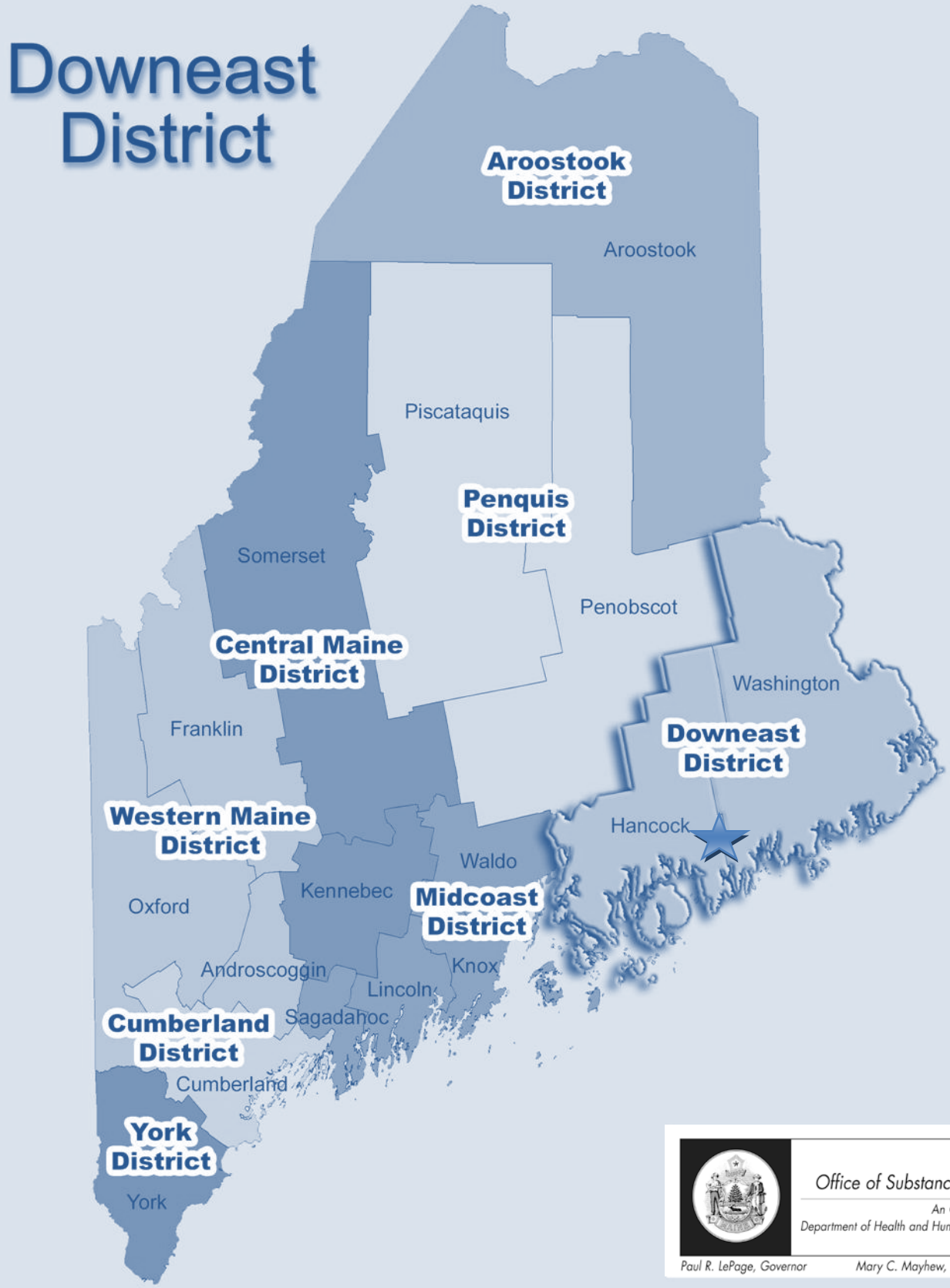
Substance Abuse Trends in Maine

Epidemiological Profile 2012



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

Paul R. LePage, Governor — Mary C. Mayhew, Commissioner

Substance Abuse Trends in Maine

Epidemiological Profile 2012

Downeast District

THIS REPORT IS PRODUCED FOR THE MAINE OFFICE OF SUBSTANCE ABUSE COMMUNITY EPIDEMIOLOGY SURVEILLANCE NETWORK WITH SUPPORT FROM THE STATE EPIDEMIOLOGICAL OUTCOMES WORKGROUP (SEOW) GRANT THROUGH THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES SUBSTANCE ABUSE AND MENTAL HEALTH ADMINISTRATION

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Introduction

Overview of Downeast Public Health District

Downeast Public Health District is comprised of two counties, Hancock and Washington, and has a population of 87,274 people. This represents approximately 6.6 percent of Maine's total population in 2010. Downeast is relatively rural with 21 people per square mile; Hancock has a higher number of persons per square mile than Washington County. Washington is the third most rural county in Maine. The State of Maine is considered an "aging" state, with 15.9 percent of the population being 65 years old and over, a higher rate than the overall US population (13%). In Downeast Public Health District, approximately 18.8% of the population is 65 years or older. The majority of the population in Downeast is Caucasian (95.1%). In 2010, 2.1 percent of the population in Downeast identified themselves as American Indian. Economically, the two counties within Downeast PHD differ greatly. In 2010, the median family income in Washington was $34,859 (the second-lowest in the state), whereas the median income in Hancock was $47,533 (the fifth-highest statewide). Just over 14 percent of the population in Downeast lives below the poverty level. Overall, Downeast PHD tends to be older and more rural compared to the rest of the state and varies greatly in terms of socioeconomic factors.

It is within the context of these demographic characteristics that substance abuse in Downeast Public Health District (PHD) must be examined.

Purpose of this Report

This report takes into account the primary objectives of the Office of Substance Abuse (OSA): to identify substance abuse patterns in defined geographical areas, establish substance abuse trends, detect emerging substances, and provide information for policy development and program planning. It also highlights all the prevention priorities identified in the OSA strategic plan: underage drinking, high-risk drinking, misuse of prescription drugs, and marijuana use. Finally, the report monitors many of the factors that contribute to substance use, such as access and perceptions of harm, as well as the common negative consequences such as crime, car crashes and overdose deaths.

This report includes data available through May 2012. Older and unchanged data are included when more recent data were not available. Five major types of indicators are included: self-reported substance consumption, consequences of substance use, factors contributing to substance use, indicators about mental health and substance abuse, and treatment admissions.

Previous county level reports with older trending data are available at the www.maineosa.org website.

Consumption of Substances

Consuming harmful substances can have detrimental effects on an individual's well-being, including increased risks of morbidity, addiction and mortality, and has a harmful effect on society as a whole including increased motor vehicle accidents and crime. However, it is the manner and frequency with which people drink, smoke and use drugs that are often linked to particular substance-related consequences. To fully understand the magnitude of substance use consequences, it is important to first understand the prevalence of substance use consumption itself. Consumption includes overall use of substances, the rate of acute or heavy consumption, and consumption by high-risk groups (e.g., youth, college students, pregnant women).

As demonstrated by the indicators below, alcohol remains the substance most often used by Downeast PHD residents across the lifespan. Alcohol and marijuana use among the youth and younger adults continues to be a concern. Downeast PHD made great gains in reducing underage drinking, marijuana use, prescription drugs, tobacco, and cocaine. Tobacco use appears to be slightly higher among high school students in Downeast PHD when compared to the rest of the state. Marijuana is the most commonly used drug in Maine and Downeast PHD is no different in this respect.

Alcohol

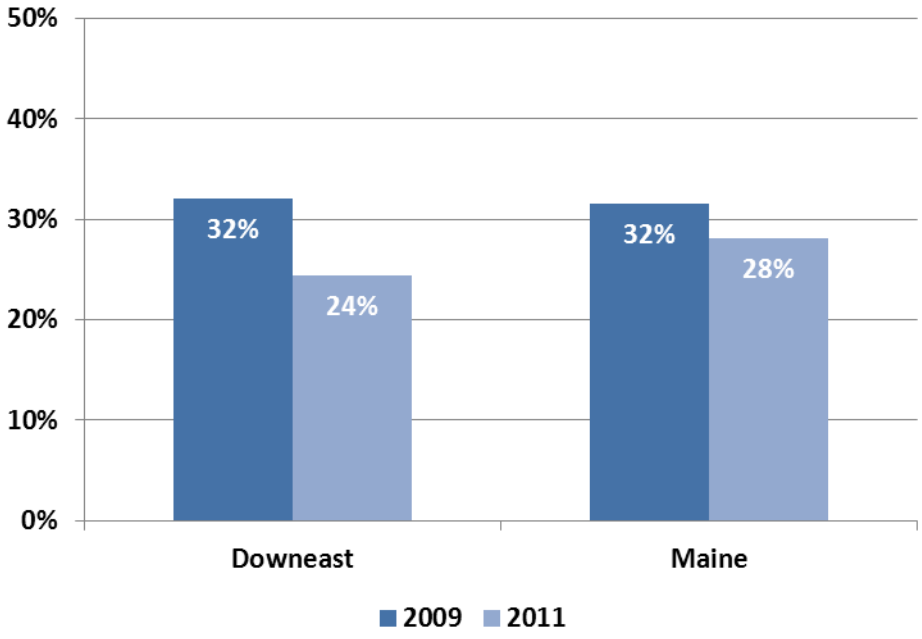
Indicator Description: ALCOHOL USE AMONG YOUTH. This measure shows the percentage of Maine high school students who reported having had one or more alcoholic drinks within 30 days prior to the survey.

Why Indicator is Important: Alcohol is the most often used substance among youth in Maine. In addition to the risks alcohol consumption carries for adults, developing adolescent brains are especially susceptible to the health risks of alcohol consumption. Adolescents who consume alcohol are more likely to have poor grades and be at risk for experiencing social problems, depression, suicidal thoughts, assault, and violence.

Data Source(s): MIYHS, 2009, 2011.

Summary: Almost one in four high school students in Downeast PHD (24%) reported having consumed one or more alcoholic beverages in the past 30 days in 2011. This is slightly lower than the statewide average.

Figure 1. Percent of high school students in Downeast PHD who had at least one drink of alcohol during past 30 days: 2009, 2011



Source: MIYHS

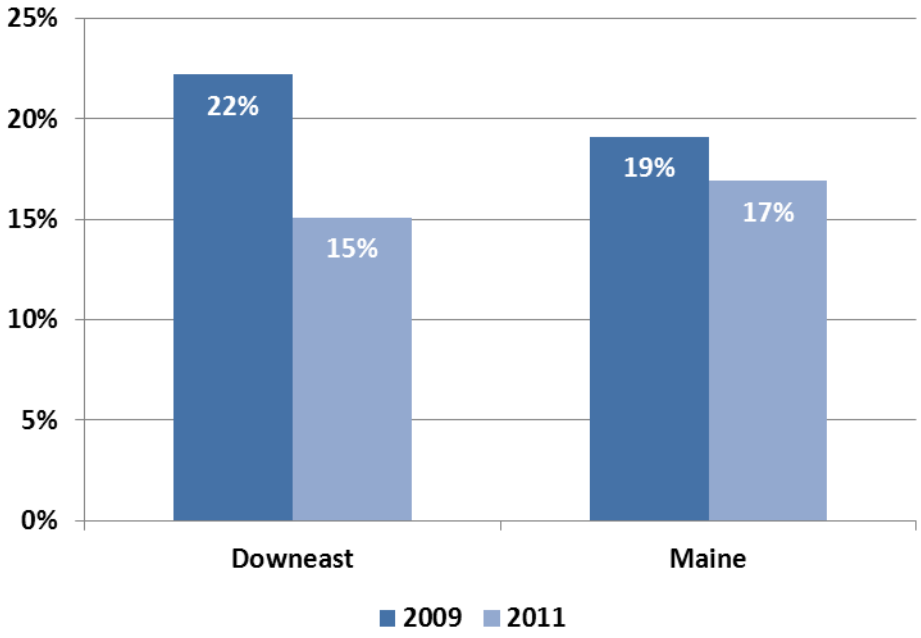
Indicator Description: HIGH-RISK ALCOHOL USE AMONG YOUTH. This indicator presents the percentage of Maine high school students who reported having had five or more alcoholic drinks in a row in one sitting at least once during the 30 days prior to the survey.

Why Indicator is Important: Youth are more likely than adults to engage in high-risk drinking when they consume alcohol. High-risk alcohol use contributes to violence and motor vehicle crashes and can result in negative health consequences for the consumer, including injuries and chronic liver disease. Youth who engage in high-risk drinking also are more likely to use drugs and engage in risky and antisocial behavior.

Data Source(s): MIYHS, 2009, 2011.

Summary: In 2011, almost one in seven high school students in Downeast PHD (15%) reported having consumed five or more alcoholic beverages in one sitting during the past 30 days. This is lower than the statewide average of 21 percent; and significantly lower than in 2009.

Figure 2. Percent of high school students in Downeast PHD who had at least five drinks in a row during past 30 days: 2009, 2011



Source: MIYHS

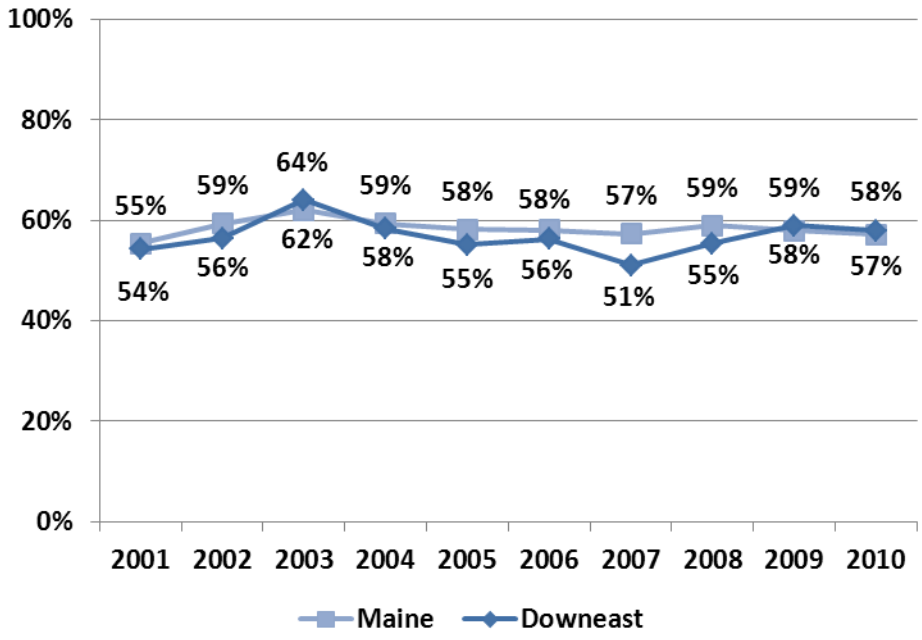
Indicator Description: ALCOHOL USE AMONG ADULTS. This indicator portrays the percentage of adults who reported having consumed one or more alcoholic drinks on one or more days within the past 30 days.

Why Indicator is Important: Alcohol is the most often used substance in Maine adults. Excessive and high-risk alcohol use may contribute to violence and result in many negative health consequences for the consumer. Moderate drinking can also have negative health effects and lead to such consequences as alcohol-related motor vehicle crashes and increased injuries. Current alcohol use in pregnant women is also linked to low birth weight babies, sudden infant death, and other developmental delays in children.

Data Source(s): BRFSS, 2001-2010.

Summary: In 2010, 58 percent of adults in Downeast PHD reported drinking at least one alcoholic beverage within the past 30 days, about the same as the statewide average of 57 percent. The rates in Downeast PHD have generally been lower than the state between 2004, and 2008, but climbed to 59 percent in 2009, making it similar to the statewide rate in 2009 and 2010.

Figure 3. Percent of adults in Downeast PHD who reported drinking during past 30 days: 2001-2010



Source: BRFSS

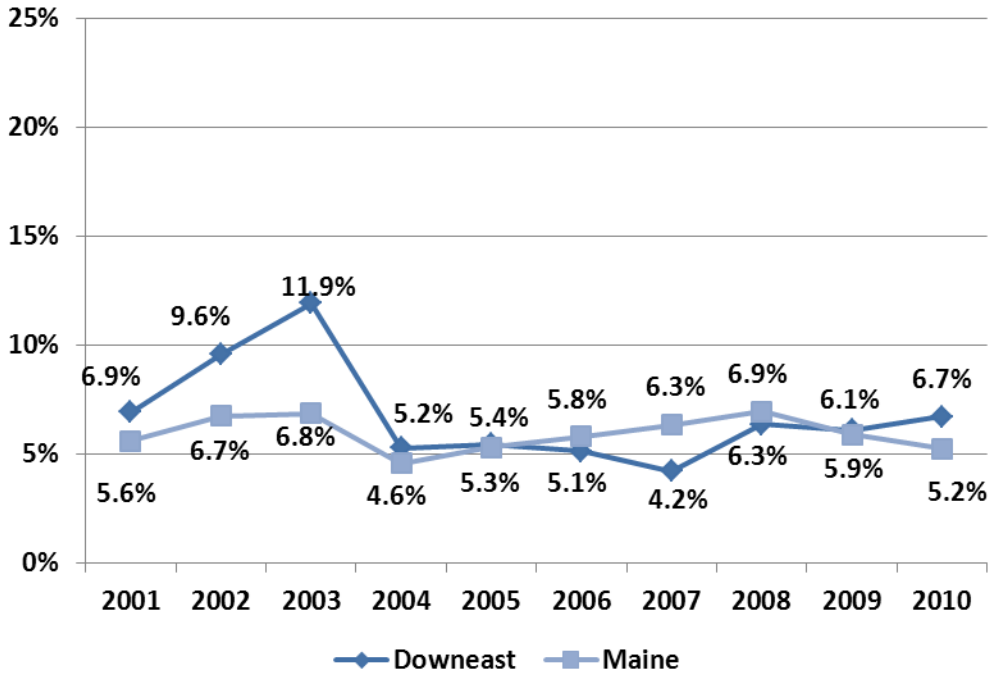
Indicator Description: HEAVY ALCOHOL USE AMONG ADULTS. This indicator examines the percentage of Maine residents who reported heavy drinking during the past 30 days. This is defined as two drinks per day for a man or one drink per day for a woman.

Why Indicator is Important: Heavy drinking is considered to be a type of high risk drinking, meaning it increases the risk for many health and social related consequences. People who consume alcohol heavily are at increased risk for a variety of negative health consequences, including alcohol abuse and dependence, liver disease, certain cancers, pancreatitis, heart disease, and death. It has also been found that the more heavily a person drinks the greater the potential for problems at home, work, and with friends.[1]

Data Source(s): BRFSS, 2001-2010.

Summary: In 2009, 6.7 percent of adults in Downeast PHD indicated they engaged in heavy drinking during the past 30 days, about the same as the statewide average. In 2004, heavy drinking rates in Downeast PHD dropped dramatically (from 11.9% to 5.2%) and remained lower till 2009, surpassing the state rate once again in 2010.

Figure 4. Percent of adults in Downeast PHD who reported heavy drinking during past 30 days: 2001-2010



Source: BRFSS

[1] Alcoholscreening.org, a service of Join Together and the Boston University School of Public Health. *Health Consequences of Excess Drinking.* Retrieved on 5/17/2012 from http://www.alcoholscreening.org/Learn-More.aspx?topicID=8&articleID=26

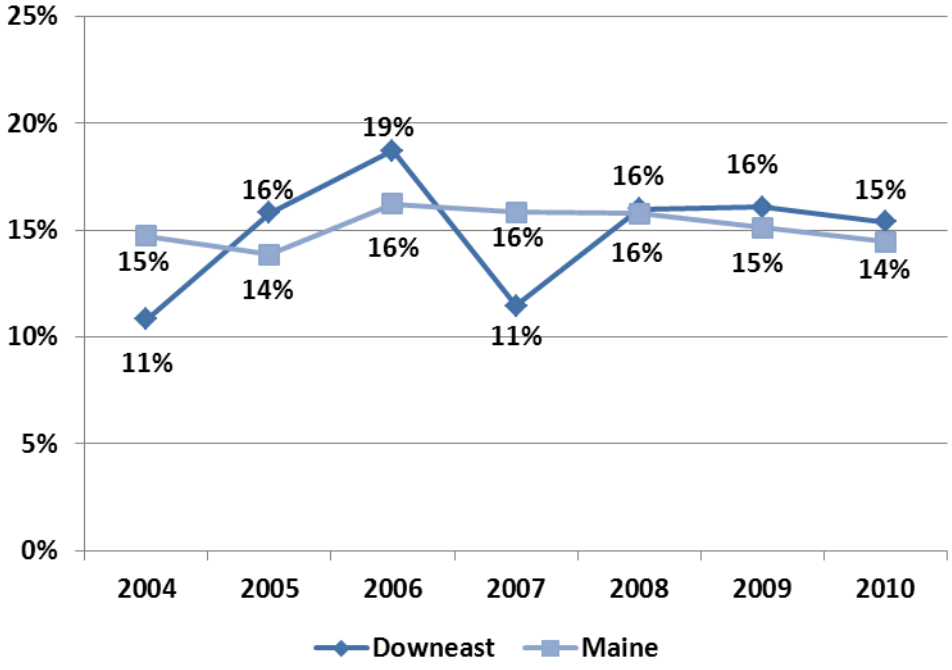
Indicator Description: HIGH-RISK ALCOHOL USE AMONG ADULTS. This indicator reflects the percentage of adults who reported engaging in high-risk "binge" drinking within the past 30 days. This is defined as five or more drinks in one sitting for a male and four or more drinks in one sitting for a female.

Why Indicator is Important: Binge drinking is considered to be a type of high-risk drinking, meaning it increases the risk for many health- and social-related consequences. It has been linked to injury (such as falls, fights, and suicides), violence, crime rates, motor vehicle crashes stroke, chronic liver disease, addiction, and some types of cancer.

Data Source(s): BRFSS, 2004-2010.

Summary: In 2010, 15 percent of adults in Downeast PHD indicated they engaged in binge drinking during the past 30 days, compared to the statewide average of 14 percent. The rate of binge drinking in Downeast has been similar to (although slightly higher than) the state rate in most years during this time period, excluding 2004, 2006, and 2007.

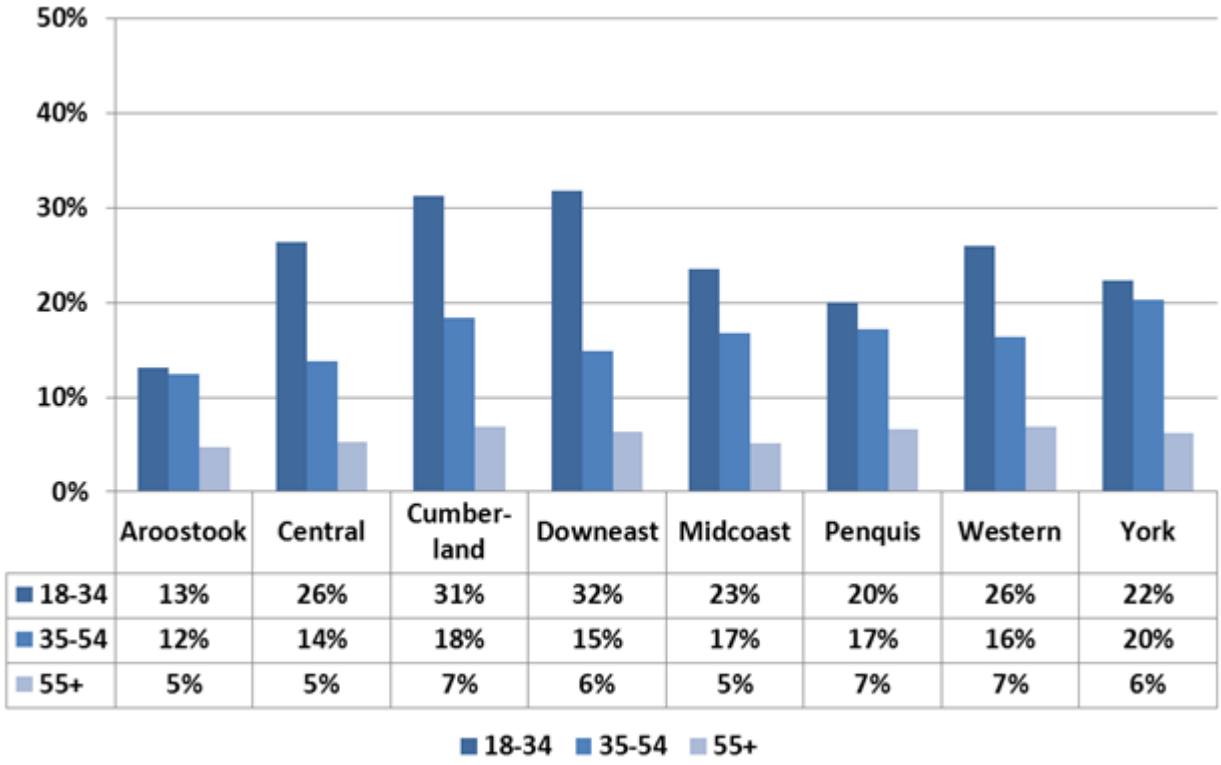
Figure 5. Percent of adults in Downeast PHD who reported binge drinking during past 30 days: 2004-2010



Source: BRFSS

Summary: In 2010, 32 percent of 18 to 34 year olds in Downeast PHD reported binge drinking in the past 30 days. This was higher than any other age group in Downeast PHD, as well as the highest reported for this age group among all PHDs.

Figure 6. Percent of adults by Public Health District who reported binge drinking in past 30 days by age group: 2009-2010[2]



	Aroostook	Central	Cumber-land	Downeast	Midcoast	Penquis	Western	York
18-34	13%	26%	31%	32%	23%	20%	26%	22%
35-54	12%	14%	18%	15%	17%	17%	16%	20%
55+	5%	5%	7%	6%	5%	7%	7%	6%

Source: BRFSS

[2] Data from years 2009 and 2010 were combined to make for a more stable estimate

Tobacco

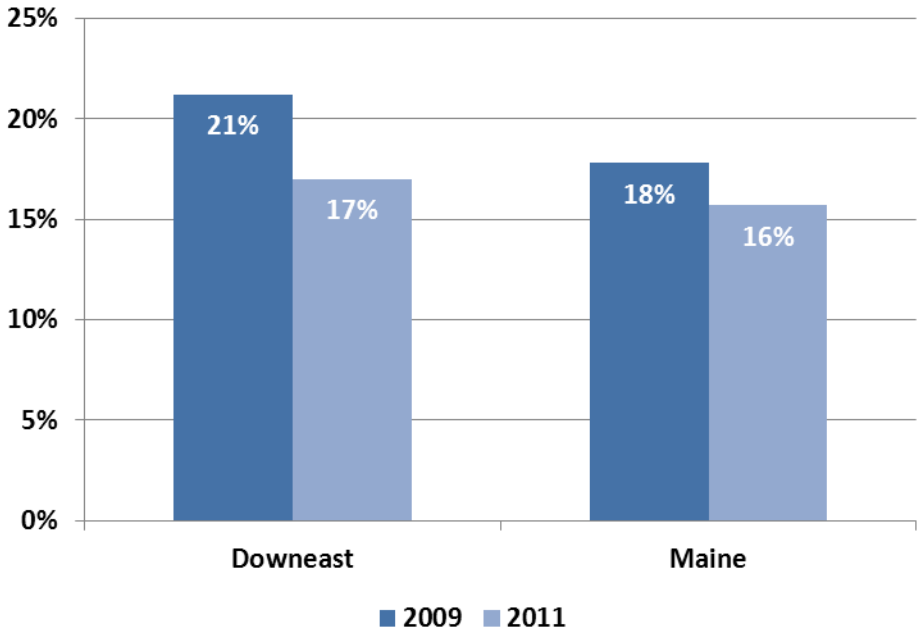
Indicator Description: SMOKING AMONG YOUTH. This indicator illustrates the percentage of Maine high school students who reported smoking a cigarette on at least one occasion within 30 days prior to the survey.

Why Indicator is Important: Use of tobacco is associated with a greater risk of negative health outcomes, including cancer, cardiovascular and chronic respiratory diseases, as well as death.

Data Source(s): MIYHS, 2009-2011.

Summary: In 2011, almost one in six high school students (17%) in Downeast PHD reported having smoked one or more cigarettes in the past 30 days. This is slightly higher than the state average (16%), but an improvement over the 2009 rate.

Figure 7. Percent of high school students in Downeast PHD who reported smoking one or more cigarettes during past 30 days: 2009, 2011



Source: MIYHS

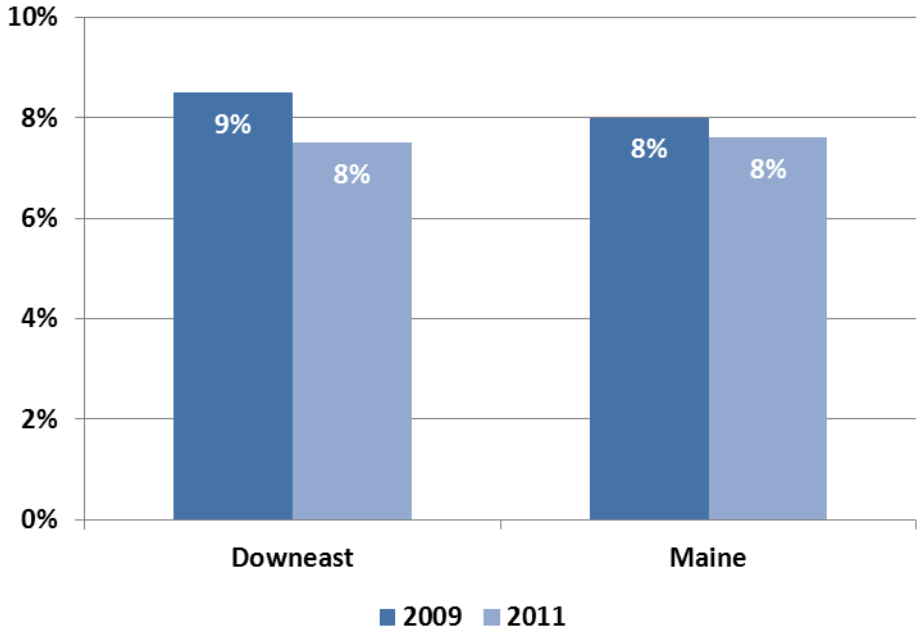
Indicator Description: SMOKELESS TOBACCO AMONG YOUTH. This indicator illustrates the percentage of Maine high school students who reported using smokeless tobacco on at least one occasion within 30 days prior to the survey.

Why Indicator is Important: Use of tobacco is associated with a greater risk of negative health outcomes, including cancer, cardiovascular and chronic respiratory diseases, as well as death.

Data Source(s): MIYHS, 2009-2011.

Summary: The percentage of high school students in Downeast PHD who report having used smokeless tobacco in the past 30 days is similar to the statewide average (8%).

Figure 8. Percent of high school students in Downeast PHD who used smokeless tobacco in the past 30 days: 2009, 2011



Source: MIYHS

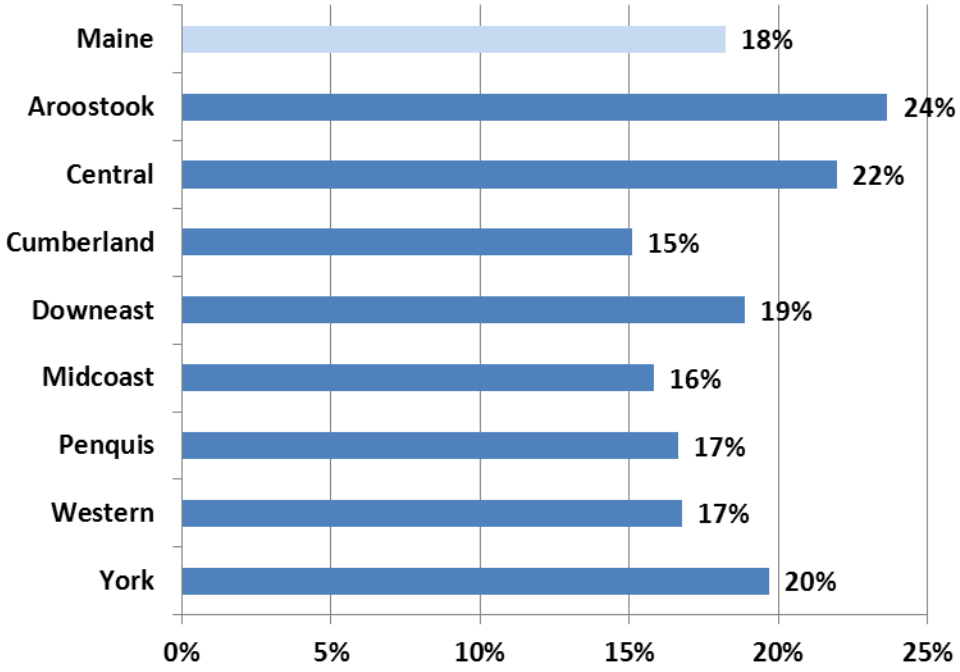
Indicator Description: SMOKING AMONG ADULTS. This indicator illustrates the percentage of Maine adults who reported using cigarettes on at least one occasion within 30 days prior to the survey.

Why Indicator is Important: Smoking is associated with a greater risk of negative health outcomes, including cancer, cardiovascular and chronic respiratory diseases, as well as death.

Data Source(s): BRFSS, 2010.

Summary: In 2010, 19 percent of adults in Downeast PHD indicated they had smoked a cigarette in the past 30 days, which is slightly higher than the statewide average of 18 percent; this represents a slight decrease from 2009, however.

Figure 9. Percent of adults by Public Health District who reporting smoking a cigarette in the past 30 days: 2010



Source: BRFSS

Prescription Drugs

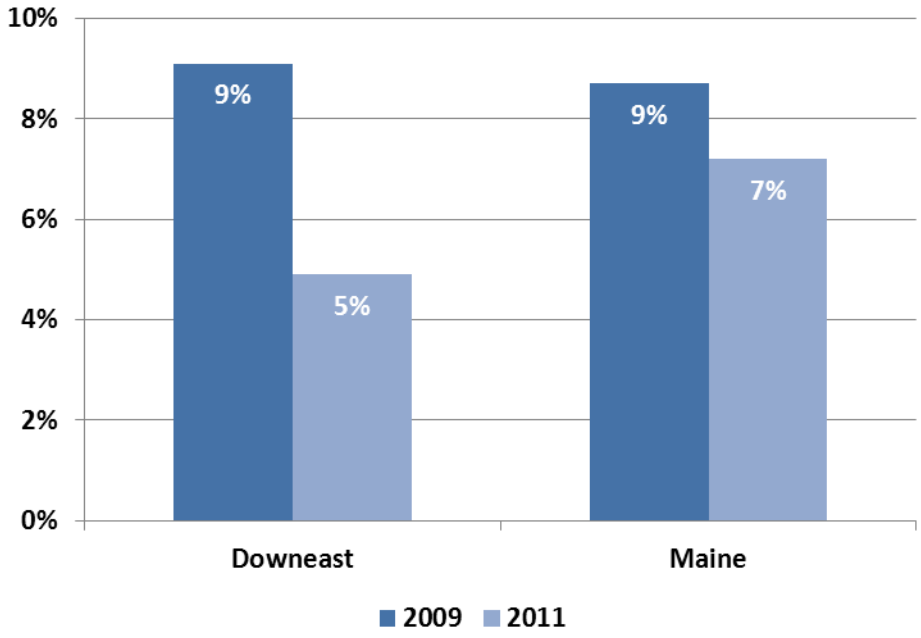
Indicator Description: MISUSE OF PRESCRIPTION DRUGS AMONG YOUTH. This indicator presents the percentage of Maine high school students who reported using prescription drugs that were not prescribed to them by a doctor within 30 days prior to the survey.

Why Indicator is Important: Young people are increasingly using available prescription drugs, including stimulants and opiates, instead of illegal drugs to get high. Abuse of prescription drugs may lead to consequences such as unintentional poisonings or overdose, automobile crashes, addiction, and increased crime.

Data Source(s): MIYHS, 2009-2011.

Summary: In 2011, five percent of high school students in Downeast PHD reported having taken prescription drugs not prescribed to them by a doctor one or more times in the past 30 days, compared to seven percent reporting similar activity statewide.

Figure 10. Percent of high school students in Downeast PHD who have taken prescription drugs not prescribed to them by a doctor in the past 30 days: 2009, 2011



Source: MIYHS

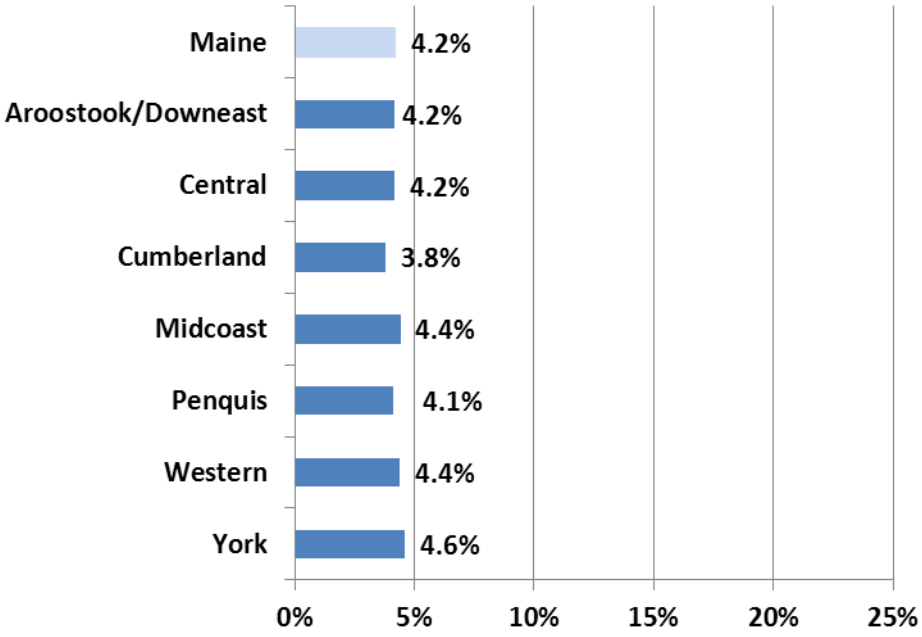
Indicator Description: NONMEDICAL USE OF PRESCRIPTION PAIN RELIEVERS AMONG MAINERS AGE 12 AND OLDER. This measure reflects the percentage of adults who reported using prescription drugs, particularly prescription pain relievers, for reasons other than their intended purpose. Because of small sample sizes, survey data from multiple years must be combined in order to produce this estimate.

Why Indicator is Important: Mainers are increasingly using available prescription drugs, particularly pain relievers, instead of illegal drugs to get high. Abuse of prescription drugs may lead to consequences such as unintentional poisonings, overdose, dependence and increased crime.

Data Source(s): NSDUH, 2006-08.

Summary: In 2006-08, 4.2 percent of people ages 12 and older in Aroostook and Downeast Public Health Districts[3] reported using prescription pain relievers for nonmedical purposes in the past year.

Figure 11. Percent of population 12 years old or older in Maine who used prescription pain relievers in past year for nonmedical use by Public Health District: 2006-2008



Source: NSDUH

[3] Due to small sample sizes, Aroostook and Downeast Public Health District (which consists of Washington County and Hancock County) were combined to produce this estimate.

Other Illegal Drugs

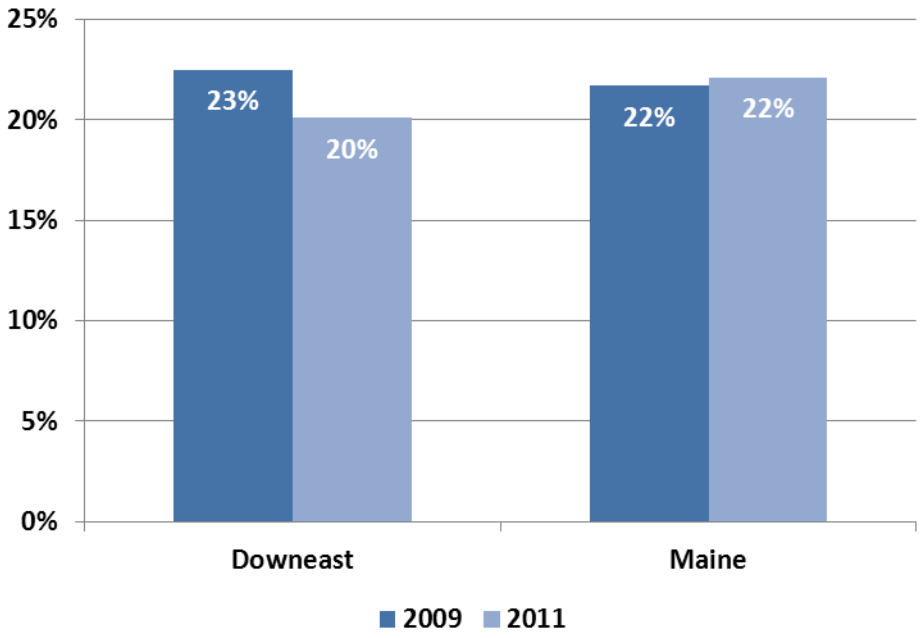
Indicator Description: CURRENT MARIJUANA USE. This measure shows the percentage of Maine residents who reported using marijuana in the past 30 days. This is presented for high school students and adults in Maine.

Why Indicator is Important: Marijuana can be addictive and is associated with increased risk for respiratory illnesses and memory impairment. Even occasional use can have consequences on learning and memory, muscle coordination, and mental health symptoms.

Data Source(s): MIYHS, 2009-2011; BRFSS, 2007, 2010.

Summary: Twenty percent (one in five) of high school students in Downeast PHD reported having used marijuana one or more times in the past 30 days compared to 22 percent statewide.

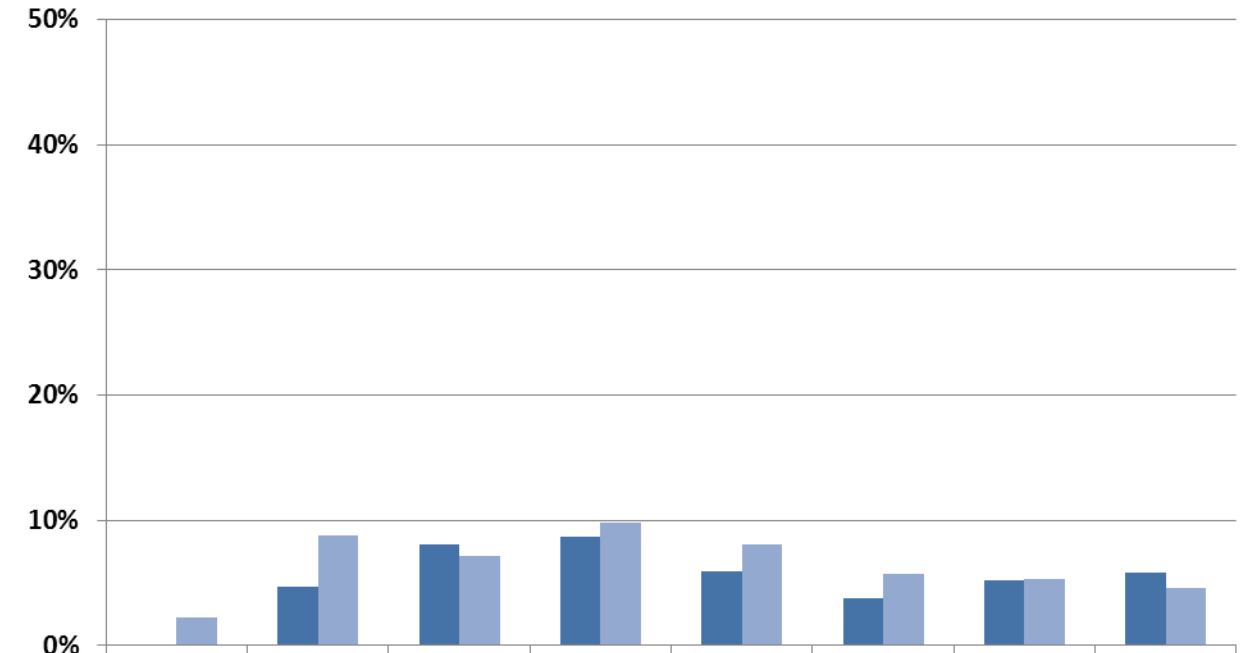
Figure 12. Percent of high school students in Downeast PHD who have used marijuana during past 30 days: 2009, 2011



Source: MIYHS

Summary: In 2010, two percent of adults in Downeast reported having used marijuana in the past 30 days. Due to the lack of respondents in 2007, adult rates for past-30 day marijuana use have been omitted.

Figure 13. Percent of adults in Downeast who have used marijuana during the past 30 days: 2007, 2010



	Aroostook	Central	Cumber-land	Downeast	Midcoast	Penquis	Western	York
2007	-	5%	8%	9%	6%	4%	5%	6%
2010	2%	9%	7%	10%	8%	6%	5%	5%

Source: BRFSS

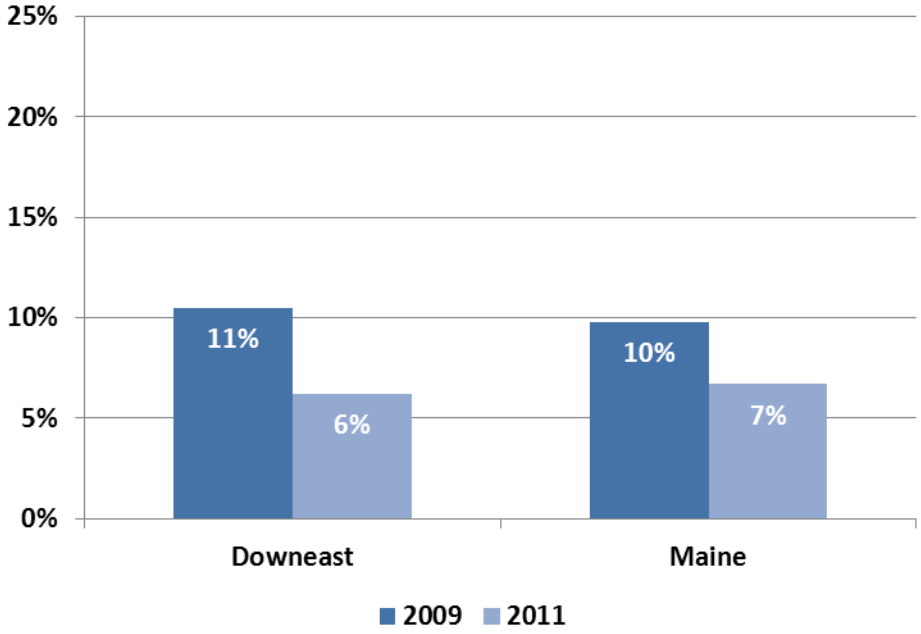
Indicator Description: LIFETIME COCAINE USE AMONG YOUTH. This indicator illustrates the percentage of Maine high school students who used cocaine at least once in their lifetime (i.e., ever).

Why Indicator is Important: Cocaine is highly addictive. Use of cocaine is associated with adverse health effects such as cardiac events, seizures, and stroke. It also increases the risk of cognitive impairment, injury, and crime.

Data Source(s): MIYHS, 2009-2011.

Summary: In 2011, six percent of high school students in Downeast PHD reported that they had used cocaine (in any form) during their lifetime; this is slightly lower than the statewide average of seven percent.

Figure 14. Percent of high school students in Downeast PHD that have used cocaine in any form during their lifetime: 2009, 2011



Source: MIYHS

Consequences Resulting from Substance Use and Abuse

Both individuals and communities suffer the consequences of substance abuse in terms of increased health care needs and criminal justice resources. While a great deal of information regarding substance use can be obtained from the data described in the previous section, information on the effects of that use on individuals and communities can be derived from what has come to be called “consequence” data. Consequences are defined as the social, economic and health problems associated with the use of alcohol and illicit drugs. Examples include illnesses related to alcohol, drug overdose deaths, property and personal crimes, as well as driving accidents, poisonings and suicides that involve alcohol or drugs.

Downeast PHD shows lower rates of drug-related crimes and consequences, although it does have a slightly higher rate of alcohol-related crime; and one of the highest rates of violent crime compared to the statewide trends. High school students in Downeast are slightly less likely to report driving a car after drinking, although the alcohol/drug-related crash rate is higher in Downeast than it is statewide; both have been declining, however.

Criminal Justice Involvement

Indicator Description: ANNUAL VIOLENT CRIME RATE. This indicator shows the number of violent crimes reported to the police, per 10,000 people. Violent crimes include simple and aggravated assaults, sexual assaults, and robberies. The rate per 10,000 allows us to see frequency with which an occurrence shows up within a population over time, as well as make relative comparisons between small and large population areas.

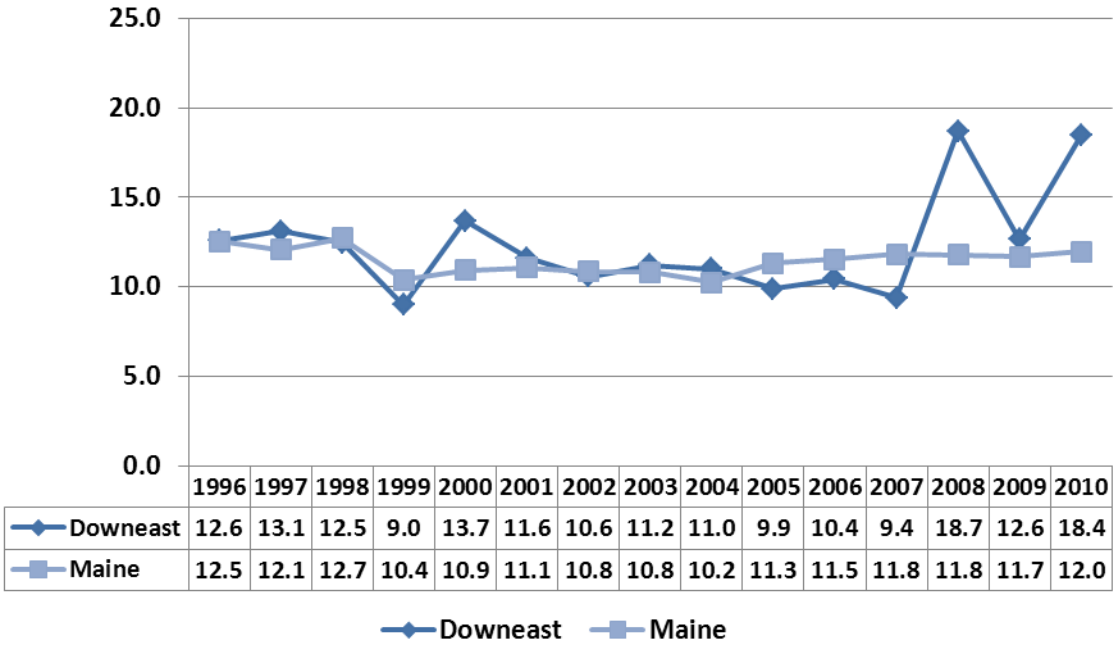
Operationalized as: $\left(\frac{\#\ of\ violent\ crimes}{population}\right) \times 10{,}000$

Why Indicator is Important: Violence is associated with alcohol, though the causal pathway is not completely understood. Drinking on the part of the victim or a perpetrator can increase the risk of assaults and assault-related injuries. Approximately 23 percent of sexual assaults and 30 percent of physical assaults are attributable to alcohol. Reported violent crimes are an under-report of the total number of actual violent crimes.

Data Source(s): DPS, UCR, 1996-2010.

Summary: In 2010, there were 18.4 violent crimes per 10,000 people in Downeast PHD compared to 12 per 10,000 people statewide. Barring 2008 and 2010, Downeast PHD has generally shown violent crime rates that were comparable to the state overall.

Figure 15. Violent crime rate per 10,000: 1996-2010



	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Downeast	12.6	13.1	12.5	9.0	13.7	11.6	10.6	11.2	11.0	9.9	10.4	9.4	18.7	12.6	18.4
Maine	12.5	12.1	12.7	10.4	10.9	11.1	10.8	10.8	10.2	11.3	11.5	11.8	11.8	11.7	12.0

Source: DPS; UCR

Indicator Description: ANNUAL ALCOHOL-RELATED ARREST RATE. This indicator reflects arrests related to alcohol per 10,000 people. Alcohol-related arrests include Operating Under the Influence (OUI), liquor law violations, and drunkenness. The rate per 10,000 allows us to see frequency with which an occurrence shows up within a population over time, as well as make relative comparisons between small and large population areas.

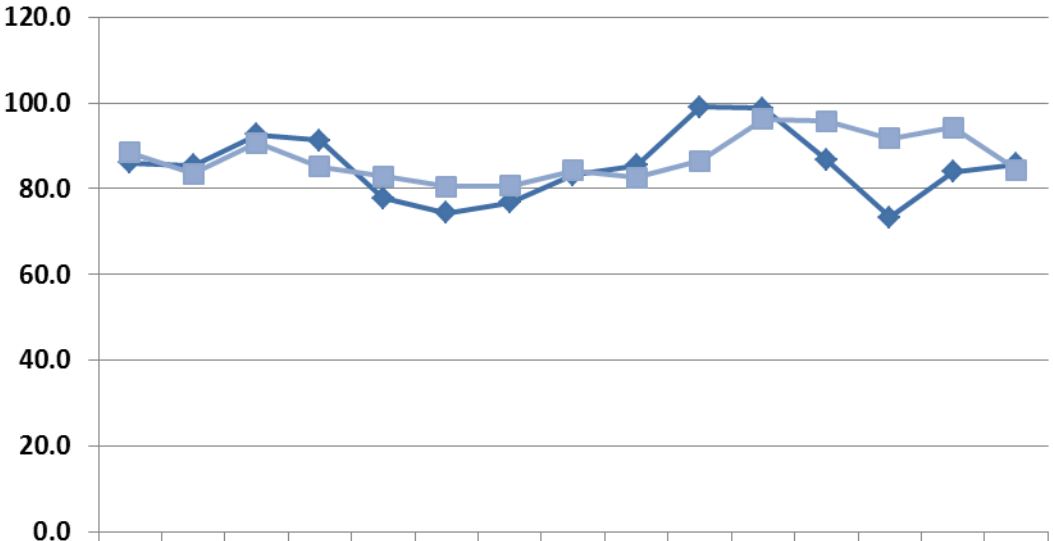
Operationalized as: $\left(\frac{\#\ of\ alcohol\ arrests}{population}\right) \times 10{,}000$

Why Indicator is Important: OUI and liquor law arrest rates can be an indication of the rate of criminal behavior, but it is important to note that they are also an *indication of the level of law enforcement*. Arrests rates are expected to increase with increased enforcement regardless of whether a decline in criminal behavior is observed. The educational component of Maine's Driver Education and Evaluation Program services an average of 4,000 Maine residents annually who receive alcohol OUIs.

Data Source(s): DPS, UCR, 1996-2010.

Summary: In 2010, Downeast PHD had 85.8 alcohol-related arrests per 10,000 people, compared to the statewide rate of 84.4 per 10,000. This represents a second uptick in what had been a decrease in such arrests since 2005 in Downeast; the statewide rate of alcohol-related arrests remained fairly stable over the same period, excluding the 2010 decrease.

Figure 16. Alcohol-related arrest rate per 10,000: 1996-2010



	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Downeast	86.1	85.5	92.6	91.3	77.8	74.4	76.8	83.3	85.4	99.0	98.8	86.8	73.4	83.9	85.8
Maine	88.4	83.6	90.7	85.1	82.9	80.5	80.7	84.2	82.6	86.4	96.3	95.7	91.8	94.2	84.4

Source: DPS; UCR

Indicator Description: ANNUAL DRUG-RELATED ARREST RATE. This indicator reflects the number of arrests that were related to drugs per 10,000 people. Drug-related arrests include manufacturing, sales, and possession. The rate per 10,000 allows us to see frequency with which an occurrence shows up within a population over time, as well as make relative comparisons between small and large population areas.

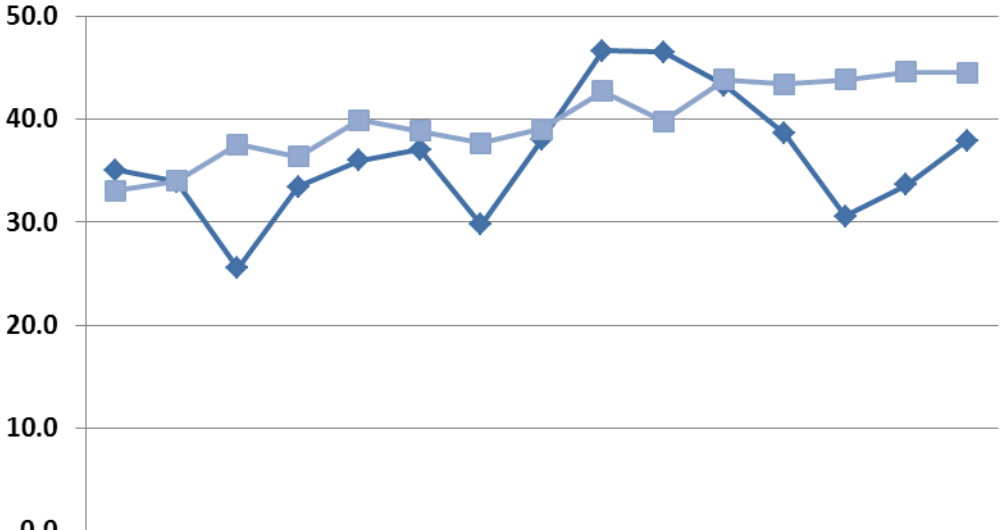
Operationalized as: $\left(\frac{\#\ of\ drug\ arrests}{population}\right) \times 10{,}000$

Why Indicator is Important: Arrest rates for drug sales, manufacturing and drug possession can be an indication of the rate of criminal behavior, but it is important to note that they are also an *indication of the level of law enforcement*. Arrests rates are expected to increase with increased enforcement regardless of whether a decline in criminal behavior is observed.

Data Source(s): DPS, UCR, 1996-2010.

Summary: In 2010, there were 37.9 drug-related arrests per 10,000 people in Downeast PHD, compared to 45 per 10,000 people statewide. This represents a second consecutive increase in such arrests after seeing rates decline steadily between 2005 and 2008 in the district.

Figure 17. Drug-related arrest rate per 10,000: 1996-2010



	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Downeast	35.0	33.9	25.6	33.4	36.0	37.0	29.8	38.0	46.6	46.5	43.3	38.6	30.6	33.6	37.9
Maine	33.1	34.0	37.6	36.4	39.9	38.9	37.7	39.1	42.7	39.8	43.8	43.4	43.8	44.6	44.5

Source: DPS; UCR

Driving Under the Influence

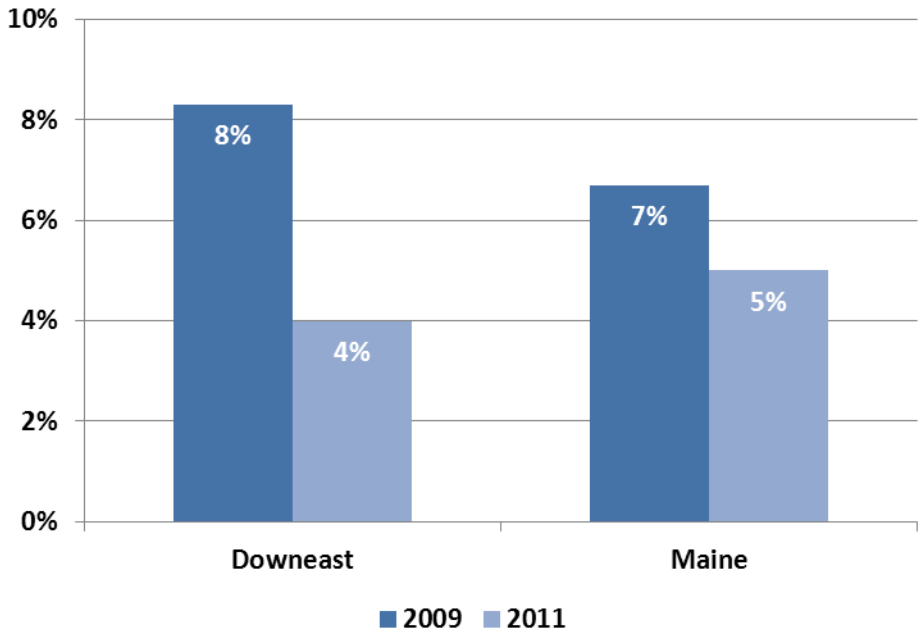
Indicator Description: DRINKING AND DRIVING AMONG YOUTH. This measure shows the proportion of high school students who reported that they drove a car after consuming alcohol at least once within 30 days prior to taking the survey.

Why Indicator is Important: Operating a vehicle after consuming alcohol increases the risk of motor vehicle crashes, injuries and death.

Data Source(s): MIYHS, 2009-2011.

Summary: In 2011, approximately four percent of high school students in Downeast PHD reported driving a vehicle at least once after drinking alcohol in the past 30 days compared to five percent statewide reporting such behavior.

Figure 18. Percent of high school students in Downeast PHD who reported drinking and driving during the past 30 days: 2009, 2011



Source: MIYHS

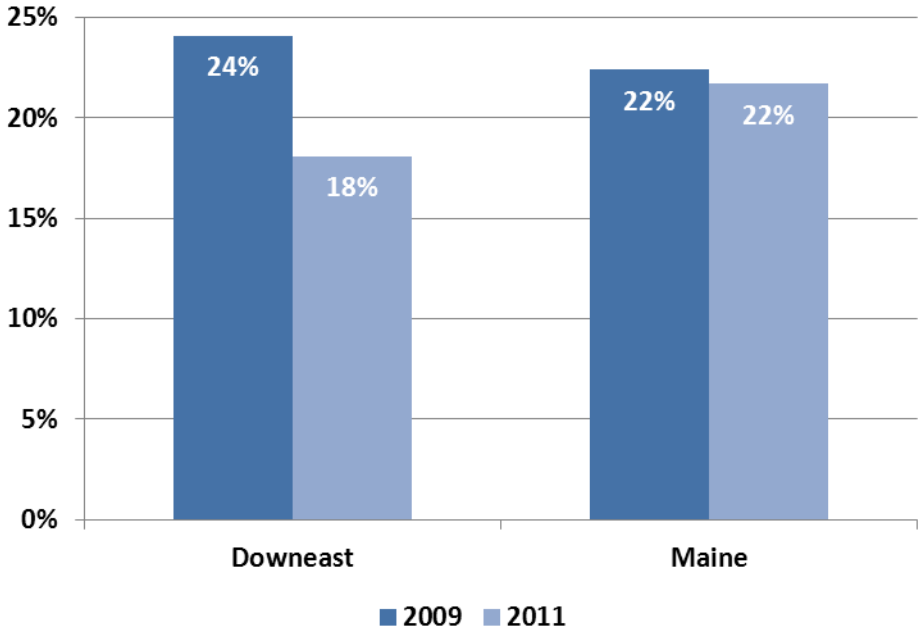
Indicator Description: YOUTH AS PASSENGERS IN VEHICLES DRIVEN BY INDIVIDUALS USING ILLEGAL DRUGS. This measure shows the proportion of high school students who reported that within 30 days prior to taking the survey they were a passenger in a car being operated by an individual who had consumed illegal drugs.

Why Indicator is Important: Operating a vehicle while under the influence of drugs increases the risk of motor vehicle crashes, injuries and death.

Data Source(s): MIYHS, 2009-2011.

Summary: Eighteen percent of high school students in Downeast PHD reported that within the past 30 days they had been passengers in a vehicle operated by someone who had taken illegal drugs, compared to 22 percent across the state who reported doing so; this represents a significant decline in the rate of such incidents from 2009 to 2011.

Figure 19. Percent of high school students in Downeast PHD who rode in a vehicle driven by someone who had taken illegal drugs: 2009, 2011



Source: MIYHS

Indicator Description: ALCOHOL/DRUG-INVOLVED MOTOR VEHICLE CRASH RATE. This indicator shows the number of motor vehicle crashes in which alcohol or drugs were a factor per 10,000 people. Due to new data collection regulations, crash rate data is no longer separated by alcohol and drugs. Alcohol and drugs are now combined into one rate. Alcohol/drug-involved crashes means that at least one driver had consumed alcohol or drugs prior to the crash. The rate per 10,000 allows us to see frequency with which an occurrence shows up within a population over time, as well as make relative comparisons between small and large population areas.

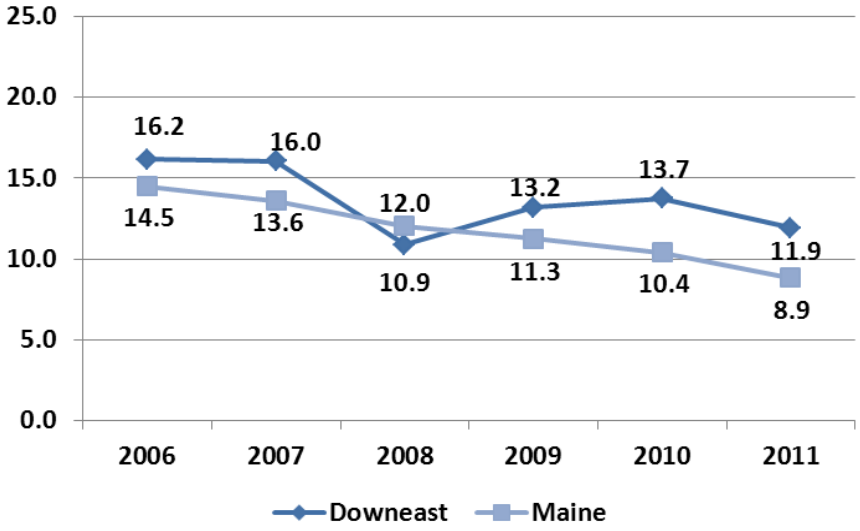
Operationalized as: $\left(\frac{\#\ of\ alcohol/drug-involved\ crashes}{population}\right) \times 10{,}000$

Why Indicator is Important: Motor vehicle crashes are the second leading cause of traumatic brain injury, with 27 percent of traumatic brain injuries occurring from motor vehicle crashes.[4] In 2009, alcohol was attributed to 96 percent of the alcohol/drug-related crashes statewide.

Data Source(s): MDOT/MBHS, 2006-2011.

Summary: In Maine and in Downeast PHD, the rate of alcohol-related crashes has been declining since 2006. In 2011, there were 11.9 alcohol-related crashes per 10,000 people in Downeast PHD (higher than the statewide rate of 8.9 per 10,000 people) and represents a decrease from 16.2 per 10,000 people in 2006 in Downeast.

Figure 20. Alcohol/Drug-related motor vehicle crash rate per 10,000: 2006-2011



Source: MDOT/MBHS

[4] *2007 Maine Injury Report*, Maine Center for Disease Control, Injury Prevention Program. Retrieved 5/17/2012 from http://www.maine.gov/dhhs/mecdc/population-health/inj/documents/2007maineinjuryreport.pdf

Hospital Visits Related to Substance Use

Indicator Description: INPATIENT ADMISSIONS RELATED TO SUBSTANCE USE. This indicator shows the number of inpatient hospital admissions (per 10,000 people) where alcohol, opiates, or other drugs were recorded as the primary diagnosis for which services were sought at admission. "Inpatient" refers to a patient whose treatment needs at least one night's residence in a hospital. The substance for which treatment was received was identified through hospital codes (ICD-9 codes) and includes those related to alcohol and psychoactive substances (303-305). The rate per 10,000 allows us to see frequency with which an occurrence shows up within a population over time, as well as make relative comparisons between small and large population areas.

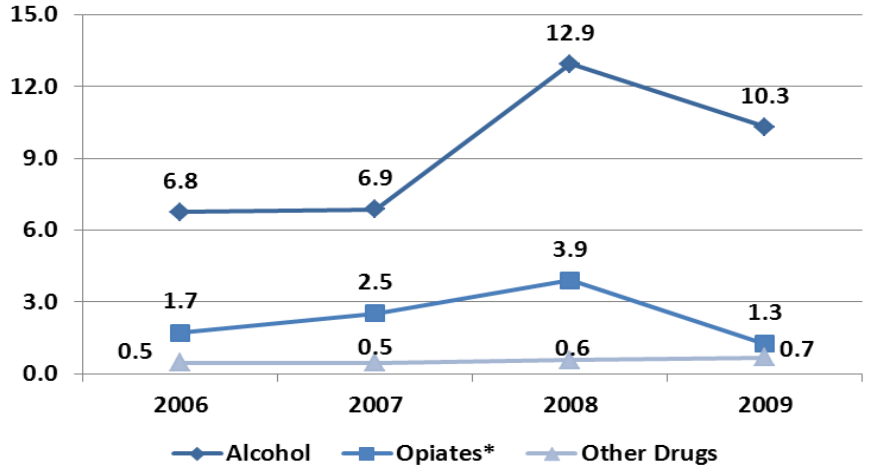
Operationalized as: $\left(\frac{\#\ of\ inpatient\ hospitalizations}{population}\right) \times 10{,}000$

Why Indicator is Important: Hospital admissions related to substance use are an indication of injury sustained through substance use and the impact it has on the healthcare system.

Data Source(s): MHDO, 2006-2009.

Summary: In 2009, inpatient admissions related to substance use decreased for alcohol and opiates after rising sharply in 2008. Inpatient rates for alcohol-related admissions in Downeast are much higher than the rate of such admissions statewide. Although not pictured here, statewide inpatient hospitalization rates for 2009 were as follows: 5.2 per 10,000 for alcohol, 1.6 per 10,000 for opiates, and 0.7 per 10,000 for other drugs.

Figure 21. Inpatient hospital admissions (per 10,000 people) related to substance use in Downeast: 2006-2009



Source: MHDO, 2006-2009

**Includes prescription narcotics, methadone, and heroin.*

Indicator Description: OUTPATIENT HOSPITAL VISITS RELATED TO SUBSTANCE USE. This indicator shows the number of outpatient hospital admissions (per 10,000 people) where alcohol, opiates, or other drugs was recorded as the primary diagnosis for which services were received. "Outpatient" refers to patients who receive treatment at a hospital or clinic but are not admitted overnight. The substance for which treatment was received was identified through hospital codes (ICD-9 codes) and includes those related to alcohol psychoactive substances (303-305). The rate per 10,000 allows us to see frequency with which an occurrence shows up within a population over time, as well as make relative comparisons between small and large population areas

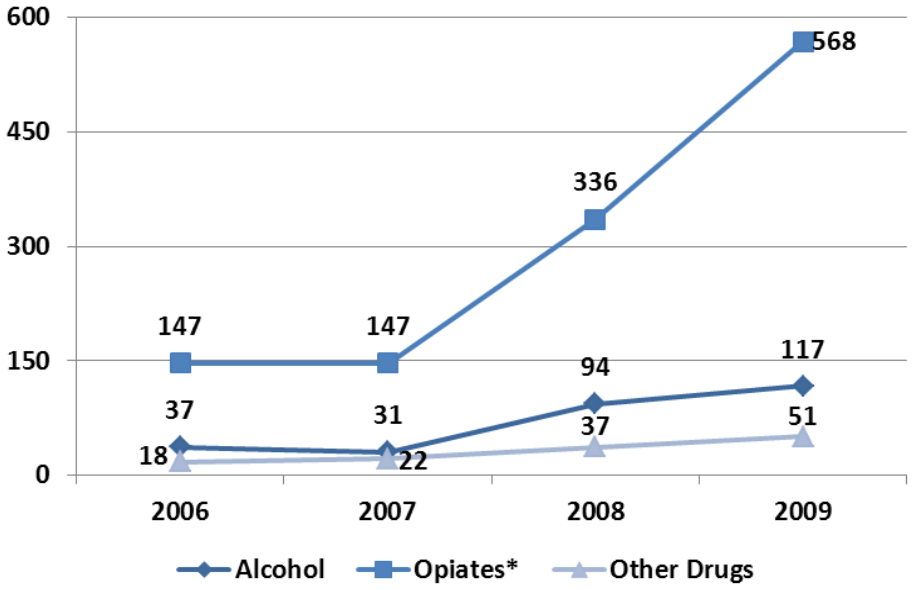
Operationalized as: $\left(\frac{\#\ of\ outpatient\ hospitalizations}{population}\right) \times 10{,}000$

Why Indicator is Important: Outpatient hospital visits related to substance use are an indication of injury sustained through substance use and the impact it has on the healthcare system.

Data Source(s): MHDO, 2006-2009.

Summary: Outpatient hospital visits related to opiate abuse have been steadily increasing since 2006. Opiates were the substance of concern more than four times as often as alcohol in 2009. Although not pictured here, statewide rates of outpatient hospital visits were as follows in 2009: 119 per 10,000 for alcohol, 271 per 10,000 for opiates, and 53 per 10,000 for other drugs.

Figure 22. Outpatient hospital visits (per 10,000 people) related to substance use in Downeast PHD: 2006-2009



Source: MHDO, 2006-2009
**Includes prescription narcotics, methadone, and heroin.*

Overdose Deaths

Indicator Description: DRUG OVERDOSE DEATH RATE. This measure shows the rate of deaths determined by the State Medical Examiner to be caused by substance abuse or overdose, per 100,000 people. The measure excludes accidental ingestion, suicides and cases where a substance was ingested prior to engaging in a behavior that resulted in death (e.g., drunk driving). The rate per 100,000 allows us to see frequency with which an occurrence shows up within a population over time, as well as make relative comparisons between small and large population areas. In this case, the base of 100,000 people was used due to small numbers.

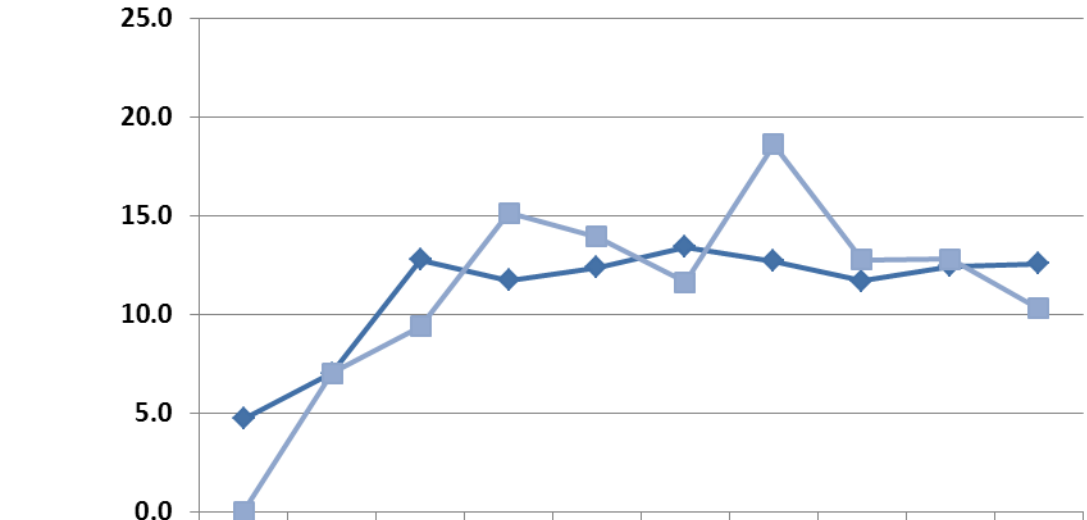
Operationalized as: $\left(\frac{\#\ of\ overdose\ deaths}{population}\right) \times 100{,}000$

Why Indicator is Important: One of the most extreme consequences of alcohol and drug abuse is overdose death; that is, the substance(s) consumed played a direct role in an individual's death. These are seen as potentially preventable deaths.

Data Source(s): Office of Chief Medical Examiner, 2000-2008, and 2010.[5]

Summary: In 2010, there were 10.3 drug overdose deaths per 100,000 people in Downeast PHD, lower than the statewide rate (12.6 per 100,000 people). The overdose death rate in Downeast PHD has fluctuated since 2003.

Figure 23. Drug-related death rate per 100,000: 2000-2008, 2010



	2000	2001	2002	2003	2004	2005	2006	2007	2008	2010
Maine	4.7	7.0	12.8	11.7	12.4	13.4	12.7	11.7	12.4	12.6
Downeast	0.0	7.0	9.4	15.2	13.9	11.6	18.6	12.8	12.8	10.3

Source: Office of the Chief Medical Examiner.

[5] Sorg, Marcella H. (2012).

Factors Contributing to Substance Use and Abuse

A body of substance abuse prevention research has identified certain groups of factors that "cause" or have an impact on substance use and the consequences related to use. That is, they appear to influence the occurrence and magnitude of substance use and its related consequences. Generically, these causal factors (also known as contributing factors) are categorized into groups which include:

- Social Access (e.g., getting drugs and alcohol from friends or family)
- Retail Availability (e.g., retailer not carding properly)
- Pricing & Promotion (e.g., two-for-one specials, industry sponsorships or signage)
- Social/Community Norms (e.g., parental/community attitudes and beliefs)
- Enforcement (e.g., lack of compliance checks)
- Perceptions of Harm (e.g., individuals' belief that using a substance is harmful)[6]
- Perceived Risk of Being Caught (e.g., individuals' belief that s/he will be caught by parents or police)[7]

Substance abuse prevention in Maine is undertaken with the assumption that making changes to these factors at the community level will result in changing behaviors around substance use and related problems. It is through positively impacting these factors that Maine can achieve population-level changes in substance consumption and consequences.

Although most high school students in Downeast PHD seem to perceive that regular use of substances poses a risk of harm, many don't think they will be caught by their parents or police if they use alcohol or marijuana. In fact, most students in Downeast PHD think it is easy to obtain alcohol and marijuana. In 2010, Downeast PHD had the highest number of liquor licensees per capita than any other public health district.

For county-level trends prior to 2009, data are available at the www.maineosa.org website or by calling Maine OSA at (207) 287-2595.

[6] Bonnie, Richard J., and Mary Ellen O'Connell, Eds. (2004). *Reducing Underage Drinking: A Collective Responsibility.* The National Academies Press: Washington, DC.

[7] *"A General Causal Model to Guide Alcohol, Tobacco and Illicit Drug Prevention: Assessing the Research Evidence."* Multi-State Technical Assistance Workshop. Washington, DC. March 16, 2006.

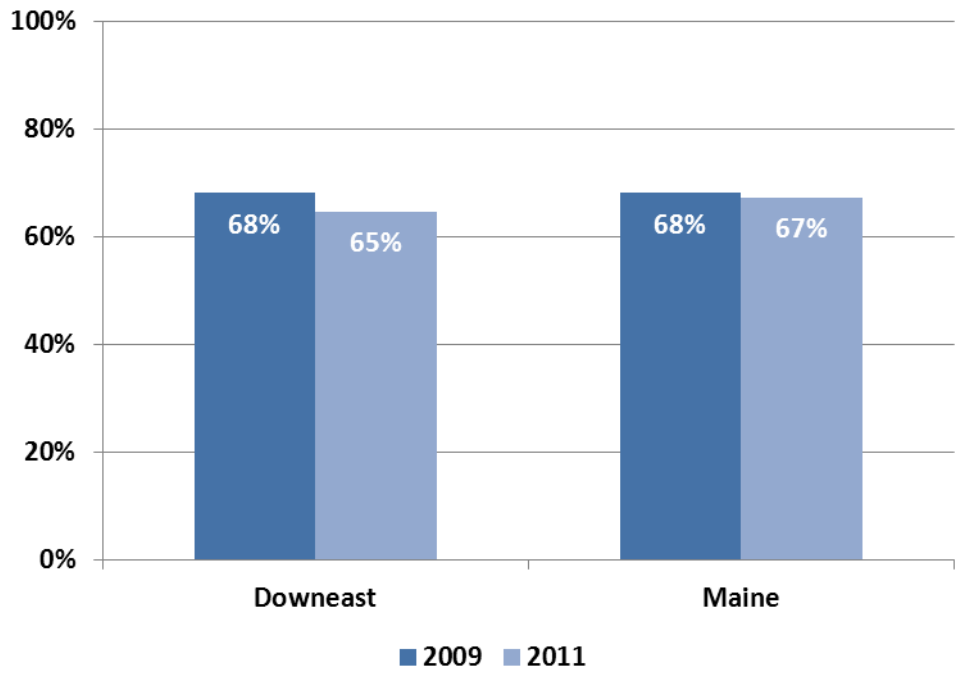
Indicator Description: PERCEIVED EASE OF OBTAINING ALCOHOL BY UNDERAGE YOUTH. This indicator reflects the percentage of high school students (grades 9 to 12) who reported that it would be easy or very easy for them to get alcohol if they wanted some.

Why Indicator is Important: According to the 2011 statewide MIYHS, students who reported that they thought alcohol was easy to obtain were three times as likely to report consuming alcohol within the past month compared to students who did not think it was easy obtain.

Data Source(s): MIYHS, 2009-2011.

Summary: Sixty-five percent of high school students in Downeast PHD (almost two out of three) indicated that it was easy to get alcohol, slightly less than the statewide rate of 67 percent.

Figure 24. Percent of high school students in Downeast PHD who reported it was easy to get alcohol: 2009, 2011



Source: MIYHS

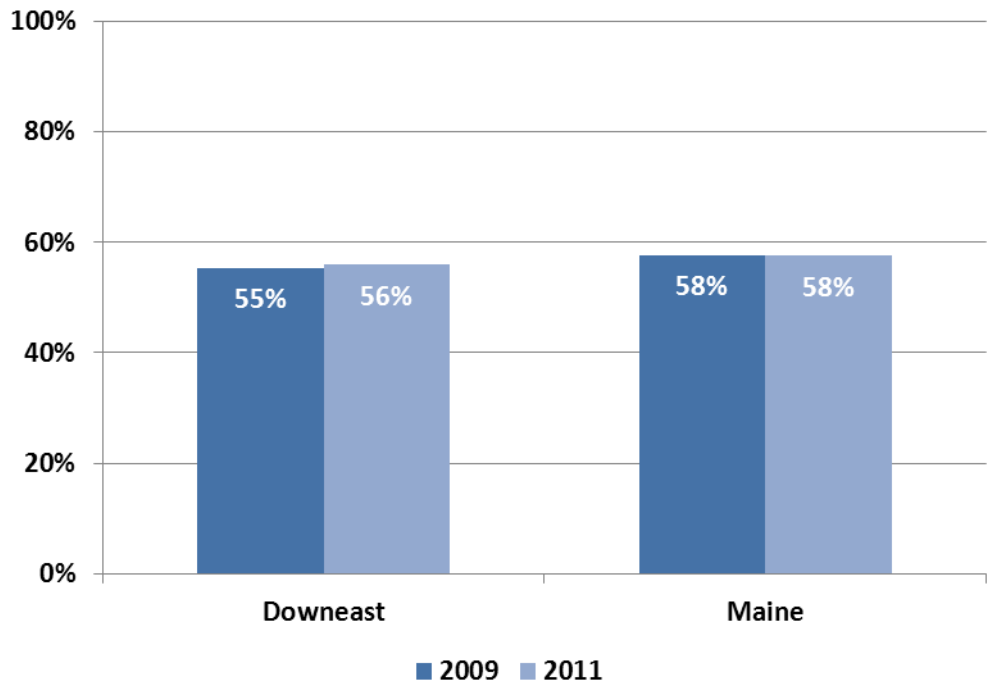
Indicator Description: PERCEIVED EASE OF OBTAINING MARIJUANA BY YOUTH. This indicator illustrates the percentage of high school students reporting it would be easy or very easy to obtain marijuana if they wanted it.

Why Indicator is Important: According to the 2011 statewide MIYHS, students who reported that they thought marijuana was easy to obtain were seven times as likely to use marijuana in the past 30 days compared to their peers who thought it was difficult to obtain.

Data Source(s): MIYHS, 2009-2011.

Summary: In 2011, more than one-half (56%) of high school students in Downeast PHD indicated that it would be easy to get marijuana; the state average was slightly higher (58%).

Figure 25. Percent of high school students in Downeast PHD who reported it would be easy to get marijuana: 2009, 2011



Source: MIYHS

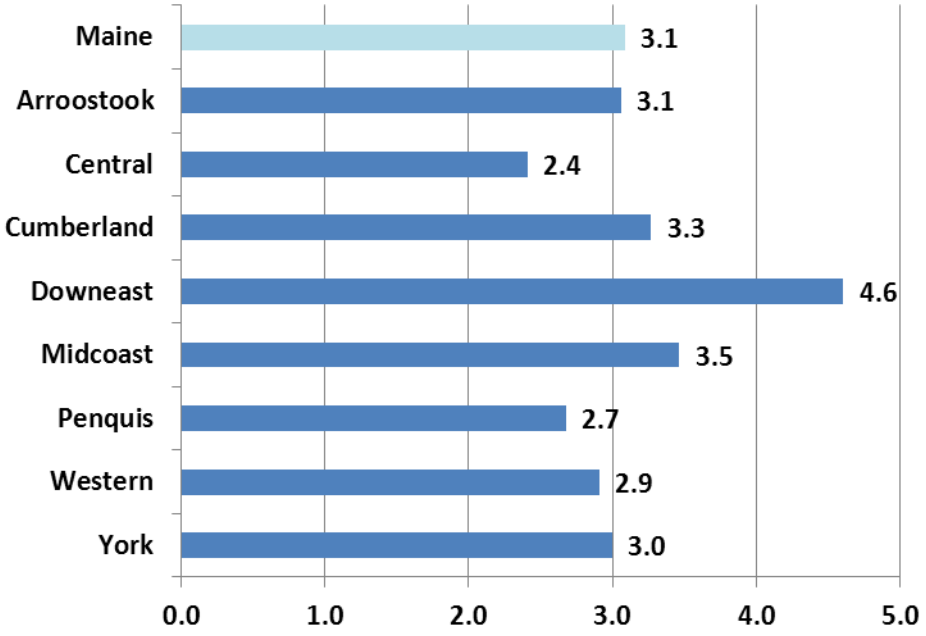
Indicator Description: NUMBER OF ALCOHOL OUTLETS PER CAPITA. This indicator reflects the number of retail establishments selling alcohol per person. This includes both on-premise (e.g., bars, restaurants) and off-premise (e.g., convenience stores) establishments. It is calculated by dividing the number of retail establishments by the number of residents in the county (based on 2010 U.S. Census figures).

Why Indicator is Important: National research shows that there is a correlation between the number of places that sell alcohol in an area (retail density) and the rate of alcohol-related crime.[8]

Data Source(s): DPS, Liquor Licensing and Compliance, 2011; U.S. Census, 2010.

Summary: At 4.6 per 1,000 residents, the number of liquor licensees in Downeast PHD was the highest per capita in the state in 2011.

Figure 26. Number of liquor licensees per 1,000 residents, by PHD: 2011



Source: DPS and U.S. Census

[8] Grube, J. W., Gruenewald, P. J. & Chen, M. J. (2010). Community alcohol outlet density and underage drinking. *Addiction*, 105, 270-278.

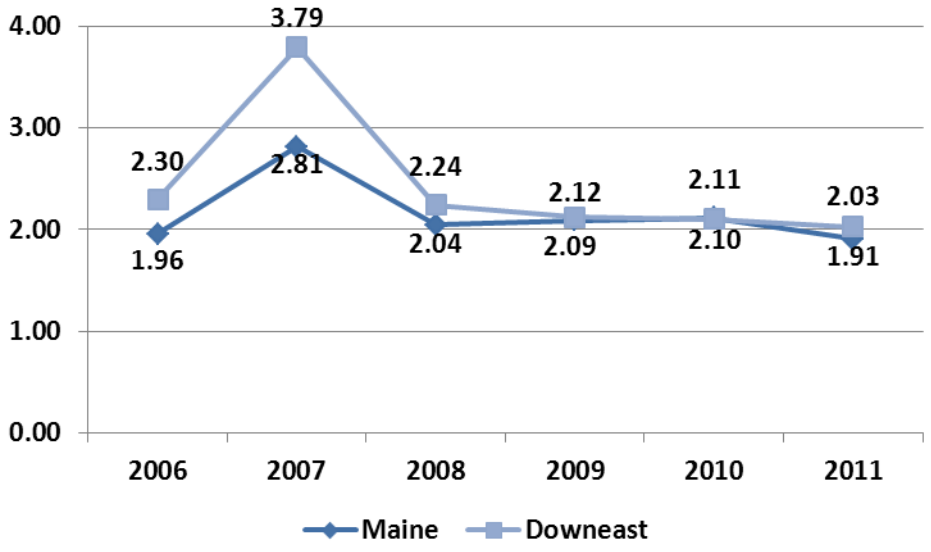
Indicator Description: NUMBER OF PRESCRIPTIONS FILLED PER CAPITA. This indicator reflects the number of "Schedule II-IV" prescriptions filled in Maine per person. It is important to note that the number of prescriptions per capita does not indicate the overall number of pills prescribed, the size/dosage of the pills, or drugs that fall within DEA "Schedules I or V". At the time of this report, all pharmacies, excluding the Veterans Administration, federally regulated methadone clinic and the Indian Health Service (IHS) center, which dispense in Maine report to the Prescription Monitoring Program. IHS is scheduled to begin reporting during the summer of 2012. The VA is working on a plan to begin reporting soon.

Why Indicator is Important: The number of prescriptions filled per capita indicates the volume of prescription pills potentially available in the community for diversion (e.g., gift, sale, or theft). A higher level of availability contributes to misuse by individuals without a prescription.

Data Source(s): PMP, 2006-2011.

Summary: After spiking substantially in 2007, prescriptions filled per capita in Downeast PHD have remained relatively stable from 2008 to 2011. During this same period of time, Downeast PHD and the state as a whole have had similar rates; both deceased slightly from 2010 to 2011.

Figure 27.Number of prescriptions filled per capita in Downeast PHD: 2006-2011.



Perceived Risk and Harm

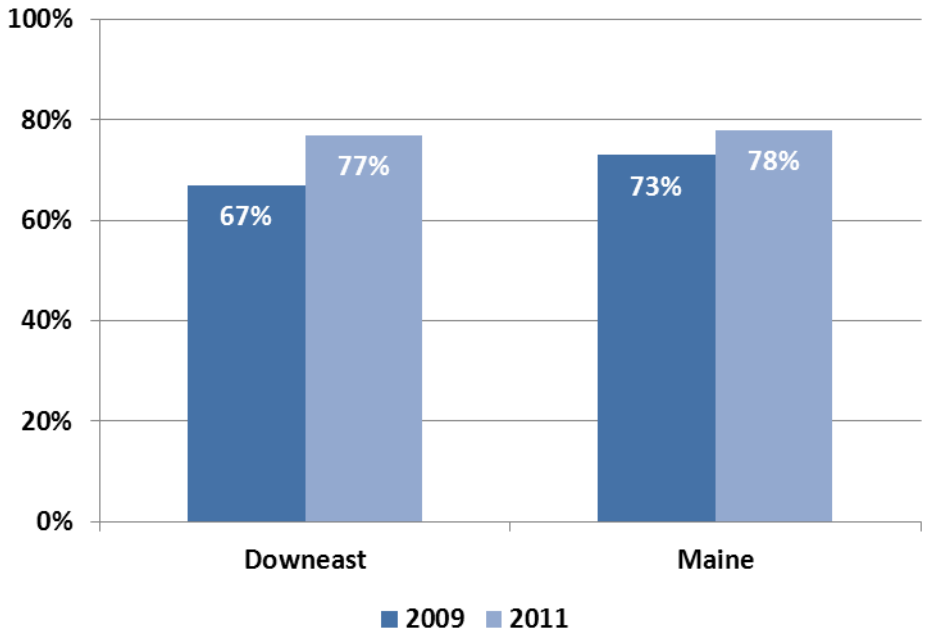
Indicator Description: PERCEIVED RISK FROM BINGE DRINKING AMONG YOUTH. This indicator reflects the percentage of individuals who perceive that there is moderate-to-great risk from drinking five or more drinks once or twice per week.

Why Indicator is Important: According to the 2011 statewide MIYHS, high school students who perceive binge drinking as a moderate-to-great risk of harm are one third as likely to binge drink in the past month than students who did not perceive harm. Adults are also less likely to binge drink if they perceive it to be risky.

Data Source(s): MIYHS, 2009-2011.

Summary: In 2011, 77 percent of high school students in Downeast PHD indicated that there is a moderate-to-great risk of people harming themselves if they consume five or more drinks regularly. This is lower than the state average (78%).

Figure 28.Percent of high school students in Downeast PHD who reported a risk of harm from consuming five or more drinks once or twice per week: 2009, 2011



Source: MIYHS

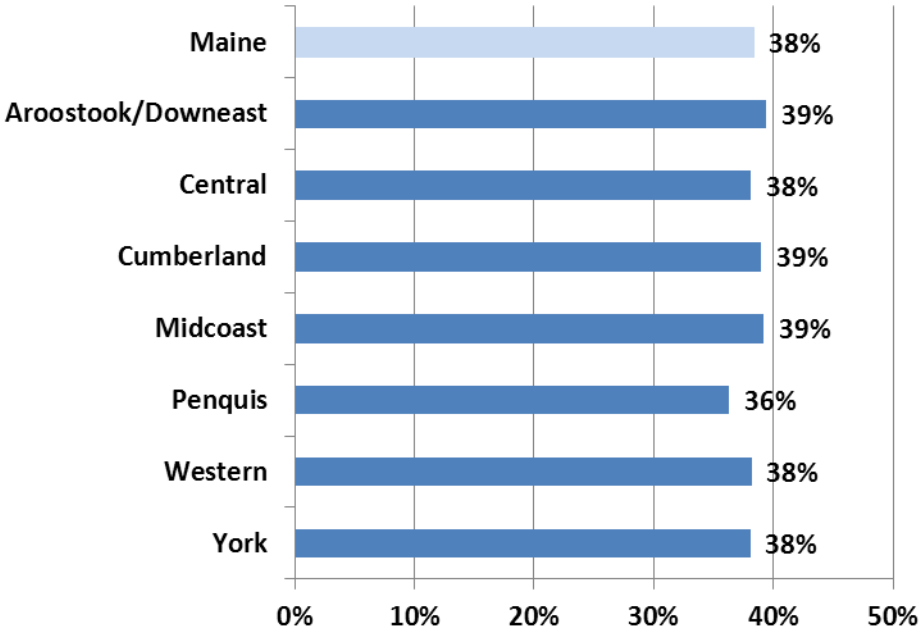
Indicator Description: PERCEIVED RISK FROM BINGE DRINKING AMONG MAINERS. This indicator reflects the percentage of Mainers age 12 and older who perceive that there is risk from consuming five or more drinks once or twice per week. Because of small sample sizes, survey data from multiple years must be combined in order to produce this estimate.

Why Indicator is Important: The perception that consuming a lot of alcohol is risky indicates an individual is knowledgeable about health risks and other negative consequences. Adults are less likely to binge drink if they perceive it to be risky.

Data Source(s): NSDUH, 2006-08.

Summary: While combined with data from the Aroostook Public Health District[9], findings indicate that the percent of the population in Maine age 12 or older in area who perceive a great risk from binge drinking is relatively on par with the state average (39% and 38%, respectively).

Figure 29. Percent of population age 12 or older who perceive a great risk from binge drinking by Public Health District: 2006-2008



Source: NSDUH

[9] Due to small sample sizes, Aroostook and Downeast Public Health District (which consists of Washington County and Hancock County) were combined to produce this estimate.

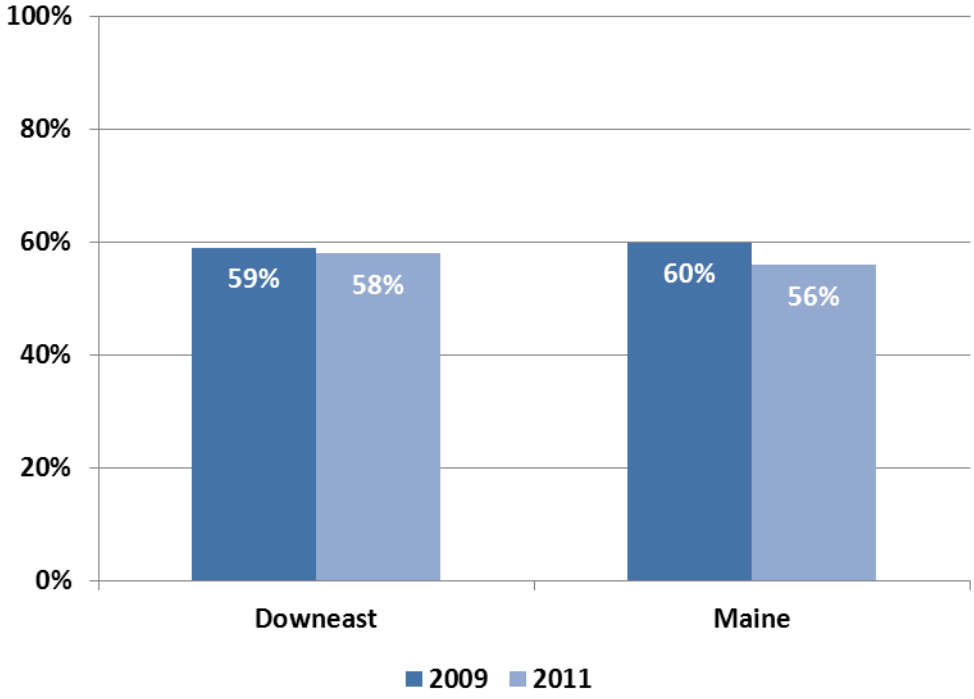
Indicator Description: PERCEIVED RISK OF REGULAR MARIJUANA USE AMONG YOUTH. This measure demonstrates the percentage of individuals who perceive a moderate-to-great risk of harm from smoking marijuana regularly.

Why Indicator is Important: According to the 2011 statewide MIYHS, high school students who do not believe there is moderate to great risk in smoking marijuana regularly are 6.5 times as likely to smoke marijuana as their peers who do perceive risk of harm.

Data Source(s): MIYHS, 2009-2011.

Summary: Almost six out of ten high school students in Downeast PHD (58%) indicated that there is a moderate-to-great risk of people harming themselves if they smoke marijuana regularly; this is slightly greater than the statewide average of 56 percent.

Figure 30. Percent of high school students in Downeast PHD who reported a risk of harm from smoking marijuana regularly: 2009, 2011



Source: MIYHS

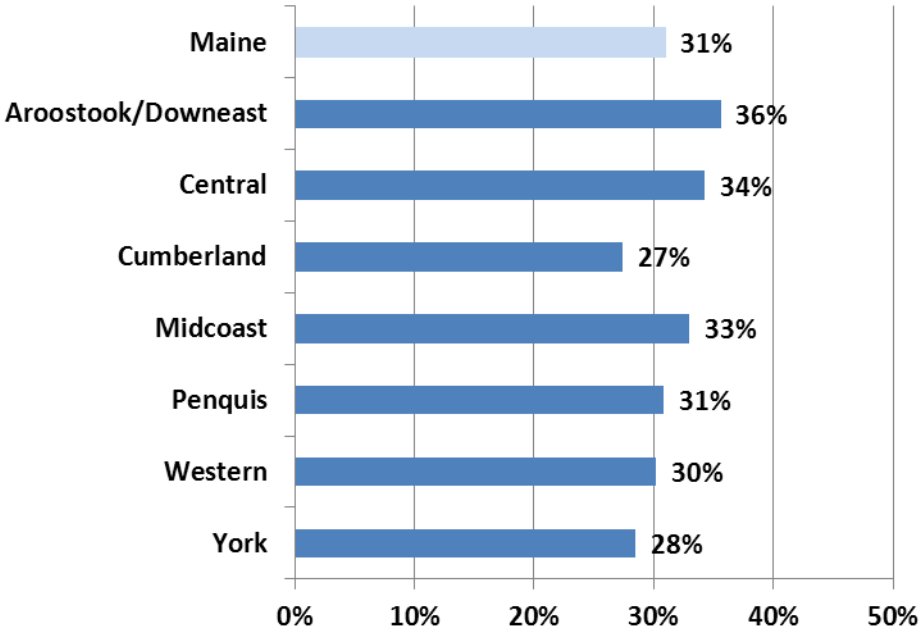
Indicator Description: PERCEIVED RISK OF REGULAR MARIJUANA USE AMONG MAINERS. This measure demonstrates the percentage of Mainers over the age of 12 who perceive a risk of harm from smoking marijuana once a month. Because of small sample sizes, survey data from multiple years must be combined in order to produce this estimate.

Why Indicator is Important: The perception that using a substance is risky indicates an individual is knowledgeable about health risks and other negative consequences associated with that substance. Perceptions of risk reduce the likelihood that an individual will engage in the behavior.

Data Source(s): NSDUH, 2006-08.

Summary: Aroostook and Downeast Public Health District[10] had the highest percentage of Mainers over the age of 12 who perceived a great risk from smoking marijuana once a month, at 36 percent (compared to 31 percent statewide).

Figure 31. Percent of population age 12 or older who perceive a great risk from smoking marijuana once a month by Public Health District: 2006-2008



Source: NSDUH

[10] Due to small sample sizes, Aroostook and Downeast Public Health District (which consists of Washington County and Hancock County) were combined to produce this estimate.

Perceived Enforcement

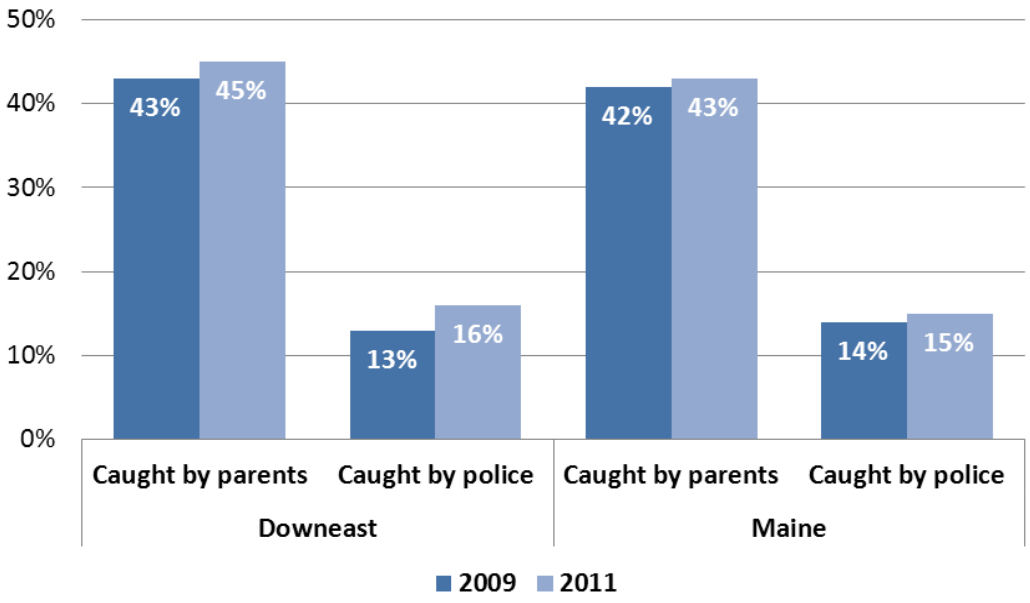
Indicator Description: PERCIEVED RISK OF BEING CAUGHT FOR DRINKING ALCOHOL AMONG YOUTH. This indicator reflects the percentage of high school students who reported that they would be caught by their parents or by police if they drank alcohol.

Why Indicator is important: According to the 2011 statewide MIYHS, high school students who believe they will be caught by their parents are one-fifth as likely to drink in the past month as compared to students who do not think they will be caught. Students who believe that they would be caught by the police are half as likely to drink alcohol in the past month as those who do not think they would be caught.

Data Source(s): MIYHS, 2009-2011.

Summary: Forty five percent of Downeast high school students indicated a perceived risk of being caught by their parents for drinking alcohol, which is slightly higher than the state average (43%). Only 16 percent of high school students indicated that they thought they would be caught by the police for drinking alcohol (compared to 15% statewide who reported that perception).

Figure 32. Perceived risk among high school students in Downeast PHD of being caught by parents or police for drinking alcohol: 2009, 2011



Source: MIYHS

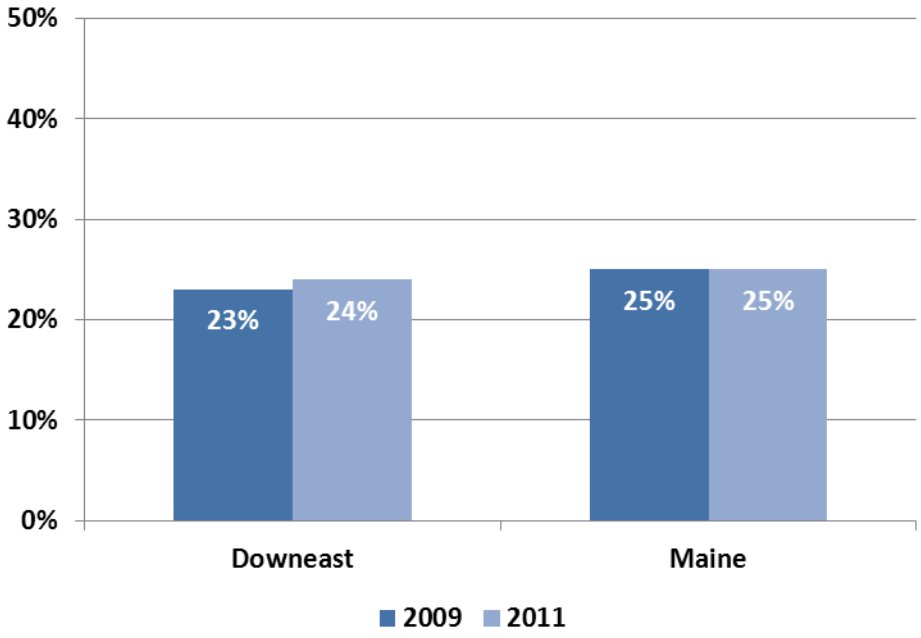
Indicator Description: PERCEIVED RISK OF BEING CAUGHT FOR SMOKING MARIJUANA AMONG YOUTH. This measure shows the percentage of high school students who reported that they thought they would be caught by police if they smoked marijuana.

Why Indicator is Important: According to the statewide 2011 MIYHS, high school students who believe they would be caught by the police are approximately half as likely to smoke marijuana as their peers.

Data Source(s): MIYHS, 2009-2011.

Summary: Twenty-four percent of high school students in Downeast PHD indicated that they thought they would be caught by the police if they smoked marijuana, compared to 25 percent statewide who reported this perception.

Figure 33. Perceived risk among high school students in Downeast PHD of being caught by police for smoking marijuana: 2009, 2011



Source: MIYHS

Mental Health, Suicide and Co-occurring Disorders

The relationship between substance use and mental health has been well documented. There are great efforts underway at the Substance Abuse Mental Health Services Administration (SAMHSA) and throughout Maine to better integrate mental health promotion and substance abuse prevention. At the individual level, it is important to know if one exists because the symptoms of each can affect the other; that is, a person who is depressed may abuse alcohol or drugs in an effort to feel better. At the community level, it is important to understand how the prevalence of one interacts with the other so that prevention and intervention efforts can better address the needs of both. The data indicators included below represent the first attempt to collect multiple mental health indicators that can be routinely monitored in relation to substance abuse in hopes that this will lead to better prevention and intervention.

About one-fifth of adults in Downeast PHD report having ever been diagnosed with depression and almost one-quarter of high school students felt sad or hopeless every day for two weeks in 2010; more than one in ten high school students reported having considered suicide. The proportion of individuals from Downeast PHD admitted for substance abuse treatment who also have a mental health diagnosis is lower than the statewide rate, but has been increasing since 2005.

Depression and Anxiety

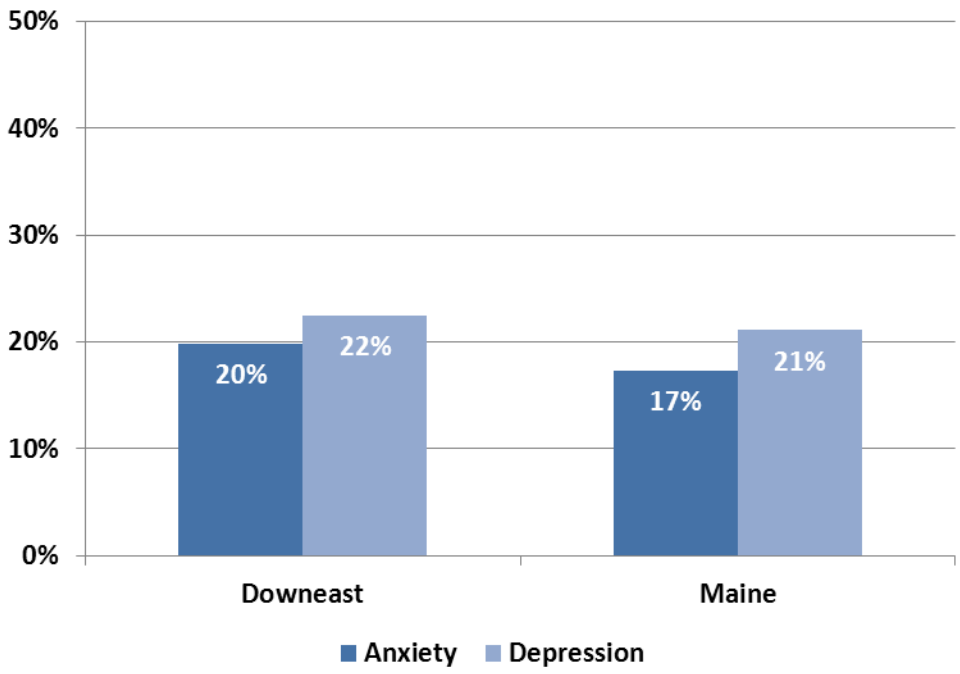
Indicator Description: DIAGNOSIS OF ANXIETY AND DEPRESSION AMONG ADULTS. This indicator examines the percentage of Maine residents age 18 and older who have ever been told by a doctor that they have a depressive or anxiety disorder.

Why Indicator is Important: The link between mental health and substance abuse is well documented. Experiencing anxiety or depression is associated with higher rates of substance abuse.

Data Source(s): BRFSS, 2006, 2008-2010.

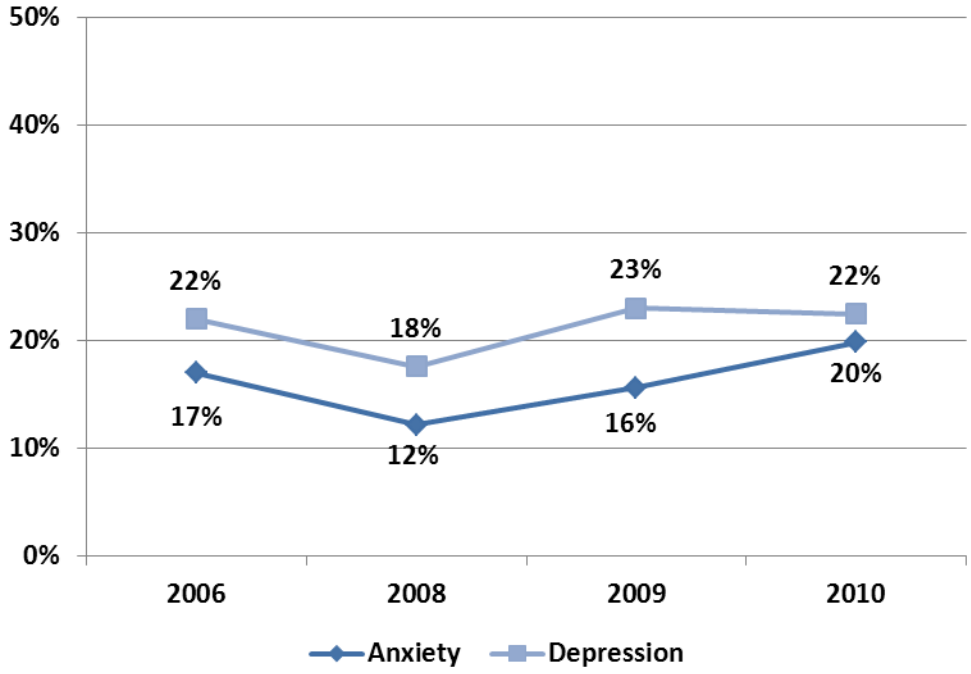
Summary: In 2010, approximately 20 percent of adults in Downeast PHD had been told they have an anxiety disorder (a 4 percentage point increase from 2009), and 22 percent had been told they have a depressive disorder (a 1 percentage point decrease). Both of these are higher than the statewide diagnosis rates. While it appears that the rate of anxiety diagnoses have changed since 2006 (see the figure on the following page), there are too few years of data available to determine whether this represents a trend.

Figure 34. Percent of adults who have ever been told they have an anxiety or depressive disorder: Downeast PHD and Maine: 2010



Source: BRFSS

Figure 35. Percent of adults in Downeast PHD who have ever been told they have an anxiety or depressive disorder: 2006, 2008-2010



Source: BRFSS

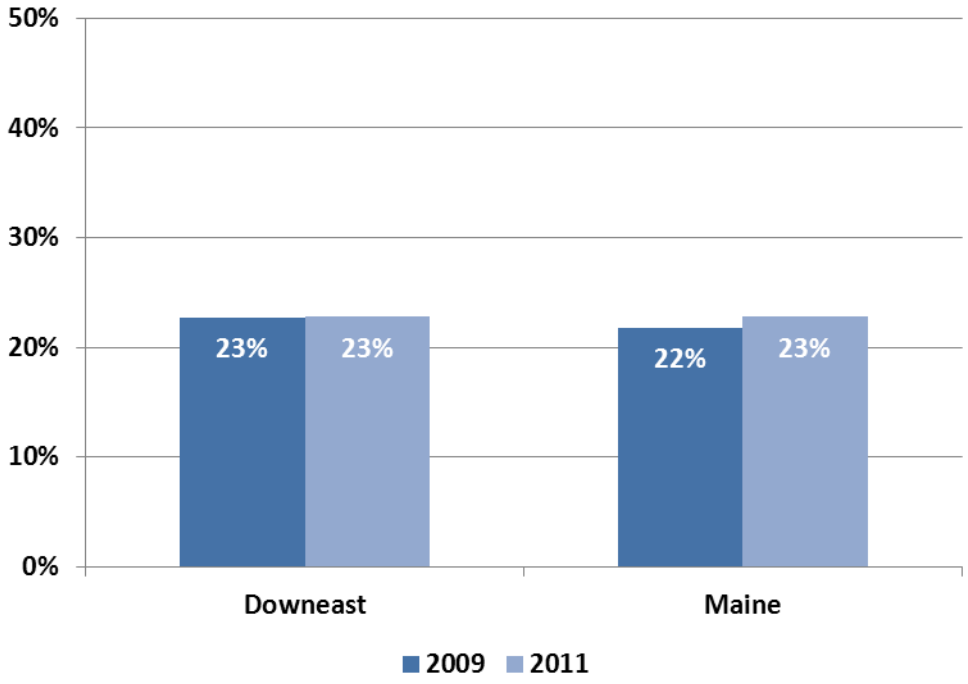
Indicator Description: DEPRESSION AMONG YOUTH. This indicator measures the percentage of high school students reporting they felt sad or hopeless almost every day for two weeks in a row during the past year.

Why Indicator is Important: Experiencing depression in the past year is associated with higher rates of substance abuse. Among youth, depression is also associated with problems with relationships and academic achievement.

Data Source(s): MIYHS, 2009-2011.

Summary: In 2011, approximately 23 percent (almost one in four) of high school students in Downeast PHD indicated that they felt sad or hopeless every day for two weeks or more in a row during the past year; this was similar to the rate reported by all Maine high school students (23%).

Figure 36. Percent of high school students in Downeast PHD who felt sad or hopeless almost every day for two weeks or more in a row during the past year: 2009, 2011



Source: MIYHS

Suicide and Suicidal Ideation

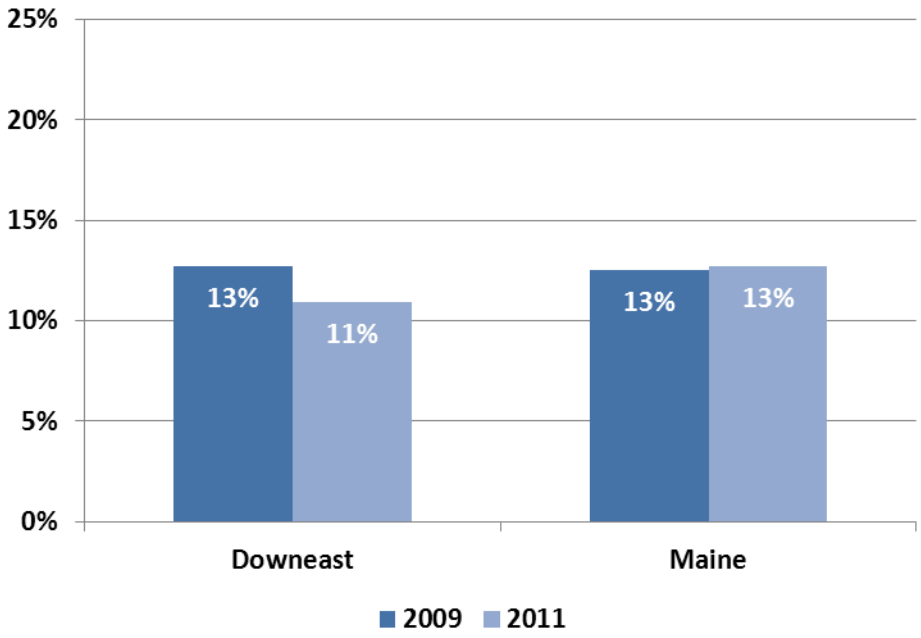
Indicator Description: SUICIDAL IDEATION AMONG YOUTH. This measure examines the percentage of high school students who reported that they seriously considered attempting suicide during the past year.

Why Indicator is Important: Suicide is the most tragic consequence of major depressive disorders. Abuse of alcohol or other drugs may increase emotional problems leading to suicidal ideation and suicidal behavior.

Data Source(s): MIYHS, 2009-2011.

Summary: In 2011, 11 percent of high school students in Downeast PHD considered suicide during the past year, slightly less than the rate reported by high school students statewide (13%).

Figure 37. Percent of high school students in Downeast PHD who considered suicide during the past year: 2009, 2011



Source: MIYHS

Mental Health and Substance Abuse Co-Occurrence

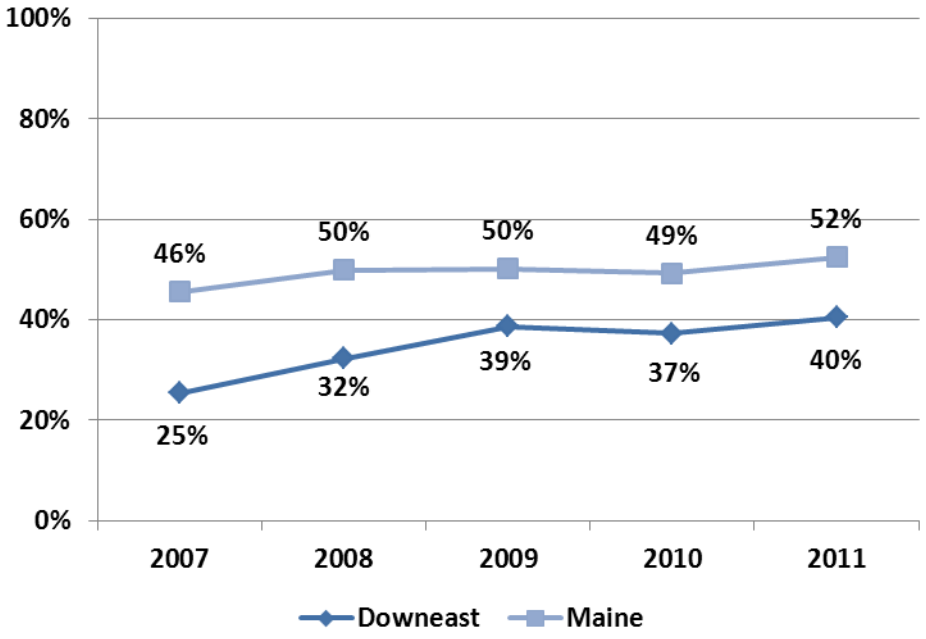
Indicator Description: CO-OCCURRING MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT. This indicator reflects the proportion of treatment admissions for substance abuse where the individual also has a mental health diagnosis.

Why Indicator is Important: The link between mental health and substance abuse is well documented. In terms of treatment, it is important to know if one exists because the symptoms of each can affect the other.

Data Source(s): TDS, 2007-2011.

Summary: From 2007 through 2011, Downeast PHD has consistently reported lower percentages of individuals admitted for substance abuse treatment who also have a mental health diagnosis compared to statewide rates of such admissions. Since 2007, however, the rate of admissions for those with co-occurring mental health and substance use disorders has increased significantly in Downeast PHD, from 25 percent to 40 percent.

Figure 38. Percent of individuals admitted for substance abuse treatment that also had a mental health diagnosis: 2007-2011



Source: TDS

Treatment Admissions for Substance Abuse

Substance abuse treatment admissions are an indicator of how many people *receive treatment* for a substance abuse problem. These admissions can be voluntary, but they can also be court-ordered. Treatment admission data should not be used as an indicator of the magnitude of the problems related to substance abuse. Rather, treatment should been seen a major consequence stemming from substance use and one that requires many resources.

The overall number of clients admitted to treatment has been declining since 2007, from 14,843 to 11,380 in 2011. Mainers continued to seek out treatment for abuse involving a wide array of substances besides alcohol; in 2011 there were 4,421 admissions for alcohol as the primary substance. This was followed by synthetic opioids (3,630) and marijuana (1,094).

In 2009, for the first time, there were more primary treatment admissions related to synthetic opioids than for alcohol in Downeast PHD. In 2011, treatment admissions for opioids had increased dramatically (occurring at a rate of 41%), surpassing alcohol-related treatment admissions by a significant margin; this rate was also higher than the statewide average for such admissions. Downeast PHD has a slightly higher proportion of secondary admissions related to marijuana as compared to the statewide average, but synthetic opioids are a close second in this respect.

Treatment Admissions

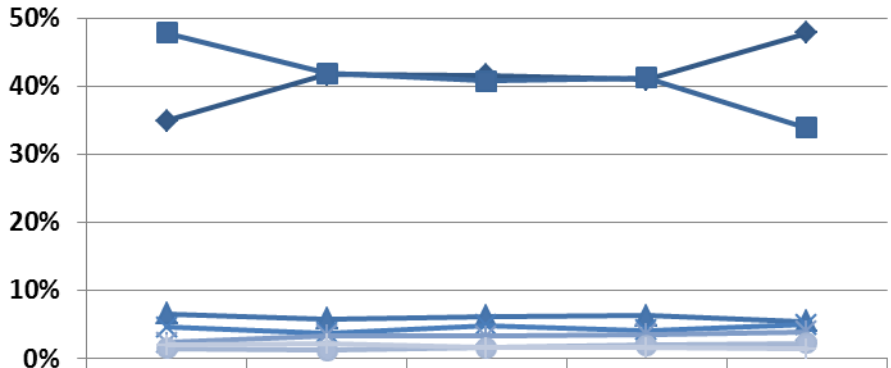
Indicator Description: PRIMARY TREATMENT ADMISSIONS. This measure reflects substance abuse treatment admissions. A "primary" substance is identified during the treatment admissions process based on use patterns (e.g., frequency, duration, quantity) and the risk(s) posed to the individual. The analysis excludes admissions for shelter/detoxification services.

Why Indicator is Important: The number of substance abuse treatment admissions is bound by both the need and the capacity for treatment. Treatment admission data are not a good indicator of substance use, abuse or dependence but provide an indication of service usage and the impact of substance use on the behavioral healthcare system.

Data Source(s): TDS, 2007-2011.

Summary: In 2011, 48 percent of all primary treatment admissions in Downeast PHD were related to synthetic opioids[11] followed by alcohol at 34 percent. Primary treatment admissions related to synthetic opioids surpassed those related to alcohol for the first time in 2009.

Figure 39. Primary drug admissions for adults in Downeast PHD: 2007-2011



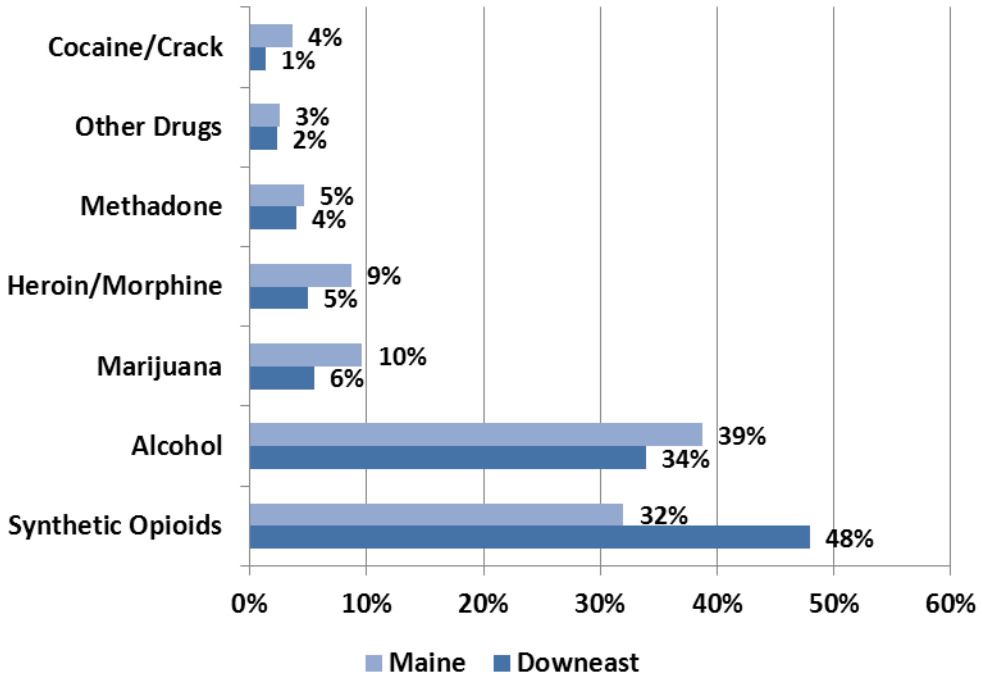
	2007	2008	2009	2010	2011
Synthetic Opioids	35%	42%	42%	41%	48%
Alcohol	48%	42%	41%	41%	34%
Marijuana	7%	6%	6%	6%	6%
Heroin/Morphine	5%	4%	5%	4%	5%
Methadone	2%	3%	3%	4%	4%
Other Drugs	2%	1%	2%	2%	2%
Cocaine/Crack	2%	2%	2%	2%	1%

Source: TDS

[11] "Synthetic opioids" excludes methadone and buprenorphine.

Summary: In 2011, 48 percent of primary treatment admissions in Downeast PHD were for synthetic opioids, significantly higher compared to the statewide rate (32%). Primary treatment admissions related to alcohol were lower in Downeast PHD (34%) than found at the state level (39%). This appears to be in line with the patterns of alcohol and substance use seen in this district.

Figure 40. Primary drug admissions for adults: 2011



Source: TDS

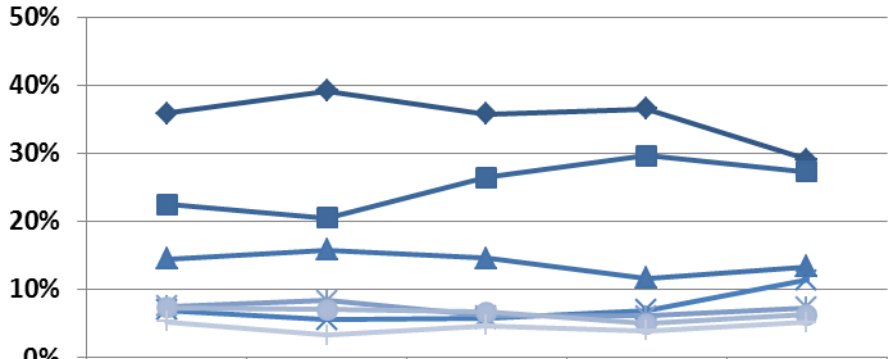
Indicator Description: SECONDARY TREATMENT ADMISSIONS. This measure reflects substance abuse treatment admissions. A "secondary" substance is identified during the admissions process as one used by the individual and for which treatment may be received, but it is not the primary substance for which treatment was sought. The analysis excludes admissions for shelter/detoxification services.

Why Indicator is Important: The number of substance abuse treatment admissions is bound by both the need and the capacity for treatment. Treatment admission data are not a good indicator of substance use, abuse or dependence but provide an indication of service usage and the impact of substance use on the behavioral healthcare system.

Data Source(s): TDS, 2007-2011.

Summary: In 2011, 29 percent of secondary treatment admissions in Downeast PHD were for marijuana, followed by synthetic opioids (27%) and then alcohol (13%). Since 2008, synthetic opioids appear to be increasing as a secondary substance in Downeast PHD, while the rate alcohol-related secondary treatment admissions appears to be fairly static.

Figure 41. Secondary drug admissions for adults in Downeast PHD: 2007-2011

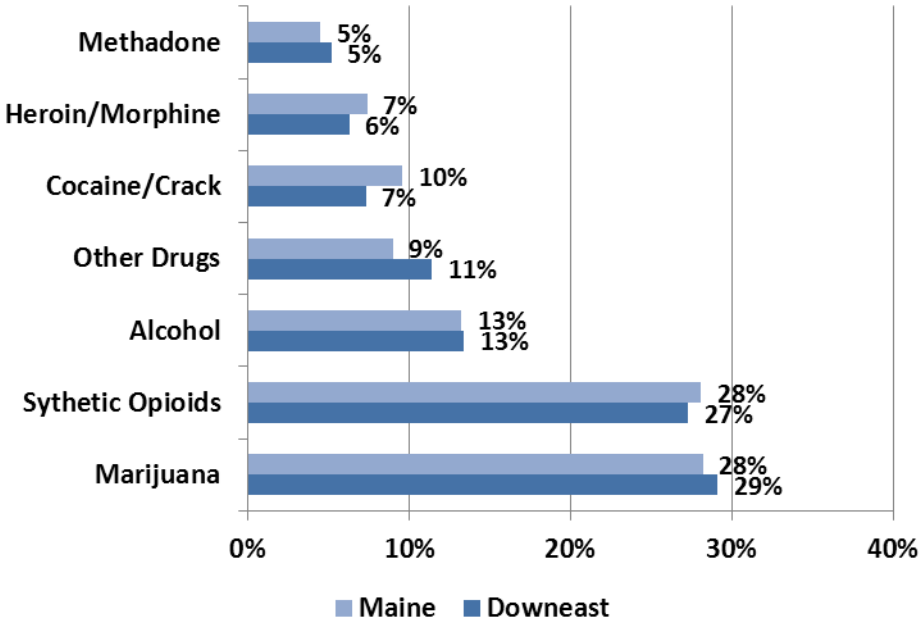


	2007	2008	2009	2010	2011
Marijuana	36%	39%	36%	37%	29%
Sythetic Opioids	23%	21%	27%	30%	27%
Alcohol	15%	16%	15%	12%	13%
Other Drugs	7%	6%	6%	7%	11%
Cocaine/Crack	8%	8%	6%	6%	7%
Heroin/Morphine	7%	7%	7%	5%	6%
Methadone	5%	3%	5%	4%	5%

Source: TDS

Summary: In 2011, the substances listed as secondary admissions in the treatment data system were similar in Downeast as they were for the State as a whole.

Figure 42. Secondary drug admissions for adults: 2011



Source: TDS

Appendix: Data Sources

This report includes data that was gathered from a number of data sources. A detailed description of each source is provided below, consisting of information about the data included in each source, and retrieval or contact information. The report includes data that were available through May 2012.

There are multiple purposes for this report. One is to provide a snapshot of the most recent data regarding substance abuse, while another is to examine trends over time. Therefore, each indicator may have multiple sources of data that are included. While each indicator provides a unique and important perspective on drug use in Maine, none should individually be interpreted as providing a full picture of drug trends in Maine. In particular, the percentages and figures from one data source do not always align with the data and percentages from a similar source. Older data are often included in order to examine an indicator among a specific population or to find trends over time. When discussing rates of prevalence, however, the user should rely upon the most recent data source available.

Description of Data Sources

Behavioral Risk Factor Surveillance System (BRFSS). The BRFSS is a national survey by the U.S. Centers for Disease Control and Prevention (CDC) to adults in all 50 states and several districts and territories. In Maine, it is administered by the Maine Center for Disease Control and Prevention (DHHS). The instrument collects data on adult risk behaviors, including alcohol abuse. BRFSS defines heavy drinking as adult men having more than two drinks per day and adult women having more than one drink per day, and binge drinking as males having five or more drinks on one occasion and females having four or more drinks on one occasion. The most recent data available are from 2010. Older data are also included for trending analyses. Public Health District data were obtained through special analysis. Contact: Timothy Diomede, SEOW Coordinator; timothy.diomede@maine.gov; (207) 287-2596.

Maine Department of Public Safety (DPS), Uniform Crime Reports (UCR). UCR data include drug and alcohol arrests. Drug arrests include sale and manufacturing as well as possession of illegal substances. Liquor arrests include all liquor law violations. OUI arrests are arrests for operating a motor vehicle under the influence of a controlled substance. DPS data are now available from 2010. Arrest data may reflect differences in resources or focus of law enforcement efforts so may not be directly comparable from year to year.
Retrieval: http://www.maine.gov/dps/cim/crime_in_maine/cim.htm

Maine Department of Public Safety (DPS), Liquor Licensing and Compliance. DPS issues and renews licenses for the manufacture, importation, storage, transportation and sale of all liquor and administers those laws relating to licensing and the collection of taxes on malt liquor and wine. DPS maintains a list of all active licenses that can be accessed online.

Retrieval: http://www.maine.gov/dps/liqr/active_licenses.htm

Maine Department of Transportation (MDOT). MDOT analyzes information on all traffic statistics. Statistics for years 2006 through 2011 regarding the year of occurrence and the number of alcohol/drug-related crashes/injuries were obtained via personal correspondence. They receive crash data from the Maine Bureau of Highway Safety. Due to the population estimates for July 1, 2010 being unavailable through the U.S. Census Bureau, only data from years 2006 through 2011 were analyzed. Contact: Duane Brunell, Safety Performance Analysis Manager; duane.brunell@maine.gov; (207) 624-3278.

Maine Integrated Youth Health Survey (MIYHS). The MIYHS is a statewide survey administered biennially through a collaborative partnership by the Maine Office of Substance Abuse (OSA) the Maine Center for Disease Control and Prevention and the Maine department of Education to students in grades 5 through 12. The survey collects information on student substance use, risk factors related to substance use, as well as consequences, perceptions and social risk factors related to substances, and collects information on many other health factors. As of the date of this report, the most recent data available are from 2011. Due to changes in the survey administration and structure, the new survey data cannot be trended with the Maine Youth Drug and Alcohol Survey (MYDAUS). Contact: Stephen Corral, Substance Abuse Program Specialist, Office of Substance Abuse, stephen.corral@maine.gov; (207) 287-2964.

Maine Health Data Organization (MHDO). MHDO data includes all inpatient admissions to all hospitals in Maine for calendar year 2009. Data categories created by the authors include alcohol, opioids, illegal drugs, and pharmaceuticals. All drug categories include intoxication, abuse, dependence, and poisoning cases related to the drug. The opioid category includes methadone, heroin, and opiates. The illegal drug category includes crack/cocaine, cannabis, and hallucinogens. The pharmaceuticals category includes all other non-opioid medications (including stimulants and depressants). Contact: Maine Health Data Organization (MHDO), lisa.parker@maine.gov; (207) 287-3225.

Maine Office of the Chief Medical Examiner. The Maine Office of the Chief Medical Examiner maintains records of all deaths associated with drug overdose. Drug categories include methadone, cocaine, benzodiazepines, oxycodone and heroin/morphine. The death data are compiled on an annual basis and must be finalized prior to release and so are not available to track changes that may occur over shorter time frames. Contact: Dr. Marcella Sorg, Director, Rural Drug & Alcohol Research Program, Margaret Chase Smith Policy Center, University of Maine; marcella_sorg@umit.maine.edu; (207) 581-2596.

National Survey on Substance Use and Health (NSDUH). The NSDUH is a national survey administered annually by the Substance Abuse and Mental Health Services Administration (SAMHSA) to youth grades 6 through 12 and adults ages 18 and up. The instrument collects information on substance use and health at the national, regional and state levels. The advantage of NSUDH is that it allows comparisons to be made across the lifespan (that is, ages

12 and up). However, NSDUH is not as current as other data sources; as of this report, data at the sub-state level are available through 2006-2008; Public Health District data were obtained through special request. Contact: Anne Rogers, Office of Substance Abuse, anne.rogers@maine.gov; (207) 287-4706.

Prescription Monitoring Program (PMP). PMP maintains a database of all transactions for class C-II through C-IV drugs dispensed in the state of Maine. It is important to note that the number of prescriptions per capita does not indicate the overall number of pills prescribed, the size/dosage of the pills, or drugs that fall within DEA "Schedules I or V". At the time of this report, all pharmacies, excluding the Veterans Administration, federally regulated methadone clinic and the Indian Health Service (IHS) center, which dispense in Maine report to the Prescription Monitoring Program. IHS is scheduled to begin reporting during the summer of 2012. Prescription counts do not reflect amounts in terms of dosage or quantity of pills, but rather represent the volume of active prescriptions during the time period. The counts included in this report represent the number of prescriptions filled between 2006 and 2011. Contact: Patricia Lapera, PMP Coordinator, Office of Substance Abuse; patricia.lapera@maine.gov; (207) 287-3363. Retrieval: http://www.maine.gov/dhhs/osa/data/pmp/index.htm

Treatment Data System (TDS). TDS is a statewide database that includes information about clients admitted to treatment in OSA-funded facilities through December 2011. Analyses in this report are based on clients' reported primary, secondary and tertiary drug(s) of choice as well as other demographic and background information that is collected at intake. Drug categories included in this report are alcohol, marijuana, cocaine, heroin, synthetic opiates and methadone/buprenorphine. Contact: Stacey Chandler, Data Control Specialist, Office of Substance Abuse, stacey.chandler@maine.gov; (207) 287-6337.

U.S. Census Bureau. The U.S. Census provides summary profiles showing frequently requested data items from various Census Bureau programs. Profiles are available for all states and counties, and for cities and towns with more than 25,000 people. Data are updated no less than annually. Retrieval for Maine census data: http://quickfacts.census.gov/qfd/states/23000.html