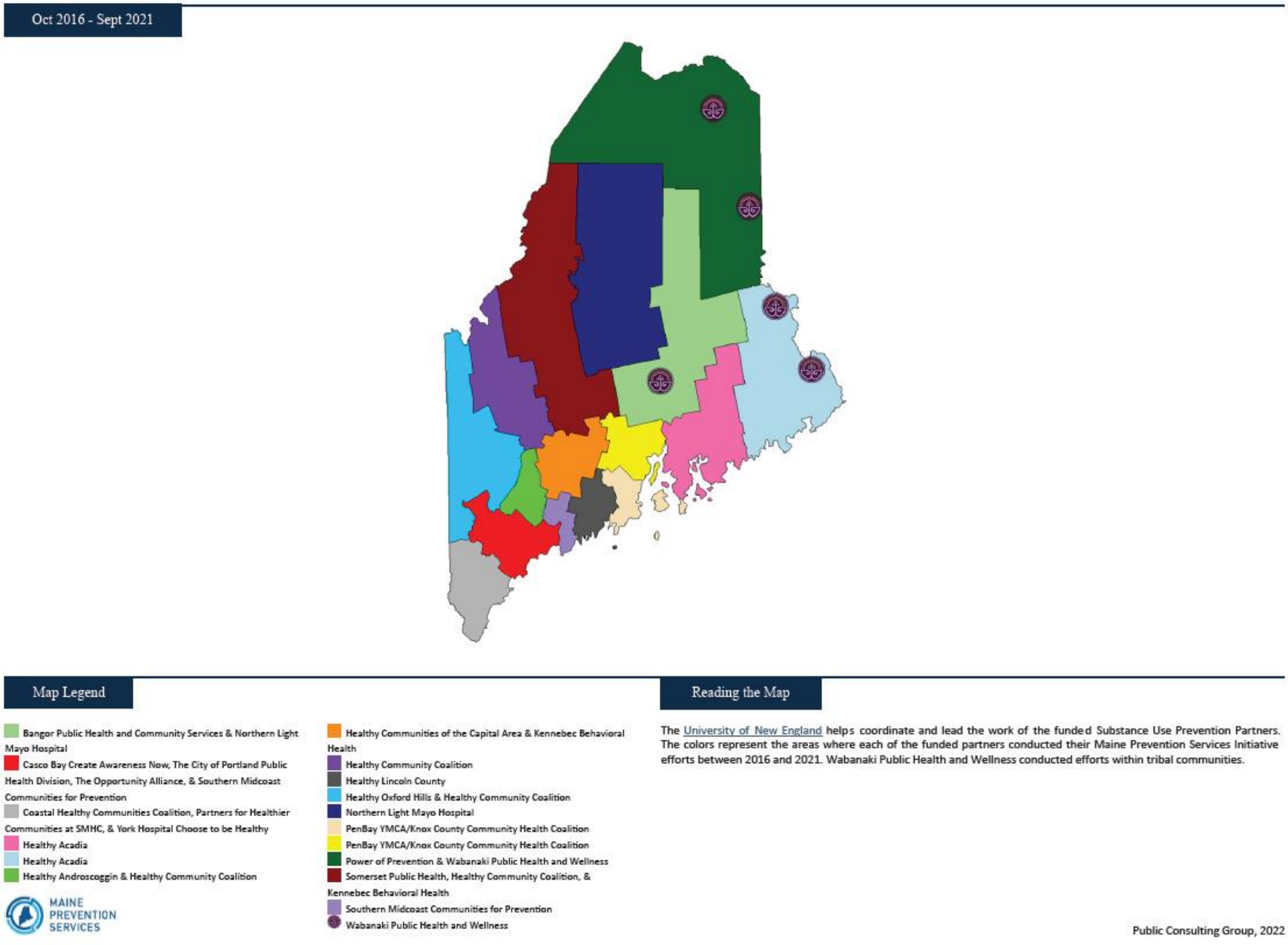
Community-based process: Building readiness and engagement of community stakeholders and target populations to address intervening variables known to impact substance use and misuse.

Alternatives: Engaging youth to participate in constructive and healthy activities to reduce the attraction to substance use.

These efforts address individual, family, peer group, organizational, and community factors that influence people's substance use choices. This comprehensive approach treats substance use prevention as a community-wide matter, which research has shown to be more effective than trying to address it through individually focused initiatives.

For more information, please refer to UNE's website: www.une.edu/research/centers/center-excellence-public-health/maine-substance-use-prevention-services

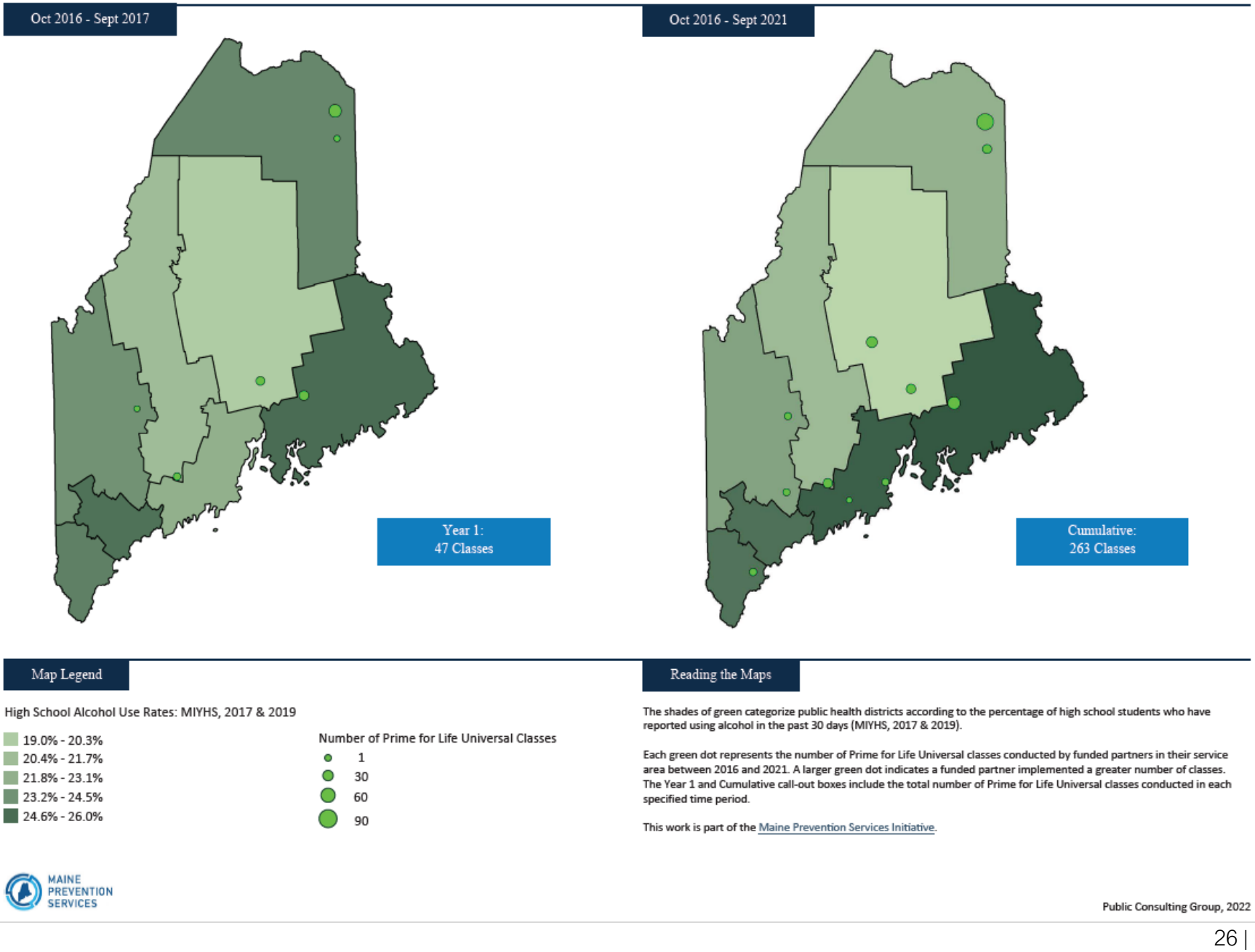
Figure 7. Substance Use Prevention: Funded Partners by Service Area (2016 – 2021).



	GOAL 1[13]: PREVENT AND REDUCE YOUTH AND YOUNG ADULT USE OF ALCOHOL AND MARIJUANA UNE and the sub-recipients implemented a variety of community-focused interventions. The most common included: multi-agency coordination and collaboration; safe storage in homes; multiple substances information dissemination and communication; and class educational services.			
	YOUTH CLASSES		**RETAILER TRAININGS**	**LAW ENFORCEMENT**
Cumulative: 2016 – 2021	**263** Prime for Life® Universal classes reaching **4,892** students	**117** Student Intervention Reintegration Program (SIRP) courses reaching **633** individuals	**210** Responsible Beverage Seller / Service Trainings reaching **528** businesses and **117,784** individuals	**114** law enforcement details implemented
2020 - 2021	18 Prime for Life® Universal Classes reaching 386 individuals	6 SIRP courses reaching 16 individuals	36 Responsible Beverage Seller / Service Trainings reaching 84 businesses and 26,368 individuals	13 law enforcement details implemented
2019 - 2020	27 Prime for Life® Universal Classes reaching 515 individuals	24* SIRP courses reaching 128 individuals	22 Responsible Beverage Seller / Service Trainings reaching 71 businesses and 21,978 individuals	12 law enforcement details implemented
2018 – 2019	50 Prime for Life® Universal Classes reaching 1,120 individuals	29 SIRP courses reaching 152 individuals	55* Responsible Beverage Seller / Service Trainings reaching 156* businesses and 14,640 individuals	39* law enforcement details implemented
2017 – 2018	120 Prime for Life® Universal Classes reaching 1,963 individuals	31 SIRP courses reaching 164 individuals	53* Responsible Beverage Seller / Service Trainings reaching 147 businesses and 12,849 individuals	24* law enforcement details implemented
2016 - 2017	48 Prime for Life® Universal Classes reaching 908 individuals	27 SIRP courses taught, reaching 173 individuals	44 Responsible Beverage Seller / Service Trainings reaching 70 businesses and 41,949 individuals	28 law enforcement details implemented

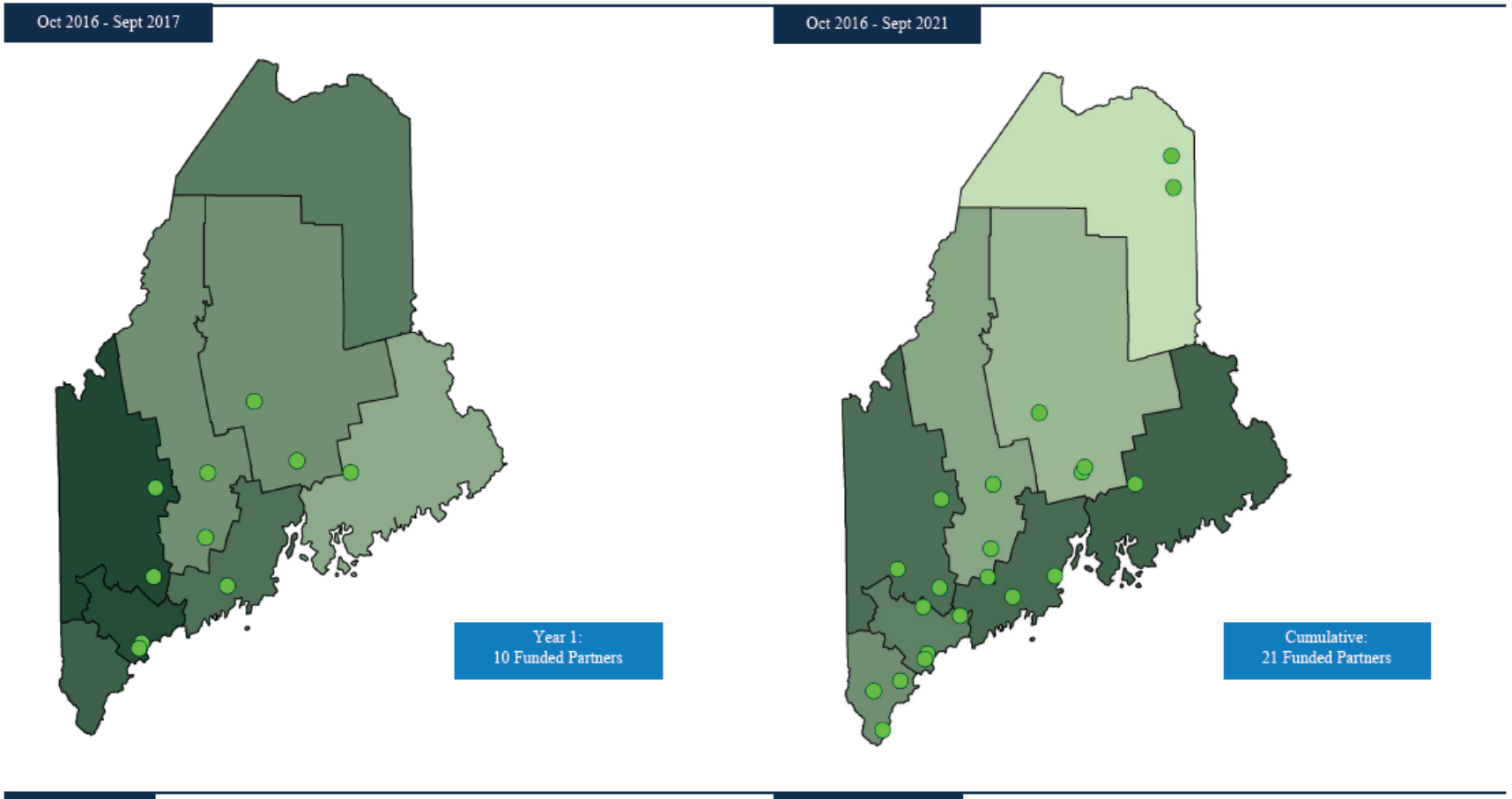
[13] In 2022, PCG conducted an in-depth validation of all years of Domain 1 data. Some data (marked with a *) has been updated accordingly.

Figure 8. Number of Prime for Life Universal Classes Conducted (2016 – 2021).



	GOAL 2: PREVENT AND REDUCE YOUTH AND ADULT MISUSE OF PRESCRIPTION DRUGS UNE and the sub-recipients implemented a variety of community-focused interventions. The most common included: prescription drug drop boxes / take-backs; *Safe Storage In Homes*; and information dissemination and communication about prescription drugs.	
	PRESCRIPTION DRUG TAKE-BACK	**SAFE STORAGE IN HOMES**
Cumulative: 2016 – 2021	**21** sub-recipients across **9** public health districts participated in drug take-back efforts, collecting **112,586** pounds of drugs	**21** sub-recipients implemented the Safe Storage In Homes intervention across **9** public health districts and reached Mainers **1,809,280** times
2020 - 2021	15 sub-recipients across the 9 public health districts participated in drug take-back efforts, collecting 35,451 pounds of drugs	17 sub-recipients implemented the *Safe Storage In Homes* intervention across 8 public health districts and reached Mainers 654,995 times
2019 - 2020	12 sub-recipients across the 9 public health districts participated in drug take-back efforts, collecting 18,100 pounds of drugs	14 sub-recipients implemented the *Safe Storage In Homes* intervention across 8 public health districts and reached Mainers 427,432 times
2018 – 2019	13 sub-recipients across the 9 public health districts participated in drug take-back efforts, collecting 29,425 pounds of drugs	14 sub-recipients implemented the *Safe Storage In Homes* intervention across 8 public health districts and reached Mainers 440,182 times
2017 – 2018	14 sub-recipients across the 9 public health districts participated in drug take-back efforts, collecting 29,610 pounds of drugs	14 sub-recipients implemented the *Safe Storage In Homes* intervention across 7 public health districts and reached Mainers 256,960 times
2016 – 2017	11 sub-recipients across 8 public health districts participated in drug take-back efforts	14 sub-recipients implemented the *Safe Storage In Homes* intervention across 8 public health districts and reached Mainers 29,711 times

Figure 9. Number of Funded Partners that Implemented Drug Take Back Efforts (2016 - 2021).



	Cross-Goal Activities[14]		
	Communication	**Materials Disseminated**	**Trainings Conducted**
Cumulative: 2016 – 2021	**9** public health districts engaged in social media and speaking engagements / community presentations	Substance use prevention information and materials provided at **433** events	**249** trainings conducted to change norms around youth substance use
2020 - 2021	8 public health districts engaged in social media and speaking engagements / community presentations	Substance use prevention information and materials provided at 56 events	50 trainings conducted to change norms around youth substance use
2019 – 2020	9 public health districts engaged in social media and speaking engagements / community presentations	Substance use prevention information and materials provided at 50* events	41 trainings conducted to change norms around youth substance use
2018 – 2019	9 public health districts engaged in social media and speaking engagements / community presentations	Substance use prevention information and materials provided at 92 events	18 trainings conducted to change norms around youth substance use
2017 – 2018	9 public health districts engaged in social media and speaking engagements / community presentations	Substance use prevention information and materials provided at 136 events	79 trainings conducted to change norms around youth substance use
2016 – 2017	9 public health districts engaged in social media and speaking engagements / community presentations	Substance use prevention information and materials provided at 99 events	61 trainings conducted to change norms around youth substance use

[14] In 2022, PCG conducted an in-depth validation of all years of Domain 1 data. Some data (marked with a *) has been updated accordingly.

Progress Toward Long-Term Outcomes

State and county level data. Tables 2 through 4 summarize youth data from the MIYHS from 2015, 2017, and 2019 on a state, public health district, and county level. The state and public health districts are shown in the blue rows. The counties within each public health district (if any) are shown in the white rows. When reading the data, it may be useful to look at trends at a district level, due to districts' larger sample sizes and smaller error margins.

Confidence intervals. Confidence intervals quantify the degree of uncertainty in rate or prevalence estimates that result from sampling or random variability. The confidence interval presents a range of values within which the true underlying rate or prevalence is likely to lie; the range is bounded by the error margins of the Upper Confidence Limit (UCL) and the Lower Confidence Limit (LCL). For example, a 95% Confidence Interval means that, if all eligible students in the population answered a specific question, we are 95% confident that the true population value of the specific question would fall between the LCL and the UCL.

Trend. Tables 2 through 4 also show the trend across multiple years. If the Confidence Intervals of the most recent year (typically 2019) do not overlap with the Confidence Interval from the base year (typically 2015), then the trend is considered to be significantly increasing (↑) or decreasing (↓). If the base year Confidence Intervals overlap with the most recent year, the trend is considered statistically unchanged (→).

Table 2. Percent of Maine High School Students That Report Any Alcohol Use in the Past 30 Days.
Data source: MIYHS 2015, 2017, and 2019.

	2015 (LCL-UCL)	2017 (LCL-UCL)	2019 (LCL-UCL)	TREND
State	23.8% (22.8 – 24.8)	22.5% (21.6 – 23.5)	22.9% (21.8 – 24.0)	→
Aroostook	28.1% (24.7 – 31.4)	23.1% (15.7 – 30.4)	21.1% (12.0 – 30.3)	→
Central	22.5% (20.3 – 24.8)	20.6% (18.0 – 23.2)	20.7% (18.9 – 22.4)	→
Kennebec	22.5% (19.9 – 25.2)	21.2% (17.4 – 24.9)	19.6% (17.6 – 21.6)	→
Somerset	22.7% (18.5 – 26.8)	19.6% (16.6 – 22.7)	22.1% (18.9 – 25.4)	→
Cumberland	24.5% (22.7 – 26.4)	24.1% (22.1 – 26.2)	24.1% (21.7 – 26.5)	→
Downeast	23.6% (20.1 – 27.1)	24.3% (22.0 – 26.7)	25.3% (21.2 – 29.4)	→
Hancock	24.7% (19.9 – 29.4)	24.9% (21.8 – 28.1)	26.0% (19.5 – 32.4)	→
Washington	22.3% (17.8 – 26.8)	23.4% (20.1 – 26.7)	23.9% (20.4 – 27.4)	→
Midcoast	23.6% (20.7 – 26.6)	21.2% (19.9 – 22.4)	24.9% (22.4 – 27.4)	→
Knox	Not Available	25.2% (24.2 – 26.1)	27.5% (26.9 – 28.1)	↑
Lincoln	18.5% (13.8 – 23.2)	19.3% (16.8 – 21.8)	25.8% (20.2 – 31.5)	→
Sagadahoc	28.4% (24.4 – 32.4)	19.5% (17.0 – 21.9)	20.8% (17.1 – 24.5)	→
Waldo	21.6% (20.6 – 22.6)	21.9% (21.0 – 22.9)	25.2% (19.5 – 30.9)	→
Penquis	23.7% (22.2 – 25.1)	19.9% (17.3 – 22.6)	19.4% (16.4 – 22.5)	→
Penobscot	23.9% (22.3 – 25.4)	19.9% (17.1 – 22.7)	19.3% (16.1 – 22.4)	→
Piscataquis	22.7% (19.2 – 26.2)	21.4% (15.4 – 27.4)	20.8% (17.8 – 23.9)	→
Western	22.1% (18.9 – 25.4)	22.6% (19.9 – 25.3)	21.8% (19.7 – 24.0)	→
Androscoggin	19.6% (13.6 – 25.5)	20.4% (17.2 – 23.6)	18.2% (15.7 – 20.7)	→
Franklin	23.8% (21.7 – 25.9)	26.4% (22.9 – 29 8)	25.2% (21.1 – 29.3)	→
Oxford	24.2% (20.3 – 28.2)	23.2% (17.8 – 28.7)	23.9% (18.8 – 29.0)	→
York	24.5% (21.4 – 27.6)	23.4% (21.0 – 25.9)	24.0% (20.7 – 27.3)	→

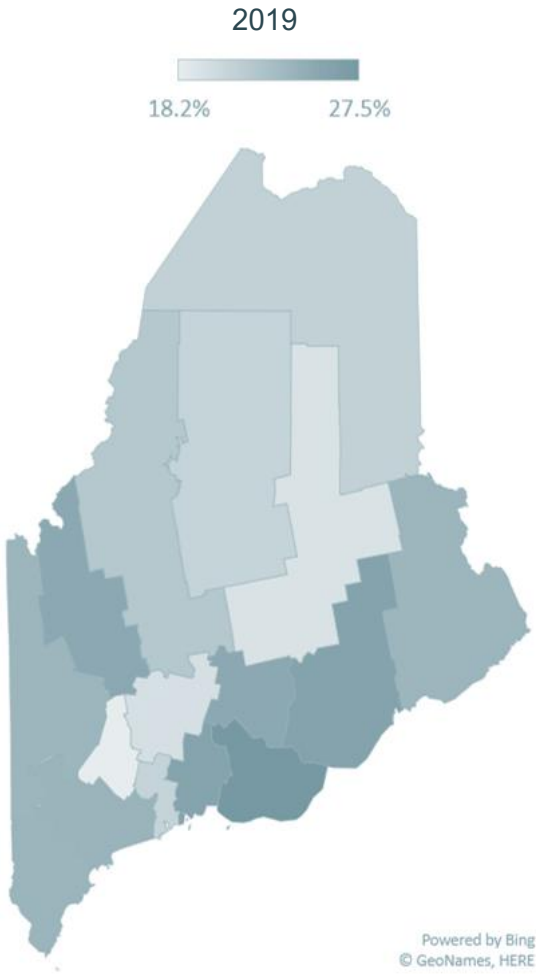


Table 3. Percent of Maine High School Students Who Report Any Use of Marijuana in the Past 30 Days.
Data source: MIYHS 2015, 2017, and 2019.

	2015 (LCL-UCL)	2017 (LCL-UCL)	2019 (LCL-UCL)	TREND
State	19.6% (18.7 – 20.6)	19.3% (18.4 – 20.2)	22.0% (21.1 – 23.0)	↑
Aroostook	17.1% (13.2 – 21.0)	14.5% (11.0 – 18.0)	18.3% (13.7 – 22.9)	→
Central	19.3% (16.9 – 21.6)	19.3% (17.1 – 21.5)	21.4% (19.2 – 23.5)	→
Kennebec	19.6% (17.0 – 22.2)	19.3% (16.2 – 22.5)	22.1% (19.4 – 24.8)	→
Somerset	18.7% (14.3 – 23.1)	19.2% (16.6 – 21.8)	20.4 (17.4 – 23.4)	→
Cumberland	20.2% (18.2 – 22.3)	19.4% (17.2 – 21.7)	23.9% (22.0 – 25.8)	→
Downeast	16.9% (14.7 – 19.2)	18.8% (17.1 – 20.4)	21.2% (18.6 – 23.8)	→
Hancock	17.0% (13.9 – 20.1)	18.6% (16.9 – 20.3)	21.5% (18.0 – 24.9)	→
Washington	16.7% (13.5 – 19.9)	19.8% (16.3 – 23.2)	20.9% (17.3 – 24.4)	→
Midcoast	21.2% (19.5 – 22.9)	22.1% (19.8 – 24.4)	23.1% (21.2 – 25.1)	→
Knox	Not Available	25.8% (18.5 – 33.0)	25.0% (23.3 – 26.7)	→
Lincoln	17.8% (14.5 – 21.0)	21.9% (17.6 – 26.2)	24.9% (21.3 – 28.5)	→
Sagadahoc	22.9% (20.3 – 25.5)	19.4% (17.6 – 21.2)	19.2% (15.5 – 22.9)	→
Waldo	23.0% (17.3 – 28.7)	21.5% (20.8 – 22.2)	23.3% (16.7 – 29.8)	→
Penquis	16.4% (13.8 – 19.1)	16.6% (13.4 – 19.7)	17.6% (14.4 – 20.9)	→
Penobscot	16.8% (13.7 – 19.8)	16.5% (13.1 – 19.9)	17.4% (14.0 – 20.8)	→
Piscataquis	15.4% (12.6 – 18.1)	19.4% (18.2 – 20.5)	20.5% (15.8 – 25.2%)	→
Western	20.0% (17.4 – 22.5)	21.6% (18.9 – 24.4)	23.3% (20.9 – 25.7)	→
Androscoggin	21.4% (18.8 – 24.0)	20.2% (15.3 – 25.2)	21.5% (19.0 – 24.0)	→
Franklin	16.3% (13.9 – 18.7)	22.5% (20.5 – 24.6)	25.8% (19.6 – 31.9)	↑
Oxford	22.9% (18.8 – 27.0)	22.7% (18.6 – 26.9)	24.1% (19.2 – 29.0)	→
York	21.4% (18.8 – 24.0)	18.4% (16.5 – 20.3)	21.7% (19.5 – 24.0)	→

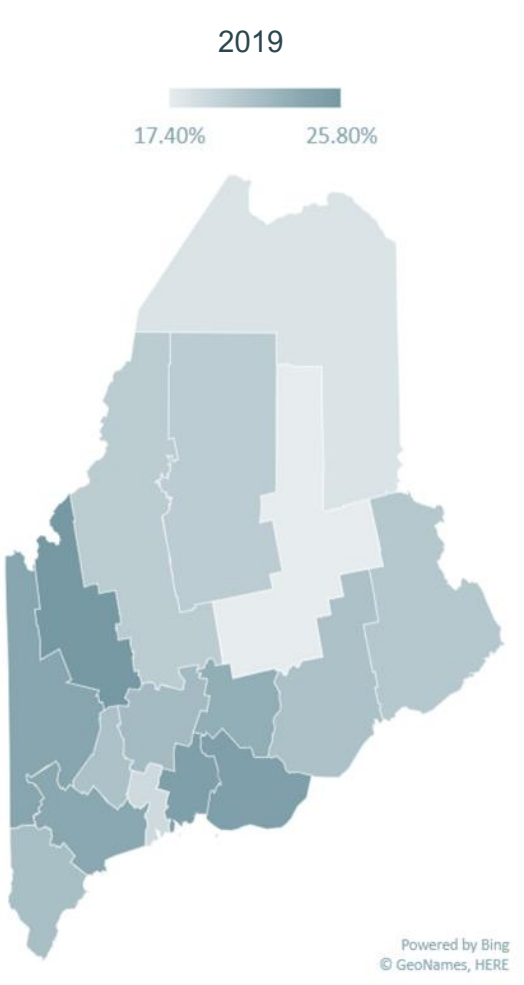
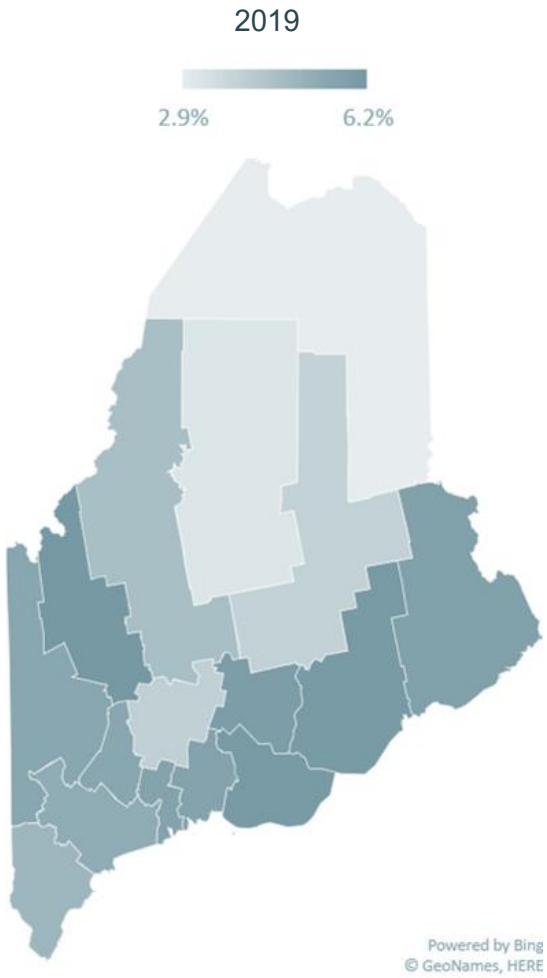


Table 4. Percent of Maine High School Students That Report Any Misuse of Prescription Drugs in the Past 30 Days.
Data source: MIYHS 2015, 2017, and 2019.

	2015 (LCL-UCL)	2017 (LCL-UCL)	2019 (LCL-UCL)	TREND
State	4.8% (4.5 – 5.2)	5.9% (5.5 – 6.2)	5.0% (4.6 – 5.4)	→
Aroostook	3.8% (2.3 – 5.3)	5.4% (3.9 – 7.0)	2.9% (2.2 – 3.7)	→
Central	4.1% (3.3 – 4.9)	4.9% (4.4 – 5.5)	4.3% (3.5 – 5.1)	→
Kennebec	4.2% (3.2 – 5.2)	5.2% (4.4 – 6.1)	4.0% (3.1 – 5.0)	→
Somerset	4.0% (2.7 – 5.3)	4.4% (3.7 – 5.2)	4.6% (3.0 – 6.1)	→
Cumberland	5.0% (4.4 – 5.6)	6.6% (5.6 – 7.6)	5.3% (4.7 – 6.0)	→
Downeast	4.4% (3.5 – 5.4)	4.2% (3.7 – 4.7)	6.0% (3.9 – 8.1)	→
Hancock	5.2% (3.5 – 6.8)	3.7% (2.9 – 4.5)	6.1% (3.0 – 9.2)	→
Washington	3.5% (2.3 – 4.6)	5.0% (4.1 – 5.9)	5.8% (2.8 – 8.9)	→
Midcoast	5.2% (4.2 – 6.2)	5.7% (5.3 – 6.2)	5.8% (4.8 – 6.9)	→
Knox	Not Available	4.7% (4.1 – 5.2)	6.1% (4.9 – 7.3)	→
Lincoln	3.2% (2.5 – 3.9)	5.3% (4.3 – 6.3)	5.7% (3.6 – 7.8)	→
Sagadahoc	6.9% (4.1 – 9.7)	7.1% (5.0 – 9.2)	5.7% (5.3 – 6.1)	→
Waldo	3.3% (0.9 – 5.7)	5.3% (3.8 – 6.8)	6.0% (0.2 – 11.7)	→
Penquis	4.1% (3.3 – 4.9)	4.9% (4.1 – 5.7)	3.9% (2.9 – 4.8)	→
Penobscot	4.1% (3.3 – 5.0)	5.0% (4.1 – 5.8)	3.9% (2.9 – 4.9)	→
Piscataquis	4.4% (3.2 – 5.7)	3.6% (1.9 – 5.3)	3.2% (0.0 – 7.2)	→
Western	4.9% (4.3 – 5.6)	6.7% (5.9 – 7.6)	5.7% (4.9 – 6.5)	→
Androscoggin	5.1% (3.9 – 6.3)	7.5% (6.2 – 8.8)	5.5% (4.9 – 6.0)	→
Franklin	4.1% (3.8 – 4.3)	6.0% (4.7 – 7.3)	6.2% (3.6 – 8.8)	→
Oxford	5.1% (4.3 – 5.9)	6.4% (5.2 – 7.5)	5.5% (3.7 – 7.3)	→
York	6.0% (4.7 – 7.2)	6.1% (5.1 – 7.1)	4.9% (3.2 – 6.7)	→



DOMAIN 2: TOBACCO USE AND EXPOSURE PREVENTION
MAINEHEALTH CENTER FOR TOBACCO INDEPENDENCE

The MaineHealth Center for Tobacco Independence (CTI) works to address tobacco prevention and exposure utilizing a community-based approach that is informed by U.S. CDC's evidence-based framework for comprehensive tobacco prevention and control.

GOALS

1. Prevent youth and young adults from tobacco use initiation.
2. Eliminate involuntary exposure to secondhand smoke.
3. Promote tobacco treatment among adults and young people.

CTI provides oversight and support to its 15 sub-recipients, known as District Tobacco Prevention Partners (DTPPs), through TA and a series of in-person and remote trainings (including those specific to categorical workplan implementation, monthly webinars, monitoring phone calls, and biannual site visits). CTI maintains a resource library/catalog that facilitates work in selected settings, including toolkits, rack cards, signs, and other education information. CTI is also responsible for statewide implementation and supportive efforts for initiatives such as Gold Star Standards of Excellence (GSSE) programs and the Smoke-free Homes Pledge.

The DTPPs work in their regions to implement tobacco use and exposure prevention strategies. One of the main strategies is working with school districts, youth-serving entities, municipalities, public places, lodgings, clinical sites[15], multi-unit housing/rental properties, and higher education institutions[16] to promote the development, revision, and implementation of tobacco-free and smoke-free policies. In addition, CTI and the DTPPs provide trainings and TA to youth groups and non-clinical providers on how to engage in respectful conversations with their peers and clients about tobacco use and promoting the Maine QuitLink as a tobacco treatment resource. Beginning in 2020, CTI also contracted with partners to undertake a formative assessment of tobacco use and prevention among the LGBTQ+ youth population in Maine.

Implementing a smoke- and tobacco-free policy is an evidence-based strategy shown to effectively:

- Reduce exposure to secondhand smoke.
- Reduce the prevalence of tobacco use.
- Increase the number of tobacco users who quit.
- Reduce initiation of tobacco use among young people.
- Reduce tobacco-related morbidity and mortality, including acute cardiovascular events.

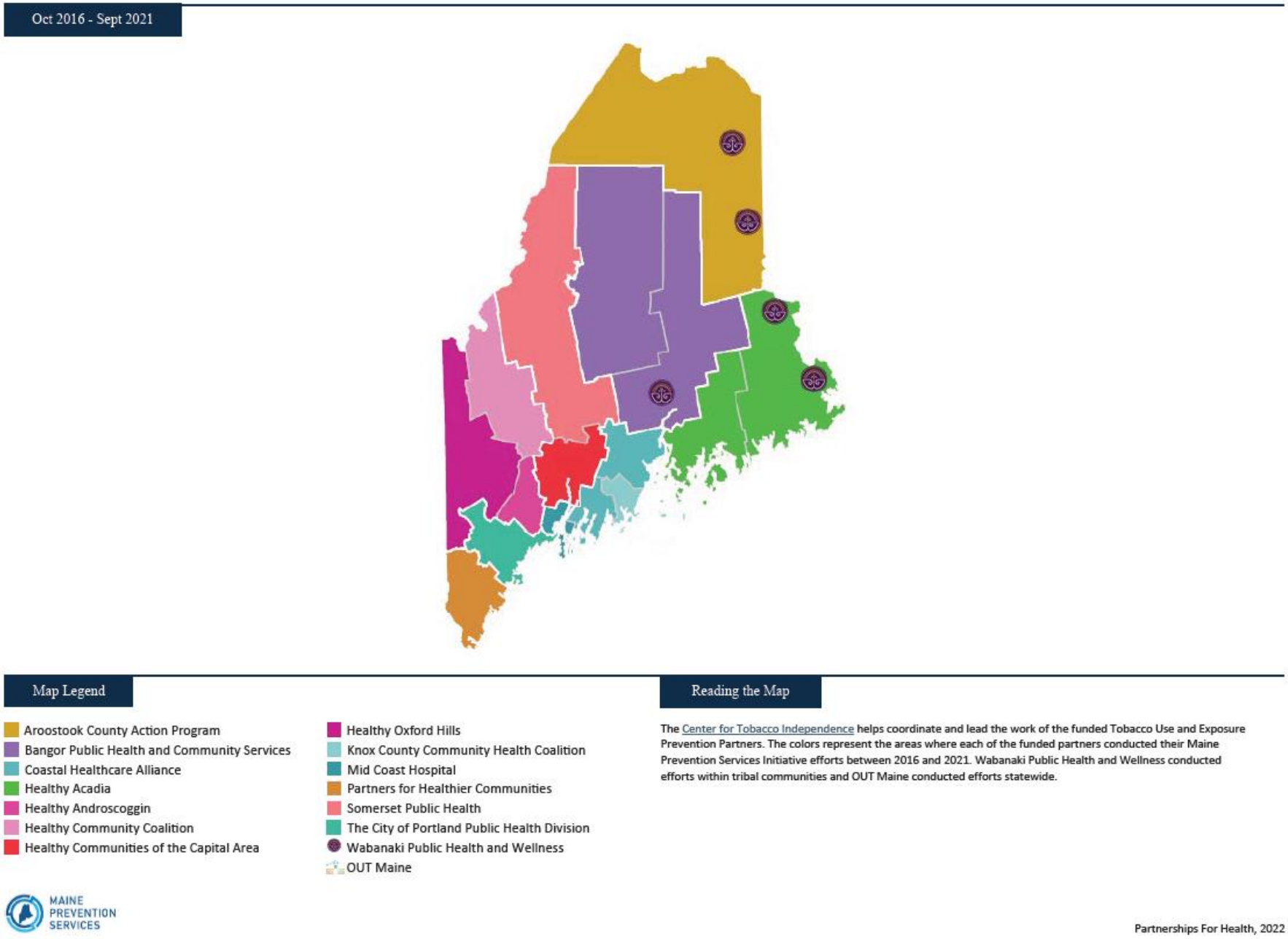
Expanded tobacco funding. In Year 4 of the MPS Initiative (2019), CTI received additional funding through the tobacco Master Settlement Agreement, known in Maine as the Fund for a Healthy Maine, to implement additional strategies focused on commercial tobacco prevention. These strategies included:

- Supporting schools to address student vaping and use of electronic nicotine delivery systems.
- Assisting employers and workplaces to implement tobacco-free policies.
- Providing education to tobacco retailers on tobacco-related laws and policies.

For more information, please refer to CTI's website: www.ctimaine.org/

[15] Clinical sites include hospitals, behavioral health sites, and health care agencies.
[16] Higher education institutions include public and private colleges/universities, as well as post-secondary proprietary schools that are recognized by the Maine Department of Education.

Figure 10. Tobacco Prevention: Funded Partners by Service Area (2016 – 2021).



GOAL 1: PREVENT YOUTH AND YOUNG ADULTS FROM TOBACCO USE INITIATION

CTI and the DTPPs provided technical assistance and/or professional development to school districts and youth-serving entities to support them in developing, revising, and implementing their policies to align with Maine Tobacco-Free Policy Criteria. They also provided TA to municipalities to support the development, revision, and implementation of tobacco-related ordinances, policies, or resolutions. In addition, CTI and the DTPPs held Sidekicks trainings to educate adult advisors and youth about respectfully talking with youth or their peers about tobacco use.

	RECEIVED TECHNICAL ASSISTANCE / TRAINING			STRENGTHENED AND / OR ADOPTED POLICIES	ADOPTED ORDINANCES, POLICIES OR RESOLUTIONS
Cumulative: 2016 – 2021	**155** school districts consisting of **478** schools with **164,148** students	**240** municipalities[17] in **16** counties with **960,255** residents	**156** Sidekicks in **14** counties with **2,126** participants	**72** school districts consisting of **244** schools with **79,523** students	**88** municipalities in **16** counties with **348,591** residents
	443 youth-serving entities	**100** public places in **15** counties		**225** youth-serving entities with **158,676** youth	**28** public places in **9** counties
2020 - 2021	59 school districts consisting of 201 schools with 72,133 students	67 municipalities in 13 counties with 361,507 residents	37 Sidekicks in 10 counties with 374 participants	8 school districts consisting of 38 schools with 12,683 students	16 municipalities in 7 counties with 37,255 residents
	109 youth-serving entities	57 public places in 14 counties		34 youth-serving entities with 17,216 youth	17 public places in 8 counties
2019 - 2020	76 school districts consisting of 298 schools with 110,447 students	83 municipalities in 16 counties with 470,130 residents	68 Sidekicks in 13 counties with 1,044 participants	13 school districts consisting of 35 schools with 11,846 students	9 municipalities in 7 counties with 32,754 residents
	105 youth-serving entities	53 public places in 13 counties		48 youth-serving entities with 96,889 youth	11 public places in 5 counties

[17] Counts: municipalities include tribal governments.

	GOAL 1: PREVENT YOUTH AND YOUNG ADULTS FROM TOBACCO USE INITIATION (CONT'D)				
	RECEIVED TECHNICAL ASSISTANCE / TRAINING			**STRENGTHENED AND / OR ADOPTED POLICIES**	**ADOPTED ORDINANCES, POLICIES OR RESOLUTIONS**
2018 – 2019	86 school districts consisting of 301 schools with 109,393 students 114 youth-serving entities	87 municipalities in 16 counties with 487,307 residents	41 Sidekicks in 11 counties with 641 participants	27 school districts consisting of 86 schools with 30,717students[18] 51 youth-serving entities with 17,967 youth	20 municipalities in 11 counties with 69,355 residents
2017 – 2018	83 school districts consisting of 297 schools with 97,629 students 120 youth-serving entities	74 municipalities in 13 counties with 353,188 residents	8 Sidekicks in 5 counties with 29 participants	23 school districts consisting of 84 schools with 24,094 students 48 youth-serving entities with 4,383 youth	27 municipalities in 11 counties with 147,395 residents
2016 – 2017	51 school districts consisting of 179 schools with 49,606 students 72 youth-serving entities	90 municipalities in 14 counties with 390,144 residents	2 Sidekicks in 2 counties with 36 participants	1 school district consisting of 1 school with 94 students 44 youth-serving entities with 21,321 youth	16 municipalities in 7 counties with 61,832 residents[19]
	With expanded funding that began in 2019, a total of 172 tobacco retailers and 113 Sidekicks groups received TA. These Sidekick groups had 1,164 participants. In addition, 52 school districts with 66,539 students and 51 youth-serving entities that serve 73,486 youth received enhanced TA to support them in developing, revising, and implementing their policies.				

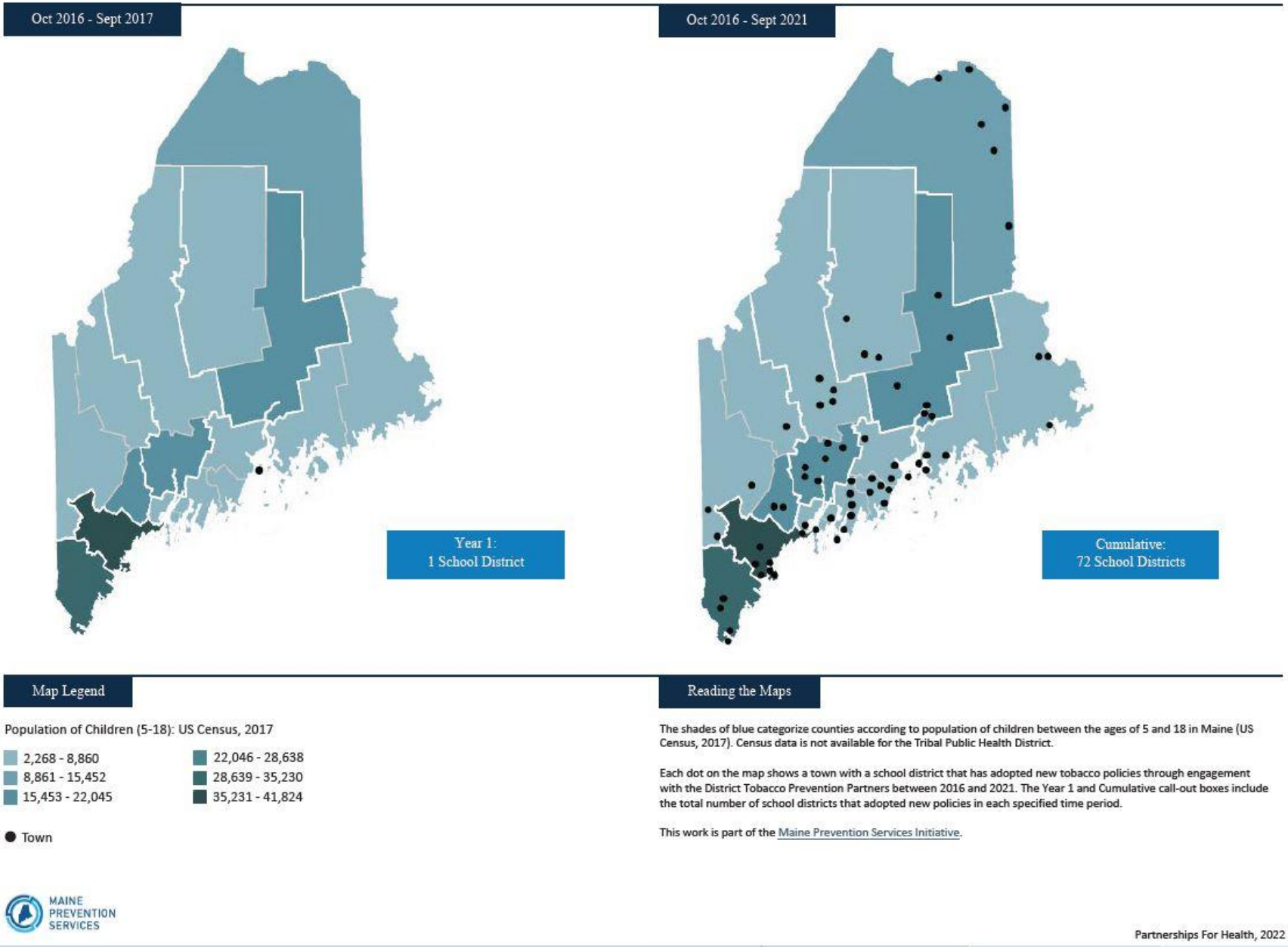
[18] Data revised due to a clerical error in 2020 reporting of Contract Period 3.
[19] Data revised due to a clerical error in reporting.

GOAL 1 EXPANDED TOBACCO FUNDING

With expanded funding that began in 2019, CTI and the DTPPs assessed tobacco retailers and provided TA on adherence to Maine's Tobacco Retailer Laws that prevent youth access to tobacco products. CTI and the DTPPS also provided general TA, as well as TA to link with Youth Engagement Groups for Sidekick groups. In addition, school districts and youth-serving entities were provided with enhanced technical assistance to support them in developing, revising, and implementing their tobacco policies.

	TOBACCO RETAILERS ASSESSED	RECEIVED TECHNICAL ASSISTANCE	RECEIVED ENHANCED TECHNICAL ASSISTANCE
Cumulative: 2016 – 2021	384 tobacco retailers in 16 counties	172 tobacco retailers in 16 counties	52 school districts consisting of 193 schools with 66,539 students
		2 Sidekick groups in 2 counties with 2 participants received TA to link with Youth Engagement Groups	
		92 Sidekick groups in 15 counties with 969 participants received general TA	51 youth-serving entities with 73,486 youth
		19 Sidekick groups in 6 counties with 193 participants received a combination of TA	
2020 - 2021	237 tobacco retailers in 16 counties	138 tobacco retailers in 16 counties	16 school districts consisting of 51 schools with 18,397 students
		-	
		24 Sidekick groups in 8 counties with 244 participants received general TA	25 youth-serving entities with 4,733 youth
		11 Sidekick groups in 6 counties with 78 participants received a combination of TA	
2019 - 2020	164 tobacco retailers in 16 counties	45 tobacco retailers in 16 counties	38 school districts consisting of 146 schools with 50,180 students
		2 Sidekick groups in 2 counties with 2 participants received TA to link with Youth Engagement Groups	
		68 Sidekick groups in 14 counties with 725 participants received general TA	29 youth-serving entities with 68,765 youth
		8 Sidekick groups in 3 counties with 115 participants received a combination of TA	

Figure 11. Locations of School Districts that Adopted New Tobacco Policies as a Result of Technical Assistance (2016 – 2021).



GOAL 2: ELIMINATE INVOLUNTARY EXPOSURE TO SECONDHAND SMOKE

CTI and the DTPPs provided technical assistance across a variety of settings to enable institutions to develop, revise, and implement tobacco-related policies. Leadership and policy strength are recognized through the Gold Star Standards of Excellence (GSSE) programs. In addition to working with organizations, CTI and DTPPs encouraged Maine residents to take Smoke-Free Pledges to keep their homes smoke-free thereby reducing exposure to secondhand smoke.

	RECEIVED TECHNICAL ASSISTANCE			ADOPTED TOBACCO-RELATED POLICIES		
Cumulative: 2016 – 2021	**269** clinical sites in **16** counties		**574** housing properties in **16** counties	**86** clinical sites in **15** counties		**263** housing properties in **14** counties
	48 colleges in **14** counties	**88** lodgings in **14** counties	**1,208** workplaces[20] in **16** counties	**11** colleges[21] in **9** counties	**22** lodgings in **7** counties	**521** workplaces in **16** counties
2020 - 2021	95 clinical sites in 15 counties		106 housing properties in 11 counties	15 clinical sites in 5 counties		30 housing properties in 8 counties
	17 colleges in 7 counties	1 lodging in 1 county	497 workplaces in 16 counties	-	1 lodging in 1 county	128 workplaces in 16 counties
2019 - 2020	109 clinical sites in 15 counties		113 housing properties in 13 counties	25 clinical sites in 12 counties		31 housing properties in 6 counties
	23 colleges in 10 counties	8 lodgings in 6 counties	453 workplaces in 16 counties	3 colleges in 3 counties	4 lodgings in 4 counties	143 workplaces in 16 counties
2018 – 2019	69 clinical sites in 14 counties		91 housing properties in 13 counties	10 clinical sites in 6 counties		31 housing properties in 8 counties
	13 colleges in 6 counties	36 lodgings in 8 counties	244 workplaces in 16 counties	2 colleges in 2 counties	12 lodgings in 6 counties	91 workplaces in 16 counties
2017 – 2018	86 clinical sites in 15 counties		202 housing properties in 16 counties	29 clinical sites in 11 counties		131 housing properties in 11 counties
	7 colleges in 4 counties	44 lodgings in 13 counties	257 workplaces in 16 counties	5 colleges in 4 counties	6 lodgings in 3 counties	112 workplaces in 15 counties

[20] From 2016-2019, workplaces included hospitals, behavioral health sites, school districts, higher education, youth-serving entities, and lodging. Policies were counted if they included employee-specific language. Beginning in Year 4 (2019-2020), it was expanded to include the additional workplaces of health care agencies and employers.

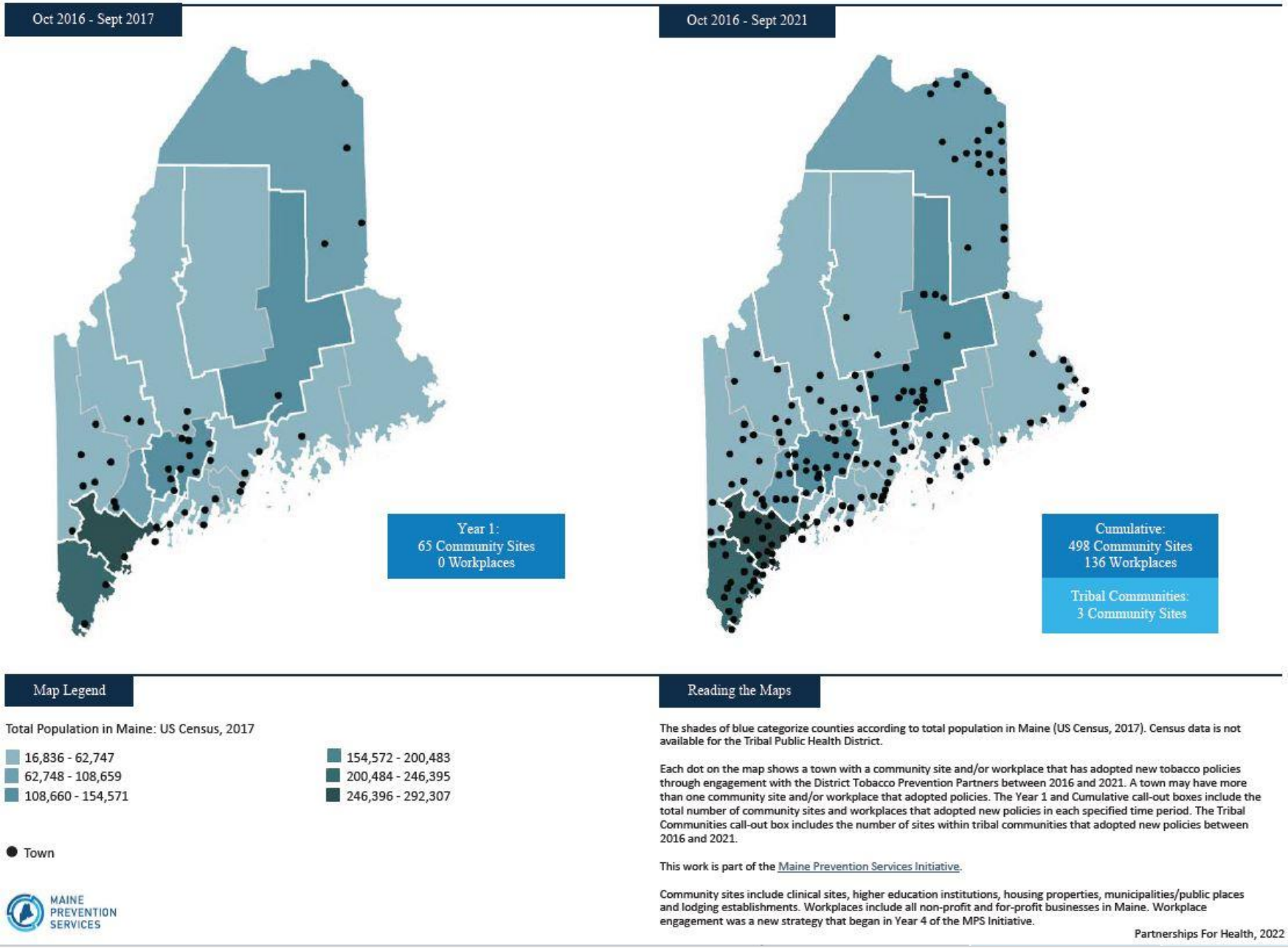
[21] Colleges refer to higher education institutions, including public and private colleges/universities, as well as post-secondary proprietary schools, trade schools, and vocational schools that are recognized by the Maine Department of Education.

	GOAL 2: ELIMINATE INVOLUNTARY EXPOSURE TO SECONDHAND SMOKE (CONT'D)					
	RECEIVED TECHNICAL ASSISTANCE			**ADOPTED TOBACCO-RELATED POLICIES**		
2016 – 2017	51 clinical sites in 14 counties		144 housing properties in 15 counties	8 clinical sites in 6 counties		39 housing properties in 11 counties
	32 colleges in 13 counties	11 lodgings in 7 counties	161 workplaces in 15 counties	1 college in 1 county	-	55 workplaces in 11 counties
	Since the beginning of the MPS Initiative, a total of **8,336** Smoke-Free Pledges were completed by Maine residents. In addition, **69** clinical sites and **13** colleges met the Gold or Platinum level of the GSSE programs for their tobacco-related policies and practices. With expanded funding that began in 2019, a total of **137** employers met the Maine Tobacco-Free Workplace Policy Criteria.					

	GOAL 2 EXPANDED TOBACCO FUNDING[22] With expanded funding beginning in 2019, CTI and the DTPPs extended their clinical policy efforts to include health care agencies[23]. This included the provision of TA, the adoption of tobacco policies, and the GSSE program. In addition, CTI and the DTPPs expanded their workplace outreach and efforts to include employers.[24] This included providing TA to support them in developing, revising, and implementing tobacco prevention, exposure, and treatment policies, and reviewing their policies for adherence to the Maine Tobacco-Free Workplace Policy Criteria.[25]	
	RECEIVED TECHNICAL ASSISTANCE	**ADOPTED TOBACCO-RELATED POLICIES**
Cumulative: 2016 – 2021	31 health care agencies in 14 counties	11 health care agencies in 7 counties
	385 employers in 15 counties	136 employers in 15 counties
2020 - 2021	14 health care agencies in 6 counties	3 health care agencies in 2 counties
	235 employers in 15 counties	78 employers in 15 counties
2019 - 2020	21 health care agencies in 12 counties	8 health care agencies in 5 counties
	170 employers in 13 counties	58 employers in 12 counties
	Since 2019, a total of **7** health care agencies met standards of the GSSE program. In addition, **134** employers and **3** lodging establishments met the Maine Tobacco-Free Workplace Policy Criteria.	

[22] The data in this table is included in the clinical sites and workplaces data in the Goal 2 table above.
[23] Health care agencies are sites that provide health care services, including primary care practices, Indian Health Service sites, tribal health centers, dental practices, Federally Qualified Health Centers (FQHCs), nursing homes, and residential care.
[24] Employers include all non-profit and for-profit businesses in Maine, excluding clinical sites, school districts, youth serving entities, and educational institutions.
[25] The Maine Tobacco-Free Workplace Policy Criteria are standards that benchmark the quality of policies, as well as the level to which they are being implemented, communicated, and enforced. These standards include prohibiting the use of all tobacco products.

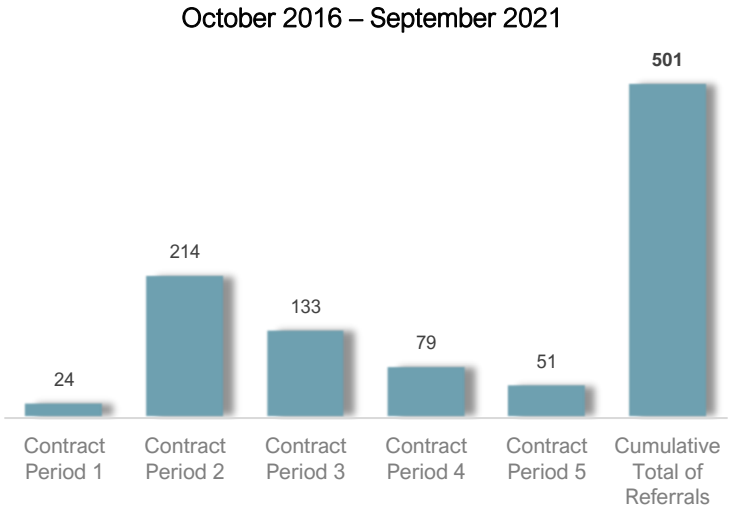
Figure 12. Locations of Community Sites and Workplaces that Adopted New Tobacco Policies as a Result of Technical Assistance (2016 – 2021).



	GOAL 3: PROMOTE TOBACCO TREATMENT AMONG ADULTS AND YOUNG PEOPLE CTI and the DTPPs held training sessions with non-clinical organizations on tobacco use and treatment and encouraged these organizations to promote the Maine QuitLink. In addition, they provided technical assistance to non-clinical organizations to promote organizations' referral of clients to the Maine QuitLink.				
	RECEIVED TRAINING	**RECEIVED TECHNICAL ASSISTANCE**	**REFERRED TO MAINE QUITLINK**		
Cumulative: 2016 – 2021	**174** training sessions in **15** counties with **1,337** participants	**112** social service agencies in **16** counties **72** animal welfare agencies in **14** counties	**448** referrals through social service agencies	**53** referrals through workplaces	**941** referrals through digital strategies[26]
2020 - 2021	42 training sessions in 12 counties with 378 participants	20 social service agencies in 9 counties 3 animal welfare agencies in 3 counties	51 referrals through social service agencies	-	82referrals through digital strategies
2019 - 2020	42 training sessions in 12 counties with 304 participants	51 social service agencies in 11 counties 32 animal welfare agencies in 8 counties	76 referrals through social service agencies	3 referrals through workplaces	758 referrals through digital strategies
2018 - 2019	46 training sessions in 13 counties with 320 participants	19 social service agencies in 10 counties 14 animal welfare agencies in 9 counties	119 referrals through social service agencies	14 referrals through workplaces	101 referrals through digital strategies
2017 – 2018	25 training sessions in 12 counties with 173 participants	30 social service agencies in 14 counties 34 animal welfare agencies in 12 counties	178 referrals through social service agencies	36 referrals through workplaces	-
2016 - 2017	21 training sessions in 11 counties with 162 participants	17 social services agencies in 11 counties 1 animal welfare agency in 1 county	24 referrals through social service agencies	-	-

[26] Digital strategies include digital connections (enrollments) from digital marketing strategies to the QuitLink. In previous years, digital strategies were web-based referrals through the QuitLink to the Maine Tobacco HelpLine.

Figure 13. Number of Maine QuitLink Referrals through Social Service Agencies and Workplaces (2016 – 2021).



PROGRESS TOWARD LONG-TERM OUTCOMES

State and county level data. Tables 5 and 6 summarize youth data from the MIYHS from 2015, 2017, and 2019 on a state, public health district, and county level. When reading the data, it may be useful to look at trends at a district level, due to districts' larger sample sizes and smaller error margins. Tables 7 and 8 summarize adult data from the BRFSS from 2011 through 2017 on a state, public health district, and county level. The state and public health districts are shown in the blue rows. The counties within each public health district (if any) are shown in the white rows.

Confidence intervals. Confidence intervals quantify the degree of uncertainty in rate or prevalence estimates that result from sampling or random variability. The confidence interval presents a range of values within which the true underlying rate or prevalence is likely to lie; the range is bounded by the error margins of the Upper Confidence Limit (UCL) and the Lower Confidence Limit (LCL). For example, a 95% Confidence Interval means that, if all eligible students in the population answered a specific question, we are 95% confident that the true population value of the specific question would fall between the LCL and the UCL.

Trend. Tables 5, 6, and 8 also show the trend across multiple years. If the Confidence Intervals of the most recent year (typically 2019) do not overlap with the Confidence Interval from the base year (typically 2015), then the trend is considered to be significantly increasing (↑) or decreasing (↓). If the base year Confidence Intervals overlap with the most recent year, the trend is considered statistically unchanged (→).

Table 5. Percent of Maine Middle School Youth Reporting Exposure to Secondhand Smoke in the Past 7 Days.
Data source: MIYHS 2015, 2017, and 2019.

	2015 (LCL-UCL)	2017 (LCL-UCL)	2019 (LCL-UCL)	TREND
State	25.4% (23.7 - 27.1)	22.8% (21.5 - 24.2)	22.1% (20.8 - 23.3)	↓
Aroostook	33.3% (31.0 - 35.6)	30.7% (25.2 - 36.2)	26.6% (22.9 - 30.4)	↓
Central	30.5% (27.4 - 33.7)	27.3% (25.0 - 29.7)	27.4% (25.4 - 29.5)	→
Kennebec	28.4% (25.1 - 31.8)	23.7% (20.9 - 26.5)	27.0% (23.9 - 30.1)	→
Somerset	34.3% (28.4 - 40.2)	33.9% (30.3 - 37.5)	27.9% (25.3 - 30.5)	→
Cumberland	17.5% (13.3 - 21.7)	16.0% (13.2 - 18.8)	14.2% (11.9 - 16.5)	→
Downeast	29.8% (23.9 - 35.7)	28.3% (24.4 - 32.2)	27.7% (21.7 - 33.6)	→
Hancock	Not Available	23.3% (18.7 - 27.9)	22.2% (18.2 - 26.3)	→
Washington	35.7% (27.6 - 43.9)	39.1% (33.9 - 44.2)	37.4% (26.4 - 48.5)	→
Midcoast	26.6% (22.9 - 30.3)	25.2% (21.6 - 28.9)	23.9% (20.6 - 27.2)	→
Knox	Not Available	24.2% (14.3 - 34.0)	23.1% (16.1 - 30.2)	→
Lincoln	34.1% (29.7 - 38.5)	24.8% (17.2 - 32.4)	21.2% (11.7 - 30.6)	→
Sagadahoc	20.3% (18.1 - 22.5)	22.8% (18.1 - 27.5)	20.1% (16.7 - 23.5)	→
Waldo	28.0% (21.9 - 34.1)	28.8% (20.3 - 37.3)	31.1% (24.2 - 37.9)	→
Penquis	25.7% (22.1 - 29.2)	25.4% (20.5 - 30.4)	25.4% (21.2 - 29.6)	→
Penobscot	23.3% (19.7 - 26.8)	23.4% (18.2 - 28.7)	25.2% (20.8 - 29.6)	→
Piscataquis	36.1% (29.8 - 42.5)	34.6% (30.1 - 39.2)	28.5% (22.8 - 34.2)	→
Western	31.9% (28.9 - 34.8)	25.9% (23.4 - 28.5)	26.9% (24.3 - 29.6)	→
Androscoggin	26.9% (23.9 - 30.0)	23.5% (20.8 - 26.2)	25.1% (22.9 - 27.3)	→
Franklin	36.4% (35.0 - 37.7)	27.9% (20.7 - 35.1)	27.4% (17.7 - 37.2)	→
Oxford	36.8% (31.7 - 41.9)	29.0% (24.5 - 33.5)	28.9% (23.1 - 34.7)	→
York	21.2% (16.3 - 26.1)	19.9% (17.2 - 22.6)	19.5% (15.2 - 23.8)	→

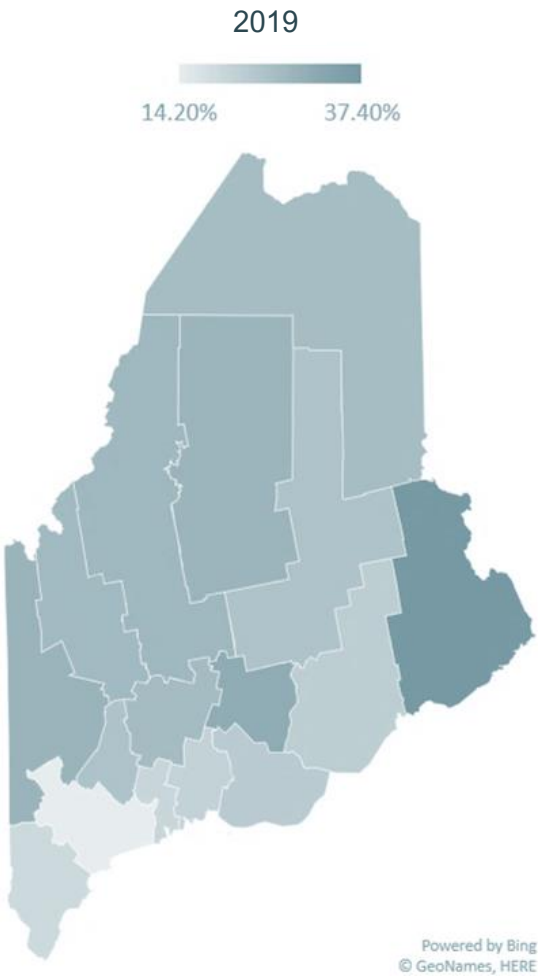


Table 6. Percent of Maine High School Youth That Report Currently Using Any Tobacco Products, Excluding E-Cigarettes. *Data source:* MIYHS 2015, 2017, and 2019.

	2015 (LCL-UCL)	2017 (LCL-UCL)	2019 (LCL-UCL)	TREND
State	15.7% (14.8 - 16.6)	13.9% (13.0 - 14.9)	10.6% (10.0 - 11.1)	↓
Aroostook	17.4% (14.7 - 20.1)	14.3% (12.7 - 15.9)	10.8% (9.1 - 12.5)	↓
Central	15.7% (13.8 - 17.6)	14.1% (11.9 - 16.3)	11.6% (10.4 - 12.8)	↓
Kennebec	15.3% (12.8 - 17.7)	14.2% (11.3 - 17.0)	10.3% (9.5 - 11.2)	→
Somerset	16.4% (13.6 - 19.2)	13.8% (10.3 - 17.4)	13.4% (10.4 - 16.5)	→
Cumberland	14.4% (12.6 - 16.2)	12.9% (10.4 - 15.4)	9.3% (8.2 - 10.5)	↓
Downeast	15.5% (12.9 - 18.0)	12.0% (9.5 - 14.5)	12.4% (10.7 - 14.2)	→
Hancock	12.9% (10.8 - 15.0)	9.9% (8.9 - 10.9)	10.6% (9.2 - 12.0)	→
Washington	18.5% (14.5 - 22.4)	15.9% (10.9 - 21.0)	14.8% (11.1 - 18.5)	→
Midcoast	17.7% (13.8 - 21.5)	13.7% (12.3 - 15.2)	12.0% (10.4 - 13.6)	↓
Knox	Not Available	14.5% (12.3 - 16.6)	11.7% (9.2 - 14.3)	→
Lincoln	13.9% (12.2 - 15.6)	13.8% (11.8 - 15.8)	12.2% (9.1 - 15.3)	→
Sagadahoc	23.4% (18.3 - 28.5)	12.9% (10.7 - 15.1)	12.4% (9.9 - 14.9)	↓
Waldo	16.2% (13.9 - 18.4)	13.2% (9.1 - 17.2)	12.2% (5.6 - 18.8)	→
Penquis	16.7% (14.1 - 19.3)	14.6% (12.0 - 17.2)	10.0% (8.1 - 11.9)	↓
Penobscot	16.6% (13.7 - 19.5)	14.0% (11.4 - 16.6)	9.7% (7.8 - 11.7)	↓
Piscataquis	18.6% (14.3 - 22.9)	22.5% (15.3 - 29.8)	14.8% (8.7 - 20.9)	→
Western	15.0% (12.5 - 17.4)	15.3% (12.7 - 17.9)	12.0% (10.5 - 13.5)	→
Androscoggin	13.4% (8.9 - 18.0)	11.8% (7.6 - 15.9)	9.6% (8.6 - 10.6)	→
Franklin	13.7% (12.7 - 14.8)	17.5% (10.0 - 25.0)	12.6% (9.5 - 15.6)	→
Oxford	16.9% (13.9 - 20.0)	18.6% (15.0 - 22.2)	13.9% (9.6 - 18.2)	→
York	15.7% (13.5 - 17.9)	14.4% (12.1 - 16.7)	9.3% (7.7 - 10.9)	↓

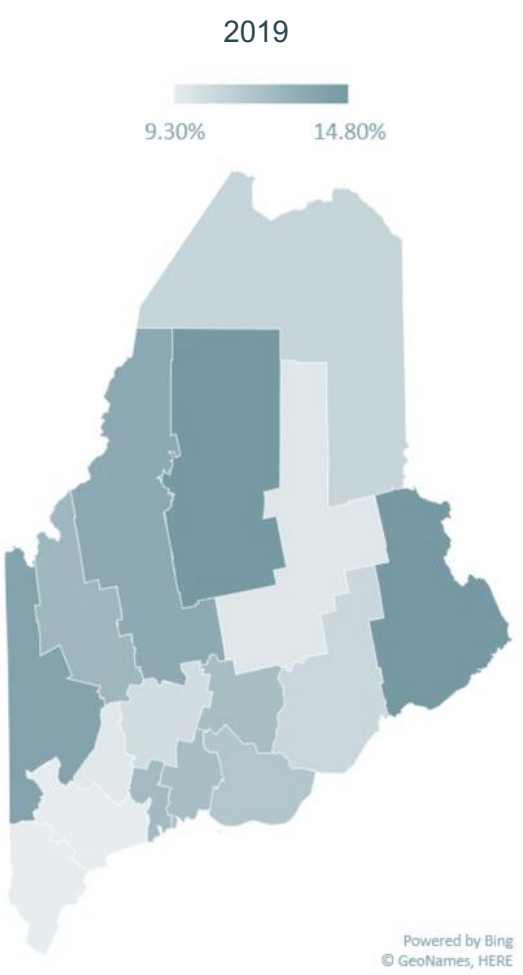
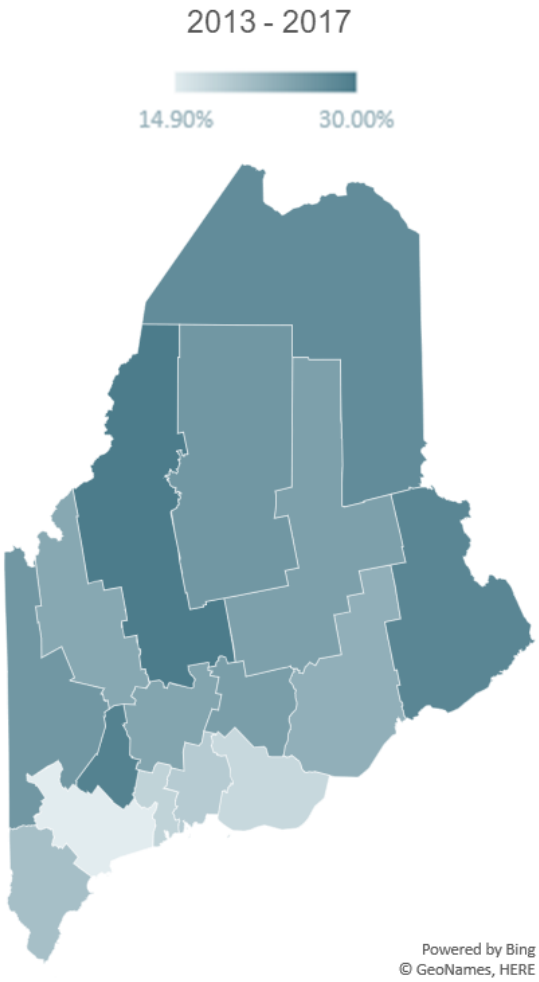


Table 7. Percent of Maine Adults Who Indicated They Are Currently Using Any Tobacco Products Including Smokeless Tobacco (Chewing Tobacco, Snuff, Or Snus) and Excluding E-Cigarettes.
Data source: BRFSS 2013 – 2017.[27]

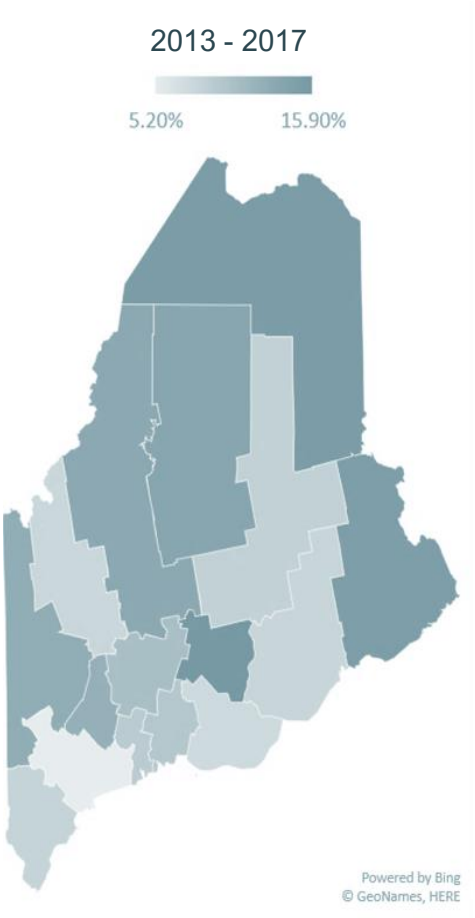
	2013 – 2017 (LCL-UCL)
State	22.9% (21.9 - 24.0)
Aroostook	27.8% (23.3 – 32.2)
Central	26.2% (23.3 – 29.0)
Kennebec	24.5% (21.2 – 27.9)
Somerset	30.0% (24.5 – 35.4)
Cumberland	14.9% (12.4 – 17.3)
Downeast	25.1% (21.4 – 28.7)
Hancock	23.1% (18.1 – 28.0)
Washington	28.6% (23.5 – 33.7)
Midcoast	20.4% (17.9 – 23.0)
Knox	17.6% (13.2 – 22.0)
Lincoln	19.3% (14.7 – 24.0)
Sagadahoc	18.3% (13.5 – 23.2)
Waldo	25.4% (19.6 – 31.2)
Penquis	25.2% (22.2 – 28.3)
Penobscot	25.1% (21.7 – 28.4)
Piscataquis	26.3% (20.1 – 32.5)
Western	27.3% (24.5 – 30.1)
Androscoggin	29.2% (24.9 – 33.5)
Franklin	24.1% (18.5 – 29.6)
Oxford	26.3% (21.6 – 31.0)
York	20.9% (18.2 – 23.7)



[27] Historical data to identify geographic trends is not available for this surveillance indicator.

Table 8. Percent of Maine Adults Who Indicated That Someone (Including Themselves) Had Smoked Cigarettes, Cigars, or Pipes Anywhere Inside Their Home in the Past 30 Days. *Data source:* BRFSS 2011 – 2017.[28]

	2011 – 2015 (LCL-UCL)	2013 – 2017 (LCL-UCL)	TREND
State	10.9% (10.1-11.7)	9.6% (8.9 – 10.3)	→
Aroostook	14.8% (11.3 – 18.4)	15.2% (11.6 – 18.8)	→
Central	12.9% (10.8 – 15.0)	11.4% (9.5 – 13.3)	→
Kennebec	13.5% (10.8 – 16.2)	10.6% (8.3 – 12.9)	→
Somerset	11.7% (8.5 – 15.0)	13.3% (9.9 – 16.7)	→
Cumberland	6.4% (4.9 – 7.9)	5.2% (3.8 – 6.6)	→
Downeast	11.1% (8.9 – 13.3)	10.6% (8.4 – 12.7)	→
Hancock	8.2% (5.7 – 10.8)	8.0% (5.4 – 10.5)	→
Washington	15.5% (11.6 – 19.3)	15.0% (11.4 – 18.6)	→
Midcoast	11.5% (9.1 – 14.0)	10.8% (8.2 – 13.3)	→
Knox	8.0% (5.3 – 10.8)	7.5% (4.9 – 10.1)[29]	→
Lincoln	12.4% (8.2 – 16.6)	9.7% (5.7 – 13.6)	→
Sagadahoc	11.4% (6.3 – 16.5)	9.2% (3.8 – 14.7)	→
Waldo	14.1% (7.8 – 20.4)	15.9% (9.3 – 22.5)	→
Penquis	10.5% (8.5 – 12.5)	9.2% (7.2 – 11.1)	→
Penobscot	9.8% (7.7 – 12.0)	8.5% (6.4 – 10.6)	→
Piscataquis	14.6% (9.5 – 19.7)	13.7% (8.9 – 18.6)	→
Western	12.9% (10.8 – 15.0)	11.7% (9.7 – 13.7)	→
Androscoggin	13.0% (9.9 – 16.2)	12.4% (9.4 – 15.5)	→
Franklin	11.0% (7.6 – 14.5)	7.8% (5.3 – 10.3)	→
Oxford	13.8% (10.0 – 17.6)	12.8% (9.2 – 16.5)	→
York	10.0% (7.8 – 12.2)	8.2% (6.4 – 10.1)	→



[28] Due to delays in 2018/2019 BRFSS data, 2017 is the most recent data available.
[29] Use caution in interpreting estimates as the unweighted numerator is less than 50.

DOMAIN 3: YOUTH ENGAGEMENT AND EMPOWERMENT
MAINE YOUTH ACTION NETWORK

GOALS

1. Increase protective factors and resilience among youth.
2. Support young people in leading change to make their schools and communities healthier.

The Opportunity Alliance's Maine Youth Action Network (MYAN) engages young people to identify prevention needs within their communities and supports youth in creating systems change to improve health. MYAN also provides training and TA to leverage statewide networks of youth-adult partnerships and youth leadership development groups.

All work is grounded in positive youth development and social-emotional learning principles. MYAN sub-contracts with 9 district-level partners referred to as District Youth Coordinators (DYCs). These sub-recipients work in their regions to implement MYAN's strategies for youth engagement and leadership development.

These strategies include:

- Build capacity of adult advisors to sustain strength-based, trauma-informed partnerships with young people.
- Create Youth Policy Boards (YPBs) that focus on substance use prevention, youth mental health, and bullying prevention through participatory action research.
- Convene Youth Engagement Groups (YEGs) to develop youth leadership and encourage youth-led action on issues relevant to local communities.

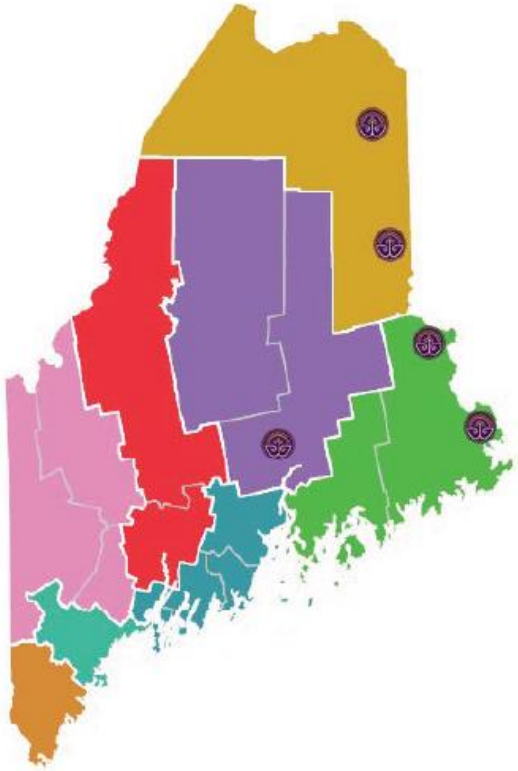
Expanded tobacco funding. In Year 4 of the MPS Initiative (2019), MYAN received additional funding through the tobacco Master Settlement Agreement, known in Maine as the Fund for a Healthy Maine, to implement additional strategies focused on commercial tobacco prevention. These strategies included:

- Supporting Sidekicks and training Sidekick groups to complete youth-led projects.
- Producing trainings that introduce restorative practices for student communities.
- Training youth groups to complete youth-led projects about restorative practices.
- Hosting trainings for school personnel and adult community partners to improve their use of restorative practices with youth.

For more information, please refer to MYAN's website: www.myan.org/

Figure 14. Youth Engagement & Empowerment: Funded Partners by Service Area (2016 – 2021)

Oct 2016 - Sept 2021



Map Legend

- Aroostook Mental Health Center
- Healthy Acadia
- Healthy Community Coalition
- Healthy Communities of the Capital Area
- OUT Maine
- Partners for Healthier Communities
- Penquis Community Action Program
- The Opportunity Alliance
- Wabanaki Public Health and Wellness

Reading the Map

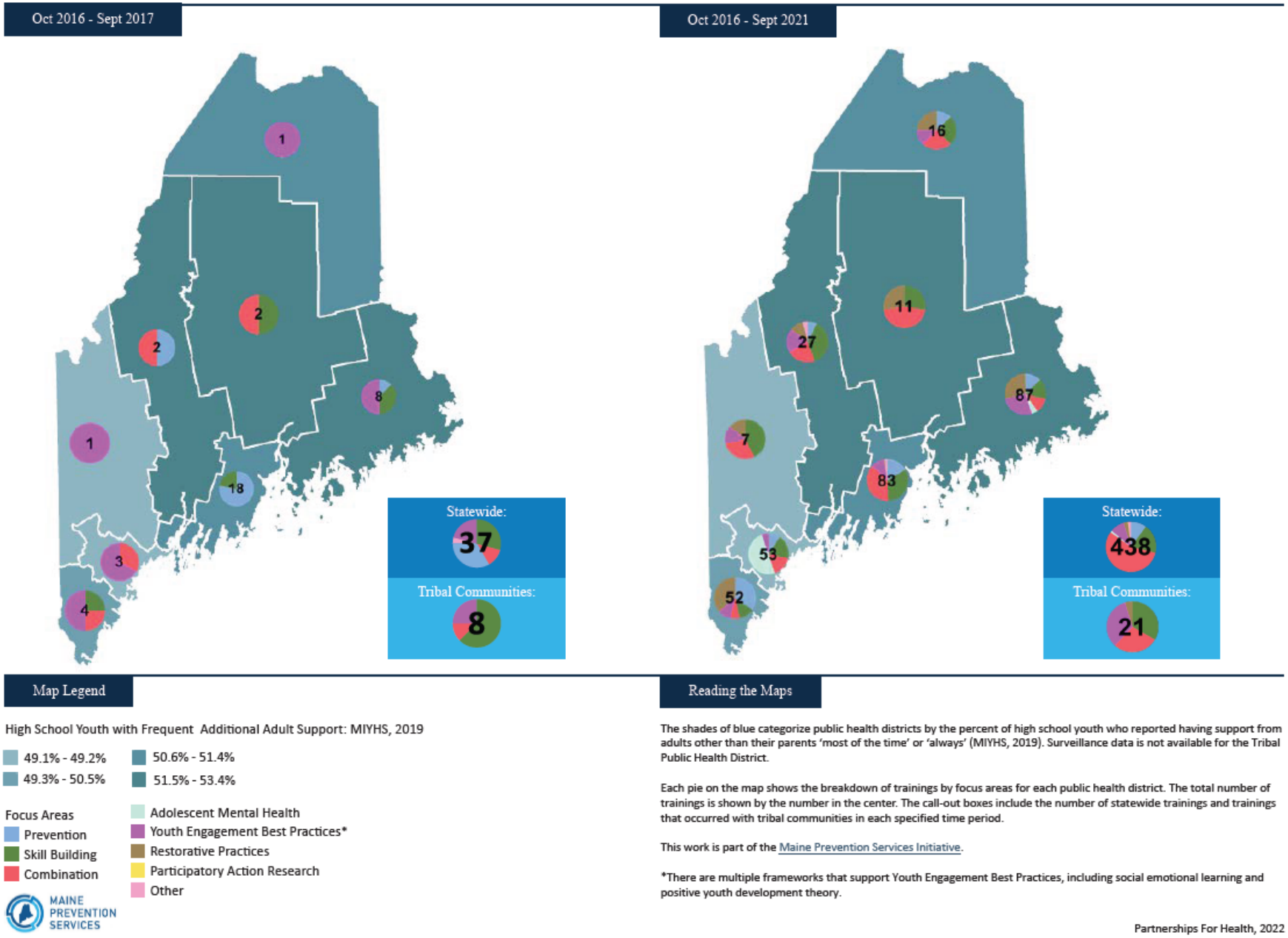
The Maine Youth Action Network helps coordinate and lead the work of the funded Youth Engagement and Empowerment Partners. The colors represent the areas where each of the funded partners conducted their Maine Prevention Services Initiative efforts between 2016 and 2021. Wabanaki Public Health and Wellness conducted efforts within tribal communities.

MAINE PREVENTION SERVICES

Partnerships For Health, 2022

	MYAN and the DYCs provided trainings to adults and youth throughout the state on a variety of topics. These trainings targeted adults, youth, and organizations and helped build youth leadership and/or strengthen the capacity of adults, organizations, and systems to use youth learning principles.	
	RECEIVED TRAINING	**MOST FREQUENT FOCUS AREAS**
Cumulative: 2016 – 2021	**795** trainings held with **10,561** adult participants and **8,833** youth participants	• Youth engagement best practices • Youth or adult skill building • Combination of focus areas
2020 - 2021	271 trainings held with 3,425 adult participants and 1,750 youth participants	• Youth or adult skill building • Restorative practices • Combination of focus areas
2019 - 2020	216 trainings held with 2,903 adult participants and 1,798 youth participants	• Youth or adult skill building • Adolescent mental health • Combination of focus areas
2018 – 2019	141 trainings held with 2,118 adult participants and 2,386 youth participants	• Holistic prevention strategies • Youth or adult skill building • Combination of focus areas
2017 – 2018	83 trainings held with 1,243 adult participants and 1,850 youth participants	• Youth or adult skill building • Holistic prevention strategies • Combination of focus areas
2016 – 2017	85 trainings held with 872 adult participants and 1,049 youth participants	• Holistic prevention strategies • Youth engagement best practices • Combination of focus areas

Figure 15. Number of Trainings by Focus Areas (2016 – 2021).



	MYAN and the DYCs convened Youth Policy Boards that focused on substance use prevention, youth mental health, and bullying prevention through participatory action research. Youth Policy Boards are groups of youth that elevate youth voices and participate in local community-level decision-making.		
	Active Youth Policy Boards	**Completed Projects**	**Most Frequent Focus Areas**
Cumulative: 2016 – 2021	**34** Youth Policy Boards with **349** unique youth members	**20** Youth Policy Boards with **203** unique youth members completed **20** projects	• Adolescent mental health • Bullying/Harassment prevention • Combination of focus areas
2020 - 2021	15 Youth Policy Boards with 157 youth members	9 Youth Policy Boards with 113 youth members completed 9 projects	• Adolescent mental health • Combination of focus areas
2019 - 2020	10 Youth Policy Boards with 78 youth members	8 Youth Policy Boards with 59 youth members completed 8 projects	• Adolescent mental health • Youth substance use prevention • Combination of focus areas
2018 – 2019	13 Youth Policy Boards with 134 youth members	2 Youth Policy Boards with 15 youth members completed 2 projects	• Youth substance use prevention • Combination of focus areas
2017 – 2018	10 Youth Policy Boards with 101 youth members	2 Youth Policy Boards with 19 youth members completed 2 projects	• Adolescent mental health • Combination of focus areas
2016 – 2017	-	-	-
	With expanded funding that began in 2019, a total of 17 Youth Policy Boards reported the impact of their completed project(s): 3 Boards educated/trained their community, 5 Boards presented recommendations to decision makers, 1 Board implemented a practice change, and 8 Boards reported a combination of impacts. These Youth Policy Boards had 180 youth members.		

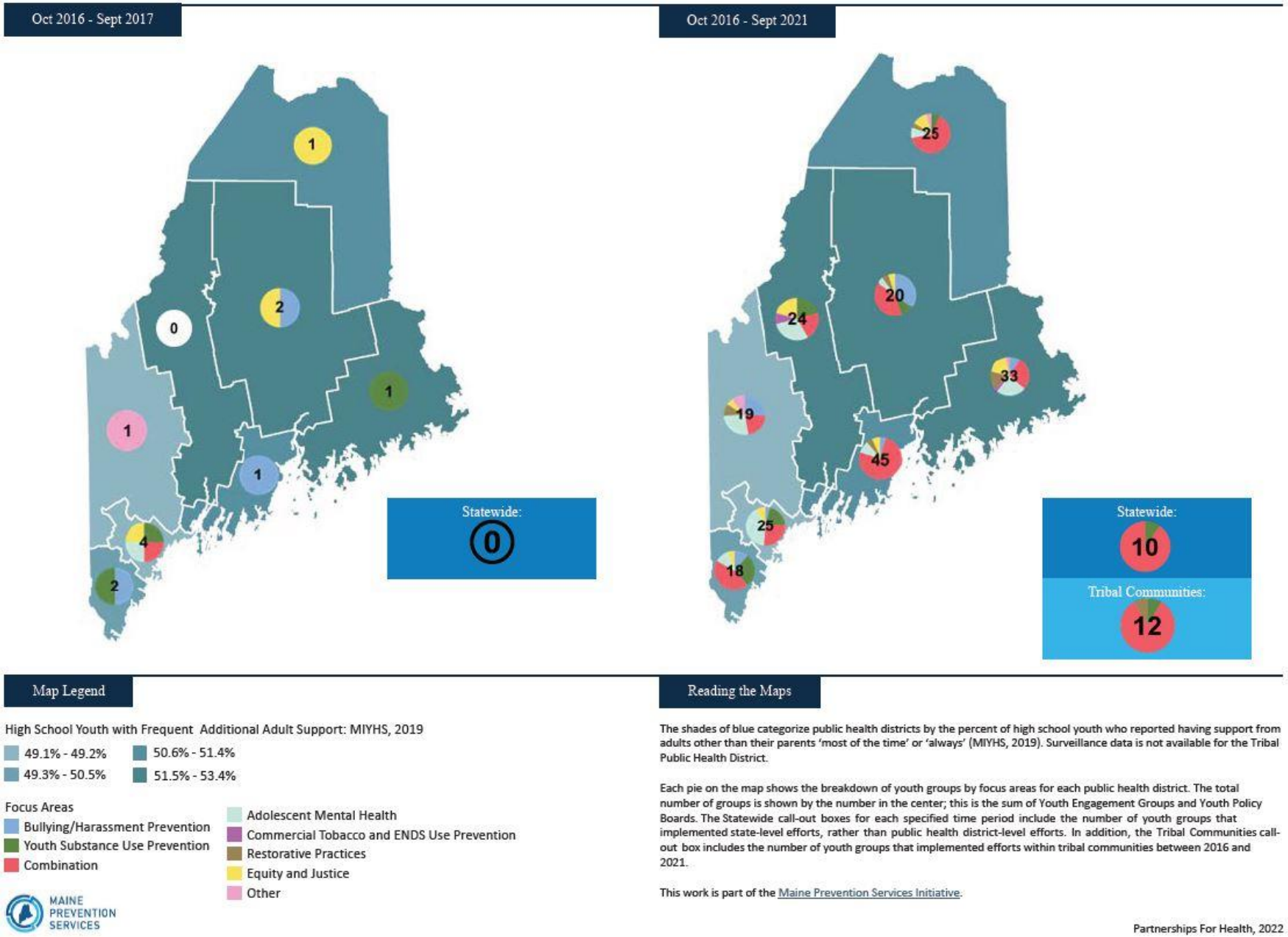
MYAN and the DYCs convened Youth Engagement Groups to develop youth leadership and encourage youth-led action on issues relevant to local communities. Youth Engagement Groups are groups of youth that are engaged in creating positive benefit in their communities.

	ACTIVE YOUTH ENGAGEMENT GROUPS	COMPLETED PROJECTS	MOST FREQUENT FOCUS AREAS
Cumulative: 2016 – 2021	**197** Youth Engagement Groups with **2,343** unique youth members	**136** Youth Engagement Groups with **1,510** unique youth members	• Adolescent mental health • Youth substance use prevention • Combination of focus areas
2020 - 2021	95 Youth Engagement Groups with 1,167 youth members	58 Youth Engagement Groups with 661 youth members	• Adolescent mental health • Restorative practices • Combination of focus areas
2019 - 2020	69 Youth Engagement Groups with 589 youth members	44 Youth Engagement Groups with 381 youth members	• Adolescent mental health • Youth substance use prevention • Combination of focus areas
2018 – 2019	52 Youth Engagement Groups with 548 youth members	25 Youth Engagement Groups with 340 youth members	• Social and/or racial justice • Youth substance use prevention • Adolescent mental health
2017 – 2018	36 Youth Engagement Groups with 420 youth members	13 Youth Engagement Groups with 131 youth members	• Social and/or racial justice • Bullying/harassment prevention • Combination of focus areas
2016 – 2017	12 Youth Engagement Groups with 150 youth members	11 Youth Engagement Groups with 118 youth members	• Bullying/harassment prevention • Social and/or racial justice • Youth substance use prevention

With expanded funding that began in 2019, a total of 171 Youth Engagement Groups were referred for and/or completed trainings. These Youth Engagement Groups had 1,790 youth members.

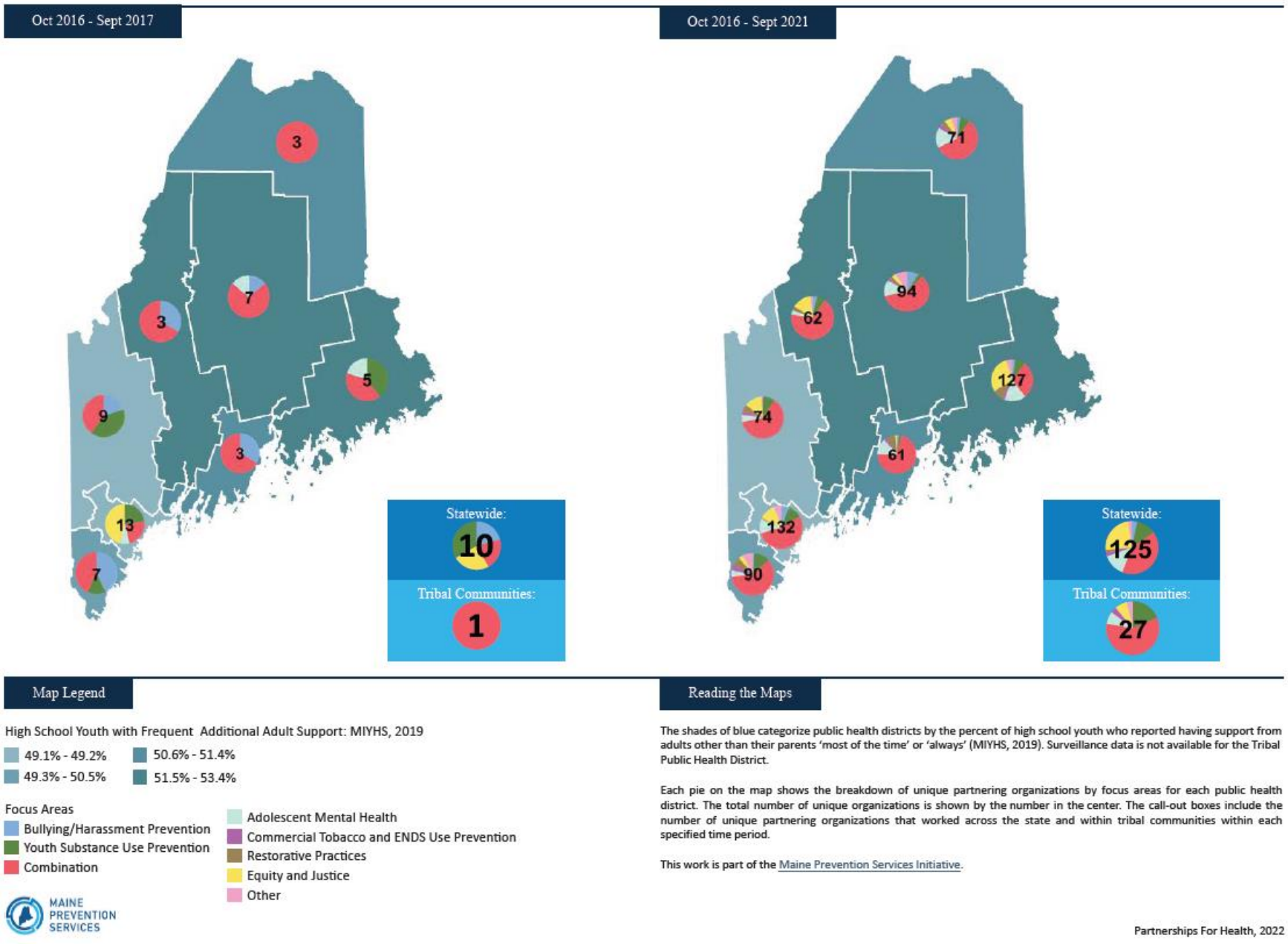
In addition, 84 Youth Engagement Groups reported the impact of their completed project(s): 38 Groups educated or trained their community; 2 Groups proposed policy through formal channels; 8 Groups implemented a practice change; 17 Groups presented recommendations to decision makers; and 25 Groups reported a combination of impacts. These Youth Engagement Groups had 938 youth members.

Figure 16. Number of Youth Engagement Groups and Youth Policy Boards by Focus Areas (2016 – 2021).



	MYAN and the DYCs partnered with organizations throughout the state to support youth prevention work. In addition, they provided many of these organizations with technical assistance to support holistic prevention efforts targeting youth.		
	ENGAGED WITH MYAN	**RECEIVED TECHNICAL ASSISTANCE**	**MOST FREQUENT FOCUS AREAS**
Cumulative: 2016 – 2021	**864** organizations	**835** organizations	• Youth substance use prevention • Adolescent mental health • Combination of focus areas
2020 - 2021	406 organizations	393 organizations	• Adolescent mental health • Youth substance use prevention • Combination of focus areas
2019 - 2020	313 organizations	324 organizations	• Adolescent mental health • Restorative practices • Combination of focus areas
2018 – 2019	259 organizations	245 organizations	• Youth substance use prevention • Adolescent mental health • Combination of focus areas
2017 – 2018	223 organizations	197 organizations	• Youth substance use prevention • Adolescent mental health • Bullying/harassment prevention
2016 – 2017	61 organizations	52 organizations	• Youth substance use prevention • Bullying/harassment prevention • Combination of focus areas

Figure 17. Number of Partnering Organizations by Focus Areas (2016 – 2021).



	EXPANDED TOBACCO FUNDING[30] With expanded funding that began in 2019, Youth Engagement Groups (YEGs) and partnering organizations expanded their focus areas and received TA on commercial tobacco and ENDS use prevention, as well as restorative practices.		
	FOCUSED ON COMMERCIAL TOBACCO AND ENDS USE PREVENTION	**FOCUSED ON RESTORATIVE PRACTICES**	**COMBINATION OF TOBACCO AND ENDS USE PREVENTION & RESTORATIVE PRACTICES**
Cumulative: 2016 – 2020	2 active YEGs with 10 youth members	12 active YEGs with 227 youth members	76 active YEGs with 840 youth members
	1 YEG with 1 youth member received TA	13 YEGs with 129 youth members received TA	81 YEGs with 1,019 youth members received TA
	19 organizations	37 organizations	300 organizations
	8 organizations received TA	30 organizations received TA	338 organizations received TA
2020 - 2021	-	10 active YEGs with 211 youth members	51 active YEGs with 581 youth members
	-	9 YEGs with 103 youth members received TA	41 YEGs with 631 youth members received TA
	16 organizations	37 organizations	192 organizations
	6 organizations received TA	5 organizations received TA	248 organizations received TA
2019 - 2020	2 active YEGs with 10 youth members	2 active YEGs with 16 youth members	49 active YEGs with 430 youth members
	1 YEG with 1 youth member received TA	4 YEGs with 26 youth members received TA	50 YEGs with 437 youth members received TA
	4 organizations	-	197 organizations
	3 organizations received TA	26 organizations received TA	134 organizations received TA

[30] The data in this table is included the previous tables.

Progress Toward Long-Term Outcomes

State and county level data. Tables 9 through 13 summarize youth data from the MIYHS from 2015, 2017, and 2019 on a state, public health district, and county level. The state and public health districts are shown in the blue rows. The counties within each public health district (if any) are shown in the white rows. When reading the data, it may be useful to look at trends at a district level, due to districts' larger sample sizes and smaller error margins.

Confidence intervals. Confidence intervals quantify the degree of uncertainty in rate or prevalence estimates that result from sampling or random variability. The confidence interval presents a range of values within which the true underlying rate or prevalence is likely to lie; the range is bounded by the error margins of the Upper Confidence Limit (UCL) and the Lower Confidence Limit (LCL). For example, a 95% Confidence Interval means that, if all eligible students in the population answered a specific question, we are 95% confident that the true population value of the specific question would fall between the LCL and the UCL.

Trend. Tables 9 through 13 also show the trend across multiple years. If the Confidence Intervals of the most recent year (typically 2019) do not overlap with the Confidence Interval from the base year (typically 2015), then the trend is considered to be significantly increasing (↑) or decreasing (↓). If the base year Confidence Intervals overlap with the most recent year, the trend is considered statistically unchanged (→).

Response options in 2019 for the MIYHS question regarding youth who reported receiving support from adults other than their parents were not the same as in 2015 and 2017. Accordingly, data in Table 12 could not be trended.

Table 9. Percent of Maine High School Youth Who Report Being Bullied on School Property During the Past 12 Months. *Data source:* MIYHS 2015, 2017, and 2019.

	2015 (LCL – UCL)	2017 (LCL – UCL)	2019 (LCL – UCL)	TREND
State	23.9% (22.9 – 25.0)	21.9% (20.9 – 23.0)	23.3% (22.2 - 24.3)	→
Aroostook	27.1% (23.9 – 30.3)	30.5% (23.7 – 37.3)	30.1% (23.6 – 36.5)	→
Central	25.4% (23.4 – 27.4)	23.9% (21.9 – 26.0)	24.2% (22.7 – 25.8)	→
Kennebec	24.7% (21.6 – 27.8)	23.0% (20.1 – 26.0)	23.1% (21.1 – 25.0)	→
Somerset	26.6% (25.4 – 27.9)	25.6% (24.0 – 27.3)	25.6% (23.0 – 28.2)	→
Cumberland	20.9% (18.5 – 23.4)	18.6% (16.4 – 20.8)	20.2% (18.5 – 21.9)	→
Downeast	21.2% (16.2 – 26.1)	18.8% (15.5 – 22.1)	23.3% (21.1 – 25.4)	→
Hancock	19.8% (12.3 – 27.3)	19.1% (14.2 – 23.9)	24.2% (21.2 – 27.1)	→
Washington	22.9% (16.7 – 29.0)	18.3% (15.0 – 21.6)	21.8% (17.7 – 25.9)	→
Midcoast	25.2% (23.5 – 26.9)	22.0% (18.8 – 25.2)	24.7% (21.9 – 27.6)	→
Knox	Not Available	18.9% (12.8 – 24.9)	22.2% (18.6 – 25.8)	→
Lincoln	23.9% (20.0 – 27.8)	21.3% (18.0 – 24.7)	22.6% (18.9 – 26.3)	→
Sagadahoc	26.2% (21.7 – 30.8)	23.1% (15.3 – 30.8)	29.3% (26.7 – 32.0)	→
Waldo	26.0% (23.1 – 28.9)	27.3% (22.4 – 32.3)	27.0% (22.8 – 31.2)	→
Penquis	26.2% (22.6 – 29.8)	25.4% (22.7 – 28.1)	23.7% (21.5 – 26.0)	→
Penobscot	26.3% (22.0 – 30.5)	24.6% (22.0 – 27.2)	23.9% (21.5 – 26.2)	→
Piscataquis	25.4% (22.6 – 28.2)	33.2% (20.6 – 45.7)	22.1% (12.3 – 32.0)	→
Western	25.3% (22.8 – 27.8)	22.7% (20.7 – 24.7)	25.6% (23.1 – 28.1)	→
Androscoggin	23.6% (19.0 – 28.2)	21.9% (18.1 – 25.7)	25.1% (20.4 – 29.7)	→
Franklin	25.3% (22.7 – 27.9)	24.7% (23.2 – 26.1)	23.9% (23.4 – 24.4)	→
Oxford	26.8% (23.9 – 29.7)	22.3% (19.7 – 24.9)	26.5% (22.8 – 30.3)	→
York	23.2% (20.0 – 26.4)	21.3% (17.9 – 24.8)	22.7% (17.9 – 27.5)	→

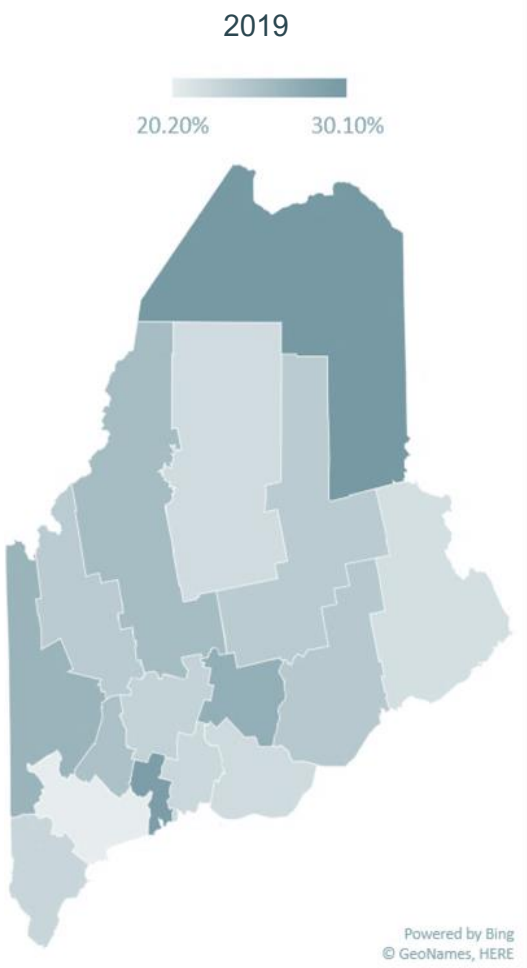


Table 10. Percent of Maine High School Youth Who Reported That in the Past 12 Months They Had Felt So Sad or Hopeless That They Stopped Doing Some Usual Activities. *Data source:* MIYHS 2015, 2017, and 2019.

	2015 (LCL – UCL)	2017 (LCL – UCL)	2019 (LCL – UCL)	TREND
State	25.9% (25.0 – 26.8)	26.9% (26.0 – 27.8)	32.1% (31.0 – 33.2)	↑
Aroostook	23.9% (22.5 – 25.4)	28.3% (24.4 – 32.2)	29.9% (26.9 – 32.9)	↑
Central	26.0% (23.9 – 28.0)	27.5% (25.2 – 29.8)	32.4% (29.7 – 35.1)	↑
Kennebec	26.4% (24.2 – 28.7)	26.2% (22.6 – 29.8)	30.9% (27.0 – 34.8)	→
Somerset	25.3% (21.7 – 28.8)	29.8% (28.4 – 31.1)	34.5% (31.0 – 38.0)	↑
Cumberland	24.8% (22.6 – 27.0)	25.3% (22.9 – 27.8)	30.0% (27.8 – 32.3)	↑
Downeast	27.0% (24.3 – 29.7)	27.6% (24.9 – 30.4)	31.6% (29.2 – 33.9)	→
Hancock	25.7% (23.8 – 27.5)	26.4% (23.2 – 29.6)	31.7% (29.5 – 33.8)	↑
Washington	28.5% (24.4 – 32.6)	29.2% (26.5 – 31.8)	31.4% (26.6 – 36.2)	→
Midcoast	25.1% (22.7 – 27.6)	27.2% (24.4 – 29.9)	33.0% (29.1 – 36.9)	↑
Knox	Not Available	24.1% (16.6 – 31.7)	29.0% (26.0 – 32.0)	→
Lincoln	23.8% (22.1 – 25.5)	24.3% (22.9 – 25.7)	33.0% (30.2 – 35.8)	↑
Sagadahoc	28.7% (26.5 – 30.8)	30.2% (29.9 – 30.6)	35.7% (25.5 – 46.0)	→
Waldo	21.1% (13.1 – 29.0)	32.1% (24.8 – 39.4)	38.4% (32.5 – 44.3)	↑
Penquis	26.6% (24.0 – 29.1)	28.6% (27.0 – 30.3)	32.7% (31.0 – 34.4)	↑
Penobscot	26.0% (23.3 – 28.7)	28.3% (26.6 – 30.1)	32.5% (30.8 – 34.2)	↑
Piscataquis	29.7% (24.7 – 34.7)	32.5% (29.0 – 35.9)	37.0% (19.8 – 54.1)	→
Western	28.6% (27.4 – 29.8)	27.3% (25.8 – 28.8)	34.9% (32.6 – 37.2)	↑
Androscoggin	29.8% (27.5 – 32.0)	26.7% (24.0 – 29.5)	34.1% (30.4 – 37.9)	→
Franklin	26.1% (24.6 – 27.6)	26.2% (23.9 – 28.5)	35.0% (30.5 – 39.5)	↑
Oxford	28.1% (26.3 – 29.8)	28.2% (25.4 – 31.1)	35.0% (31.1 – 38.8)	↑
York	25.3% (22.9 – 27.8)	26.5% (24.5 – 28.6)	32.2% (28.2 – 36.3)	↑

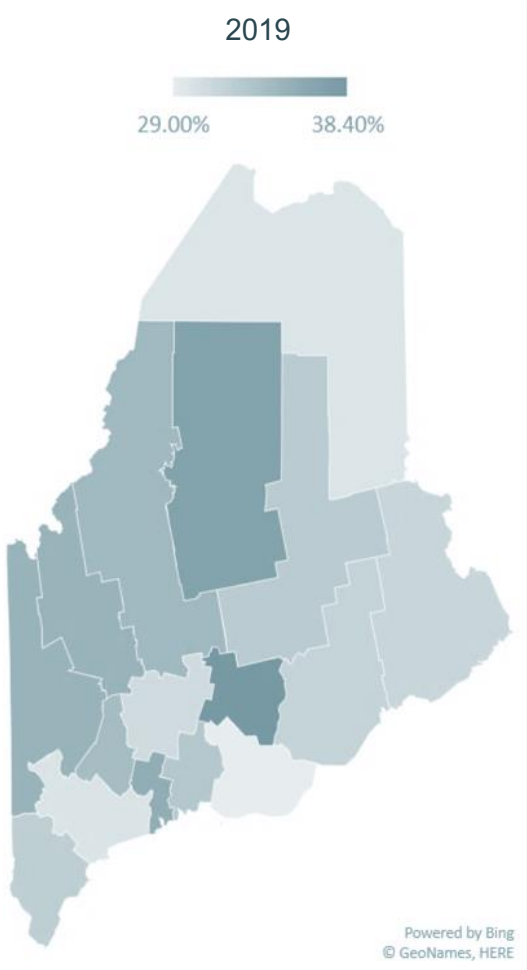


Table 11. Percent of Maine High School Youth Who Reported Having At Least One Teacher Who Really Cared and Gave Them Support When They Needed It. *Data source:* MIYHS 2015, 2017, and 2019.

	2015 (LCL – UCL)	2017 (LCL – UCL)	2019 (LCL – UCL)	TREND
State	79.7% (78.8 – 80.5)	81.5% (80.8 – 82.3)	80.5% (79.5 – 81.4)	→
Aroostook	78.7% (75.9 – 81.5)	78.6% (76.4 – 80.7)	80.8% (74.8 – 86.9)	→
Central	78.6% (76.8 – 80.5)	81.5% (79.9 – 83.2)	79.3% (76.4 – 82.2)	→
Kennebec	78.4% (76.0 – 80.8)	81.6% (79.6 – 83.5)	79.6% (74.8 – 84.4)	→
Somerset	79.0% (76.0 – 82.1)	81.4% (78.6 – 84.2)	78.9% (76.5 – 81.3)	→
Cumberland	80.8% (79.2 – 82.4)	81.8% (79.8 – 83.8)	79.8% (77.9 – 81.8)	→
Downeast	81.8% (78.7 – 84.9)	83.6% (80.1 – 87.1)	81.3% (78.0 - 84.6)	→
Hancock	85.5% (82.5 – 88.4)	84.7% (80.0 – 89.3)	82.1% (77.3 – 87.0)	→
Washington	77.5% (73.8 – 81.2)	81.3% (78.6 – 84.1)	80.0% (77.1 – 82.9)	→
Midcoast	79.8% (78.0 – 81.7)	80.9% (79.0 – 82.7)	81.5% (78.8 – 84.3)	→
Knox	Not Available	80.6% (78.5 – 82.7)	84.1% (78.9 – 89.2)	→
Lincoln	79.9% (74.6 – 85.3)	78.9% (75.5 – 82.2)	81.8% (79.5 – 84.1)	→
Sagadahoc	80.0% (77.7 – 82.4)	84.1% (82.7 – 85.6)	81.8% (81.5 – 82.1)	→
Waldo	77.5% (75.0 – 80.0)	77.7% (72.6 – 82.8)	72.6% (69.0 – 76.2)	→
Penquis	80.1% (78.1 – 82.1)	80.5% (78.2 – 82.8)	81.8% (80.1 – 83.5)	→
Penobscot	79.9% (77.7 – 82.0)	81.1% (78.6 – 83.6)	81.9% (80.1 – 83.7)	→
Piscataquis	80.8% (76.2 – 85.5)	74.1% (72.7 – 75.4)	78.0% (76.3 – 79.6)	→
Western	78.9% (77.1 – 80.7)	81.8% (80.0 – 83.6)	80.9% (78.9 – 83.0)	→
Androscoggin	77.4% (75.4 – 79.5)	81.6% (79.0 – 84.1)	81.3% (77.1 – 85.4)	→
Franklin	79.8% (76.7 – 82.9)	82.7% (78.0 – 87.4)	81.3% (79.2 – 83.3)	→
Oxford	80.5% (77.5 – 83.5)	81.7% (79.1 – 84.4)	80.5% (78.0 – 82.9)	→
York	78.7% (75.9 – 81.5)	81.7% (80.1 – 83.3)	80.0% (77.7 – 82.3)	→

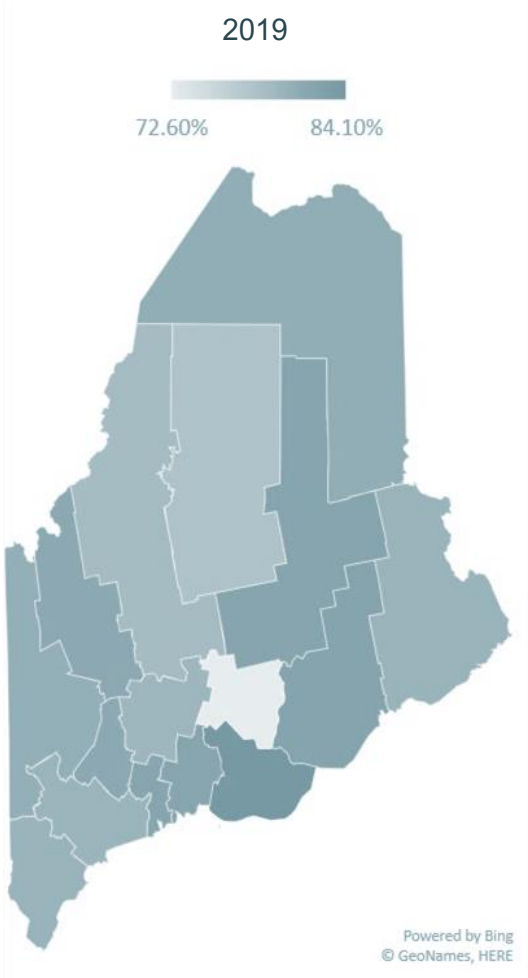


Table 12. Percent of Maine High School Youth Who Reported Receiving Support From Adults Other Than Their Parents. *Data source:* MIYHS 2015, 2017, and 2019.

	2015 (LCL – UCL)	2017 (LCL – UCL)	2019 (LCL – UCL)	TREND
State	66.1% (65.0 – 67.2)	65.8% (64.6 – 66.9)	50.7% (49.7 – 51.6)	NA
Aroostook	65.6% (62.8 – 68.5)	61.5% (54.3 – 68.6)	51.4% (48.8 – 54.1)	NA
Central	66.7% (63.9 – 69.5)	66.5% (63.7 – 69.3)	52.4% (50.4 – 54.3)	NA
Kennebec	68.7% (64.5 – 73.0)	67.7% (64.9 – 70.4)	54.0% (51.6 – 56.4)	NA
Somerset	63.4% (61.7 – 65.1)	64.7% (59.2 – 70.2)	50.3% (47.8 – 52.8)	NA
Cumberland	67.2% (64.9 – 69.5)	66.6% (64.2 – 68.1)	49.1% (46.9 – 51.3)	NA
Downeast	70.5% (68.2 – 72.8)	66.8% (61.2 – 72.3)	53.4% (50.4 – 56.5)	NA
Hancock	71.2% (67.4 – 75.0)	70.2% (63.3 – 77.1)	54.1% (50.1 – 58.1)	NA
Washington	68.6% (65.2 – 72.0)	61.8% (57.1 – 66.5)	51.8% (47.9 – 55.7)	NA
Midcoast	64.9% (62.5 – 67.3)	65.9% (63.0 – 68.8)	51.3% (50.0 – 52.6)	NA
Knox	Not Available	66.8% (63.6 – 70.0)	51.8% (51.4 – 52.2)	NA
Lincoln	64.7% (55.4 – 73.9)	69.0% (65.1 – 73.0)	53.2% (49.7 – 56.8)	NA
Sagadahoc	63.2% (59.6 – 66.8)	65.9% (57.8 – 74.1)	51.0% (50.2 – 51.8)	NA
Waldo	64.4% (64.0 – 64.9)	56.3% (51.8 – 60.9)	46.8% (45.8 – 47.9)	NA
Penquis	66.9% (63.4 – 70.4)	66.3% (63.3 – 69.3)	52.4% (49.7 – 55.1)	NA
Penobscot	67.3% (63.3 – 71.4)	66.4% (63.2 – 69.6)	52.7% (49.8 – 55.6)	NA
Piscataquis	62.4% (55.1 – 69.7)	60.5% (56.5 – 64.6)	45.2% (42.4 – 48.0)	NA
Western	64.1% (61.4 – 66.8)	64.1% (62.0 – 66.1)	49.2% (48.0 – 50.4)	NA
Androscoggin	64.5% (60.4 – 68.6)	61.4% (57.4 – 65.4)	47.8% (45.8 – 49.8)	NA
Franklin	63.9% (53.9 – 73.9)	68.3% (65.0 – 71.7)	51.1% (48.2 – 54.0)	NA
Oxford	64.0% (60.9 – 67.1)	65.4% (61.8 – 69.0)	50.2% (47.9 – 52.4)	NA
York	65.2% (61.1 – 69.2)	66.0% (62.2 – 69.8)	50.5% (47.0 – 53.9)	NA

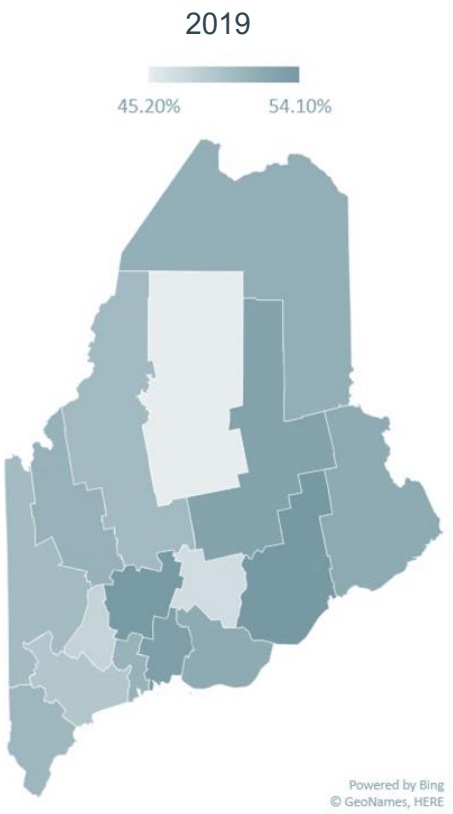
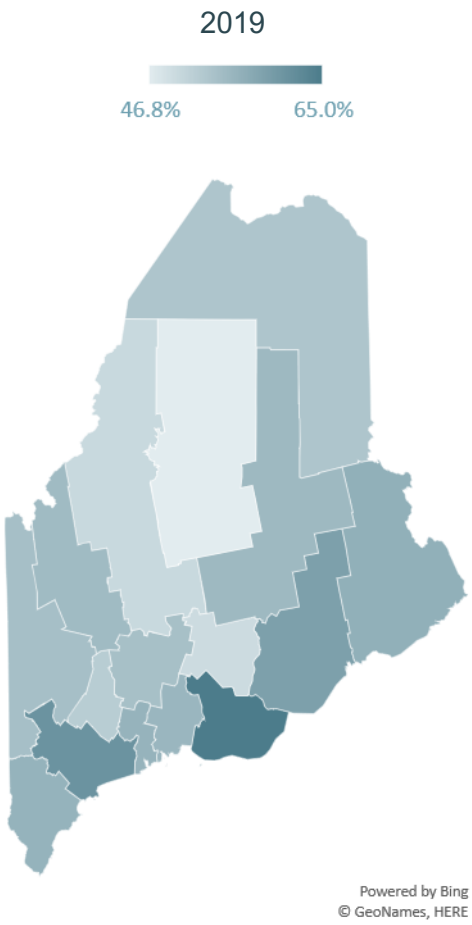


Table 13. Percent of Maine High School Youth Who Reported Feeling Like They Mattered to People in Their Community. *Data source:* MIYHS 2015, 2017, and 2019.

	2015 (LCL – UCL)	2017 (LCL – UCL)	2019 (LCL – UCL)	TREND
State	51.3% (50.0 – 52.5)	57.3% (55.9 – 58.6)	56.6% (55.0 – 58.2)	↑
Aroostook	51.9% (49.1 – 54.6)	50.5% (45.9 – 5.0)	53.1% (49.6 – 56.5)	→
Central	48.8% (46.8 – 50.8)	55.1% (52.8 – 57.5)	52.2% (49.5 – 54.9)	→
Kennebec	50.0% (47.3 – 52.6)	57.8% (54.7 – 60.8)	54.0% (50.3 – 57.6)	→
Somerset	46.9% (44.6 – 49.2)	50.6% (47.6 – 53.6)	49.9% (46.4 – 53.3)	→
Cumberland	56.3% (53.6 – 59.1)	62.0% (58.8 – 65.2)	61.2% (58.4 – 64.0)	→
Downeast	52.2% (46.8 – 57.7)	58.4% (54.0 – 62.8)	58.1% (52.9 – 63.4)	→
Hancock	58.3% (52.4 – 64.1)	60.8% (55.3 – 66.2)	59.1% (51.0 – 67.2)	→
Washington	45.7% (43.0 – 48.5)	54.1% (49.8 – 58.5)	56.6% (55.5 – 57.7)	↑
Midcoast	51.8% (48.8 – 54.8)	58.1% (55.5 – 60.6)	57.9% (51.4 – 64.3)	→
Knox	Not Available	59.9% (53.5 – 66.3)	65.0% (56.8 – 73.2)	→
Lincoln	51.7% (47.3 – 56.0)	59.8% (56.0 – 63.6)	55.5% (50.3 – 60.6)	→
Sagadahoc	49.4% (47.5 – 51.2)	58.4% (55.9 – 61.0)	56.0% (47.4 – 64.6)	→
Waldo	52.6% (47.0 – 58.1)	48.4% (46.4 – 50.3)	49.5% (44.8 – 54.2)	→
Penquis	47.5% (44.5 – 50.5)	53.7% (50.5 – 57.0)	54.8% (51.2 – 58.3)	↑
Penobscot	47.6% (44.2 – 50.9)	54.5% (51.1 – 57.9)	55.1% (51.4 – 58.8)	↑
Piscataquis	47.6% (40.4 – 54.9)	47.2% (42.1 – 52.4)	46.8% (36.0 – 57.5)	→
Western	46.5% (44.3 – 48.7)	53.8% (51.5 – 56.2)	52.9% (50.3 – 55.6)	↑
Androscoggin	47.0% (43.6 – 50.4)	53.2% (50.2 – 56.3)	51.9% (47.6 – 56.2)	→
Franklin	47.9% (45.7 – 50.2)	56.7% (54.2 – 59.2)	54.8% (48.6 – 61.1)	→
Oxford	45.9% (41.9 – 49.8)	53.1% (48.0 – 58.2)	54.1% (50.5 – 57.6)	↑
York	51.7% (47.6 – 55.8)	58.4% (53.4 – 63.3)	56.1% (50.5 – 61.7)	→



DOMAIN 4: MASS-REACH HEALTH COMMUNICATION
RINCK ADVERTISING

For the MPS Initiative, Rinck Advertising's (Rinck) work is focused on providing statewide communication for tobacco and substance use prevention, as well as tobacco treatment through various multi-media campaigns.

Given the nature of the work and the changing media landscape, cumulative data since the beginning of the MPS Initiative are not available for this domain. The data reflects campaign outcomes from the fourth year of the MPS Initiative. In addition, the data reflects the period of campaign implementation and does not reflect the planning, development, and creative stages of the campaigns. Therefore, funding for the below-listed campaigns may have been received in the previous contract period.

GOALS

1. Stem the rising tide of opioid misuse and decrease substance-exposed infants.
2. Ensure Maine has the lowest smoking rates in the nation.
3. Prevent the development and progression of chronic disease related to, or affected by, tobacco and substance use.

Expanded tobacco funding. In Year 4 of the MPS Initiative (2019), Rinck received additional funding through the tobacco Master Settlement Agreement, known in Maine as the Fund for a Healthy Maine, to implement additional tobacco-related mass-reach campaigns. This included an anti-vaping campaign targeting youth, as well as an awareness campaign on youth tobacco and substance use that targeted parents and guardians.

For more information about Rinck, please refer to their website: www.rinckadvertising.com/

MEDIA TERMINOLOGY

Ad Views: The total number of times an ad is viewed. This number is not unique and does not measure the number of people who have viewed an ad, since one person might view an ad more than once.
Ad Clicks: The number of times an ad is clicked on after it is viewed.
Click-Through Rates: The percentage of users who click on an ad after it has been viewed. This is calculated by: ad clicks divided by ad views, multiplied by 100.
Conversion Rates: The percentage of users who take a desired action on a webpage (beyond just viewing the content). Examples of conversions include downloading a document, watching a video, or completing a form.
Engagements: Any activity associated with a specific messaging campaign, such as likes, comments, shares, replies, retweets, mentions, etc.
Gross Rating Points (GRPs): The number of times the audience saw/heard an ad. In general, 1 GRP represents 1% of the target audience. For a campaign, CDC Best Practices suggest that ads should reach 75% to 85% of the target audience during each quarter of the year.
Programmatic Display: A method of buying static ads on a massive network of websites in real time. Ads are highly targeted to the individual not only by ensuring there is relevant content on the site but also by utilizing information we know about that individual user, such as demographic characteristics, geographic location, interests, behaviors, etc.

Substance-Exposed Infants Campaign

The Campaign aimed to increase awareness about the dangers of substance and tobacco use while pregnant by encouraging individuals to engage with 211 Maine and the Maine QuitLink through calls and online enrollment. The Campaign targeted pregnant individuals, as well as Maine adults of child-bearing age (15 to 44). The Campaign ran statewide during multiple time periods – between September 2020 and January 2021 and again between May and September 2021.

September 2020 – January 2021:

10,800,000 impressions across all campaign platforms, including YouTube, Pinterest, Facebook/Instagram, programmatic display/video, and paid search.

The Campaign resulted in **2,669** clicks to call 211 Maine and **5,445** clicks to enroll with the Maine QuitLink.

May 2021 – September 2021:

12,100,000 impressions across all campaign platforms, including YouTube, Pinterest, Facebook/Instagram, programmatic display/video, and paid search.

Across all platforms, there were **703,500** video views and **31,000** ad clicks.

Eyes Open for ME Campaign

The Campaign aimed to generate awareness of prescription medication misuse; drive affected users to the Eyes Open for ME website for resources; and promote engagement with 211 Maine to connect with substance use services and resources. The Campaign targeted Maine adults between the ages of 18 and 54 and ran statewide between March and June 2021.

13,240,575 impressions across all platforms, including YouTube, Facebook/Instagram, Snapchat, programmatic display/video, and paid search.

Across all platforms, there were over **16,000** visits to the Eyes Open for ME website and **935** clicks to engage with 211 Maine and other resources.

Good to Know Campaign

The Campaign was implemented after Maine legalized the adult use of marijuana for residents over the age of 21. The Campaign aimed to provide education for Mainers safely, legally, and responsibly navigating the marijuana landscape in the state. In addition, the Campaign aimed to discourage marijuana use among potential underage users. The Campaign targeted Mainers between the ages of 18 and 54 years old, as well as youth between 13 and 20 years old. The Campaign ran statewide between June and September 2021.

15,074,248 impressions across all campaign platforms, including Facebook/Instagram, Snapchat, YouTube, paid search, local digital, programmatic display/video.

Across all platforms, there were **4,298,899** video views, with a **93.3%** view rate on YouTube, far exceeding the industry benchmark of 20.0%.

Secondhand Smoke Exposure Awareness Campaign

The Campaign used radio ads and paid social media to raise awareness of the dangers of exposure to secondhand tobacco smoke. In addition, the Campaign aimed to increase referrals for tobacco cessation support through the Maine QuitLink. The Campaign targeted all Maine adults over the age of 18, with a focus on parents/grandparents, pet owners, individuals with low socio-economic status, veterans, and members of the LGBTQ community. The Campaign ran statewide between July and November 2021.

18,598,573 impressions across all campaign platforms, including paid social media, traditional/digital radio, and programmatic display.

The Campaign resulted in 10 clicks to call and 3,601 clicks to enroll with the Maine QuitLink.

Smoke-Free Home Pledge Campaign

The Campaign aimed to promote and increase Smoke-Free Home Pledge throughout the state. Primarily using Facebook ads, the Campaign promoted the Pledge and Smoke-Free Home Kits from Breathe Easy. The Campaign targeted Maine adults and ran statewide between March and July 2021.

1,254,990 impressions from Facebook, with a click-through rate of 1.42% which exceeds the industry benchmark of 0.90%.

The Campaign resulted in the submission of 1,658 Smoke-Free Home Pledges.

Quit Your Way Campaign

The Campaign aimed to promote tobacco use and vaping cessation among Maine adults by promoting the Maine QuitLink and encouraging viewers to engage with the QuitLink through calls and online enrollment for services. The Campaign ran between December 2020 and September 2021.

36,000,000 impressions across all campaign platforms, including YouTube, Pinterest, Quora, Facebook/Instagram, Snapchat, TikTok, programmatic display/video, and local digital.

The Campaign resulted in over 4,200 clicks to call and over 21,000 clicks to enroll with the Maine QuitLink for tobacco cessation services.

Times Have Changed Campaign

The Campaign aimed to increase parents', guardians', and adults' awareness of the prevalence and risks of underage use of tobacco and other substances. The Campaign focused on vaping and what adults can do to support youth in making positive decisions by driving parents/guardians to the Times Have Changed website for resources and information, In addition, the Campaign promoted the Vaping Support Line (1-888-9NO-VAPE). The second flight of the Campaign ran between April and August 2021.

9,700,000 impressions across all six platforms: YouTube, Pinterest, Quora, Facebook/Instagram, TikTok, programmatic display and video, with nearly 20,000 GRPs on television.

The Campaign resulted in 1,628 clicks to call the Vaping Support Line.

YOUTH ANTI-VAPING CAMPAIGN

The Campaign aimed to provide education for youth about the dangers and misconceptions of e-cigarette use and vaping. It also promoted the prevention of use, as well as quitting by driving youth to visit the Vape-Free Maine website for resources and the text-to-quit service "This is Quitting". The Campaign targeted youth between the ages of 13 and 20 and the second flight ran between November 2020 and March 2021.

43,000,000 impressions across all digital platforms, including YouTube, Snapchat, Facebook/Instagram, TikTok, Pinterest, and programmatic display.

There were **3,636,779** video views on YouTube, with a view rate of **93.5%** which exceeds the 20.0% industry benchmark.

The Campaign resulted in **509** texts to quit.

DOMAIN 5: OBESITY PREVENTION
MAINEHEALTH LET'S GO!

MaineHealth Let's Go! focuses on working with communities to create environments that support healthy choices. Let's Go! sub-contracts with15 local community implementation partners. Known as Let's Go! Dissemination Partners, each partner provides an organizational home for their communities' Let's Go! Coordinator(s) who works in their service area to implement Let's Go! strategies for obesity prevention.

GOALS

1. Create healthier school environments.
2. Create healthier early care and education environments.
3. Increase clinical promotion of healthy eating and active living behaviors.

Main strategies include working with school districts and early care and education (ECE) sites to create healthier environments for youth through increasing implementation of evidence-based strategies and strengthening wellness policies. The strengthening of wellness policies in school districts and ECE sites is an evidence-based strategy shown to effectively:

- Increase consumption of fruit and vegetables.
- Increase physical activity during the school day.
- Decrease sugar-sweetened beverage consumption.
- Reduce recreational screen time[31].

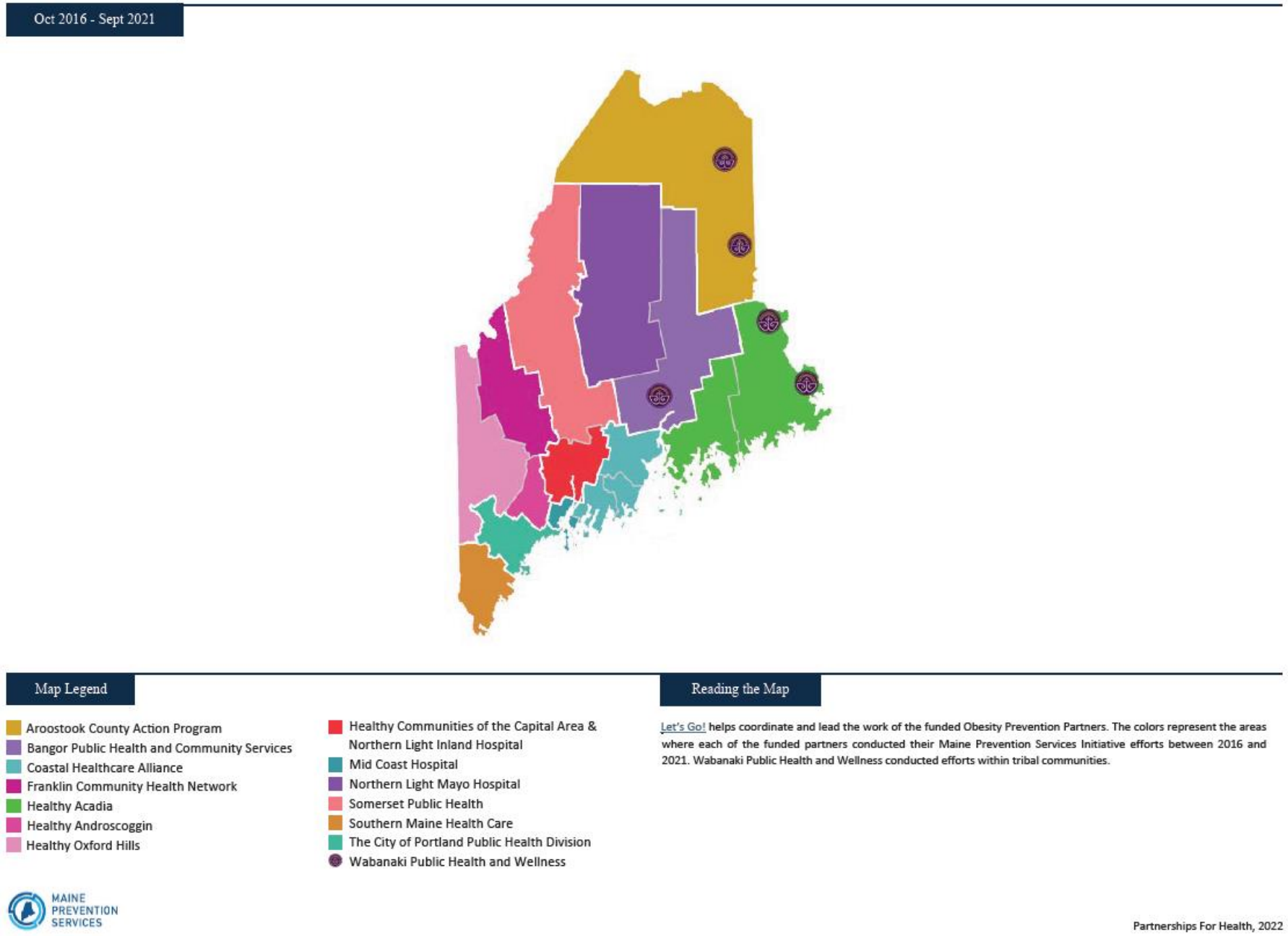
During the wellness policy process, Let's Go! reviews all wellness policies in the state and provides recommendations for how each school district can strengthen their policies to align with the Healthy Hunger-Free Kids Act. The sub-recipient then works with the school district to revise the policy and bring it before the school board.

Let's Go! and their sub-recipients register school districts, as well as state licensed ECEs and out-of-school sites with the Let's Go! Program; support school cafeterias in assessing their healthy food environments; assist school districts in the adoption, communication, and implementation of revised wellness policies; and recognize schools and ECE sites that have improved their nutrition and physical activity environments. Additionally, the Let's Go!'s Healthcare Team, based at the Central Office, work with healthcare practices across the state to ensure adherence to national standards on the prevention, assessment and treatment of childhood obesity.

For more information, please refer to Let's Go!'s website: www.mainehealth.org/lets-go

[31] Recreational screen time is defined as time spent on electronic devices (e.g., smartphones, tablets, TVs, gaming systems, etc.) that does not promote activity or learning. This may include time spent on social media, watching TV or movies, and/or playing video games. Recreational screen time does not include time spent on a screen for educational or learning purposes (MaineHealth Let's Go!, n.d.).

Figure 18. Obesity Prevention: Funded Partners by Service Area (2016 – 2021).

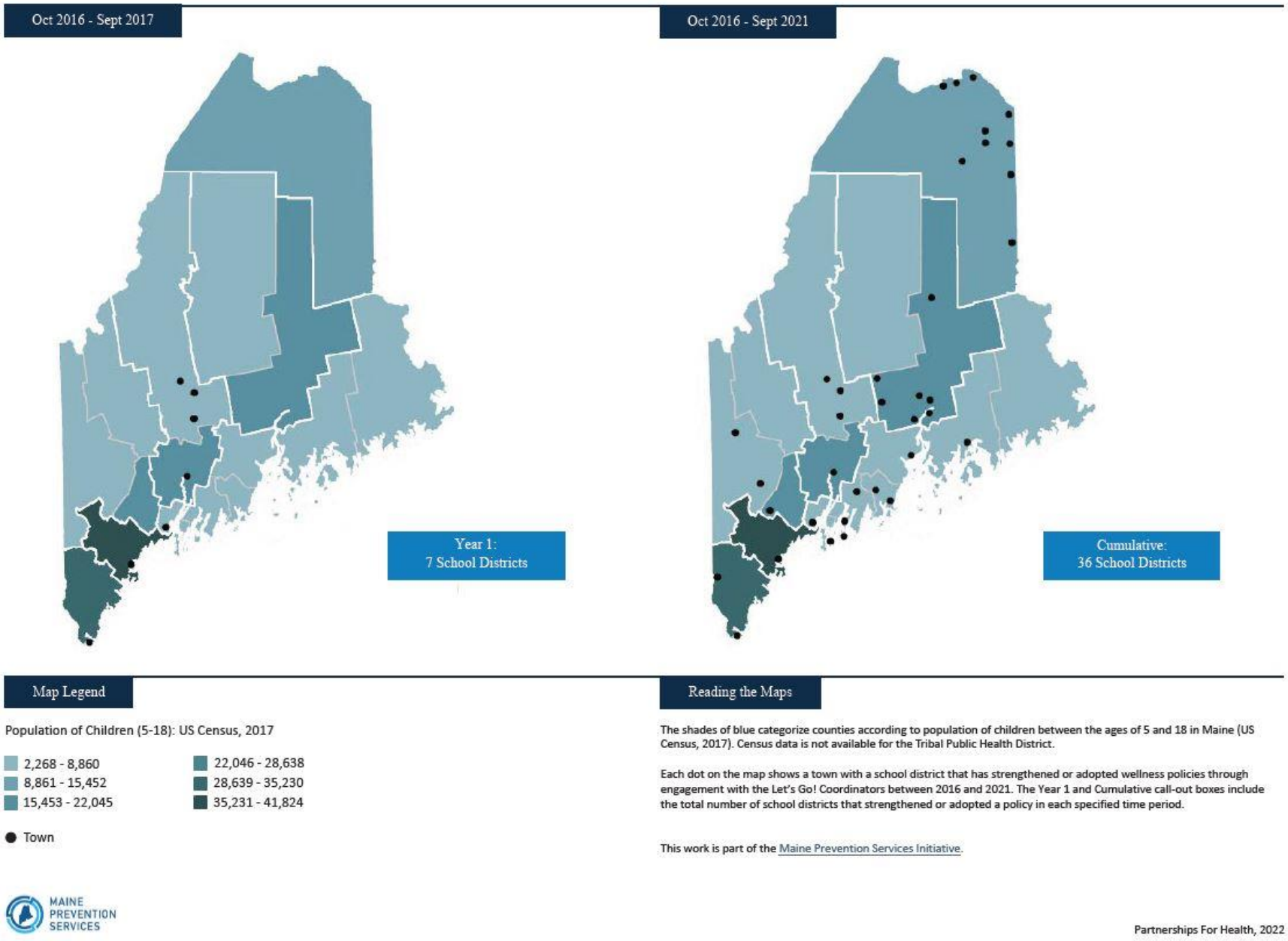


	GOAL 1: CREATE HEALTHIER SCHOOL ENVIRONMENTS TO PREVENT OBESITY Let's Go! and the Coordinators provided technical assistance and/or professional development to school districts to support them in developing, revising, and implementing their wellness policies to align with and exceed the Healthy Hunger-Free Kids Act of 2010. In addition, they worked with schools and school districts to develop and implement Healthy Eating and Active Living (HEAL) Action Plans which capture practical ways to implement policy statements. Policy and implementation strength are recognized through the Let's Go! recognition program.				
	RECEIVED PROFESSIONAL DEVELOPMENT	**RECEIVED TECHNICAL ASSISTANCE**	**STRENGTHENED POLICIES**	**DEVELOPED / REVISED HEAL ACTION PLANS**	
Cumulative: 2016 – 2021	**87** school districts with **115,833** students **276** schools with **91,457** students	**125** school districts with **148,606** students **427** schools with **143,201** students	**36** school districts with **38,683** students	**379** schools with **125,477** students	**72** school districts with **95,126** students
2020 - 2021	1 school district with 201 students 71 schools with 20,061 students	58 school districts with 85,688 students 232 schools with 80,922 students	4 school districts with 4,865 students	66 schools with 22,681 students	8 school districts with 16,408 students
2019 - 2020	6 school districts with 6,012 students 37 schools with 10,530 students	54 school districts with 75,051 students 309 schools with 101,812 students	6 school districts with 2,586 students	309 schools with 101,812 students	22 school districts with 30,747 students
2018 – 2019	34 school districts with 53,562 students 113 schools with 37,330 students[32]	104 school districts with 129,180 students[32] 286 schools with 92,390 students[32]	8 school districts with 3,617 students	162 schools with 52,709 students	24 school districts with 29,460 students
2017 – 2018	63 school districts with 90,320 students 102 schools with 31,570 students	79 school districts with 96,777 students 239 schools with 74,079 students	12 school districts with 12,592 students	147 schools with 47,776 students	18 school districts with 21,672 students

[32] Data revised due to a clerical error in 2020 reporting of Contract Period 3.

	Goal 1: Create Healthier School Environments to Prevent Obesity (cont'd)				
	Received Professional Development	**Received Technical Assistance**	**Strengthened Policies**	**Developed / Revised HEAL Action Plans**	
2016 – 2017	30 school districts with 45,129 students	37 school districts with 50,193 students	7 school districts with 15,435 students	192 schools with 59,897 students	30 school districts with 41,542 students
	114 schools with 36,903 students	220 schools with 69,125 students			
	Since the beginning of the MPS Initiative, **104** school districts with **129,985** students have registered with Let's Go!. **135** schools in **64** school districts with **37,589** students have met the Gold level of Let's Go!'s recognition program.				

Figure 19. Locations of School Districts that Strengthened or Adopted Wellness Policies as a Result of Technical Assistance (2016 – 2021).



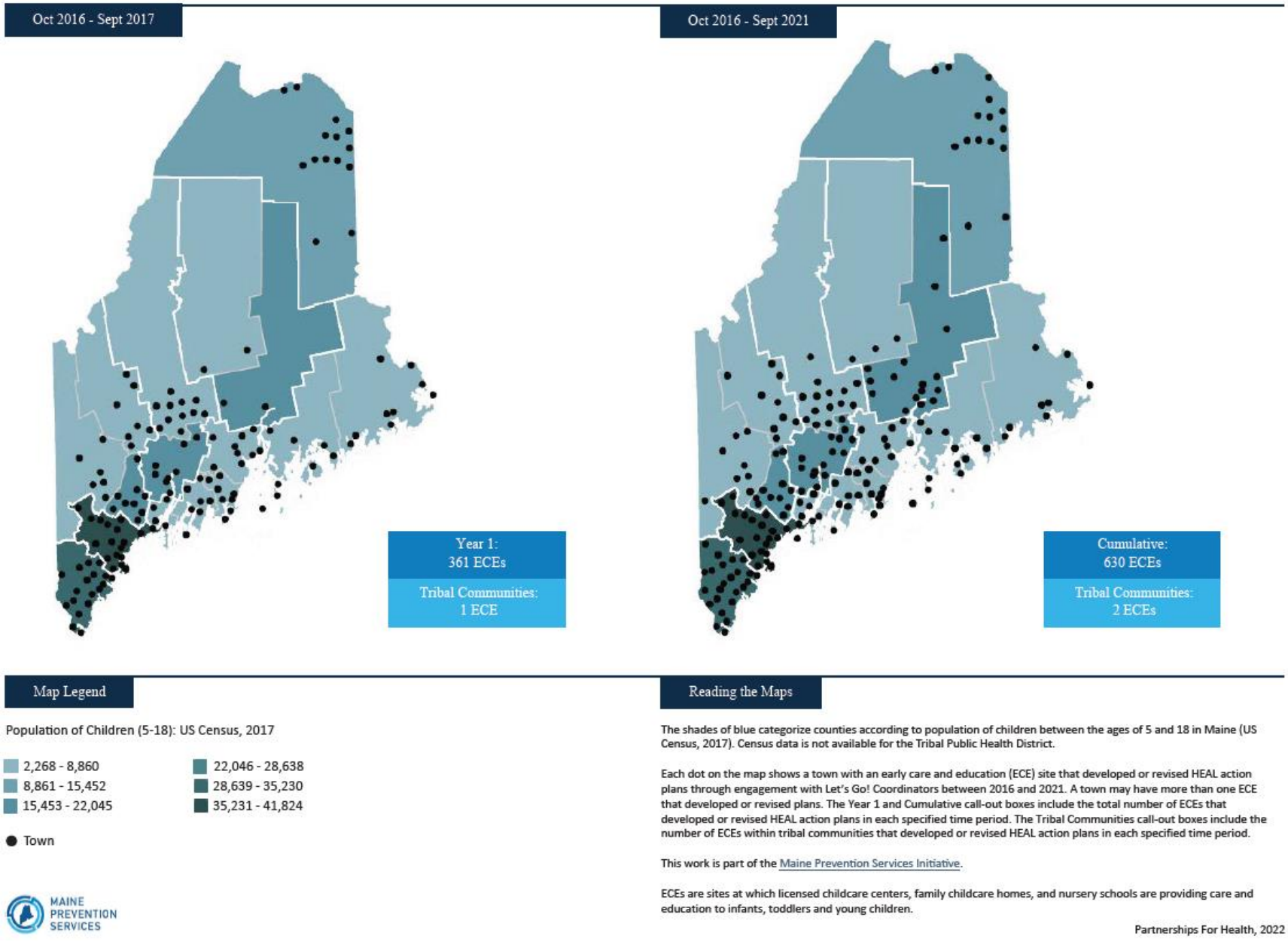
GOAL 2: CREATE HEALTHIER EARLY CARE AND EDUCATION ENVIRONMENTS TO PREVENT OBESITY

Let's Go! and the Coordinators provided technical assistance and/or professional development to ECE sites to support them in developing, revising, and implementing their policies to improve physical activity and/or strengthen healthy food environments. In addition, they worked with ECE sites to develop and implement Healthy Eating and Active Living (HEAL) Action Plans which capture practical ways to implement policy statements. Policy and implementation strength are recognized through the Let's Go! recognition program.

	RECEIVED PROFESSIONAL DEVELOPMENT	RECEIVED TECHNICAL ASSISTANCE	DEVELOPED / REVISED HEAL ACTION PLANS
Cumulative: 2016 – 2021	**455** ECE sites in **16** counties with a licensed capacity of **16,439** children	**833** ECE sites in **16** counties with a licensed capacity of **28,747** children	**630** ECE sites in **16** counties with a licensed capacity of **22,688** children
2020 - 2021	19 ECE sites in 8 counties with a licensed capacity of 473 children	386 ECE sites in 16 counties with a licensed capacity of 14,133 children	127 ECE sites in 12 counties with a licensed capacity of 5,066 children
2019 - 2020	77 ECE sites in 7 counties with a licensed capacity of 3,634 children	447 ECE sites in 16 counties with a licensed capacity of 16,483 children	245 ECE sites in 15 counties with a licensed capacity of 8,616 children
2018 – 2019	193 ECE sites in 15 counties with a licensed capacity of 7,262 children	553 ECE sites in 16 counties with a licensed capacity of 20,613 children	276 ECE sites in 16 counties with a licensed capacity of 11,693 children
2017 – 2018	145 ECE sites in 16 counties with a licensed capacity of 5,515 children	452 ECE sites in 16 counties with a licensed capacity of 15,613 children	200 ECE sites in 16 counties with a licensed capacity of 6,435 children
2016 – 2017	253 ECE sites in 16 counties with a licensed capacity of 9,036 children	368 ECE sites in 16 counties with a licensed capacity of 13,045 children	361 ECE sites in 16 counties with a licensed capacity of 12,808 children

Since the beginning of the MPS Initiative, a total of **660** ECE sites with a licensed capacity to serve **22,156** children were registered with Let's Go!. In addition, **516** ECE sites met the Gold level of Let's Go! recognition program. These ECE sites had a licensed capacity to serve **18,311** children.

Figure 20. Locations of Early Care and Education Sites that Developed or Revised Healthy Eating and Active Living (HEAL) Action Plans as a Result of Technical Assistance (2016 – 2021).



GOAL 3: INCREASE CLINICAL PROMOTION OF HEALTHY EATING AND ACTIVE LIVING BEHAVIORS

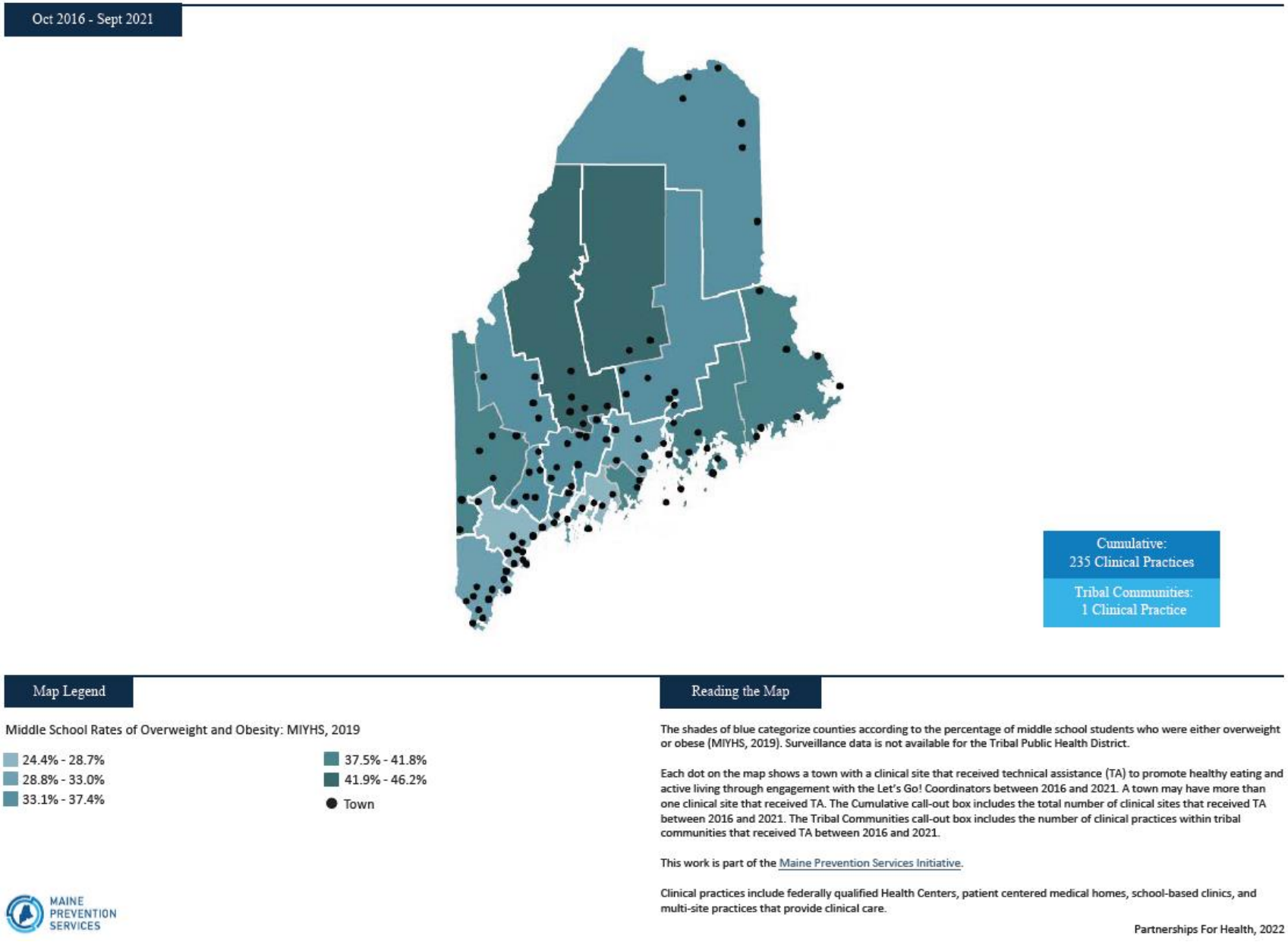
Let's Go! provided technical assistance and training to clinical practices on strategies to promote healthy eating and active living among pediatric patients. The strength of their practices is recognized through the Let's Go! recognition program.

	RECEIVED TECHNICAL ASSISTANCE	RECEIVED MPS LG! RECOGNITION
Cumulative: 2016 – 2021	**235** clinical practices in **16** counties	**148** clinical practices in **16** counties
2020 - 2021	93 clinical practices in 16 counties	87 clinical practices in 15 counties
2019 - 2020	200 clinical practices in 14 counties	84 clinical practices in 16 counties
2018 – 2019	158 clinical practices in 16 counties[33]	111 clinical practices in 16 counties
2017 – 2018	150 clinical practices in 15 counties	112 clinical practices in 15 counties
2016 – 2017	-	-

Since the beginning of the MPS Initiative, a total of **160** clinical practices were registered with Let's Go!.

[33] Data point was updated from Year 3 to reflect all clinical practices that received TA.

Figure 21. Locations of Clinical Practices that Received Technical Assistance (2016 – 2021).



Progress Toward Long-Term Outcomes

State and county level data. Tables 14 and 15 summarize youth data from the MIYHS from 2015, 2017, and 2019 on a state, public health district, and county level. "Healthy weight" indicates that a student is at or above the 5th percentile but below the 85th percentile for body mass index, by age and sex.

The state and public health districts are shown in the blue rows. The counties within each public health district (if any) are shown in the white rows. When reading the data, it may be useful to look at trends at a district level, due to districts' larger sample sizes and smaller error margins.

Confidence intervals. Confidence intervals quantify the degree of uncertainty in rate or prevalence estimates that result from sampling or random variability. The confidence interval presents a range of values within which the true underlying rate or prevalence is likely to lie; the range is bounded by the error margins of the Upper Confidence Limit (UCL) and the Lower Confidence Limit (LCL). For example, a 95% Confidence Interval means that, if all eligible students in the population answered a specific question, we are 95% confident that the true population value of the specific question would fall between the LCL and the UCL.

Trend. Tables 14 and 15 also show the trend across multiple years. If the Confidence Intervals of the most recent year (typically 2019) do not overlap with the Confidence Interval from the base year (typically 2015), then the trend is considered to be significantly increasing (↑) or decreasing (↓). If the base year Confidence Intervals overlap with the most recent year, the trend is considered statistically unchanged (→).

Table 14. Percent of Maine Middle School Youth at a Healthy Weight.
Data source: MIYHS 2015, 2017, and 2019.

	2015 (LCL-UCL)	2017 (LCL-UCL)	2019 (LCL-UCL)	TREND
State	65.8% (64.1 - 67.4)	65.3% (63.7 - 66.9)	64.9% (63.4 - 66.4)	→
Aroostook	60.9% (56.8 - 65.1)	62.5% (58.6 - 66.4)	61.6% (56.0 - 67.2)	→
Central	64.8% (61.0 - 68.5)	58.9% (56.6 - 61.2)	57.9% (54.2 - 61.6)	→
Kennebec	66.0% (60.4 - 71.6)	59.5% (57.2 - 61.8)	62.8% (58.0 - 67.6)	→
Somerset	62.6% (59.5 - 65.7)	58.1% (52.9 - 63.2)	51.2% (44.1 - 58.3)	↓
Cumberland	70.4% (67.5 - 73.3)	71.7% (68.1 - 75.3)	71.5% (68.9 - 74.0)	→
Downeast	60.3% (51.8 - 68.8)	62.8% (58.1 - 67.4)	56.5% (48.7 - 64.4)	→
Hancock	Not Available	65.0% (58.8 - 71.3)	58.0% (47.0 - 68.9)	→
Washington	52.7% (45.5 - 59.9)	56.3% (47.2 - 65.4)	54.5% (47.8 - 61.2)	→
Midcoast	64.7% (60.9 - 68.5)	66.3% (60.5 - 72.1)	64.8% (58.7 - 71.0)	→
Knox	Not Available	70.6% (56.0 - 85.1)	57.7% (35.0 - 80.3)	→
Lincoln	65.6% (59.9 - 71.3)	62.9% (55.6 - 70.2)	74.1% (65.2 - 82.9)	→
Sagadahoc	65.6% (62.2 - 69.0)	69.9% (60.8 - 79.0)	63.5% (60.7 - 66.4)	→
Waldo	62.1% (54.1 - 70.1)	62.0% (52.4 - 71.7)	68.1% (61.6 - 74.6)	→
Penquis	62.4% (57.9 - 66.8)	60.2% (57.0 - 63.4)	62.4% (59.6 - 65.2)	→
Penobscot	62.6% (57.9 - 67.3)	60.9% (57.2 - 64.5)	62.7% (59.7 - 65.6)	→
Piscataquis	61.4% (49.1 - 73.8)	55.6% (52.5 - 58.7)	57.5% (54.6 - 60.5)	→
Western	60.6% (56.7 - 64.5)	60.0% (56.9 - 63.1)	61.2% (58.6 - 63.8)	→
Androscoggin	63.9% (60.9 - 66.8)	62.0% (59.6 - 64.4)	63.2% (60.5 - 65.9)	→
Franklin	52.3% (47.2 - 57.3)	57.1% (43.0 - 71.1)	61.3% (55.3 - 67.3)	→
Oxford	62.3% (58.3 - 66.3)	58.9% (53.8 - 64.0)	58.4% (53.1 - 63.8)	→
York	69.7% (64.8 - 74.7)	69.5% (65.6 - 73.5)	67.9% (63.1 - 72.6)	→

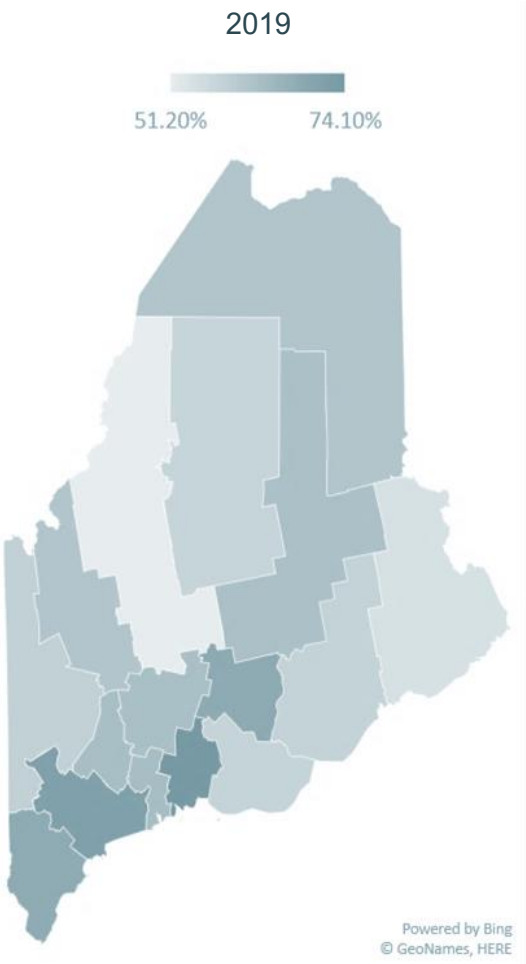
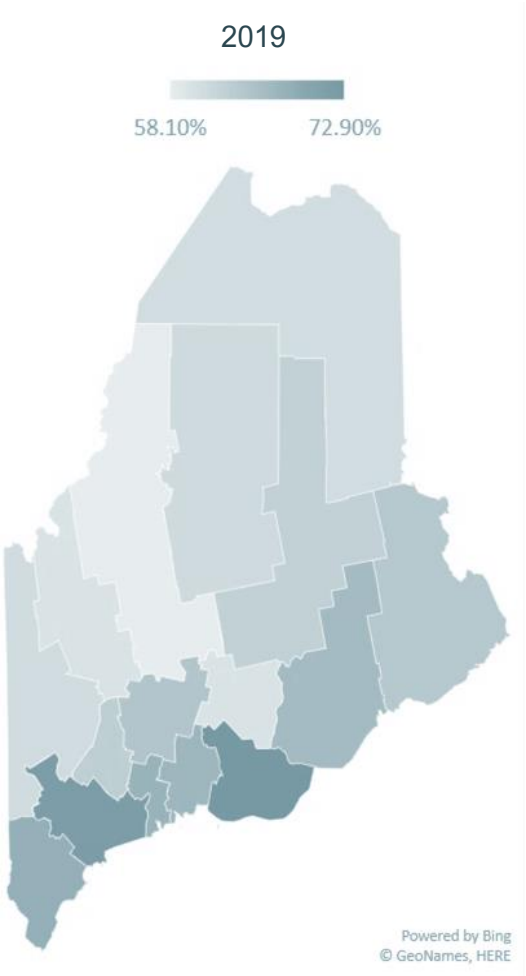


Table 15. Percent of Maine High School Youth at a Healthy Weight.
Data source: MIYHS 2015, 2017, and 2019.

	2015 (LCL-UCL)	2017 (LCL-UCL)	2019 (LCL-UCL)	TREND
State	67.6% (66.4 - 68.9)	65.5% (64.3 - 66.8)	66.4% (65.0 - 67.8)	→
Aroostook	63.4% (61.9 - 64.9)	61.5% (57.5 - 65.5)	60.8% (57.9 - 63.8)	→
Central	63.8% (62.2 - 65.4)	63.4% (61.1 - 65.7)	61.9% (60.1 - 63.7)	→
Kennebec	64.4% (61.8 - 67.0)	63.9% (60.3 - 67.6)	64.7% (62.1 - 67.4)	→
Somerset	62.6% (61.8 - 63.4)	62.2% (61.2 - 63.3)	58.1% (56.1 - 60.2)	↓
Cumberland	73.4% (70.8 - 76.0)	70.4% (67.7 - 73.0)	72.0% (69.5 - 74.4)	→
Downeast	65.0% (59.2 - 70.8)	65.8% (62.1 - 69.5)	65.3% (59.8 - 70.9)	→
Hancock	69.3% (61.9 - 76.7)	68.9% (65.7 - 72.0)	66.3% (58.4 - 74.1)	→
Washington	60.3% (53.4 - 67.2)	59.3% (53.9 - 64.7)	64.1% (58.2 - 70.0)	→
Midcoast	68.5% (65.5 - 71.6)	66.0% (61.4 - 70.5)	68.3% (64.5 - 72.2)	→
Knox	Not Available	68.1% (52.6 - 83.5)	72.9% (67.7 - 78.0)	→
Lincoln	68.9% (67.3 - 70.6)	65.9% (62.0 - 69.9)	67.1% (62.7 - 71.5)	→
Sagadahoc	69.6% (68.1 - 71.1)	67.3% (65.1 - 69.5)	67.7% (64.7 - 70.7)	→
Waldo	60.2% (57.9 - 62.4)	57.5% (55.6 - 59.4)	59.8% (57.4 - 62.1)	→
Penquis	63.9% (61.6 - 66.2)	61.9% (59.5 - 64.4)	62.7% (60.3 - 65.1)	→
Penobscot	63.9% (61.4 - 66.4)	62.7% (60.5 - 65.0)	62.8% (60.3 - 65.4)	→
Piscataquis	63.6% (58.7 - 68.4)	52.8% (42.3 - 63.4)	61.2% (55.0 - 67.4)	→
Western	64.2% (62.3 - 66.2)	61.2% (59.7 - 62.6)	61.4% (59.3 - 63.5)	→
Androscoggin	63.6% (62.7 - 64.6)	60.3% (58.7 - 62.0)	63.1% (61.6 - 64.5)	→
Franklin	66.5% (62.1 - 70.8)	60.5% (58.1 - 63.0)	59.8% (55.6 - 64.0)	→
Oxford	64.0% (59.8 - 68.1)	62.3% (59.0 - 65.5)	60.9% (56.5 - 65.2)	→
York	69.1% (64.7 - 73.5)	67.2% (62.7 - 71.8)	68.2% (63.1 - 73.4)	→



Public Health District Summaries

2016-2021

This summary highlights activities that took place within the Aroostook Public Health District during all five years of the MPS Initiative. Please refer to domain-specific websites and reports for more information.

Prevent and Reduce Youth and Young Adults Use of Alcohol, Marijuana, and Misuse of Prescription Drugs

2 community partners taught Prime for Life® Universal classes to individuals who may consider making high-risk choices regarding substance use or misuse. In addition, 1 Student Intervention Reintegration Program (SIRP) course was taught to help youth engaging in at-risk behavior to make healthier choices. The SIRP course reached 2 individuals.

14 Responsible Beverage Seller / Service Trainings were conducted. Through these trainings, 2,598 individuals were reached. In addition, 19 law enforcement details were implemented in Aroostook Public Health District.

2 sub-recipients participated in drug take-back efforts, with a total of 13,156 pounds of drugs collected[34]. In addition, 1 sub-recipient implemented the Safe Storage in Homes intervention, through which Mainers were reached 39,697 times throughout the MPS Initiative.

9 trainings were conducted to change the social norms around youth substance use.

Prevent Youth and Young Adults from Tobacco Use Initiation

17 school districts and 70 youth-serving entities received technical assistance and/or professional development to support them in developing, revising, and implementing their policies to align with the Maine Tobacco-Free School Policy Criteria or Maine Tobacco-Free Child Care Policy Criteria. Approximately 9,618 students attend these schools.

As a result, 6 school districts met the Maine Tobacco-Free School Policy Criteria for their tobacco policies. Approximately 4,606 students attend schools in these districts. In addition, 49 youth-serving entities met the Maine Tobacco-Free Child Care Policy Criteria for their tobacco policies. Approximately 715 youth are served by these entities.

With expanded funding that began in 2019, a total of 1 school district and 1 youth-serving entity also received enhanced technical assistance to support them in developing, revising, and implementing their tobacco policies. 513 students attend schools in this district and 25 youth are served by this youth-serving entity. In addition, 5 tobacco retailers received technical assistance on adherence to Maine's Tobacco Retailer Laws, and 10 Sidekicks groups received various forms of technical assistance.

28 municipalities and 14 public places received technical assistance and/or professional development to support them in developing, revising, and implementing tobacco-related ordinances, policies, or resolutions. Approximately 56,984 residents live in these municipalities.

As a result, 22 municipalities and 8 public places adopted tobacco-related ordinances, policies, or resolutions. Approximately 52,685 residents live in these municipalities.

7 Sidekicks training sessions were held to educate adult advisors and youth about respectfully talking with youth or their peers about tobacco use. A total of 225 people attended these trainings.

Eliminate Involuntary Exposure to Secondhand Smoke

18 clinical sites, 39 housing properties, 3 higher education institutions, and 9 lodgings received technical assistance to support them in developing, revising, and implementing policies that prohibit the use of tobacco products and create smoke-free environments.

As a result, 9 clinical sites, 31 housing properties, 2 higher education institutions, and 3 lodgings adopted tobacco/smoke-free policies.

125 workplaces received technical assistance to support them in developing, revising, and implementing workplace tobacco policies. This included 17 school districts, 3 higher education institutions, 15 clinical sites, 21 employers, and 68 youth-serving entities.

[34] This data includes 2017-2020. The data was not collected in 2016-2017.

As a result, 73 workplaces adopted tobacco policies for employees. This included 8 school districts, 3 higher education institutions, 5 clinical sites, 8 employers, and 49 youth-serving entities.

With expanded funding that began in 2019, a total of 8 employers met the Maine Tobacco-Free Workplace Criteria. 9 clinical sites and 3 higher education institutions achieved Gold or Platinum levels of Gold Star Standards of Excellence programs.

Promote Tobacco Treatment Among Adults and Young People

18 training sessions were held with non-clinical organizations on tobacco use and treatment, and promotion of the Maine QuitLink and Sidekicks training. A total of 113 people attended these trainings.

12 social service agencies and 5 animal welfare agencies received technical assistance to promote the Maine QuitLink.

Youth Engagement and Empowerment

16 trainings were held with 127 adults and 231 youth on a variety of topics, including: building the capacity of adult advisors in holistic prevention and engagement with youth; youth or adult skill building; and best practices of strength-based partnerships with youth.

4 Youth Policy Boards were active and focused on youth substance use prevention and a combination of areas. 21 Youth Engagement Groups were active and focused on social and/or racial justice and a combination of areas. In addition, a total of 17 Youth Engagement Groups were referred for or received training on restorative practices, Sidekicks, Sources of Strength, and/or general MYAN training.

Technical assistance was provided to 70 local organizations to support holistic prevention efforts targeting youth.

Create Healthier School Environments to Prevent Obesity

To support school districts in developing, revising, and implementing their wellness policies, staff in 12 school districts with 7,871 students received professional development and staff in 12 school districts with 7,909 students received technical assistance.

As a result, 10 school districts adopted revised policies that are compliant with the Healthy Hunger-Free Kids Act of 2010. Approximately 3,779 students attend these schools.

32 school cafeterias received recognition for the Smarter Lunchroom Scorecards' values on healthier food environments. The cafeterias are situated in 13 school districts. Approximately 8,245 students attend schools in these districts.

11 schools in 7 school districts achieved the Gold level of Let's Go!'s recognition program. Approximately 1,988 students attend these schools.

Create Healthier Early Care and Education Environments to Prevent Obesity

54 early care and education sites registered with Let's Go! to promote healthy environments for young children. These sites have a licensed capacity to serve 1,184 children.

As a result, 55 early care and education sites achieved the Gold level of Let's Go!'s recognition program. These sites have a licensed capacity to serve 1,155 children.

Domain 1: Substance Use Prevention[35]	Power of Prevention www.carymedicalcenter.org
Domain 2: Tobacco Use and Exposure Prevention	Aroostook County Action Program www.acap-me.org/
Domain 3: Youth Engagement and Empowerment	Aroostook Mental Health Center www.amhc.org/
Domain 4: Mass-Reach Health Communications	Rinck Advertising www.rinckadvertising.com/
Domain 5: Obesity Prevention	Aroostook County Action Program www.acap-me.org/

[35] Aroostook County Action Program was once a Domain 1 partner and contributed towards the cumulative efforts in Aroostook County.

This summary highlights activities that took place within the Central Public Health District during all five years of the MPS Initiative. Please refer to domain-specific websites and reports for more information.

Prevent and Reduce Youth and Young Adults Use of Alcohol, Marijuana, and Misuse of Prescription Drugs

3 community partners taught Prime for Life® Universal classes to individuals who may consider making high-risk choices regarding substance use or misuse. In addition, 13 Student Intervention Reintegration Program (SIRP) courses were taught to help youth engaging in at-risk behavior to make healthier choices. The SIRP courses reached 82 individuals.

3 sub-recipients participated in drug take-back efforts, with a total of 9,104 pounds of drugs collected[36]. In addition, 4 sub-recipients implemented the Safe Storage in Homes intervention, through which Mainers were reached 391,734 times throughout the MPS Initiative.

66 trainings were conducted to change the social norms around youth substance use.

Prevent Youth and Young Adults from Tobacco Use Initiation

16 school districts and 39 youth-serving entities received technical assistance and/or professional development to support them in developing, revising, and implementing their policies to align with the Maine Tobacco-Free School Policy Criteria or Maine Tobacco-Free Child Care Policy Criteria. Approximately 17,541 students attend these school districts.

As a result, 10 school districts met the Maine Tobacco-Free School Policy Criteria for their tobacco policies. Approximately 9,237 students attend schools in these districts. In addition, 14 youth-serving entities met the Maine Tobacco-Free Child Care Policy Criteria for their tobacco policies. Approximately 6,213 youth are served by these entities.

With expanded funding that began in 2019, a total of 5 school districts and 6 youth-serving entities also received enhanced technical assistance to support them in developing, revising, and implementing their tobacco policies. 2,058 students attend schools in these districts and 912 youth are served by these youth-serving entities. In addition, 17 tobacco retailers received technical assistance on adherence to Maine's Tobacco Retailer Laws and 12 Sidekicks groups received various forms of technical assistance.

28 municipalities and 8 public places received technical assistance and/or professional development to support them in developing, revising, and implementing tobacco-related ordinances, policies, or resolutions. Approximately 95,981 residents live in these municipalities.

As a result, 12 municipalities and 5 public places adopted tobacco-related ordinances, policies, or resolutions. Approximately 34,872 residents live in these municipalities.

27 Sidekicks training sessions were held to educate adult advisors and youth about respectfully talking with youth or their peers about tobacco use. A total of 424 people attended these trainings.

Eliminate Involuntary Exposure to Secondhand Smoke

36 clinical sites, 61 housing properties, 8 higher education institutions, and 4 lodgings received technical assistance to support them in developing, revising, and implementing policies that prohibit the use of tobacco products and create smoke-free environments.

As a result, 16 clinical sites, 25 housing properties, 3 higher education institutions, and 1 lodging establishment adopted tobacco/smoke-free policies.

153 workplaces received technical assistance to support them in developing, revising, and implementing workplace tobacco policies. This included 16 school districts, 7 higher education institutions, 31 clinical sites, 58 employers, and 40 youth-serving entities.

As a result, 53 workplaces adopted tobacco policies for employees. This included 11 school districts, 3 higher education institutions, 10 clinical sites, 15 employers, and 14 youth-serving entities.

In addition, with expanded funding that began in 2019, a total of 15 employers and 1 lodging establishment met the Maine Tobacco-Free Workplace Criteria.

[36] This data includes 2017-2020. The data was not collected in 2016-2017.

8 clinical sites and 3 higher education institutions achieved Gold or Platinum levels of Gold Star Standards of Excellence programs.

Promote Tobacco Treatment Among Adults

35 training sessions were held with non-clinical organizations on tobacco use and treatment, and the promotion of the Maine QuitLink and Sidekicks training. A total of 389 participants attended these trainings.

22 social service agencies and 2 animal welfare agencies received technical assistance to promote the Maine QuitLink.

Youth Engagement and Empowerment

27 trainings were held with 520 adults and 127 youth on a variety of topics, including: building the capacity of adult advisors in holistic prevention and engagement with youth and best practices of strength-based partnerships with youth.

6 Youth Policy Boards were active and focused on youth substance use prevention or a combination of focus areas. 18 Youth Engagement Groups were active and focused on social and/or racial justice, youth substance use prevention, or a combination of focus areas. In addition, 9 Youth Engagement Groups were referred for or received training on restorative practices, Sidekicks, Sources of Strength, and/or general MYAN training.

Technical assistance was provided to 61 local organizations to support holistic prevention efforts targeting youth.

Create Healthier School Environments to Prevent Obesity

To support school districts in developing, revising, and implementing their wellness policies, staff in 14 school districts with 19,524 students received professional development and staff in 18 school districts with 20,225 students received technical assistance.

As a result, 4 school districts adopted revised policies that are compliant with the Healthy Hunger-Free Kids Act of 2010. Approximately 5,132 students attend these schools.

54 school cafeterias received recognition for the Smarter Lunchroom Scorecards' values on healthier food environments. The cafeterias are situated in 17 school districts. Approximately 15,893 students attend schools in these districts

28 schools in 11 school districts achieved the Gold level of Let's Go!'s recognition program. Approximately 6,035 students attend these schools.

Create Healthier Early Care and Education Environments to Prevent Obesity

93 early care and education sites registered with Let's Go! to promote healthy environments among young children. These sites have a licensed capacity to serve 3,167 children.

As a result, 72 early care and education sites achieved the Gold level of Let's Go!'s recognition program. These sites have a licensed capacity to serve 2,939 children.

Domain 1: Substance Use Prevention	Healthy Communities of the Capital Area www.hccame.org/
	Kennebec Behavioral Health www.kbhmaine.org/
	Somerset Public Health www.somersetpublichealth.org/
	Healthy Community Coalition www.mainehealth.org/franklin-community-health-network/healthy-communities
Domain 2: Tobacco Use and Exposure Prevention	Somerset Public Health www.somersetpublichealth.org/
	Healthy Communities of the Capital Area www.hccame.org/
Domain 3: Youth Engagement and Empowerment	Healthy Communities of the Capital Area www.hccame.org/
Domain 4: Mass-Reach Health Communications	Rinck Advertising www.rinckadvertising.com/
Domain 5: Obesity Prevention	Healthy Communities of the Capital Area www.hccame.org/
	Northern Light Inland Hospital www.northernlighthealth.org/Inland-Hospital
	Somerset Public Health www.somersetpublichealth.org/

This summary highlights activities that took place within the Cumberland Public Health District during all five years of the MPS Initiative. Please refer to domain-specific websites and reports for more information.

PREVENT AND REDUCE YOUTH AND YOUNG ADULTS USE OF ALCOHOL, MARIJUANA, AND MISUSE OF PRESCRIPTION DRUGS
1 community partner taught Prime for Life® Universal classes to individuals who may consider making high-risk choices regarding substance use or misuse. In addition, 51 Student Intervention Reintegration Program (SIRP) courses were taught to help youth engaging in at-risk behavior to make healthier choices. The SIRP sources reached 297 individuals.
15 Responsible Beverage Seller / Service Trainings were conducted. Through these trainings, 22,679 individuals were reached. In addition, 50 law enforcement details were implemented in Cumberland Public Health District.
3 sub-recipients participated in drug take-back efforts, with a total of 26,259 pounds of drugs collected[37]. In addition, 3 sub-recipients implemented the Safe Storage in Homes intervention, through which Mainers were reached 40,447 times throughout the MPS Initiative.
44 trainings were conducted to change the social norms around youth substance use.
PREVENT YOUTH AND YOUNG ADULTS FROM TOBACCO USE INITIATION
15 school districts and 82 youth-serving entities received technical assistance and/or professional development to support them in developing, revising, and implementing their policies to align with the Maine Tobacco-Free School Policy Criteria or Maine Tobacco-Free Child Care Policy Criteria. Approximately 37,456 students attend these schools. As a result, 8 school districts met the Maine Tobacco-Free School Policy Criteria for their tobacco policies. Approximately 22,905 students attend schools in these districts. In addition, 38 youth-serving entities met the Maine Tobacco-Free Child Care Policy Criteria for their tobacco policies. Approximately 24,400 youth are served by these entities. With expanded funding that began in 2019, a total of 4 school districts and 9 youth-serving entities also received enhanced technical assistance to support them in developing, revising, and implementing their tobacco policies. 11,758 students attend schools in these districts, and 2,611 youth are served by these youth-serving entities. In addition, 37 tobacco retailers received technical assistance on adherence to Maine's Tobacco Retailer Laws, and 22 Sidekicks groups received various forms of technical assistance.
27 municipalities and 14 public places received technical assistance and/or professional development to support them in developing, revising, and implementing tobacco-related ordinances, policies, or resolutions. Approximately 283,575 residents live in these municipalities. As a result, 5 municipalities and 3 public places adopted tobacco-related ordinances, policies, or resolutions. Approximately 54,867 residents live in these municipalities/tribal governments.
24 Sidekicks training sessions were held to educate adult advisors and youth about respectfully talking with youth or their peers about tobacco use. A total of 432 people attended these trainings.
ELIMINATE INVOLUNTARY EXPOSURE TO SECONDHAND SMOKE
82 clinical sites, 142 housing properties, 14 higher education institutions, and 14 lodgings received technical assistance to support them in developing, revising, and implementing policies that prohibit the use of tobacco products and create smoke-free environments. As a result, 13 clinical sites, 72 housing properties, 3 higher education institutions, and 8 lodgings adopted tobacco/smoke-free policies.
243 workplaces received technical assistance to support the development, revision, and implementation of workplace tobacco policies. This included 15 school districts, 12 higher education institutions, 47 clinical sites, 85 employers, and 82 youth-serving entities.

[37] This data includes 2017-2020. The data was not collected in 2016-2017.

As a result, 78 workplaces adopted tobacco policies for employees. This included 9 school districts, 4 higher education institutions, 7 clinical sites, 21 employers, and 37 youth-serving entities.

In addition, with expanded funding that began in 2019, a total of 19 employers and 1 lodging establishment met the Maine Tobacco-Free Workplace Criteria.

14 clinical sites and 3 higher education institutions achieved Gold or Platinum levels of Gold Star Standards of Excellence programs.

Promote Tobacco Treatment Among Adults

28 training sessions were held with non-clinical organizations on tobacco use and treatment, and promotion of the Maine QuitLink and Sidekicks training. A total of 190 people attended these trainings.

14 social service agencies and 9 animal welfare agencies received technical assistance to promote the Maine QuitLink.

Youth Engagement and Empowerment

Technical assistance was provided to 120 local organizations to support holistic prevention efforts targeting youth.

53 trainings were held with 339 adults and 687 youth on a variety of topics, including: building the capacity of adult advisors in holistic prevention and engagement with youth and adolescent mental health.

4 Youth Policy Boards were active and focused on adolescent mental health or a combination of focus areas. 21 Youth Engagement Groups were active and focused on adolescent mental health, youth substance use prevention, or a combination of focus areas. In addition, 16 Youth Engagement Groups were referred for or received training on restorative practices, Sidekicks, Sources of Strength, and/or general MYAN training.

Create Healthier School Environments to Prevent Obesity

To support school districts in developing, revising, and implementing their wellness policies, staff in 9 school districts with 25,685 students received professional development and staff in 10 school districts with 25,816 students received technical assistance.

As a result, 1 school district adopted revised policies that are compliant with the Healthy Hunger-Free Kids Act of 2010. Approximately 6,829 students attend these schools.

58 school cafeterias received recognition for the Smarter Lunchroom Scorecards' values on healthier food environments. The cafeterias are situated in 13 school districts. Approximately 27,141 students attend schools in these districts

19 schools in 12 school districts achieved the Gold level of Let's Go!'s recognition program. Approximately 6,926 students attend these schools.

Create Healthier Early Care and Education Environments to Prevent Obesity

118 early care and education sites registered with Let's Go! to promote healthy environments among young children. These sites have a licensed capacity to serve 5,133 children.

As a result, 96 early care and education sites achieved the Gold level of Let's Go!'s recognition program. These sites have a licensed capacity to serve 4,227 children.

Domain 1: Substance Use Prevention	Casco Bay Create Awareness Now www.cascobaycan.org/
	The City of Portland Public Health Division www.portlandmaine.gov/224/Public-Health
	Southern Midcoast Communities for Prevention *Formerly Access Health* - https://accesshealthme.org/
	The Opportunity Alliance www.opportunityalliance.org/
Domain 2: Tobacco Use and Exposure Prevention	The City of Portland Public Health Division www.portlandmaine.gov/224/Public-Health
	Mid Coast Hospital www.midcoasthealth.com/wellness/tobacco/
Domain 3: Youth Engagement and Empowerment	The Opportunity Alliance www.opportunityalliance.org/
Domain 4: Mass-Reach Health Communications	Rinck Advertising www.rinckadvertising.com/
Domain 5: Obesity Prevention	The City of Portland Public Health Division www.portlandmaine.gov/224/Public-Health

This summary highlights activities that took place within the Downeast Public Health District during all five years of the MPS Initiative. Please refer to domain-specific websites and reports for more information.

PREVENT AND REDUCE YOUTH AND YOUNG ADULTS USE OF ALCOHOL, MARIJUANA, AND MISUSE OF PRESCRIPTION DRUGS
1 community partner taught Prime for Life® Universal classes to individuals who may consider making high-risk choices regarding substance use or misuse.
40 Responsible Beverage Seller / Service Trainings were conducted. Through these trainings, 16,795 individuals were reached.
1 sub-recipient participated in drug take-back efforts, with a total of 6,152 pounds of drugs collected[38]. In addition, 1 sub-recipient implemented the Safe Storage in Homes intervention, through which Mainers were reached 206,392 times throughout the MPS Initiative.
5 trainings were conducted to change the social norms around youth substance use.
PREVENT YOUTH AND YOUNG ADULTS FROM TOBACCO USE INITIATION
25 school districts and 38 youth-serving entities received technical assistance and/or professional development to support them in developing, revising, and implementing their policies to align with the Maine Tobacco-Free School Policy Criteria or Maine Tobacco-Free Child Care Policy Criteria. Approximately 5,499 students attend these schools. As a result, 8 school districts met the Maine Tobacco-Free School Policy Criteria for their tobacco policies. Approximately 1,255 students attend schools in these districts. In addition, 18 youth-serving entities met the Maine Tobacco-Free Child Care Policy Criteria for their tobacco policies. Approximately 6,482 youth are served by these entities. With expanded funding that began in 2019, a total of 2 school districts and 5 youth-serving entities also received enhanced technical assistance to support them in developing, revising, and implementing their tobacco policies. 1,690 students attend schools in these districts and 262 youth are served by these youth-serving entities. In addition, 11 tobacco retailers received technical assistance on adherence to Maine's Tobacco Retailer Laws, and 6 Sidekick groups received various forms of technical assistance.
27 municipalities and 6 public places received technical assistance and/or professional development to support them in developing, revising, and implementing tobacco-related ordinances, policies, or resolutions. Approximately 48,182 residents live in these municipalities. As a result, 9 municipalities and 3 public places adopted tobacco-related ordinances, policies, or resolutions. Approximately 20,804 residents live in these municipalities/tribal governments.
7 Sidekicks training sessions were held to educate adult advisors and youth about respectfully talking with youth or their peers about tobacco use. A total of 125 people attended these trainings.
ELIMINATE INVOLUNTARY EXPOSURE TO SECONDHAND SMOKE
12 clinical sites, 36 housing properties, 4 higher education institutions, and 7 lodgings received technical assistance to support them in developing, revising, and implementing policies that prohibit the use of tobacco products and create smoke-free environments. As a result, 5 clinical sites, 10 housing properties, and 3 lodgings adopted tobacco/smoke-free policies.
133 workplaces received technical assistance to support the development, revision, and implementation of workplace tobacco policies. This included 25 school districts, 4 higher education institutions, 9 clinical sites, 58 employers, and 38 youth-serving entities. As a result, 67 workplaces adopted tobacco policies for employees. This included 9 school districts, 1 higher education institution, 4 clinical sites, 34 employers, and 19 youth-serving entities.

[38] This data includes 2017-2020. The data was not collected in 2016-2017.

In addition, with expanded funding that began in 2019, a total of 34 employers and 1 lodging establishment met the Maine Tobacco-Free Workplace Criteria.
5 clinical sites and 1 higher education institution achieved Gold or Platinum levels of Gold Star Standards of Excellence programs.
PROMOTE TOBACCO TREATMENT AMONG ADULTS
20 training sessions were held with non-clinical organizations on tobacco use and treatment, and promotion of the Maine QuitLink and Sidekicks training. A total of 87 people attended these trainings.
12 social service agencies and 4 animal welfare agencies received technical assistance to promote the Maine QuitLink.
YOUTH ENGAGEMENT AND EMPOWERMENT
87 trainings were held with 1,073 adults and 940 youth on a variety of topics, including: building the capacity of adult advisors in holistic prevention and engagement with youth; restorative practices; and best practices of strength-based partnerships with youth.
6 Youth Policy Boards were active and focused on adolescent mental health or a combination of focus areas. 27 Youth Engagement Groups were active and focused on restorative practices, youth substance use prevention, or a combination of focus areas. In addition, 23 Youth Engagement Groups were referred for or received training on restorative practices, Sidekicks, Sources of Strength, and/or general MYAN training.
Technical assistance was provided 127 local organizations to support holistic prevention efforts targeting youth.
CREATE HEALTHIER SCHOOL ENVIRONMENTS TO PREVENT OBESITY
To support school districts in developing, revising, and implementing their wellness policies, staff in 13 school districts with 6,683 students received professional development and staff in 11 school districts with 3,549 students received technical assistance. As a result, 1 school district adopted revised policies that are compliant with the Healthy Hunger-Free Kids Act of 2010. Approximately 212 students attend this school.
16 school cafeterias received recognition for the Smarter Lunchroom Scorecards' values on healthier food environments. The cafeterias are situated in 11 school districts. Approximately 3,794 students attend schools in these districts
CREATE HEALTHIER EARLY CARE AND EDUCATION ENVIRONMENTS TO PREVENT OBESITY
40 early care and education sites registered with Let's Go! to promote healthy environments among young children. These sites have a licensed capacity to serve 1,048 children. As a result, 29 early care and education sites achieved the Gold level of the Let's Go!'s recognition program. These sites have a licensed capacity to serve 1,017 children.

Domain 1: Substance Use Prevention	Healthy Acadia www.healthyacadia.org/
Domain 2: Tobacco Use and Exposure Prevention	Healthy Acadia www.healthyacadia.org/
Domain 3: Youth Engagement and Empowerment	Healthy Acadia www.healthyacadia.org/
Domain 4: Mass-Reach Health Communications	Rinck Advertising www.rinckadvertising.com/
Domain 5: Obesity Prevention	Healthy Acadia www.healthyacadia.org/

This summary highlights activities that took place within the Midcoast Public Health District during all five years of the MPS Initiative. Please refer to domain-specific websites and reports for more information.

Prevent and Reduce Youth and Young Adults Use of Alcohol, Marijuana, and Misuse of Prescription Drugs

2 community partners taught Prime for Life® Universal classes to individuals who may consider making high-risk choices regarding substance use or misuse. In addition, 15 Student Intervention Reintegration Program (SIRP) courses were taught to help youth engaging in at-risk behavior to make healthier choices. The SIRP courses reached 91 individuals.

23 Responsible Beverage Seller / Service Trainings were conducted. Through these trainings, 12,642 individuals were reached. In addition, 15 law enforcement details were implemented in Midcoast Public Health District.

3 sub-recipients participated in drug take-back efforts, with a total of 13,562 pounds of drugs collected[39]. In addition, 3 sub-recipients implemented the Safe Storage in Homes intervention, through which Mainers were reached 388,293 times throughout the MPS Initiative.

31 trainings were conducted to change the social norms around youth substance use.

Prevent Youth and Young Adults from Tobacco Use Initiation

32 school districts and 46 youth-serving entities received technical assistance and/or professional development to support them in developing, revising, and implementing their policies to align with the Maine Tobacco-Free School Policy Criteria or Maine Tobacco-Free Child Care Policy Criteria. Approximately 20,244 students attend these schools.

As a result, 21 school districts met the Maine Tobacco-Free School Policy Criteria for their tobacco policies. Approximately 16,027 students attend schools in these districts. In addition, 16 youth-serving entities met the Maine Tobacco-Free Child Care Policy Criteria for their tobacco policies. Approximately 18,524 youth are served by these entities.

With expanded funding that began in 2019, a total of 12 school districts and 9 youth-serving entities also received enhanced technical assistance to support them in developing, revising, and implementing their tobacco policies. 8,131 students attend schools in these districts and 2,563 youth are served by these youth-serving entities. In addition, 21 tobacco retailers received technical assistance on adherence to Maine's Tobacco Retailer Laws, and 25 Sidekicks groups received various forms of technical assistance.

41 municipalities and 19 public places received technical assistance and/or professional development to support them in developing, revising, and implementing tobacco-related ordinances, policies, or resolutions. Approximately 105,752 residents live in these municipalities.

As a result, 11 municipalities and 2 public places adopted tobacco-related ordinances, policies, or resolutions. Approximately 42,389 residents live in these municipalities/tribal governments.

32 Sidekicks training sessions were held to educate adult advisors and youth about respectfully talking with youth or their peers about tobacco use. A total of 452 people attended these trainings.

Eliminate Involuntary Exposure to Secondhand Smoke

22 clinical sites, 52 housing properties, 4 higher education institutions, and 17 lodgings received technical assistance to support them in developing, revising, and implementing policies that prohibit the use of tobacco products and create smoke-free environments.

As a result, 8 clinical sites, 22 housing properties, and 1 higher education institution adopted tobacco/smoke-free policies.

161 workplaces received technical assistance to support the development, revision, and implementation of workplace tobacco policies. This included 32 school districts, 4 higher education institutions, 13 clinical sites, 67 employers, and 44 youth-serving entities.

As a result, 65 workplaces adopted tobacco policies for employees. This included 21 school districts, 1 higher education institution, 7 clinical sites, 20 employers, and 16 youth-serving entities.

[39] This data includes 2017-2020. The data was not collected in 2016-2017.

In addition, with expanded funding that began in 2019, a total of 21 employers met the Maine Tobacco-Free Workplace Criteria.
7 clinical sites achieved Gold or Platinum levels of Gold Star Standards of Excellence programs.
PROMOTE TOBACCO TREATMENT AMONG ADULTS
26 training sessions were held with non-clinical organizations on tobacco use and treatment, and promotion of the Maine QuitLink and Sidekicks training. A total of 134 people attended these trainings.
18 social service agencies and 26 animal welfare agencies received technical assistance to promote the Maine QuitLink.
YOUTH ENGAGEMENT AND EMPOWERMENT
Technical assistance was provided to 59 local organizations to support holistic prevention efforts targeting youth.
83 trainings were held with 2,394 adults and 1,159 youth on a variety of topics, including: building the capacity of adult advisors in holistic prevention and engagement with youth; youth or adult skill building; and best practices of strength-based partnerships with youth.
3 Youth Policy Boards were active and focused on adolescent mental health. 42 Youth Engagement Groups were active and focused on social and/or racial justice, restorative practices, or a combination of focus areas. In addition, 37 Youth Engagement Groups were referred for or received training on restorative practices, Sidekicks, Sources of Strength, and/or general MYAN training.
CREATE HEALTHIER SCHOOL ENVIRONMENTS TO PREVENT OBESITY
To support school districts in developing, revising, and implementing their wellness policies, staff in 10 school districts with 8,706 students received professional development and staff in 22 school districts with 16,765 students received technical assistance. As a result, 7 school districts adopted revised policies that are compliant with the Healthy Hunger-Free Kids Act of 2010. Approximately 6,769 students attend this school.
67 school cafeterias received recognition for the Smarter Lunchroom Scorecards' values on healthier food environments. The cafeterias are situated in 24 school districts. Approximately 16,060 students attend schools in these districts
35 schools in 15 school districts achieved the Gold level of Let's Go!'s recognition program. Approximately 8,241 students attend these schools.
CREATE HEALTHIER EARLY CARE AND EDUCATION ENVIRONMENTS TO PREVENT OBESITY
83 early care and education sites registered with Let's Go! to promote healthy environments among young children. These sites have a licensed capacity to serve 2,696 children. As a result, 60 early care and education sites achieved the Gold level of Let's Go!'s recognition program. These sites have a licensed capacity to serve 2,055 children.

Domain 1: Substance Use Prevention	Southern Midcoast Communities for Prevention *Formerly Access Health* - https://accesshealthme.org/
	Healthy Lincoln County https://www.healthylincolncounty.org/
	Knox County Community Health Coalition www.facebook.com/knoxcountycommunityhealthcoalition
Domain 2: Tobacco Use and Exposure Prevention	Coastal Healthcare Alliance www.mainehealth.org/pen-bay-medical-center/about
	Knox County Community Health Coalition www.facebook.com/knoxcountycommunityhealthcoalition
	Mid Coast Hospital www.midcoasthealth.com/wellness/tobacco/
Domain 3: Youth Engagement and Empowerment	OUT Maine www.outmaine.org/
Domain 4: Mass-Reach Health Communications	Rinck Advertising www.rinckadvertising.com/
Domain 5: Obesity Prevention	Mid Coast Hospital www.midcoasthealth.com/
	Coastal Healthcare Alliance www.mainehealth.org/pen-bay-medical-center

This summary highlights activities that took place within the Penquis Public Health District during all five years of the MPS Initiative. Please refer to domain-specific websites and reports for more information.

PREVENT AND REDUCE YOUTH AND YOUNG ADULTS USE OF ALCOHOL, MARIJUANA, AND MISUSE OF PRESCRIPTION DRUGS
2 community partners taught Prime for Life® Universal classes to individuals who may consider making high-risk choices regarding substance use or misuse.
85 Responsible Beverage Seller / Service Trainings were conducted. Through these trainings, 27,260 individuals were reached. In addition, 5 law enforcement details were implemented in Penquis Public Health District.
2 sub-recipients participated in drug take-back efforts, with a total of 7,237 pounds of drugs collected.[40] In addition, 2 sub-recipients implemented the Safe Storage in Homes intervention, through which Mainers were reached 149,705 times throughout the MPS Initiative.
23 trainings were conducted to change the social norms around youth substance use.
PREVENT YOUTH AND YOUNG ADULTS FROM TOBACCO USE INITIATION
21 school districts and 29 youth-serving entities received technical assistance and/or professional development to support them in developing, revising, and implementing their policies to align with the Maine Tobacco-Free School Policy Criteria or Maine Tobacco-Free Child Care Policy Criteria. Approximately 20,350 students attend these schools. As a result, 9 school districts met the Maine Tobacco-Free School Policy Criteria for their tobacco policies. Approximately 6,047 students attend schools in these districts. In addition, 15 youth-serving entities met the Maine Tobacco-Free Child Care Policy Criteria for their tobacco policies. Approximately 72,331 youth are served by these entities. With expanded funding that began in 2019, a total of 10 school districts and 4 youth-serving entities also received enhanced technical assistance to support them in developing, revising, and implementing their tobacco policies. 6,719 students attend schools in these districts and 65,050 youth are served by these youth-serving entities. In addition, 55 tobacco retailers received technical assistance on adherence to Maine's Tobacco Retailer Laws, and 3 Sidekicks groups received various forms of technical assistance.
18 municipalities and 2 public places received technical assistance and/or professional development to support them in developing, revising, and implementing tobacco-related ordinances, policies, or resolutions. Approximately 58,228 residents live in these municipalities. As a result, 8 municipalities and 2 public places adopted tobacco-related ordinances, policies, or resolutions. Approximately 26,840 residents live in these municipalities/tribal governments.
8 Sidekicks training sessions were held to educate adult advisors and youth about respectfully talking with youth or their peers about tobacco use. A total of 28 people attended these trainings.
ELIMINATE INVOLUNTARY EXPOSURE TO SECONDHAND SMOKE
25 clinical sites, 55 housing properties, 6 higher education institutions, and 3 lodgings received technical assistance to support them in developing, revising, and implementing policies that prohibit the use of tobacco products and create smoke-free environments. As a result, 17 clinical sites, 1 higher education institution, and 15 housing properties adopted tobacco/smoke-free policies.
95 workplaces received technical assistance to support the development, revision, and implementation of workplace tobacco policies. This included 21 school districts, 6 higher education institutions, 22 clinical sites, 18 employers, and 29 youth-serving entities. As a result, 55 workplaces adopted tobacco policies for employees. This included 9 school districts, 1 higher education institution, 17 clinical sites, 10 employers, and 18 youth-serving entities.

[40] This data includes 2017-2020. The data was not collected in 2016-2017.

In addition, with expanded funding that began in 2019, a total of 9 employers met the Maine Tobacco-Free Workplace Criteria.
16 clinical sites and 1 higher education institution achieved Gold or Platinum levels of Gold Star Standards of Excellence programs.
PROMOTE TOBACCO TREATMENT AMONG ADULTS
9 training sessions were held with non-clinical organizations on tobacco use and treatment, and promotion of the Maine QuitLink and Sidekicks training. A total of 151 people attended these trainings.
10 social service agencies and 1 animal welfare agency received technical assistance to promote the Maine QuitLink.
YOUTH ENGAGEMENT AND EMPOWERMENT
Technical assistance was provided to 93 local organizations to support holistic prevention efforts targeting youth.
11 trainings were held with 183 adults and 157 youth on a variety of topics, including: building the capacity of adult advisors in holistic prevention and engagement with youth and restorative practices.
3 Youth Policy Boards were active and focused on bullying/harassment prevention or a combination of focus areas. 17 Youth Engagement Groups were active and focused on bullying/harassment prevention, youth substance use prevention, or a combination of focus areas. In addition, 20 youth engagement groups were referred for or received training on restorative practices, Sidekicks, Sources of Strength, and/or general MYAN training.
CREATE HEALTHIER SCHOOL ENVIRONMENTS TO PREVENT OBESITY
To support school districts in developing, revising, and implementing their wellness policies, staff in 8 school districts with 11,704 students received professional development and staff in 19 school districts with 18,854 students received technical assistance. As a result, 7 school districts adopted revised policies that are compliant with the Healthy Hunger-Free Kids Act of 2010. Approximately 8,742 students attend this school.
25 school cafeterias received recognition for the Smarter Lunchroom Scorecards' values on healthier food environments. The cafeterias are situated in 5 school districts. Approximately 9,309 students attend schools in these districts
7 schools in 5 school districts achieved the Gold level of Let's Go!'s recognition program. Approximately 1,840 students attend these schools.
CREATE HEALTHIER EARLY CARE AND EDUCATION ENVIRONMENTS TO PREVENT OBESITY
59 early care and education sites registered with Let's Go! to promote healthy environments among young children. These sites have a licensed capacity to serve 1,966 children. As a result, 45 early care and education sites achieved the Gold level of Let's Go!'s recognition program. These sites have a licensed capacity to serve 1,387 children.

Domain 1: Substance Use Prevention	Bangor Public Health and Community Services www.bangorpublichealth.org/
	Northern Light Mayo Hospital www.northernlighthealth.org/Mayo
Domain 2: Tobacco Use and Exposure Prevention	Bangor Public Health and Community Services www.bangorpublichealth.org/
Domain 3: Youth Engagement and Empowerment	Penquis Community Action Program www.penquis.org/
Domain 4: Mass-Reach Health Communications	Rinck Advertising www.rinckadvertising.com/
Domain 5: Obesity Prevention	Bangor Public Health and Community Services www.bangorpublichealth.org/
	Northern Light Mayo Hospital www.northernlighthealth.org/Mayo

This summary highlights activities that took place within the Tribal Public Health District during all five years of the MPS Initiative. Please refer to domain-specific websites and reports for more information.

Prevent and Reduce Youth and Young Adults Use of Alcohol, Marijuana, and Misuse of Prescription Drugs

1 community partner taught Prime for Life® Universal classes to individuals who may consider making high-risk choices regarding substance use or misuse.

1 sub-recipient participated in drug take-back efforts, with a total of 234 pounds of drugs collected.[41] In addition, 1 sub-recipient implemented the Safe Storage in Homes intervention, through which Mainers were reached 1,303 times throughout the MPS Initiative.

Prevent Youth and Young Adults from Tobacco Use Initiation

1 school district and 13 youth-serving entities received technical assistance and/or professional development to support them in developing, revising, and implementing their policies to align with the Maine Tobacco-Free School Policy Criteria or Maine Tobacco-Free Child Care Policy Criteria. Approximately 770 students attend these schools.

As a result, 2 youth-serving entities met the Maine Tobacco-Free Child Care Policy Criteria for their tobacco policies. Approximately 440 youth are served by these entities.

With expanded funding that began in 2019, a total of 1 school district and 2 youth-serving entities also received enhanced technical assistance to support them in developing, revising, and implementing their tobacco policies. 93 students attend schools in this district and 140 youth are served by these youth-serving entities. In addition, 4 Sidekicks groups received various forms of technical assistance.

4 municipalities/tribal governments and 4 public places received technical assistance and/or professional development to support them in developing, revising, and implementing tobacco-related ordinances, policies or resolutions. Approximately 2,002 residents live in these municipalities.

2 Sidekicks training sessions were held to educate adult advisors and youth about respectfully talking with youth or their peers about tobacco use. A total of 5 people attended these trainings.

Eliminate Involuntary Exposure to Secondhand Smoke

9 clinical sites and 6 housing properties received technical assistance to support them in developing, revising, and implementing policies that prohibit the use of tobacco products and create smoke-free environments.

As a result, 1 clinical site and 2 housing properties adopted tobacco/smoke-free policies.

23 workplaces received technical assistance to support the development, revision, and implementation of workplace tobacco policies. This included 1 school district, 7 clinical sites, 2 employers, and 13 youth-serving entities.

As a result, 4 workplaces adopted tobacco policies for employees. This included 1 school district and 3 youth-serving entities.

1 clinical site achieved Gold or Platinum level of Gold Star Standards of Excellence programs

Promote Tobacco Treatment Among Adults

1 training session was held with non-clinical organizations on tobacco use and treatment. A total of 2 people attended this training.

3 social service agencies received technical assistance to promote the Maine QuitLink.

[41] This data includes 2017-2020. The data was not collected in 2016-2017.

YOUTH ENGAGEMENT AND EMPOWERMENT
21 trainings were held with 73 adults and 244 youth on a variety of topics, including: building the capacity of adult advisors in holistic prevention and engagement with youth; social emotional learning competencies; and best practices of strength-based partnerships with youth.
2 Youth Policy Boards were active and focused on youth substance use or a combination of focus areas. 8 Youth Engagement Groups were active and focused on a combination of focus areas. In addition, 8 Youth Engagement Groups were referred for or received training on restorative practices, Sidekicks, Sources of Strength, and/or general MYAN training.
Technical assistance was provided to 27 local organizations to support holistic prevention efforts targeting youth.
CREATE HEALTHIER SCHOOL ENVIRONMENTS TO PREVENT OBESITY
To support school districts in developing, revising, and implementing their wellness policies, staff in 1 school district with 629 students received professional development and staff in 1 school district with 637 students received technical assistance.
CREATE HEALTHIER EARLY CARE AND EDUCATION ENVIRONMENTS TO PREVENT OBESITY
4 early care and education sites registered with Let's Go! to promote healthy environments among young children. These sites have a licensed capacity to serve 97 children.

Domain 1: Substance Use Prevention	Wabanaki Public Health and Wellness[42] www.wabanakiphw.org
Domain 2: Tobacco Use and Exposure Prevention	Wabanaki Public Health and Wellness www.wabanakiphw.org
Domain 3: Youth Engagement and Empowerment	Wabanaki Public Health and Wellness www.wabanakiphw.org
Domain 4: Mass-Reach Health Communications	Rinck Advertising www.rinckadvertising.com/
Domain 5: Obesity Prevention	Wabanaki Public Health and Wellness www.wabanakiphw.org

[42] Wabanaki Public Health and Wellness was a Substance Use Prevention partner from 2016 to June 2021.

This summary highlights activities that took place within the Western Public Health District during all five years of the MPS Initiative. Please refer to domain-specific websites and reports for more information.

Prevent and Reduce Youth and Young Adults Use of Alcohol, Marijuana, and Misuse of Prescription Drugs

3 community partners taught Prime for Life® Universal classes to individuals who may consider making high-risk choices regarding substance use or misuse. In addition, 1 Student Intervention Reintegration Program (SIRP) courses were taught to help youth engaging in at-risk behavior to make healthier choices.

16 Responsible Beverage Seller / Service Trainings were conducted. Through these trainings, 17,721 individuals were reached. In addition, 22 law enforcement details were implemented in Western Public Health District.

3 sub-recipients participated in drug take-back efforts, with a total of 22,321 pounds of drugs collected[43]. In addition, 3 sub-recipients implemented the Safe Storage in Homes intervention, through which Mainers were reached 212,612 times throughout the MPS Initiative.

6 trainings were conducted to change the social norms around youth substance use.

Prevent Youth and Young Adults from Tobacco Use Initiation

16 school districts and 80 youth-serving entities received technical assistance and/or professional development to support them in developing, revising, and implementing their policies to align with the Maine Tobacco-Free School Policy Criteria or Maine Tobacco-Free Child Care Policy Criteria. Approximately 28,608 students attend these schools.

As a result, 6 school districts met the Maine Tobacco-Free School Policy Criteria for their tobacco policies. Approximately 11,211 students attend schools in these districts. In addition, 42 youth-serving entities met the Maine Tobacco-Free Child Care Policy Criteria for their tobacco policies. Approximately 27,266 youth are served by these entities.

With expanded funding that began in 2019, a total of 9 school districts and 7 youth-serving entities also received enhanced technical assistance to support them in developing, revising, and implementing their tobacco policies. 17,900 students attend schools in these districts and 1,796 youth are served by these youth-serving entities. In addition, 22 tobacco retailers received technical assistance on adherence to Maine's Tobacco Retailer Laws and 19 Sidekicks groups received various forms of technical assistance.

51 municipalities and 6 public places received technical assistance and/or professional development to support them in developing, revising, and implementing tobacco-related ordinances, policies, or resolutions. Approximately 164,983 residents live in these municipalities.

As a result, 17 municipalities and 2 public places adopted tobacco-related ordinances, policies, or resolutions. Approximately 85,159 residents live in these municipalities/tribal governments.

35 Sidekicks training sessions were held to educate adult advisors and youth about respectfully talking with youth or their peers about tobacco use. A total of 343 people attended these trainings.

Eliminate Involuntary Exposure to Secondhand Smoke

50 clinical sites, 101 housing properties, 6 higher education institutions, and 28 lodgings received technical assistance to support them in developing, revising, and implementing policies that prohibit the use of tobacco products and create smoke-free environments.

As a result, 11 clinical sites, 29 housing properties, and 4 lodgings adopted tobacco/smoke-free policies.

163 workplaces received technical assistance to support the development, revision, and implementation of workplace tobacco policies. This included 16 school districts, 4 higher education institutions, 30 clinical sites, 33 employers, and 79 youth-serving entities.

As a result, 72 workplaces adopted tobacco policies for employees. This included 7 school districts, 1 higher education institution, 6 clinical sites, 13 employers, and 45 youth-serving entities.

[43] This data includes 2017-2020. The data was not collected in 2016-2017.

In addition, with expanded funding that began in 2019, a total of 13 employers met the Maine Tobacco-Free Workplace Criteria.
7 clinical sites, and 1 higher education institution achieved Gold or Platinum levels of Gold Star Standards of Excellence programs.
PROMOTE TOBACCO TREATMENT AMONG ADULTS
35 training sessions were held with non-clinical organizations on tobacco use and treatment, and promotion of the Maine QuitLink and Sidekicks training. A total of 256 people attended these trainings.
15 social service agencies and 16 animal welfare agencies received technical assistance to promote the Maine QuitLink.
YOUTH ENGAGEMENT AND EMPOWERMENT
7 trainings were held with 70 adults and 63 youth on a variety of topics, including: building the capacity of adult advisors in holistic prevention and engagement with youth and network building.
3 Youth Policy Boards were active and focused on bullying/harassment prevention. 16 Youth Engagement Groups were active and focused on bullying/harassment prevention, adolescent mental health, or a combination of focus areas. In addition, 15 Youth Engagement Groups were referred for or received training on restorative practices, Sidekicks, Sources of Strength, and/or general MYAN training.
Technical assistance was provided to 72 local organizations to support holistic prevention efforts targeting youth.
CREATE HEALTHIER SCHOOL ENVIRONMENTS TO PREVENT OBESITY
To support school districts in developing, revising, and implementing their wellness policies, staff in 9 school districts with 12,338 students received professional development and staff in 19 school districts with 29,778 students received technical assistance. As a result, 4 school districts adopted revised policies that are compliant with the Healthy Hunger-Free Kids Act of 2010. Approximately 5,927 students attend these schools.
76 school cafeterias received recognition for the Smarter Lunchroom Scorecards' values on healthier food environments. The cafeterias are situated in 18 school districts. Approximately 28,515 students attend schools in these districts
14 schools in 7 school districts achieved the Gold level of Let's Go!'s recognition program. Approximately 3,667 students attend these schools.
CREATE HEALTHIER EARLY CARE AND EDUCATION ENVIRONMENTS TO PREVENT OBESITY
106 early care and education sites registered with Let's Go! to promote healthy environments among young children. These sites have a licensed capacity to serve 3,268 children. As a result, 75 early care and education sites achieved the Gold level of Let's Go!'s recognition program. These sites have a licensed capacity to serve 2,838 children.

Domain 1: Substance Use Prevention	Healthy Androscoggin www.healthyandroscoggin.org/
	Healthy Community Coalition www.mainehealth.org/franklin-community-health-network/healthy-communities
	Healthy Oxford Hills www.healthyoxfordhills.org/
Domain 2: Tobacco Use and Exposure Prevention	Healthy Androscoggin www.healthyandroscoggin.org/
	Healthy Community Coalition www.mainehealth.org/franklin-community-health-network/healthy-communities
	Healthy Oxford Hills www.healthyoxfordhills.org/
Domain 3: Youth Engagement and Empowerment	Healthy Community Coalition www.mainehealth.org/franklin-community-health-network/healthy-communities
Domain 4: Mass-Reach Health Communications	Rinck Advertising www.rinckadvertising.com/
Domain 5: Obesity Prevention	Healthy Androscoggin www.healthyandroscoggin.org/
	Franklin Community Health Network www.mainehealth.org/franklin-community-health-network
	Healthy Oxford Hills www.healthyoxfordhills.org/

This summary highlights activities that took place within the York Public Health District during all five years of the MPS Initiative. Please refer to domain-specific websites and reports for more information.

PREVENT AND REDUCE YOUTH AND YOUNG ADULTS USE OF ALCOHOL, MARIJUANA, AND MISUSE OF PRESCRIPTION DRUGS
2 community partners taught Prime for Life® Universal classes to individuals who may consider making high-risk choices regarding substance use or misuse. In addition, 36 Student Intervention Reintegration Program (SIRP) courses were taught to help youth engaging in at-risk behavior to make healthier choices. The SIRP courses reached 161 individuals.
17 Responsible Beverage Seller / Service Trainings were conducted. Through these trainings, 18,089 individuals were reached. In addition, 3 law enforcement details were implemented in York Public Health District.
3 sub-recipients participated in drug take-back efforts, with a total of 14,561 pounds of drugs collected.[44] In addition, 3 sub-recipients implemented the Safe Storage in Homes intervention, through which Mainers were reached 379,097 times throughout the MPS Initiative.
65 trainings were conducted to change the social norms around youth substance use.
PREVENT YOUTH AND YOUNG ADULTS FROM TOBACCO USE INITIATION
12 school districts and 46 youth-serving entities received technical assistance and/or professional development to support them in developing, revising, and implementing their policies to align with the Maine Tobacco-Free School Policy Criteria or Maine Tobacco-Free Child Care Policy Criteria. Approximately 24,062 students attend these schools. As a result, 4 school districts met the Maine Tobacco-Free School Policy Criteria for their tobacco policies. Approximately 8,235 students attend schools in these districts. In addition, 31 youth-serving entities met the Maine Tobacco-Free Child Care Policy Criteria for their tobacco policies. Approximately 2,305 youth are served by these entities. With expanded funding that began in 2019, a total of 8 school districts and 8 youth-serving entities also received enhanced technical assistance to support them in developing, revising, and implementing their tobacco policies. 17,677 students attend schools in these districts and 127 youth are served by these youth-serving entities. In addition, 4 tobacco retailers received technical assistance on adherence to Maine's Tobacco Retailer Laws and 12 Sidekicks groups received various forms of technical assistance.
16 municipalities and 27 public places received technical assistance and/or professional development to support them in developing, revising, and implementing tobacco-related ordinances, policies, or resolutions. Approximately 144,568 residents live in these municipalities. As a result, 4 municipalities and 3 public places adopted tobacco-related ordinances, policies, or resolutions. Approximately 30,975 residents live in these municipalities/tribal governments.
14 Sidekicks training sessions were held to educate adult advisors and youth about respectfully talking with youth or their peers about tobacco use. A total of 92 people attended these trainings.
ELIMINATE INVOLUNTARY EXPOSURE TO SECONDHAND SMOKE
15 clinical sites, 82 housing properties, 3 higher education institutions, and 6 lodgings received technical assistance to support them in developing, revising, and implementing policies that prohibit the use of tobacco products and create smoke-free environments. As a result, 6 clinical sites, 57 housing properties, 1 higher education institution, and 3 lodging establishments adopted tobacco/smoke-free policies.
112 workplaces received technical assistance to support the development, revision, and implementation of workplace tobacco policies. This included 12 school districts, 3 higher education institutions, 8 clinical sites, 43 employers, and 46 youth-serving entities.

[44] This data includes 2017-2020. The data was not collected in 2016-2017.

As a result, 54 workplaces adopted tobacco policies for employees. This included 4 school districts, 4 clinical sites, 15 employers, and 31 youth-serving entities

In addition, with expanded funding that began in 2019, a total of 15 employers met the Maine Tobacco-Free Workplace Criteria.

2 clinical sites and 1 higher education institution achieved Gold or Platinum levels of Gold Star Standards of Excellence programs.

Promote Tobacco Treatment Among Adults

2 training sessions were held with non-clinical organizations on tobacco use and treatment, and promotion of the Maine QuitLink. A total of 15 people attended these trainings.

6 social service agencies and 9 animal welfare agencies received technical assistance to promote the Maine QuitLink.

Youth Engagement and Empowerment

Technical assistance was provided to 88 local organizations to support holistic prevention efforts targeting youth.

52 trainings were held with 302 adults and 817 youth on a variety of topics, including: commercial tobacco and ENDS use prevention; restorative practices; and youth or adult skill-building competencies.

2 Youth Policy Boards were active and focused on a bullying/harassment prevention or a combination of focus areas. 16 Youth Engagement Groups were active and focused on youth substance use prevention, educational access/equity, or a combination of focus areas. In addition, 16 Youth Engagement Groups were referred for or received training on restorative practices, Sidekicks, Sources of Strength, and/or general MYAN training.

Create Healthier School Environments to Prevent Obesity

To support school districts in developing, revising, and implementing their wellness policies, staff in 11 school districts with 22,693 students received professional development and staff in 13 school districts with 25,073 students received technical assistance.

As a result, 2 school districts adopted revised policies that are compliant with the Healthy Hunger-Free Kids Act of 2010. Approximately 1,293 students attend these schools.

52 school cafeterias received recognition for the Smarter Lunchroom Scorecards' values on healthier food environments. The cafeterias are situated in 13 school districts. Approximately 24,354 students attend schools in these districts.

21 schools in 8 school districts achieved the Gold level of Let's Go!'s recognition program. Approximately 8,892 students attend these schools.

Create Healthier Early Care and Education Environments to Prevent Obesity

103 early care and education sites registered with Let's Go! to promote healthy environments among young children. These sites have a licensed capacity to serve 3,597 children.

As a result, 84 early care and education sites achieved the Gold level of Let's Go!'s recognition program. These sites have a licensed capacity to serve 2,693 children.

Domain 1: Substance Use Prevention	Choose to Be Healthy www.facebook.com/choosetobehealthy/
	Coastal Healthy Communities Coalition www.une.edu/chcc
	Partners for Healthier Communities www.facebook.com/partnersforhealthiercommunities/
Domain 2: Tobacco Use and Exposure Prevention	Partners for Healthier Communities www.facebook.com/partnersforhealthiercommunities/
Domain 3: Youth Engagement and Empowerment	Partners for Healthier Communities www.facebook.com/partnersforhealthiercommunities/
Domain 4: Mass-Reach Health Communications	Rinck Advertising www.rinckadvertising.com/
Domain 5: Obesity Prevention	Southern Maine Health Care www.mainehealth.org/southern-maine-health-care

REFERENCES

American Psychological Association. (2014). *School Connectedness*. Retrieved from Programs and Projects: https://www.apa.org/pi/lgbt/programs/safe-supportive/school-connectedness

Baker, E. P. (2005). The Public Health Infrastructure and Our Nation's Health. *Annual Review of Public Health*. 303 - 18. doi: 10.1146/annurev.publhealth.26.021304.144647

Becker, W. F. (2020). When Epidemics Collide: Coronavirus Disease 2019 (COVID-19) and the Opioid Crisis. *Annals of Internal Medicine*.

Brown, T. F. (2014). Social Movements in Health. *Annual Review Public Health*, 385-98.

Campbell, P. C. (2005). Developing A Local Public Health Infrastructure: The Maine Turning Point Experience. *Public Health Management Practice*, 158-164.

Case, A. D. (2020). *Deaths of Despair and the Future of Capitalism .* Princeton, NJ: Princeton University Press.

Chazdon, S., Emery, M., Hansen, D., Higgins, L., & Sero, R. (2017). *A Field Guide to Ripple Effects Mapping.* Minneapolis: Libraries Publishing.

Columbia Mailman School of Public Health. (2021, March 8). *COVID-10 Lockdown Linked to Uptick in Tobacco Use*. Retrieved from Public Health Now: https://www.publichealth.columbia.edu/public-health-now/news/covid-19-lockdown-linked-uptick-tobacco-use

Cortez, C. M. (2021). Changes in Short-term, Long-term, and Preventive Care Delivery in US Office-Based and Telemedicine Visits During the COVID-19 Pandemic. *JAMA Health Forum*.

DeSalvo, K. H. (2021, April 7). *Public Health COVID Impact Assessment: Lessons Learned and Compelling Needs.* Retrieved from National Academy of Medicine: https://nam.edu/public-health-covid-19-impact-assessment-lessons-learned-and-compelling-needs/

Digital Public Library of America. (n.d.). *Influenza in Maine: 1918 Epidemic.* DigitalMaine Respository. Retrieved from https://digitalmaine.com/flu_1918/#

Frieden, T. (2014). Six Components Necessary for Effective Public Health Program Implementation. *American Journal of Public Health*, 17 -22.

Institute of Medicine (US) Committee for the Study of the Future of Public Health. (1988). *The Future of Public Health.* Washington (DC): National Academies Press (US).

Institute of Medicine (US) Committee on Assuring the Health of the Public in the 21st Century. (2002). *The Future of the Public's Health in the 21st Century.* The Governmental Public Health Infrastructure. Washington (DC): National Academies Press (US). Retrieved from https://www.ncbi.nlm.nih.gov/books/NBK221231/

Institute of Medicine. (2003). *The Future of the Public's Health in the 21st Century.* Washington, DC: National Academies Press.

Lange, S., Kompaniyets, L., Freedman, D., Kraus, E., Porter, R., Blanck, H., & Goodman, A. (2021). Longitudinal Trends in Body Mass Index Beofre and During COVID-19 Pandemic Among Persons Aged 2-19 Years - United States, 2018-2020. *Morbidity and Mortality Weekly Report, 70*(37), 1278 - 1283.

Lavinghouze, S. R. (2014). The Component Model of Infrastructure: A Practical Approach to Understanding Public Health Program Infrastructure. *American Journal of Public Health*, e14-e24.

Lavinghouze, S. R. (2013). Consideration of an Applied Model of Public Health Program Infrastructure. *Journal of Public Health Management Practice*, E28-E37.

Maine Center for Disease Control & Prevention. (2022). *Division of Public Health Systems*. Retrieved from Local Public Health Districts: https://www.maine.gov/dhhs/mecdc/public-health-systems/lphd/index.shtml

MaineHealth Let's Go! (n.d.). *What to Know About Recreational Screen Time.* MaineHealth Let's Go! Retrieved from https://www.mainehealth.org/-/media/Lets-Go/Files/Childrens-Program/Tools/What-to-Know-About-Recreational-Screen-Time.pdf

Maine Public Health Assocation. (n.d.). *Public Health Infrastructure Member Section*. Retrieved from Maine's Governmental Public Health System: https://mainepublichealth.org/membership/membership-committees/public-health-infrastructure-member-section/

Maine Public Health Association. (2021). *Substance Use In Maine: Increased Concerns with COVID-19 Impacts.* Maine Public Health Association. Retrieved from https://mainepublichealth.org/wp-content/uploads/2021/06/MPHA-Substance-Use-and-COVID_Final.pdf

MIYHS. (2009). *Maine Integrated Youth Health Survey.* Augusta: Maine Center for Disease Control and Prevention.

MIYHS. (2015). *Maine Integrated Youth Health Survey.* Augusta: Maine Center for Disease Control and Prevention.

MIYHS. (2017). *Maine Integrated Youth Health Survey.* Augusta: Maine Center for Disease Control and Prevention.

MIYHS. (2019). *Maine Integrated Youth Health Survey.* Augusta: Maine Center for Disease Control and Prevention.

National Public Health Performance Standards Program. (n.d.). *State Public Health System Performance Assessment: Model Standards (Version 2.0).* Atlanta, GA: Centers for Disease Control and Prevention.

Office of the State Economist. (2021). *Maine Population Outlook 2018 to 2028.* Augusta, ME: Maine Department of Administrative and Financial Services.

Oliver, T. (2006). The Politics of Public Health Policy. *Annual Review of Public Health*, 195-233.

Paul, C. (2019, December 31). A look back at 10 of the biggest social movements of the 2010s, and how they shaped Seattle. *The Seattle Times*.

Pleyers, G. (2020). The Pandemic is a Battlefield. Social Movements in the COVID-19 Lockdown. *Journal of Civil Society*, 295-312.

Remington, T. (2022). Inequality and Workforce Development in the post-COVID-19 Environment: The Case of Maine. *Economic and Political Studies*, 116-125.

Rural Health Information Hub. (2022). *Maine*. Retrieved from Rural Health Information Hub: https://www.ruralhealthinfo.org/states/maine#:~:text=Maine%20covers%2030%2C843%20square%20miles,Maine%20(USDA%2DERS).

Scheffert, D. (2020). *Social Capital and Our Community.* University of Minnesota Extension.

Sorg, M. L. (2022). *Maine Monthly Overdose Report For December 2021.* Portland, ME: Margaret Chase Smith Policy Center, University of Maine.

State of Childhood Obesity. (n.d.). *Impact of the COVID-19 Pandemic on Childhood Obesity.* State of Childhood Obesity. Retrieved from https://stateofchildhoodobesity.org/stories/impact-of-the-pandemic-on-childhood-obesity/

Substance Abuse and Mental Health Services Administration. (n.d.). *About Us*. Retrieved from SAMHSA: https://www.samhsa.gov/about-us

U.S. Census Bureau. (n.d.). *QuickFacts Maine*. Retrieved from United States Census Bureau: https://www.census.gov/quickfacts/ME

U.S. Centers for Disease Control and Prevention. (2017). *Best Practices User Guide: Program Infrastructure in Tobacco Prevention and Control.* Atlanta, GA: US Department of Health and Human Services, Centers for Diseases Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health.

U.S. Centers for Disease Control and Prevention. (2022, March 31). *CDC Newsroom*. Retrieved from New CDC Data Illuminate Youth Mental Health Threats during the COVID-19 Mandemic: https://www.cdc.gov/media/releases/2022/p0331-youth-mental-health-covid-19.html

U.S. Department of Health & Human Services. (2021, March 18). *Public Health Systems & Best Practices: 10 Essential Public Health Services*. Retrieved from Centers for Disease Control and Prevention: https://www.cdc.gov/publichealthgateway/publichealthservices/essentialhealthservices.html

U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. (n.d.). *National Survey on Drug Use and Health - Maine (2011/2012 - 2018/2019).* Rockville, MD: Sustance Abuse and Mental Health Services Administration.

U.S. Food and Drug Administration. (2022). *E-Cigarettes, Vapes, and other Electronic Nicotine Delivery Systems (ENDS).* Retrieved from https://www.fda.gov/tobacco-products/products-ingredients-components/e-cigarettes-vapes-and-other-electronic-nicotine-delivery-systems-ends

Van Dyke, N. T. (2019). The Cultural Outcomes of Social Movements. In D. S. Snow, *Companion to Social Movements* (pp. 482 - 498). John Wiley & Sons Ltd.

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