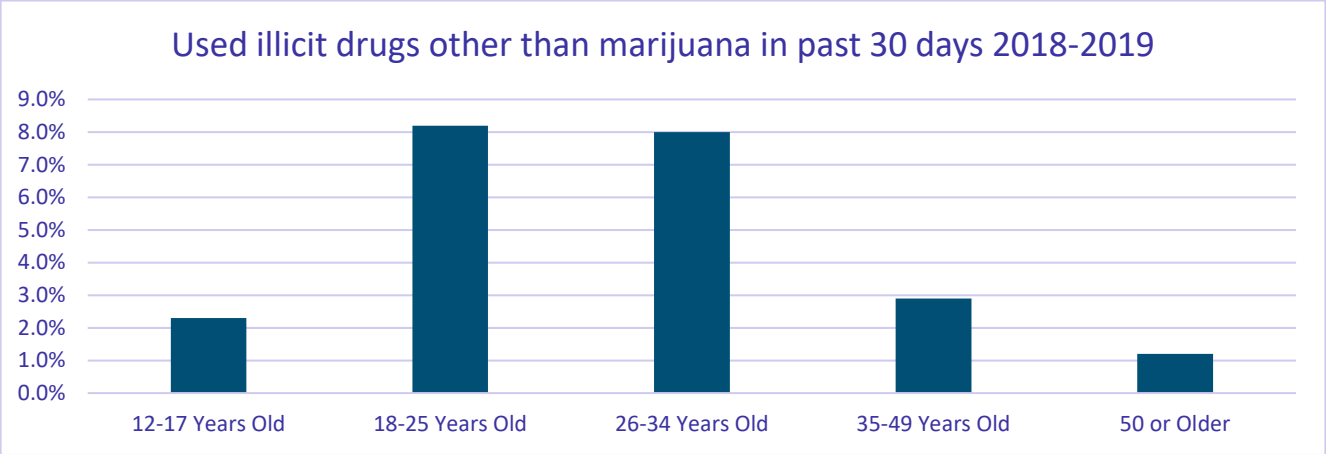
Maine Recovery Council Needs Assessment Data, 2023

Funding Aims

On October 10, 2023, the Maine Recovery Council voted on a goal for their spending. That goal was to reduce overdose deaths by 25% by December 31, 2025 and to mitigate other harms caused by opioid misuse. Recommend using calendar year 2023 as baseline, which is not available at this writing (YTD, Jan-Nov 559 overdose deaths).

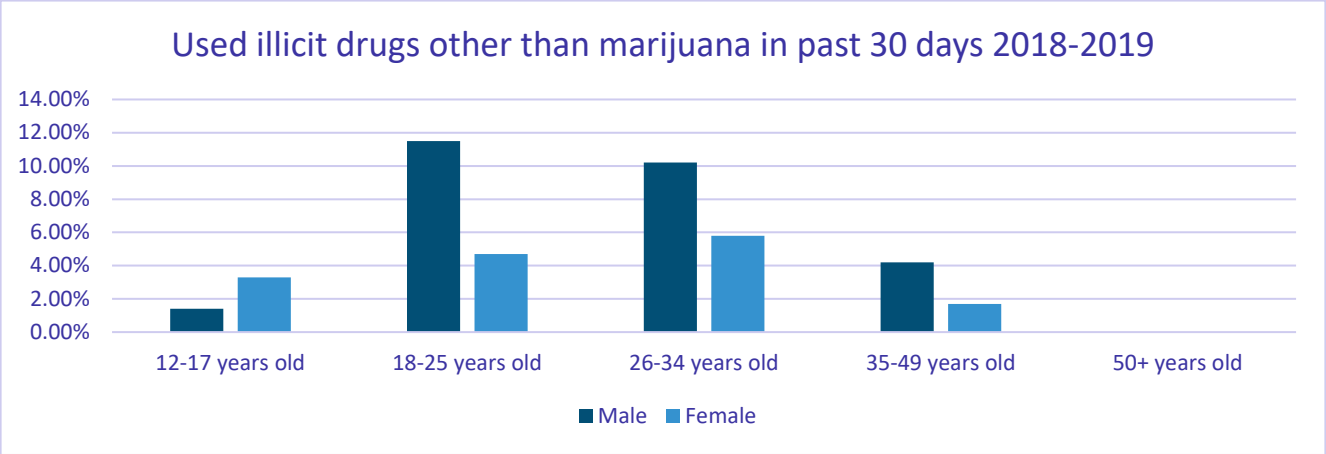
Who Uses Drugs in Maine

Approximately 8% of 18-34 year-olds in Maine had misused drugs other than marijuana in the past 30 days in the two-year period of 2018-2019, the most recent available data from the National Survey on Drug Use and Health (NSDUH). NSDUH is a household survey and as such, misses people who are institutionalized or unhoused, though it does capture people living in homeless shelters. Other age groups are much less likely to use drugs that might lead to overdose.



Preliminary data from 2021 shows much lower prevalence of drug use other than marijuana for all ages, with only 1.8% of adolescents, 4.0% of 18-25 year-olds and 1.9% of those over age 26 using drugs other than marijuana in the past month. The small sample size in a single year prevents further breakdown of the older age group. The COVID-19 pandemic was still at its peak early in 2021, so the data may reflect both reduced opportunity for use and differences in data collection methods. Those that continued to use

in 2020 and 2021 may have been the highest risk group as deaths increased rather than decreasing with lower reported use.

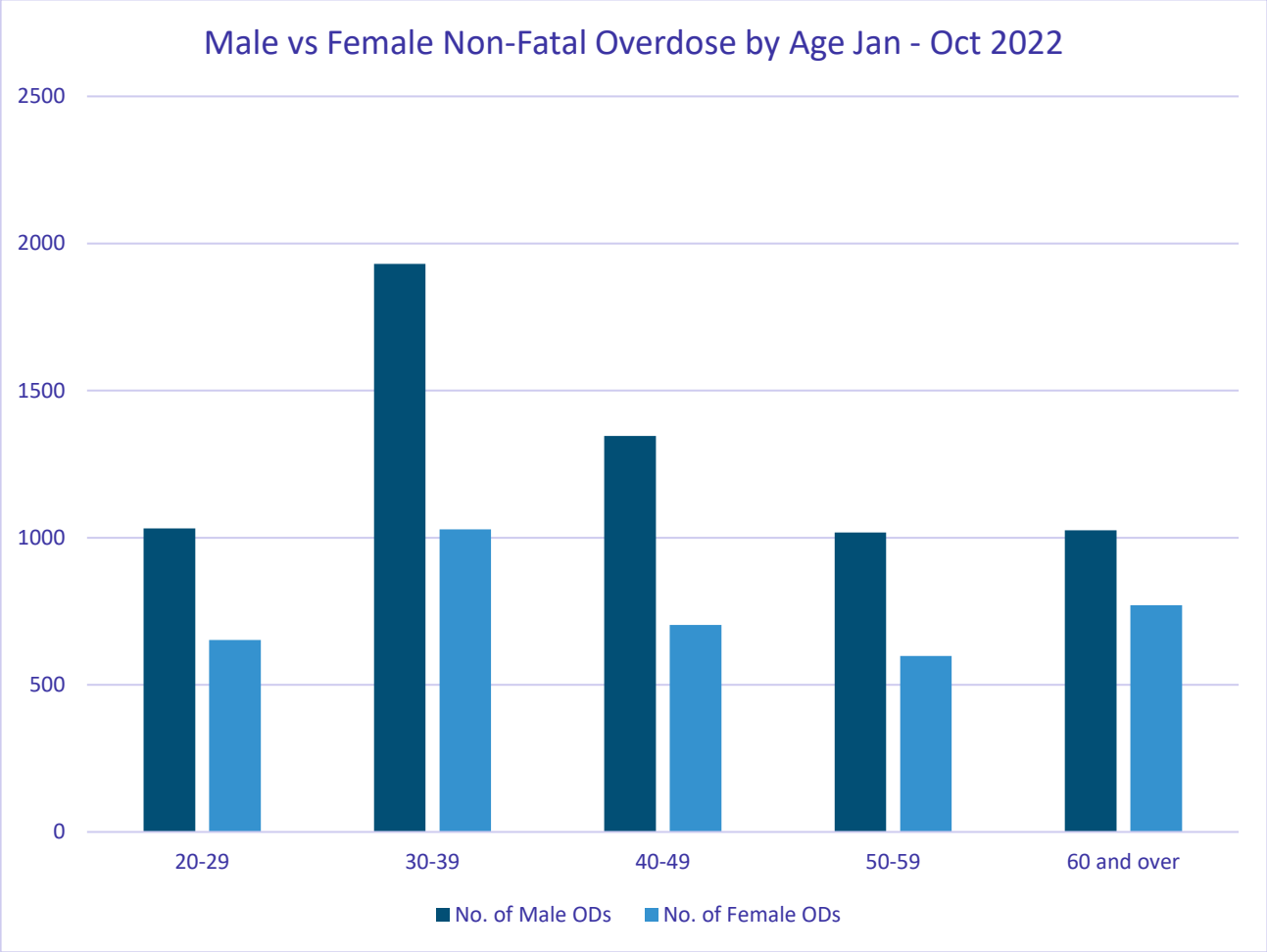


Males are more likely to use than females at all ages except for adolescence where girls are more likely to use than boys. The difference in that age group is small but mirrors a change in alcohol and tobacco consumption in adolescents where girls began to use more than boys in the past decade. The proportions for people 50+ are suppressed because the numbers are too small in one category, probably women.

Who Overdoses in Maine

Non-Fatal Overdose

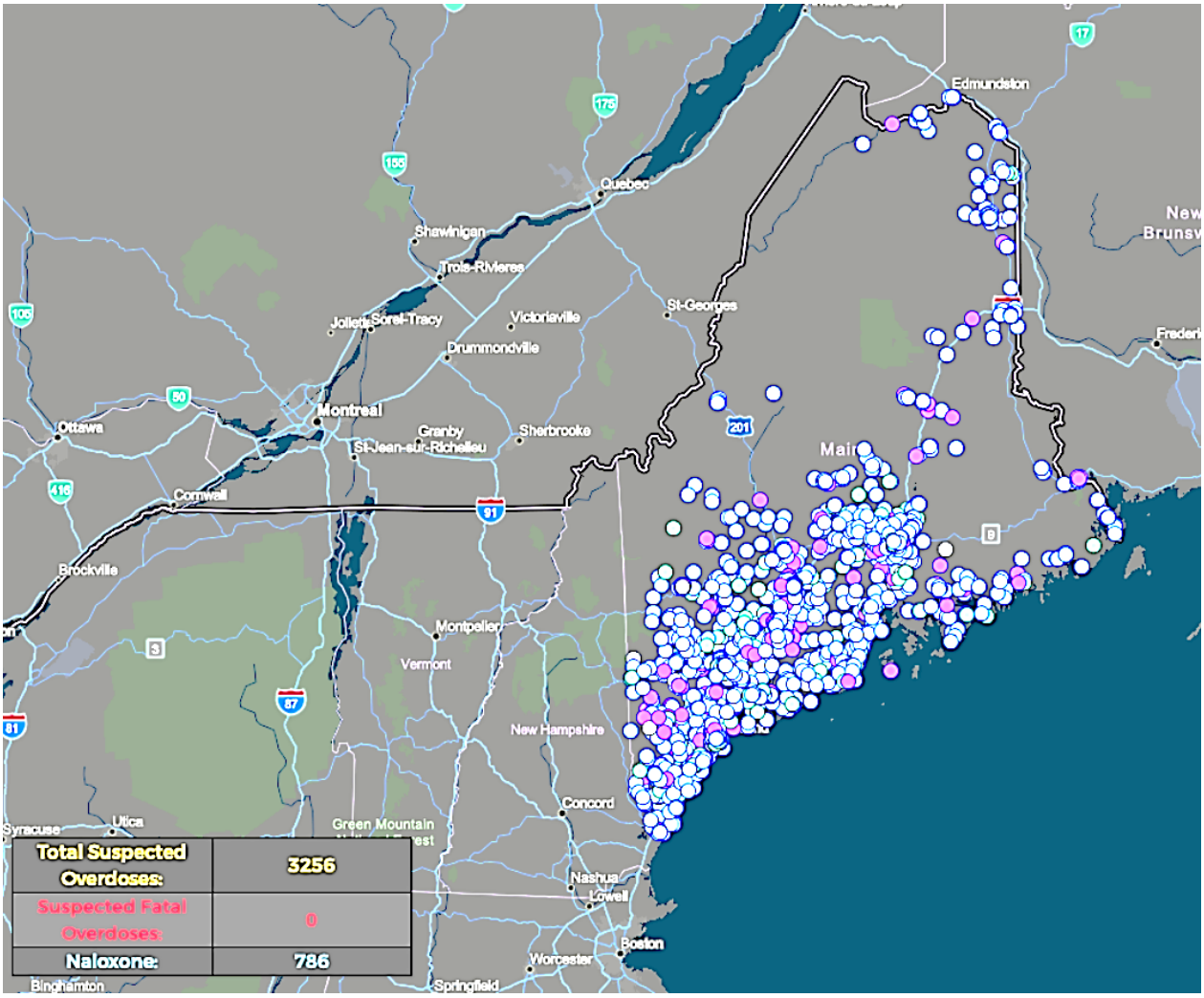
Males of all ages are more likely to have a non-fatal overdose than females of any age. In the 10-month period January through October, 2022, the most recent data where this detail is available,



6352 or 58% of the 10,971 non-fatal overdoses reported male. The proportion of males over females is slightly higher among those age 30-49 at 65%.

Non-fatal overdoses occur all over the state.

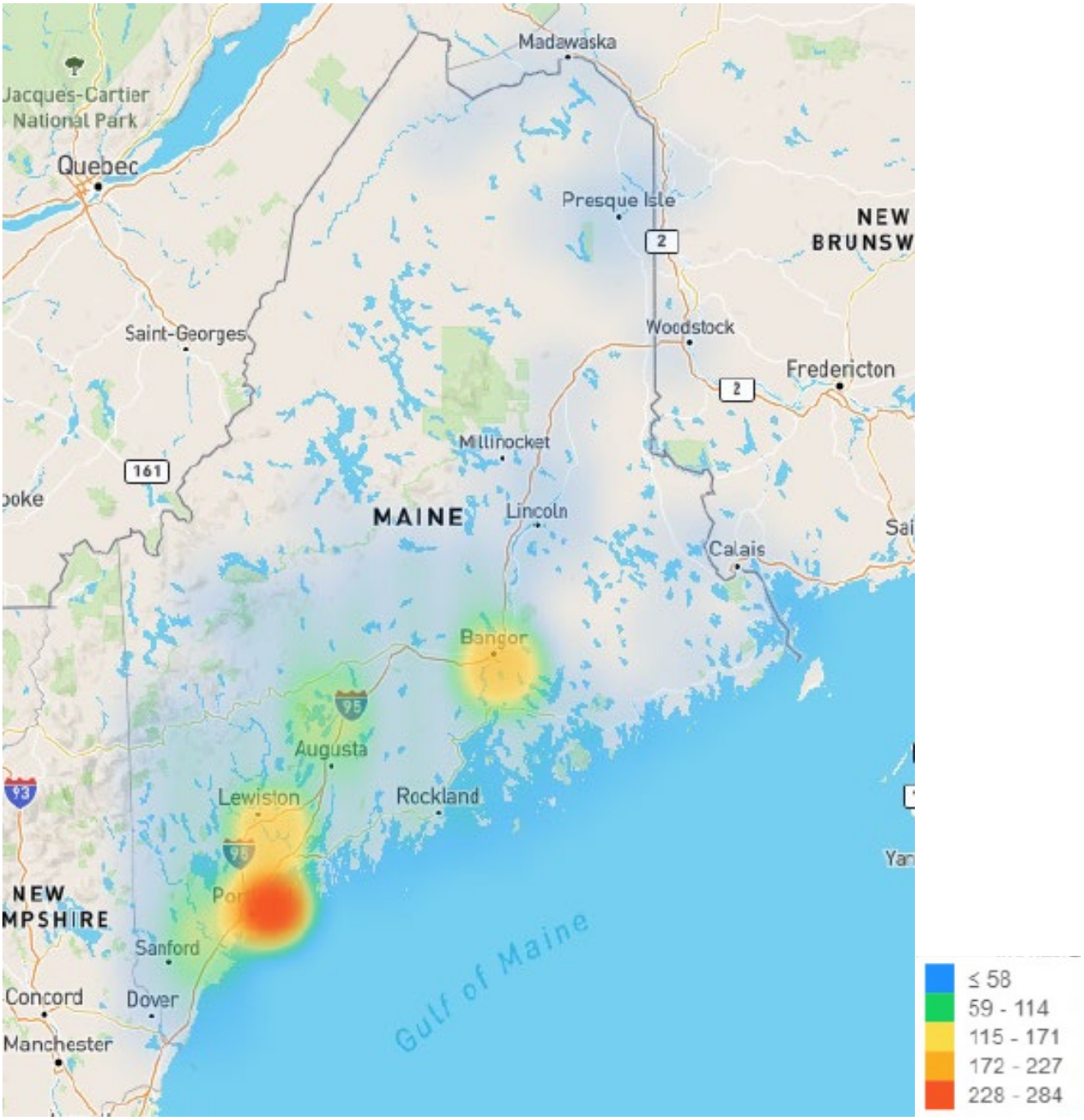
Jan 1- Sep 22, 2023 OD Map Non-Fatal Overdose



*OD Map is not used by all municipalities and captures about ½ of total overdoses.

However, there are more overdoses in the population centers as the heat map below demonstrates.

January – September, 2023 OD Map Non-Fatal Overdose Heat Map



Androscoggin and Penobscot counties have slightly higher than expected numbers of non-fatal overdoses compared to their population proportion. York County has slightly fewer than expected based on population alone.

Table 3 from Maine Monthly Overdose Report, October 2023 page 3

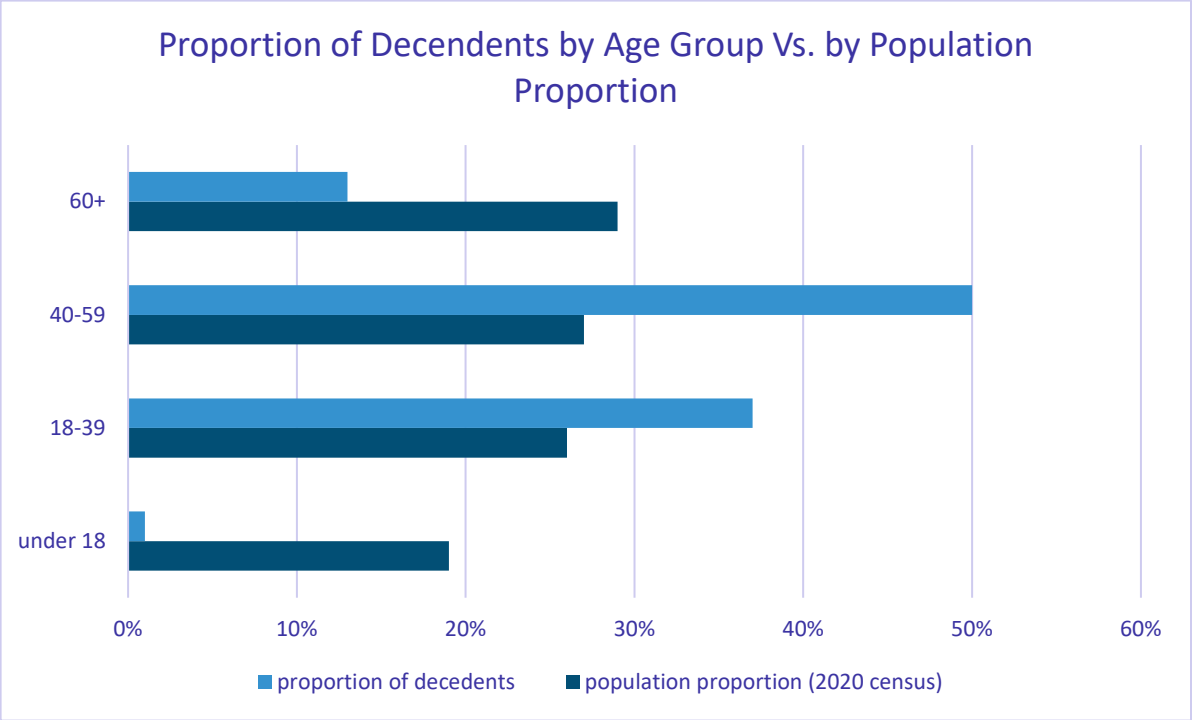
Table 3: County of EMS incident among suspected and confirmed nonfatal overdoses

	% 2020 estimated Census population	Jan–Dec 2022 N = 9377		Jan-Oct 2023 Est. N = 7544		Oct 2023 Est. N = 743	
Androscoggin	8%	1055	(11%)	777	10%	68	9%
Aroostook	5%	490	(5%)	371	5%	50	7%
Cumberland	22%	2194	(23%)	1727	23%	160	22%
Franklin	2%	140	(1%)	120	2%	16	2%
Hancock	4%	287	(3%)	224	3%	17	2%
Kennebec	9%	922	(10%)	749	10%	63	8%
Knox	3%	245	(3%)	260	3%	31	4%
Lincoln	3%	162	(2%)	157	2%	29	4%
Oxford	4%	410	(4%)	302	4%	32	4%
Penobscot	11%	1293	(14%)	1081	14%	99	13%
Piscataquis	1%	90	(1%)	93	1%	11	1%
Sagadahoc	3%	130	(1%)	110	1%	7	1%
Somerset	4%	392	(4%)	374	5%	42	6%
Waldo	3%	199	(2%)	164	2%	14	2%
Washington	2%	221	(2%)	152	2%	14	2%
York	16%	1147	(12%)	883	12%	90	12%

*EMS nonfatal overdose counts include incidents where a patient may have died after admission to the ED. Please note numbers will fluctuate from month-to-month as public safety agencies catch up their reporting. Due to methodological convention, alcohol-only cases are excluded from this table. However, we recognize that alcohol is a large part of substance misuse epidemic. Cases with both drugs and alcohol are included.

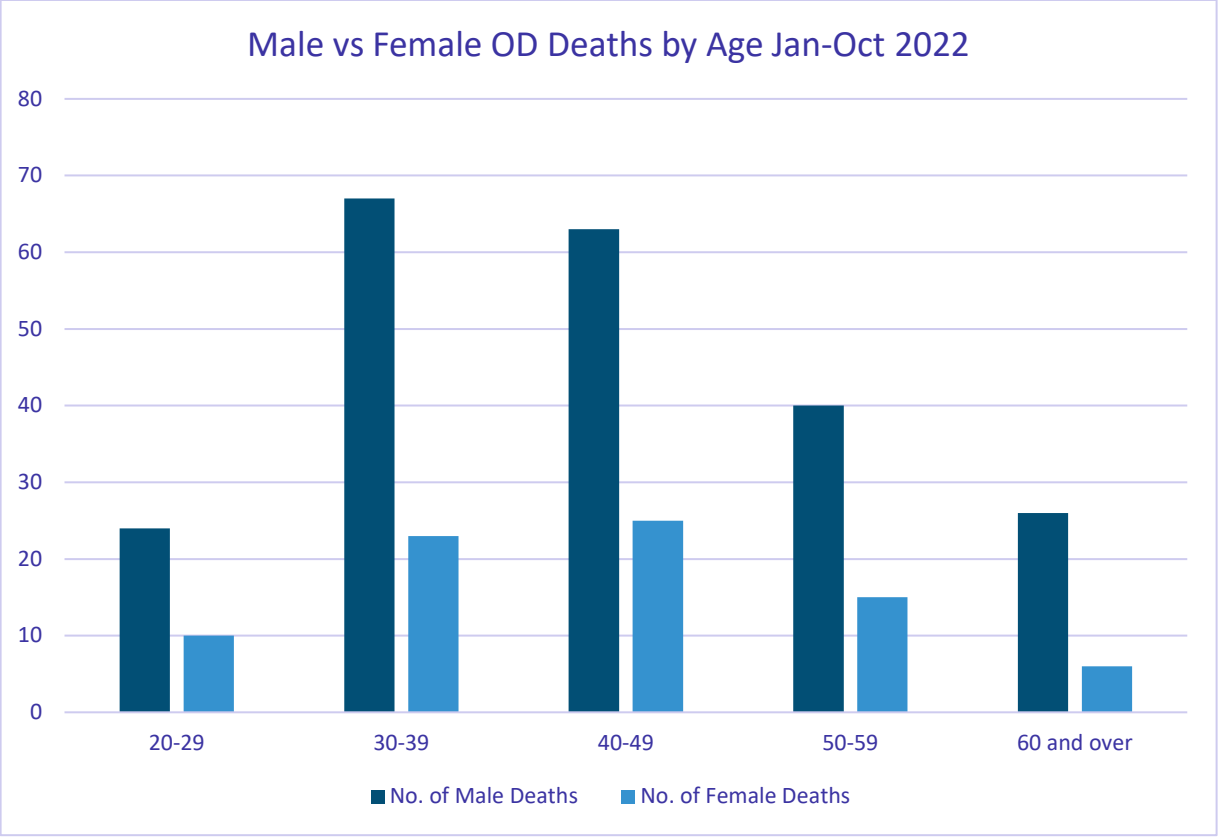
Fatal Overdose

While people in their 30's are the most likely to have an overdose, people in their 40's and 50's are most likely to die of an overdose. Overdose deaths are disproportionately distributed by age and occur primarily among working age adults.



Males are also more likely to die from overdose. The difference between men and women is even greater when comparing overdose deaths to overdoses that did not result in death. 2022 dates used are for comparison to non-fatal overdose as that was the most recent time period for detailed age and sex data availability for non-fatal overdoses. The distribution by age and sex is similar

for deaths in the time period in 2023, though there are fewer deaths overall in 2023 than there were in 2022.

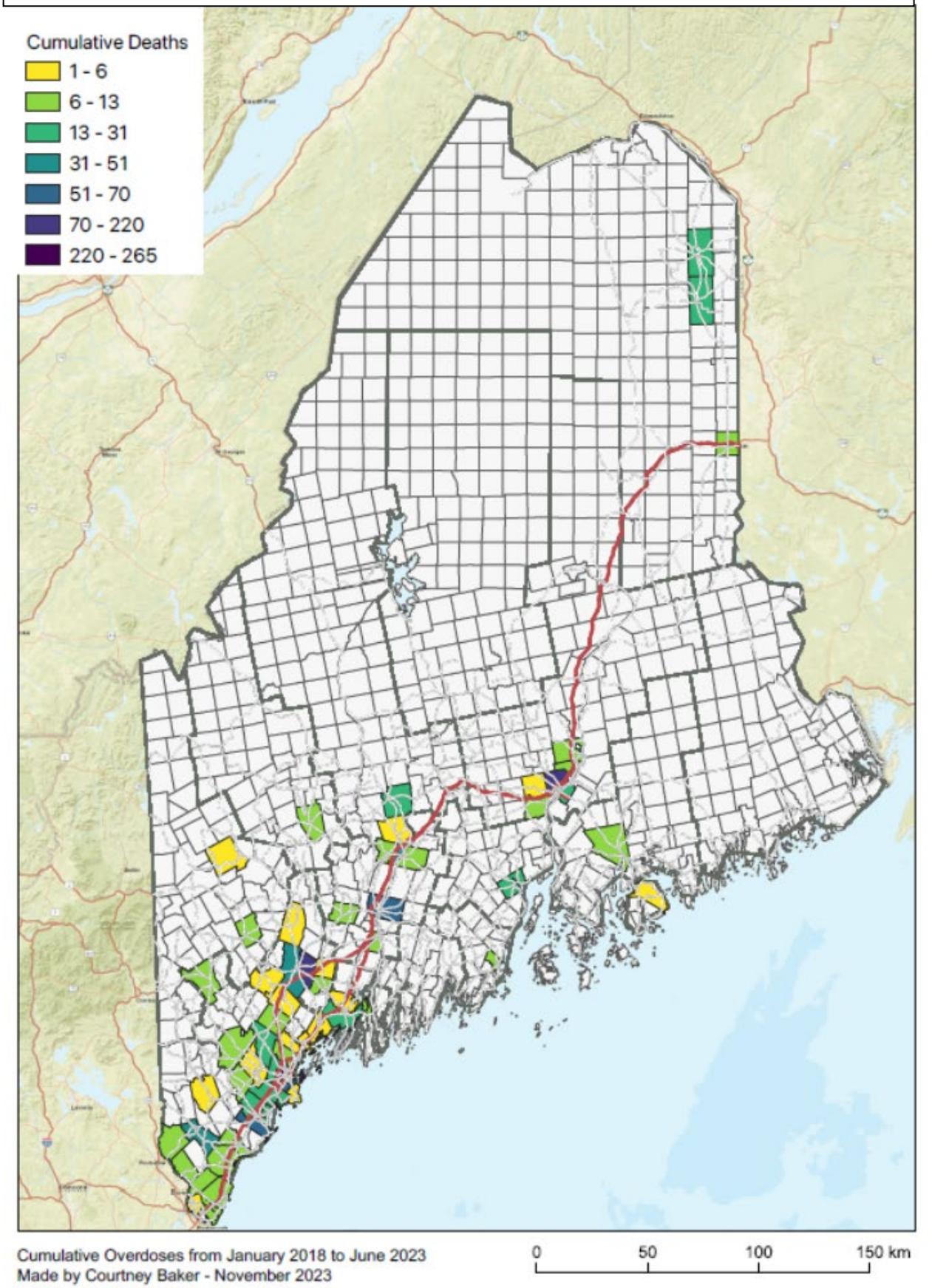


In 2023 to date (January-October)

73% of overdose decedents are male
91% of overdose decedents are white, but the 4% who are black is higher than the population proportion of 2%.
62% of overdose decedents are over age 40
11% of overdose decedents are unhoused
35% of overdose decedents had at least one known prior non-fatal OD

The geographical distribution of fatal overdoses is much the same as non-fatal overdoses, with population centers having the greatest number of overdose deaths and some municipalities having a slightly higher than expected number of deaths based on their population.

Cumulative Overdose Deaths from January, 2018 through June, 2023



Cumulative Overdoses from January 2018 to June 2023
Made by Courtney Baker - November 2023

Drugs that cause overdose death

Fentanyl is the primary cause of overdose death. Fentanyl in combination with stimulants made up over half of the overdose deaths to date in 2023. It would be important to understand how much of the mixture of fentanyl with stimulants is deliberate and how much is contamination of stimulants with fentanyl unbeknownst to the user as the harm reduction and treatment strategies applied may be different for each type of drug user.

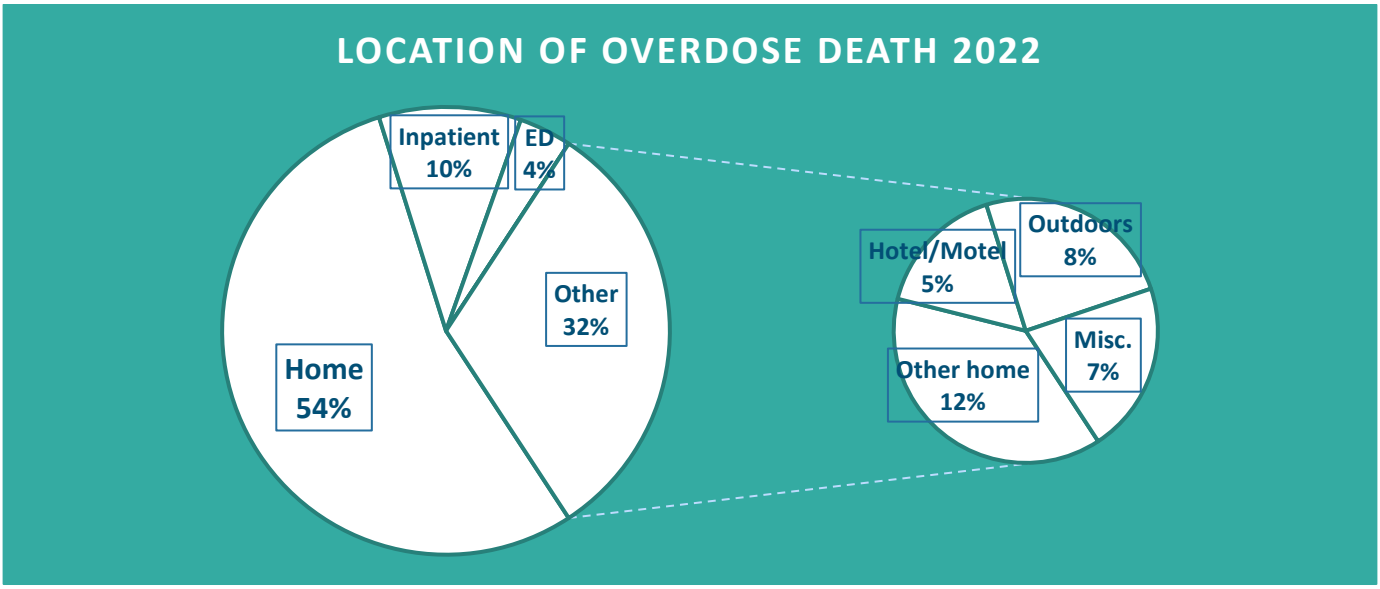
Table 8 from the October 2023 Maine Monthly Overdose Report page 7.

Table 8: Key drug categories and combinations causing death among confirmed overdoses

Cause of death (alone or in combination with other drugs) Sample size for confirmed cases only	Jan–Dec 2022 N = 723		Jan–Oct 2023 Est. N = 480		Oct 2023 Est. N = 27	
Fentanyl or fentanyl analogs	560	(77%)	373	78%	17	63%
Heroin	19	(3%)	11	2%	1	4%
Cocaine	213	(29%)	173	36%	12	44%
Methamphetamine	234	(32%)	151	31%	8	30%
Pharmaceutical opioids**	156	(22%)	89	19%	6	22%
Fentanyl and heroin	18	(2%)	11	2%	1	4%
Fentanyl and cocaine	171	(24%)	143	30%	9	33%
Fentanyl and methamphetamine	189	(26%)	124	26%	5	19%
Fentanyl and xylazine	46	(6%)	41	9%	2	7%
Fentanyl and tramadol	10	(1%)	3	1%	0	0%

**Nonpharmaceutical tramadol is now being combined with fentanyl in pills and powders for illicit drug use. When found in combination with fentanyl, and in the absence of a known prescription, tramadol is categorized as a nonpharmaceutical opioid.

People who die from an overdose are most likely to die at home.



Conclusions

Young adults, particularly men under age 30, are the most likely to use drugs that could lead to overdose. However, people in their 30's, particularly men, are more likely to experience an overdose, and people between age 40-59 are more likely to die of an overdose. Targeting different age groups for different strategies may be more effective and efficient. Targeting middle aged men would reach the group most at risk of dying.

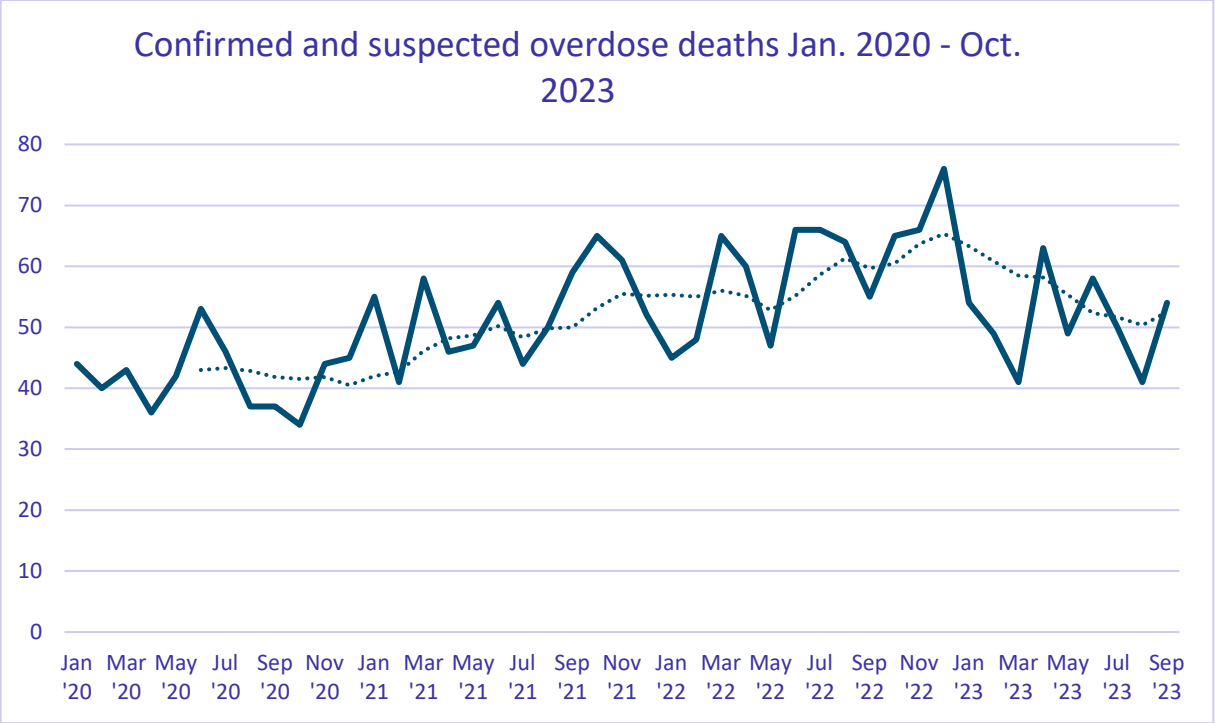
Both fatal and non-fatal overdoses are distributed mostly by population but a few counties and townships stand out as having a higher proportion than population would dictate (Penobscot, Androscoggin, Bangor area, Augusta, Lewiston, Portland, Biddeford, Sanford). Targeting these population centers may have a greater

impact on reducing death rates and achieving the target of a 25% reduction in deaths.

Most fatal and non-fatal overdoses involve fentanyl in combination with other drugs. It would be useful to conduct research to understand whether people are seeking out the combination or using it accidentally as strategies for addressing people with primarily stimulant use disorders will be different from those for people with opioid use disorders or polysubstance use disorder.

Most people die at home alone. Addressing use in isolation is a target that may have rapid results.

The trajectory for overdose deaths appears to be on a downward trend.



Dotted line is a six-month rolling average for smoothing purposes

Recovery Council members were particularly interested in addressing disparities in access to care as a means of mitigating other harms caused by opioid misuse. These outcomes could be captured in time to travel to services and wait time to enter services. Travel time data is not currently available. Wait time varies by service and should be measured separately for each level of care.

Who Receives Services in Maine

The Treatment Episode Dataset (TEDS) is collected by SAMHSA from all states. It reports on treatment admissions to publicly funded treatment programs. 2021 is the most recent year available. Data for 2021 indicates the treatment system in Maine was still below full capacity and there was much missing data due to the pandemic, so 2019 data is reported here with notes on how 2021 differs proportionately. Data are reported as admissions, not individuals. One individual could have multiple admissions over the course of the year.

In 2021 6058 admissions to treatment for SUD were reported compared to 8481 in 2019. 60% of admissions were male, 95% were White, with less than 2% of any other race or of Hispanic ethnicity.

Very few admissions were for drugs other than opioids or alcohol in either year.

2019 Treatment admissions by primary substance

Substance use (primary)	Freq.	Percent
Missing/unknown/not collected/invalid	14	0.17
None	3	0.04
Alcohol	3,179	37.48
Cocaine/crack	379	4.47
Marijuana/hashish	282	3.33
Heroin	2,988	35.23
Non-prescription methadone	153	1.8
Other opiates and synthetics	1,146	13.51
Hallucinogens	7	0.08
Methamphetamine/speed	209	2.46
Other amphetamines	19	0.22
Other stimulants	19	0.22
Benzodiazepines	58	0.68
Other sedatives or hypnotics	7	0.08
Other drugs	18	0.21
Total	8,481	100

2021 Treatment admissions by primary drug

Substance use (primary)	Freq.	Percent
Missing/unknown/not collected/invalid	17	0.28
None	29	0.48
Alcohol	2,048	33.81
Cocaine/crack	230	3.8
Marijuana/hashish	176	2.91
Heroin	2,598	42.89
Non-prescription methadone	23	0.38
Other opiates and synthetics	559	9.23
Hallucinogens	9	0.15
Methamphetamine/speed	274	4.52
Other amphetamines	11	0.18
Other stimulants	9	0.15
Benzodiazepines	48	0.79
Other sedatives or hypnotics	7	0.12
Over-the-counter medications	5	0.08
Other drugs	15	0.25
Total	6,058	100

2021 has significant missing data on treatment with MOUD, but in 2019 47% of admissions for people with OUD were for MOUD.

There was a significant increase in the proportion of admissions covered by Medicaid in 2021. In 2019, Medicaid covered 45% of admissions and in 2021, Medicaid covered 70% of admissions. The change was primarily from admissions that had no insurance (from 26% in 2019 to 14% in 2021) and missing or unknown (from 14% in 2019 to 3% in 2021). Private insurance payment went from 9.5% of admissions in 2019 to 8% in 2021.

In 2019 more admissions reported having co-occurring psychological problems than did not (3980 vs 2874), though 20% of admissions were missing this data point. In 2021, data on co-occurring disorders was missing from 60% of admissions.

Most admissions had prior admissions. While this may be a result of people moving through the treatment continuum, as each transition is documented as a new admission, it is also a result of repeated admissions for the same small set of people over time. For example, the most common occurrence for an admission to free standing detox, generally the first step in the continuum for people that use it, is to have had five or more previous admissions.

2019 Previous SUD treatment admissions by service

Type of treatment		Previous substance use treatment admissions						
service/setting	Missing	No prior	One prior	Two prior	Three prior	Four prior	Five or more prior	Total
Detox, 24-hour, hospital	0	53	24	29	21	22	61	210
Detox, 24-hour, free-standi	2	228	130	113	122	94	547	1,236
Rehab/residential, short	0	115	76	62	36	30	63	382
Rehab/residential, long	0	67	93	80	54	32	104	430
Ambulatory, intensive	3	312	253	213	126	68	131	1,106
Ambulatory, non-intensive	13	1702	1,194	798	456	243	400	4,806
Ambulatory, detox	0	128	61	55	28	15	24	311
Total	18	2605	1,831	1350	843	504	1,330	8,481

Maine did not collect data on wait times for most admissions in 2019. In 2021, there were fewer missing data on wait time compared to 2019. In 2021, most admissions occurred within a week, even for residential treatment. This may be due to lowered demand due to the pandemic, increased availability or a combination of both.

2019 Days waiting to treatment by service

Type of treatment	Days waiting to enter substance use treatment						
service/setting	Missing	0	1-7	8-14	15-30	31 or more	Total
Detox, Hospital	202	8	0	0	0	0	210
Detox, Freestanding	1,223	8	5	0	0	0	1,236
Rehab/residential, short	260	3	14	12	30	63	382
Rehab/residential, long	223	14	10	9	32	142	430
Ambulatory, IOP	1,029	72	4	0	1	0	1,106
Ambulatory, non-intensive	3,841	809	111	18	11	16	4,806
Ambulatory, detox	298	12	0	0	0	1	311
Total	7,076	926	144	39	74	222	8,481

2021 Days waiting to treatment by service

Type of treatment	Days waiting to enter substance use treatment						
service/setting	Missing	0	1-7	8-14	15-30	31 or more	Total
Detox, Hospital	38	236	7	4	8	25	318
Detox, Freestanding	17	297	2	0	0	0	316
Rehab/residential, short	9	67	117	67	59	49	368
Rehab/residential, long	19	9	23	16	21	85	173
Ambulatory, IOP	76	204	118	28	10	13	449
Ambulatory, non-intensive	557	2,330	820	195	151	89	4,142
Ambulatory, detox	4	288	0	0	0	0	292
Total	720	3,431	1,087	310	249	261	6,058

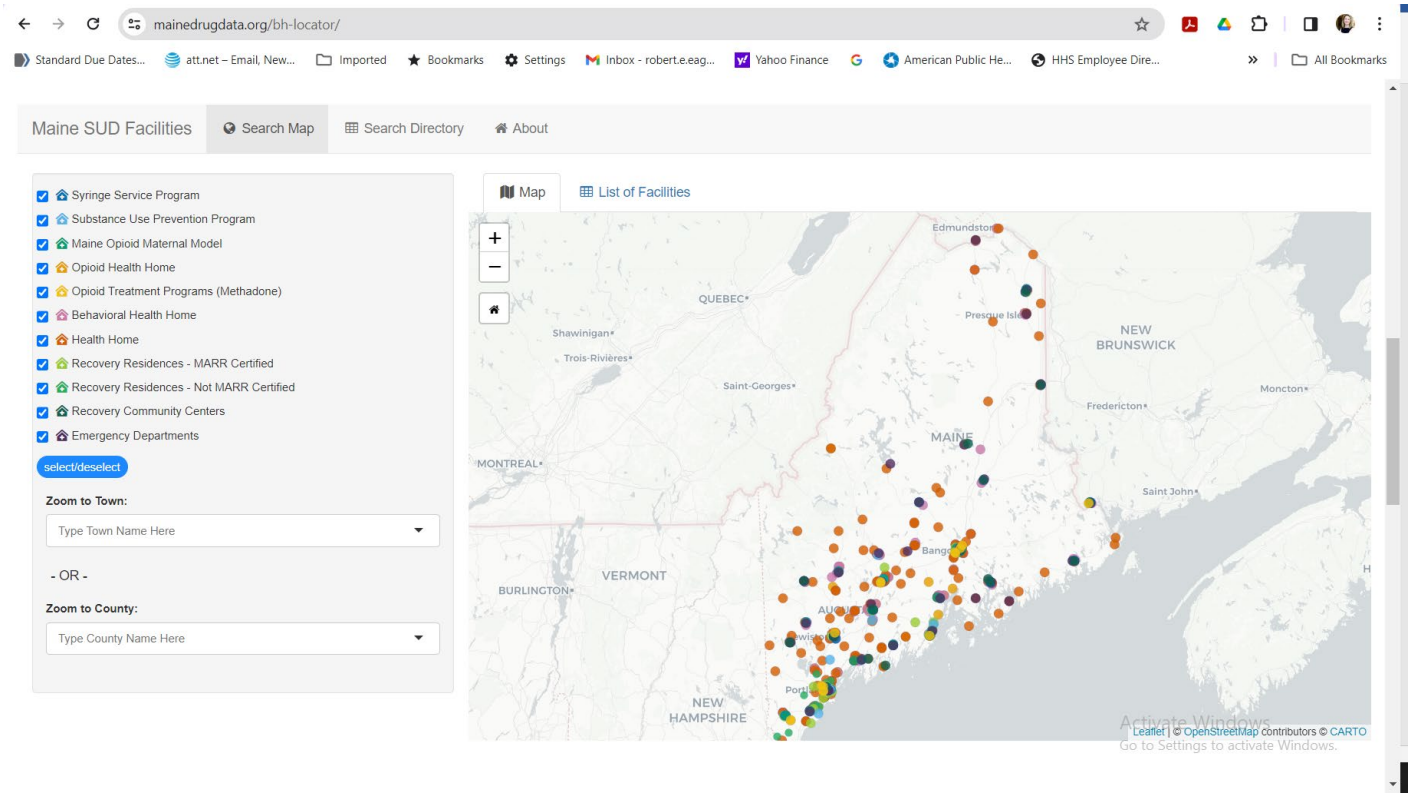
For treatment admissions, the age of first use of people admitted is most likely to be late teens and early twenties except for alcohol and marijuana, but a large number of opioid use admissions did begin in their early teens. It is interesting to note that age of initiation of opioids is more evenly spread across the age span than other drugs. While most prevention efforts target youth, prevention activities aimed at opioids specifically may need to cross age spans from middle school through adulthood.

Age of first use of primary drug for treatment admissions in 2019 by drug category

Substance use (primary)	missing	11 years	12-14 years	15-17 years	18-20 years	21-24 years	25-29 years	30 years	Total
Missing	11	0	1	0	0	0	2	0	14
None	3	0	0	0	0	0	0	0	3
Alcohol	60	282	943	1103	499	155	53	84	3179
Cocaine/crack	8	2	44	88	94	61	35	47	379
Marijuana/hashish	6	52	104	90	20	2	4	4	282
Heroin	71	16	230	559	664	497	416	535	2988
Non-prescription methadone	2	2	7	16	29	20	28	49	153
Other opiates and synthetics	27	13	80	213	233	162	167	251	1146
Hallucinogens	0	0	0	2	2	0	1	2	7
Methamphetamine/speed	4	1	13	33	40	25	33	60	209
Other amphetamines	0	0	2	7	3	1	1	5	19
Other stimulants	0	1	0	5	4	2	3	4	19
Benzodiazepines	2	2	13	13	5	9	2	12	58
Other sedatives or hypnotics	0	0	1	2	1	1	0	2	7
Other drugs	2	0	4	2	1	3	3	3	18
Total	196	371	1442	2133	1595	938	748	1058	8481

Geographic availability of services

Screenshot of all service types availability from Maine Drug Data website



Maine has made an effort to ensure geographic availability of harm reduction, treatment and recovery services. The recent decisions of the Recovery Council to fund start up for detoxification services in underserved areas and a Recovery Center in the only county that did not have one demonstrate the Council's desire to ensure fairness in geographic availability of services as a primary goal of distributed funding.

Conclusions

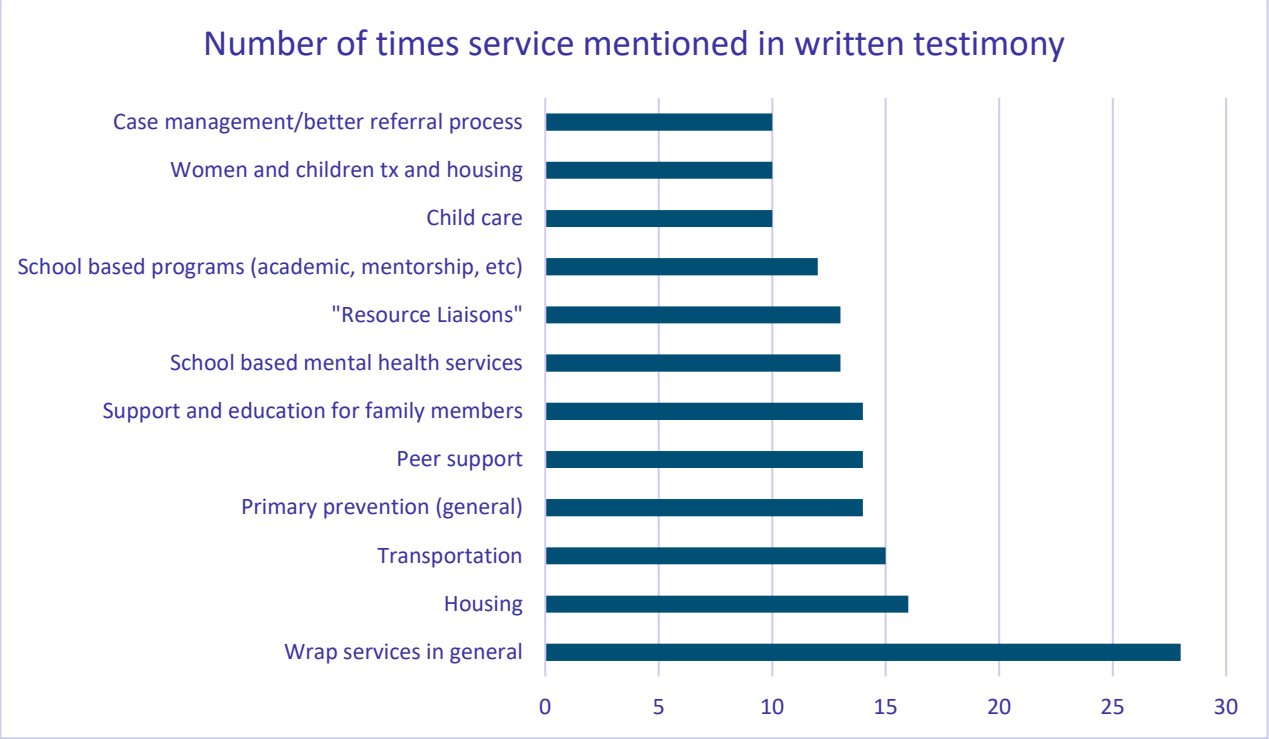
The Maine Recovery Council has made geographic availability a priority with its current funding decisions. While ensuring that there are services in every county is a first step, measuring wait time to receive services or travel time for service users to obtain services may be better markers of availability as most service users are not as conscious of county lines, but are very conscious of time. The state may have more current data regarding service wait times than obtained for this report. As service utilization comes out of the pandemic low, it will be important to see if wait times remain as low as they seem for most admissions in 2021. Travel times are not currently available, but could be created from service user data using GPS to measure travel time from their home address to the service location.

This review of the data also suggests that primary prevention needs to expand from services primarily provided to children to services that better cover the age span when considering prevention interventions to address opioid use disorder. Data on drug use and age of initiation of the people that enter treatment indicates that opioids are a risk regardless of age of initiation and that initiation happens across the lifespan.

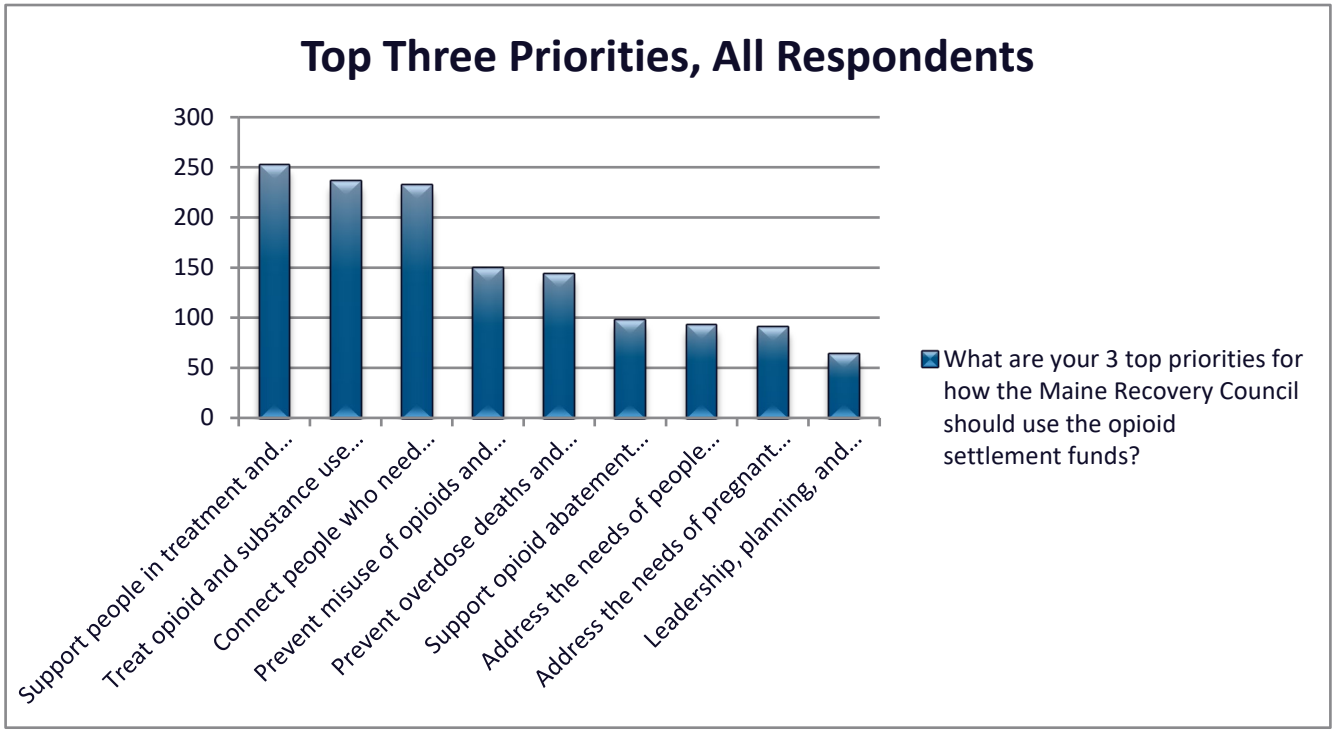
Community Input

Data on community priorities was collected via a public hearing held on November 2, 2023 and a survey administered during the month of November, 2023. A separate report on the survey outcomes will be provided to the Council. Below are some general findings from community input.

Written testimony to the public hearing was analyzed for themes. In the 84 letters that were analyzed, there were 75 different themes including specific requests for funding. The themes that were most often repeated are shown in the graph below.



The survey was completed by 480 respondents. Most of the respondents were people that work in the field. Responses were received from residents of all counties. Three priorities stood out from the rest: support people in treatment and recovery, treat opioid and other substance use disorders, and connect people with the services they need. These were the top three priorities of all respondent groups including providers, family members, people with lived experience and people who identified as other.



By a wide margin, respondents preferred a spending plan that funded both large and small projects (71%) and funded both new and existing programs (65%).

Future Data Needs

The Recovery Council could benefit from routine, at least quarterly, data reports that provide information on the evolution of drug use and its consequences as well as the outcomes of the projects and programs it funds. That data can come from existing sources such as that which is collected for the state opioid data webpage https://mainedrugdata.org/maine-drug-data-hub/maine-drug-data/, from grantee reporting, and from some additional sources that are not currently easily available. Those sources could include wastewater testing and ongoing data collection from people who use drugs, for example. Data that is collected from the prescription monitoring program and treatment programs for federal reporting could also be provided in real time rather than with the two year lag of this report. The Recovery Council should consider working with the state to create capacity to use data to inform decision making via ongoing reporting, development of resources from which specific research questions from existing data can be queried, and by developing predictive modeling and quality improvement capabilities at the program planning level.

Specific proposals about data that would be useful for each category of funding is described below.

Prevention

Current trends in data on drug use in both national data collection like NSDUH and the local data collected in the Maine School Survey indicate a rise in age of first use, with many people initiating use of alcohol and other drugs after they leave school. Data on young adult drug use and programs that target individuals in their late teens and early 20's are lacking. Previous needs assessments for the Maine CDC have identified this gap in knowledge and resources.

Treatment

Data from the prescription monitoring program was not available at the time of this writing. Routine monitoring of prescribing practices, continuity of care, and travel times for patients that receive care would help the Recovery Council identify gaps in access and utilization of MOUD. Additionally, field research to understand why people do not seek out care or leave treatment prematurely might provide insight to inform the Recovery Council's future funding decisions and quality improvement efforts. Monitoring movement from detoxification to treatment services, especially for people with OUD will be important in ensuring that funded detoxification programs reduce the risk of death rather than raise it.

Harm Reduction

Monitoring use of flexible funds, the number of people using services and whether there are fewer overdoses, reduced transmission of infectious disease and fewer wounds needing treatment will help the Recovery Council identify additional service gaps and assess effectiveness of funded services. Monitoring changes in death rates and demographics of people who died as well as non-fatal overdoses and overdose reversals will also help the Recovery Council track changes in need that might warrant changes in funding. Field research with people who use drugs but do not use services may help identify unmet needs or program changes that would improve outcomes.

Recovery Support

Tracking what services are provided with flexible funding, numbers of people served, and service requests will help the Recovery Council identify gaps in services that support recovery and ensure services are received by those that need them.