Aroostook County

Substance Abuse Prevention Strategic Plan

Maine Office of Substance Abuse
Strategic Planning and Environmental Programming Grant

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Introduction

In Spring 2007, the Aroostook County Substance Abuse Prevention Collaborative Project conducted a comprehensive, countywide assessment of substance abuse. Findings from the assessment and feedback from community members were used to create the five-year Aroostook County Substance Abuse Prevention Strategic Plan. Funding to implement some of the underage and high-risk drinking and prescription drug abuse strategies will be provided by the Maine Office of Substance Abuse. ASAP also applied for two Federal grants which would fund implementation of most of the prescription drug abuse and capacity building strategies. On behalf of ASAP, Cary Medical Center and CADET were awarded one of the grants (Drug Free Communities) which will begin September 30, 2007.

Vision

Aroostook Substance Abuse Prevention's vision is of a healthy, safe and productive County fashioned through the reduction of substance abuse.

Description of Geographic Areas Covered in the Strategic Plan and Collaborating Partners

Geographic areas covered:

Allagash, Caribou, Connor, Cyr Plantation, Dyer Brook, Eagle Lake, Easton, Fort Kent, Frenchville, Grand Isle, Hamlin, Hodgdon, Houlton, Island Falls, Madawaska, Mars Hill, New Canada, New Sweden, Oakfield, Presque Isle, Sherman, Square Lake, Saint Agatha, St. Francis, St. John, Stockholm, Van Buren, Wallagrass, Westmanland, Winterville, Woodland

Description of Planning Team and Process

The Strategic Planning and Environmental Programming Project Team included: Aroostook Mental Health Center, Cary Medical Center, Community Alcohol and Drug Education Team, Community Voices, Houlton Band of Maliseet Indians, Link for Hope Coalition, Presque Isle Mic Mac Youth Program, St. John Valley Partnership, STOP, The Aroostook Medical Center, The Power of Prevention, United Way, and University of Maine Presque Isle.

The team met monthly since the start of the project and provided guidance on how to approach the assessment process and strategies to include in the strategic plan.

A list of data and information used can be found in Appendix 1 (Assessment Report).

Processes Used to Interpret Information and Make Decisions

Process used to interpret information:

- Review of what information can be conveyed by diverse data sources.
- Data from focus groups, key informant interviews and qualitative questions on the adult and youth surveys were reviewed for common themes. The number of times a theme was mentioned was tallied in order to identify key themes.
- Survey data were entered into SPSS and frequencies of responses to each question were tallied and then matched with themes that emerged from qualitative data to see if there were any similarities.
- The Tri-Ethnic Prevention Research Center's Readiness Assessment and Readiness Assessment scoring criteria were used to identify community readiness in each of the four County regions (North, Central 1, Central 2, and South). Data was interpreted based on the interpretation guidelines provided by the Tri-Ethnic Center.
- Data were presented to the Assessment Committee to obtain their feedback.

Process used to make decisions:

- Decisions related to data gathering (what to gather and how to do so) were made through discussion and consensus among Assessment Committee members.
- Decisions related to strategic planning (substances to target, strategies to implement) were made through discussion and consensus among Assessment Committee members.
- The strategic planning process took into account feedback and suggestions, about the problem of substance abuse and how to address it, received from community members who completed surveys, participated in key informant interviews and/or attended the community meetings held in five communities Countywide.

Prioritization of Goals and Objectives

Priority Goals

1. Build a sustainable, comprehensive, countywide approach to prevention that includes consistent, ongoing implementation of strategies targeting both individual and environmental/community level change.
   Why it is a priority
   a. Our resource assessment revealed that there are three substance abuse prevention coalitions in the County (Community Voices, Link for Hope Coalition and CADET). Only one has funding (Community Voices). Both Community Voices and CADET utilize a multi-faceted approach to prevention that targets community level change. However, both Link for Hope and CADET's capacity to address prevention is limited because they have no funding or staff. Moreover, one area of the County (Presque Isle and surrounding towns) has no substance abuse prevention coalition. Substance abuse prevention events and programs are conducted by some civic and religious groups (example: Elks) and schools but are generally not coordinated.
   b. Aroostook County has a small workforce with knowledge of substance abuse prevention.

   c. Coordination of prevention activities among diverse communities has been very limited throughout the County.

2. Reduce youth and adult misuse of alcohol and decrease harms associated with alcohol misuse.

   Why it is a priority

   a. Assessment findings revealed alcohol is the most frequently consumed substance among Aroostook County residents of all ages and is connected to more harms than any other substance.

3. Reduce youth and adult misuse of prescription drugs and decrease harms associated with prescription drug misuse.

   Why it is a priority

   a. Assessment findings revealed prescription drug abuse as the third most frequently abused substance for youth and adults. However, data suggests the level of harm it causes may be greater than marijuana.

4. Reduce youth and adult abuse of marijuana and decrease harms associated with marijuana misuse.

   a. Assessment findings revealed marijuana as the second most frequently abused substance among County residents of all ages and that it is connected to multiple harms.

5. Decrease abuse of inhalants, stimulants and over-the-counter medicines.

   a. Assessment findings revealed inhalants as the third most frequently abused substance for youth at the County level. However, at the regional level, in three of the four County regions youth reporting ever using inhalants was greater than reports of ever using prescription drugs and stimulants.

6. Establish comprehensive, coordinated and local substance abuse intervention resources.

   a. Information from key informant interviews and community members suggested a need for (1) a local, long term inpatient facility, especially for youth, (2) after-care support services for individuals recently completing inpatient treatment, and (3) a treatment drug court.

Problem Statement: Lack of a comprehensive, countywide approach to prevention that includes consistent, ongoing implementation of strategies targeting both individual and environmental/community level change.

Goal 1: Build a sustainable, comprehensive, countywide approach to prevention that includes consistent, ongoing implementation of strategies targeting both individual and environmental/community level change.

Objectives	Strategies	Who will implement strategy:	Benchmarks
Objective 1: Increase community readiness to address substance abuse by one Phase in each region. Capacity Building Actions: 1. Explore locally relevant methods to engage diverse community members and groups as leaders in prevention planning and implementation. 2. Expand and improve the efficacy of dissemination. 3. Identify differences in communities and how communities can help each other to advance prevention	1. Conduct visits and/or presentations with community leaders, members and groups and encourage participation in addressing the problem.	-AMHC -Community Voices -CADET -Link for Hope -Drug Free Communities	Outcome: Each region of the County will move from their current phase of readiness (either pre-planning or preparation) to the next phase of readiness. Time frame: 1 year
	2. Approach and engage local educational and health outreach programs to assist in the effort with flyers, posters, or brochures.	-AMHC -Community Voices -CADET -Link for Hope -Betsy – Houlton Band of Maliseets -Drug Free Communities -TAMC[19]	

efforts throughout the County.	3. Point out media articles that describe local critical incidents.	-Community Voices -CADET -Drug Free Communities -Link for Hope -TAMC	
	4. Prepare and submit articles for church bulletins, local newsletters, etc.	-CADET -Link for Hope -Myrth Schwartz MicMac Band -Drug Free Communities -TAMC	
	5. Present information at local community events and to unrelated community groups.	-Northern and Southern HMPs -CADET -Link for Hope -Myrth Schwartz MicMac Band --Drug Free Communities -Maliseet Health Department -TAMC	

[19] The Aroostook Medical Center

	6. Post flyers and posters.	-AMHC -Community Voices -Betsy – Houlton Band of Maliseets -Link for Hope -Myrth Schwartz MicMac Band -Drug Free Communities -TAMC	
	7. Publish newspaper editorials/articles with general information and local implications.	-AMHC -Community Voices -Betsy – Houlton Band of Maliseets -Link for Hope -Myrth Schwartz MicMac Band -CADET -Drug Free Communities -TAMC	
	8. Disseminate information about prevention activities in multiple formats (newspaper, newsletters, web site, television, blog).	-AMHC -Community Voices -Betsy – Houlton Band	

		of Maliseets -CADET -Drug Free Communities -Link for Hope -TAMC	
	9. Obtain technical assistance from the Prevention Centers about how to effectively engage diverse community groups as leaders in prevention planning and implementation and how to expand and improve efficacy of dissemination. Share information with collaborative partners.	-Drug Free Communities	
	10. Work with collaborative partners to identify differences in communities and how communities can help each other advance prevention efforts.	-CADET -Drug Free Communities -Link for Hope -TAMC	
Objective 2: Increase the substance abuse prevention workforce in Aroostook County.	1. Provide field supervision to at least one Bachelor's or Master's level college student per year.	-AMHC -Drug Free Communities	Outcomes: 1. Provision of field supervision to at least one student per year. Time Frame: Ongoing 2. Provision of at least five educational opportunities. Time Frame: 5 years
	2. Collaborate with OSA, Aroostook's two University of Maine campuses, and health care providers to develop educational opportunities to build the prevention workforce in Aroostook County.	-Drug Free Communities	

	3. Promote and disseminate information about prevention training and education.	-Drug Free Communities -TAMC	3. Criterion referenced increase in substance abuse prevention providers in the County. Time Frame: 5 years
Objective 3: Facilitate countywide collaboration in strategic plan implementation. Capacity Building Actions: 1. Obtain technical assistance about how to effectively facilitate and maintain collaborative efforts.	1. Review the strategic plan and progress toward achieving goals with County partners at countywide CCHC meetings held six times per year.	-Northern and Southern HMPs -CADET -AMHC -Community Voices -Link for Hope	Outcomes: 1. Ongoing countywide collaboration in strategic plan implementation. Time Frame: Ongoing 2. Organization and maintenance of active community support network. Time Frame: 1 years and ongoing
	2. Choose a name and develop a logo for the countywide collaborative (to be put on all materials distributed etc.)	-Substance abuse collaborative	
	3. Identify barriers to ongoing, sustainable countywide involvement and strategies to overcome barriers.	Drug Free Communities	
	4. Facilitate ongoing attendance of diverse groups at County meetings by addressing barriers to attendance.	Drug Free Communities	
	5. Identify and address barriers to engagement of diverse community groups.	Drug Free Communities	
	6. Continually work to engage diverse groups in prevention activities.	Drug Free Communities	
	7. Organize a network of community members committed to providing human and financial resources to prevent substance abuse.	-Community Voices -Northern and Southern HMPs	

		-CADET -Link for Hope	
Objective 4: Establish a Youth Advisory Council	1. Recruit youth from existing YAP, ATLC, Link for Hope and Native American youth groups. 2. Coordinate with youth groups to get youth feedback. 3. Seek youth representative's guidance at countywide CCHC meetings.	-Northern and Southern HMPs -AMHC -Link for Hope -Myrth Schwartz MicMac Band	Outcome: Active Youth Advisory Council Time Frame: 6 months and ongoing
Objective 5: Develop a sustainability plan that identifies non-grant funded sustainability strategies. Capacity Building Actions: 1. Build capacity to identify and obtain resources necessary to implement sustained evidence-based prevention efforts. 2. Build capacity to diversify sustainable and consistent funding sources.	1. Complete the Finance Project Sustainability Planning Workbook. 2. Seek technical assistance from the Prevention Centers.	-Drug Free Communities -Drug Free Communities	Outcomes: 1. Written sustainability plan. Time Frame: 1 year 2. Access at least one non-grant driven funding stream. Time Frame: 2 years

	3. Explore potential collaboration with Northern Maine Development Commission on issues related to substance abuse and poverty.	-Drug Free Communities	
Objective 6: Increase awareness about substance abuse prevention.	1. Complete phases 1-5 of the CDC CDCynergy social marketing planning system.	-Drug Free Communities	Outcome: Development and dissemination of social marketing materials. Time Frame: 1 year
	2. Substance abuse prevention collaborative will coordinate awareness efforts.	-Northern and Southern HMPs -AMHC -CADET -Community Voices -Betsy – Houlton Band of Maliseets -Link for Hope -Myrth Schwartz MicMac Band	
Objective 7: Conduct ongoing assessments and evaluations of collaborative functioning. Capacity Building Actions:	1. Seek technical assistance from the Prevention Centers to increase capacity in identified areas and to develop a method to assess group functioning (see Strategy 3).	-Drug Free Communities	1. Improved internal and external functioning of collaborative based on changes made from assessments. Time Frame: Twice per year

1. Build capacity to gather local data. 2. Build capacity to conduct systematic evaluation and monitoring.	2. Collaborate with the Prevention Centers to assess cultural competence and design a plan to improve cultural competency.	-Drug Free Communities	and ongoing 2. Reports of increased capacity to gather, evaluate and monitor data. Time Frame: 4 years
	3. Twice annually assess collaborative partners' perceptions of the internal and external functioning of the collaborative group.	-Drug Free Communities	

Problem Statement: Misuse of alcohol by youth and adults. Harms associated with alcohol misuse (domestic violence, child abuse, substance-induced deaths, arrests, poisonings, treatment admissions) were *more frequent* than harm caused by *any other* substance.

Goal 2: Reduce youth and adult misuse of alcohol. Decrease harms associated with alcohol misuse.

Objectives	Strategies	Who will implement strategy:	Benchmarks
Objective 1: Increase effectiveness of enforcement policies and practices for underage drinking and drug abuse.	1. Collaborate with local law enforcement to establish underage drinking as shared priority. (Resource: Maliseet Tribal Police)	-Community Voices -Chief Gahagan (CADET) -Drug Free Communities -Link for Hope	1. Ongoing collaboration with law enforcement. Time frame: 9 months and ongoing. 2. Community member support for enforcement activities as evidenced by community member involvement in prevention activities. Time frame: 2 years 3. Consistent enforcement of legal consequences by judiciary and corrections as evidenced by reports from community members and law enforcement. Time frame: 5 years 4. Consistent enforcement of
	2. Use media to increase support for enforcement.	- Northern HMP -Drug Free Communities -Link for Hope	
	3. Collaborate with courts/justice system to assess barriers to more stringent enforcement of legal consequences. (time frame: 1.5 years)	- Northern HMP -Drug Free Communities	
	4. Collaborate with schools and youth to develop and implement uniform policies and enforcement procedures. (time frame: 2-3 years)	-CADET -Drug Free Communities -Link for Hope	

	5. Educate parents about the dangers of furnishing or hosting underage drinking parties.	-Southern HMP -Community Voices -Drug Free Communities	school policies in at least 4 schools as evidenced by reports from students. Time frame: 4 years 5. Decreased parental and adult provision of alcohol to minors as evidenced by reports from law enforcement and community members. Time Frame: Year 3 and Year 5
	6. Publicize penalties for furnishing alcohol to minors or hosting underage drinking parties. (Resource: Maliseet Tribal Police)	- Community Voices -Link for Hope	
	7. Collaborate with police and District Attorney to publicize in local papers incidents of adults prosecuted for furnishing alcohol or hosting underage drinking parties in their homes. (Resource: Maliseet Tribal Police)	-Law enforcement does on ongoing basis	
	8. Work with law enforcement to establish a department policy for underage drinking enforcement. (Resource: Maliseet Tribal Police)	- Northern and Southern HMPs	
	9. Provide training to law enforcement officers around best practices and model policy implementation.	-Southern HMP	
	10. Work with the State to mandate liquor enforcement training for law enforcement.	-Southern HMP	
	11. Initiate a conversation with judges and probation/parole officers about community perceptions related to decreased consequences for substance	-Drug Free Communities	

	related violations and potential ways to educate the community.		
	12. Work at the State level to examine current sentencing guidelines for substance-related violations and potential changes to guidelines.	-Drug Free Communities	
Objective 2: Increase youth and parent perceptions of risk related to underage and high risk drinking. Objective 3: Increase parent perception that their attitudes and behaviors related to alcohol use influence their children's decisions to use alcohol and increase parent knowledge of how to influence their children. Objective 4: Increase community knowledge about youth mental health issues and the increased risk for substance abuse among youth with unidentified/untreated mental health problems.	1. Collaborate with youth, parents and other stakeholders to develop public education and social marketing campaigns.	-Northern and Southern HMP School Health Coordinators -AMHC for Objective 4 -Drug Free Communities	1. Criterion referenced increase in youth and adult designation of "great risk" as a response to MYDAUS and ASAP Survey questions about risk associated with underage and high risk drinking Time Frame: Year 2 and Year 4
	2. Collaborate with schools/student assistance groups to communicate information to youth and parents. (time frame: Year 2 and ongoing)	-Northern and Southern HMP School Health Coordinators -AMHC for Objective 4 -Drug Free Communities	2. Criterion referenced increase in youth report of parent attitudes toward alcohol use as "very wrong". Time Frame: 4 years
	3. Collaborate with early intervention programs to reach high risk families. (time frame: Year 2 and ongoing) (Resource: Maliseet Head Start)	-Northern and Southern HMPs -AMHC for Objective 4 -Myrth Schwartz MicMac Band -Drug Free	3. Criterion referenced increase in parent perception that their attitudes influence their children's decisions (as compared to baseline from ASAP Survey). Time Frame: 3 years

		Communities	4. Increase in community knowledge (need to obtain baseline data for this). Time Frame: 5 years
	4. Collaborate and work with community leaders and groups to communicate information to community members. (time frame: Year 2)	-Northern and Southern HMPs -AMHC for Objective 4 -Myrth Schwartz MicMac Band -Drug Free Communities	
	5. Approach media to gain their support and to obtain donations of media resources for the public education and social marketing campaigns.	-Northern and Southern HMPs -AMHC for Objective 4 -CADET -Drug Free Communities	
	6. Disseminate public education and social marketing campaign information. (time frame: Year 2 and ongoing)	-Northern and Southern HMPs -AMHC for Objective 4 -Drug Free Communities	
Objective 5: Increase use of recommended parental monitoring practices for underage drinking.	1. Collaborate with youth, parents and other stakeholders to develop public education and social marketing campaigns based on the Search Institute's 40 Developmental Assets and OSA's	-CADET -Drug Free Communities -Link for Hope	1. Criterion referenced decrease in risk of substance abuse due to family management. Time Frame: Year 4 2. Criterion referenced decrease

	Parent Campaign.		in % of youth reporting past 30 day alcohol use and previous 2 weeks binge drinking. Time Frame: Year 4
	2. Partner and collaborate with schools, media, parent groups, medical providers, businesses and others to communicate information to parents (one possible tool: public signs). (time frame: Year 2 and ongoing)	- Northern and Southern HMPs -Drug Free Communities	
	3. Collaborate with early intervention programs to reach high risk families (resource: Youth Network). (time frame: Year 2 and ongoing)	-Northern and Southern HMPs -Myrth Schwartz MicMac Band	
	4. Collaborate and work with community leaders and groups to communicate information to community members. (time frame: Year 2 and ongoing)	-Northern and Southern HMPs -Myrth Schwartz MicMac Band -AMHC -Drug Free Communities	
	5. Dissemination of public education and social marketing campaigns. (time frame: Year 2 and ongoing)	-Northern and Southern HMPs -AMHC -Drug Free Communities -TAMC	

	6. Assess the legal ramifications and policies related to school and police department notification of parents for suspicions of substance abuse or if the youth is caught with substances.	-Drug Free Communities	
	7. Collaborate with schools and police departments to establish policies requiring parent notification for suspicions of substance abuse or if the youth is caught with substances. (time frame: years 3-4)	To be determined based on findings from Strategy 6	
Objective 6: Create communities that provide the support and resources necessary to decrease youth risk of underage and high risk drinking.	1. Implementation of the 40 Developmental Assets approach in 5 communities throughout the County. (time frame: 5 years)	-CADET -Drug Free Communities -Link for Hope	1. Criterion referenced decrease in % of youth reporting past 30 day alcohol use and previous 2 weeks binge drinking. Time Frame: Year 4
	2. Pass ordinances restricting use of alcohol at community events. (time frame: 4-5 years)	**To be completed in second half of plan**	
	3. Assess whether there is a need for additional social activities for youth, particularly evening/night activities (resource: local recreation departments)	-CADET -Drug Free Communities -Link for Hope	
	4. If there is a need, identify what would be needed to increase activities (i.e. volunteers, funding,	-Substance abuse collaborative will review	

	transportation, promotions) and engage in a planning process. (time frame: Year 2)		
	5. Work at the State level to set standards for outdoor advertising of alcohol. (time frame: Years 2-5)	-Pete McCorison – AMHC -Community Voices	
	6. Work at the State level to set standards for placement of alcohol in stores. (time frame: Years 2-5)	-Pete McCorison – AMHC -Community Voices	
Objective 7: Increase effectiveness of retailers' policies and practices that restrict access to alcohol by underage youth.	1. Conduct retailer training.	-Northern and Southern HMPs	Criterion referenced decreased risk of substance abuse due to availability of alcohol. Time Frame: Year 4
	2. Use media to increase perception of enforcement of ID checks. (time frame: Years 2-5)	**To be completed in second half of plan**	
	3. Work with retailers to implement Responsible Retailing Systems. (time frame: Years 2-5)	**To be completed in second half of plan**	
	4. Establish a policy mandating responsible beverage service training for all new employees. (time frame: Years 2-5)	**To be completed in second half of plan**	
	9. Work with the State to get a liquor enforcement officer. (time frame: Years 2-5)	-CADET	

	10. Work with the State to mandate 100% ID checks. (time frame: Years 2-5)	**To be completed in second half of plan**	
Objective 8: Build connections with Canadian border communities involved in prevention work to address substance abuse issues that cross the border for Maine and Canada.	1. Identify substance abuse prevention groups in Canadian border towns.	-Drug Free Communities	Outcome: Collaboration on issues of joint concern. Time Frame: 1 year and ongoing
	2. Initiate dialogue about alcohol and drug abuse issues.	-Drug Free Communities	
	3. Establish a system to maintain communication with Canadian prevention groups.	-Drug Free Communities	
	4. Evaluate the potential for collaboration on substance abuse prevention.	-Drug Free Communities	
Objective 9: Decrease access to alcohol in Canada.	1. Collaborate with US Border and Customs to establish underage drinking as shared priority.	-Drug Free Communities	Outcomes: 1. Criterion referenced decreased risk of substance abuse due to availability of alcohol. Time Frame: Year 4 2. Criterion referenced decrease in reports by youth they purchase and/or consume alcohol in Canada (baseline from ASAP Survey). Time Frame: Years 3 and 5
	2. Collaborate with US Border and Customs to identify and address issues related to access to alcohol in Canada and underage youth bringing alcohol into the US.	-Drug Free Communities	
	3. Modify the Border Binge Drinking Reduction Program.	-Drug Free Communities	

	4. Implement the Border Binge Drinking Reduction Program. (time frame: Years 3-5)	-Drug Free Communities	
Objective 10: Increase retailers' use of policies and practices that discourage high risk drinking.	1. Collaborate with retailers to limit promotions that encourage high-risk drinking.	-Northern and Southern HMPs	Outcome: Criterion referenced decrease in retailer reports of prevalence of high risk drinking among patrons. Time Frame: Years 2 and 4
	2. Educate merchants about the negative impacts of low pricing and promotion.	-Northern and Southern HMPs	
	3. Use media to increase awareness of negative impacts of low pricing and promotion.	-Northern and Southern HMPs	
	4. Work at the State level to establish policies at bars and college or workplace parties to limit high risk drinking (example: limit serving sizes, 1 drink per customer at a time, comparably priced non-alcoholic drinks). (time frame: Years 2-5)	-Drug Free Communities	
	5. Work at the State level to establish a system to conduct bar checks and leverage penalties for service to visibly intoxicated persons of legal age. (time frame: Years 2-5)	-Drug Free Communities	

Problem Statement: Misuse of prescription drugs by youth and adults. Harms associated with prescription drug misuse (domestic violence, child abuse, arrests, poisonings, treatment admissions) are prevalent and increasing.

Goal 3: Reduce youth and adult misuse of prescription drugs. Decrease harms associated with prescription drug misuse.

Objectives	Strategies	Who will implement strategy:	Benchmarks
Objective 1: Increase community members' (youth, adults, elders and their family members and caregivers) perceptions of risks related to prescription drug abuse. Objective 2: Increase parent perception that their attitudes and behaviors related to prescription drug use influence their children's decisions to use prescription drugs and increase parent knowledge of how to influence their children. Objective 3: Increase community knowledge about youth mental health issues and the increased risk for	1. Collaborate with youth, parents and other stakeholders to develop public education and social marketing campaigns.	-CADET -Link for Hope -Myrth Schwartz MicMac Band -AMHC Obj. 3	Criterion referenced increase in youth and adult designation of "great risk" as a response to ASAP Survey questions about risk associated with prescription drug misuse. Time Frame: Years 2 and 4 Criterion referenced increase in parent perception that their attitudes influence their children's decisions (as compared to baseline from ASAP Survey). Time Frame: 3 years
	2. Collaborate with schools/student assistance groups to communicate information to youth and parents. (time frame: Year 2 and ongoing)	-CADET -AMHC Obj. 3 -Link for Hope	
	3. Collaborate with hospitals and medical providers to educate patients about the risks and side effects of prescription drug abuse. (time frame: Year 2 and ongoing)	-CADET -Link for Hope	

substance abuse among youth with unidentified/untreated mental health problems.	4. Collaborate with early intervention programs to reach high risk families. (time frame: Year 2 and ongoing)	-Drug Free Communities	Increase in community knowledge (need to obtain baseline data for this). Time Frame: 5 years
	5. Collaborate and work with community leaders and groups to communicate information to community members. (time frame: Year 2 and ongoing)	-CADET -AMHC Obj. 3 -Link for Hope	
	6. Approach media to gain their support and to obtain donations of media resources for the public education and social marketing campaigns.	-CADET -AMHC Obj. 3 -Link for Hope	
	7. Disseminate public education and social marketing campaign information. (time frame: Year 2 and ongoing)	-CADET -AMHC Obj. 3 -Link for Hope	
Objective 4: Increase use of recommended parental monitoring practices to prevent prescription drug misuse. Capacity Building Activities:	1. Collaborate with youth, parents and other stakeholders to develop public education and social marketing campaigns based on the Search Institute's 40 Developmental Assets.	-CADET -Drug Free Communities -Link for Hope	1. Criterion referenced decrease in risk of substance abuse due to family management. Time Frame: Year 4
	2. Collaborate with schools, media, parent groups, medical providers, businesses and others to communicate information to parents.	-Drug Free Communities -Link for Hope	2. Criterion referenced decrease in % of youth reporting ever using prescription drugs.

	(time frame: Year 2 and ongoing)		Time Frame: Year 4
	3. Collaborate with early intervention programs to reach high risk families. (time frame: Year 2 and ongoing)	-Drug Free Communities -Myrth Schwartz MicMac Band	
	4. Collaborate and work with community leaders and groups to communicate information to community members. (time frame: Year 2 and ongoing)	-Drug Free Communities -Myrth Schwartz MicMac Band -AMHC -Link for Hope	
	5. Dissemination of public education and social marketing campaigns. (time frame: Year 2 and ongoing)	-Drug Free Communities -AMHC -Link for Hope -TAMC	
Objective 5: Create communities that provide the support and resources necessary to decrease youth risk of abusing prescription drugs.	1. Implementation of the 40 Developmental Assets approach in 5 communities throughout the County. (time frame: 5 years)	-CADET -Drug Free Communities -Link for Hope	1. Criterion referenced decrease in % of youth reporting ever using prescription drugs. Time Frame: Year 4
	2. Assess whether there is a need for additional social activities for youth, particularly evening/night activities (resource: local recreation departments).	-CADET -Drug Free Communities -Link for Hope	

	3. If there is a need, identify what would be needed to increase activities (i.e. volunteers, funding, transportation, promotions) and engage in a planning process. (time frame: Year 2)	-Substance abuse collaborative will review	
Objective 6: Increase medical provider readiness to participate in solving the prescription drug abuse problem. (Resource: Maliseet Health Department – Larry Tonzi)	1. Educate medical providers about the prescription drug problem (magnitude, who is using, harms) in the County through one-on-one visits or at pre-scheduled hospital group meetings.	-Drug Free Communities -Link for Hope	Increased readiness to prevent prescription drug abuse. Time Frame: 1 year
	2. Educate medical providers about the risks of prescribing controlled substances through one-on-one visits or at pre-scheduled hospital group meetings.	-Drug Free Communities -Link for Hope	
	3. Discuss descriptive *local* incidents related to the issue.	-Drug Free Communities	
	4. Prepare and submit articles for hospital and other medical newsletters circulated in the County.	-Drug Free Communities -Link for Hope	
	5. Discuss how medical providers can be involved in solving the problem.	-Drug Free Communities -Link for Hope	

	6. Establish a medical provider workgroup to participate in strategy implementation in each region.	-Drug Free Communities	
Objective 7: Decrease promotion of prescription drugs.	1. Collaborate with hospitals and medical providers to establish policies, if none exist, around prescription drug advertisement.	-Drug Free Communities -Link for Hope -Maliseet Health Department	1. Criterion referenced decrease in % of youth reporting ever using prescription drugs. Time Frame: 4 years 2. Youth and adult reports of seeing less advertisements for prescription drugs on most recent visit to medical providers (as compared to baseline from ASAP Survey). Time Frame: Years 3 and 5
	2. Work at the State and/or Federal level to put limits on promotion of Rx drugs to doctors and through the media.	-CADET -Maliseet Health Department	
Objective 8: Increase use of the Prescription Monitoring Program.	1. Educate pharmacists, medical providers and hospitals about the PMP.	-Northern HMP -Drug Free Communities -Link for Hope	Outcomes: 1. Criterion referenced increase in number of medical providers and pharmacists using the PMP (need to obtain baseline). Time Frame: 3 years
	2. Collaborate with pharmacists, medical providers and hospitals to identify and address barriers to regular use of the PMP.	-Northern HMP -Drug Free Communities	
	3. Work at the State and Tribal level to require pharmacists and/or doctors to check the PMP prior to filling a prescription for a controlled substance. (time frame: 2-5 years)	-Drug Free Communities -Maliseet Health Department	

	4. Work at the State level to increase the frequency of pharmacy uploads to the PMP. (time frame: 2-5 years)	-Drug Free Communities	
Objective 9: Increase medical provider use of policies and practices that safeguard against prescription drug abuse.	1. Expand dialog with medical providers about monitoring and screening practices (what are they currently doing?) (pain contracts, urine testing prior to prescribing, addiction or addiction risk screening prior to prescribing, random urine testing while patient is prescribed narcotics, after hours policy for replacement of narcotics, referrals for alternative treatments if appropriate). (Resource: Maliseet Health Department – Larry Tonzi).	-Drug Free Communities -Maliseet Health Department	Increased report of use of specified monitoring and screening practices (as compared to baseline from ASAP Survey). Time Frame: 4 years
	2. Identify and address barriers to implementation of policies and practices.	-Drug Free Communities -Maliseet Health Department	
	3. Work at the State level to mandate use of specific monitoring and screening practices and address barriers to such a strategy. (time frame: 2-5 years)	-Drug Free Communities	
	4. Work at the State level to require prescription of non-controlled substance alternatives prior to prescribing controlled substances. (time frame: 2-5 years)	-Drug Free Communities	

Objective 10: Increase awareness of and access to alternative treatments for pain management.	1. Identify alternative treatments for pain management that are available in the County (resource: collaborative with alternative treatment groups).	-Drug Free Communities	Decreased average number of scheduled drug prescriptions per person (according to data from the PMP). Time Frame: Years 3 and 5
	2. Assess accessibility (financial, geographic, and availability) of treatments.	-Drug Free Communities	
	3. Educate medical providers and community members about alternative treatments. (time frame: Year 2)	-Drug Free Communities	
	4. Collaborate with medical providers develop strategies to increase patient knowledge of alternative treatments. (time frame: Year 2)	-Drug Free Communities	
	5. Work at the State level to increase coverage of alternative treatments by health insurance carriers. (time frame: 2-5 years)	-Drug Free Communities	
	6. Work at the State and Tribal level to create policies requiring use of alternative treatments concurrent with initial use of prescribed painkillers and prior to *long term* prescribing of painkillers (with exceptions where appropriate). (time frame: 2-5 years)	-Drug Free Communities -Maliseet Health Department	
Objective 11: Decrease access to prescription drugs.	1. Initiate conversation with hospitals around current community education initiatives around prescription drugs.	-Drug Free Communities	Criterion referenced increase in number of adults reporting they dispose of prescription

	2. Use public education to inform community members that it is illegal to share prescription drugs.	**To be determined based on strategy 1**	drugs at local disposal area (baseline ASAP Survey). Time Frame: Years 3 and 5 Adult reports that they implement measures to safeguard prescriptions. Time Frame: 4 years
	3. Collaborate with medical providers and hospitals to educate the community about access to prescription drugs on the internet and to report sites that do not require a prescription to purchase drugs.	**To be determined based on strategy 1**	
	4. Collaborate with medical providers and hospitals to educate the community about safeguarding their prescription drugs in their homes. (time frame: Year 2 and ongoing)	-Drug Free Communities	
	5. Work with communities to establish a place for people to dispose of prescription drugs.	-Northern and Southern HMPs -Maliseet Health Department (promotion)	
	6. Use public education to increase awareness of where people can dispose of prescription drugs. (time frame: Year 2 and ongoing)	-Northern and Southern HMPs -TAMC	

Objective 12: Increase medical provider knowledge of addiction and pain management. Capacity Building Activities:	1. Provide ongoing educational opportunities for medical providers (such as research-based pain and addiction assessment methods, effective pain management practices, how to work with addicted patients, issues related to their identified concerns about prescribing and not prescribing painkillers). (time frame: ongoing)	-AMHC -Drug Free Communities -Maliseet Health Department (send staff)	1. Medical provider reports of increased knowledge of addiction and pain management. Time Frame: Ongoing (after each opportunity) and 3 years (re-administer ASAP survey) 2. Community member reports of medical provider increased knowledge of addiction and pain management. Time Frame: 2 years
	2. Establish a system through which to provide information to new providers who come to the County. (time frame: 2 years)	-Drug Free Communities -CCHCs	

Problem Statement: Misuse of marijuana by youth and adults. Harms associated with marijuana misuse (domestic violence, child abuse/neglect, arrests, treatment admissions) are prevalent.

Goal 4: Reduce youth and adult misuse of marijuana. Decrease harms associated with marijuana misuse.

Objectives	Strategies	Who will implement strategy:	Benchmarks
Objective 1: Increase youth and parent perceptions of risk related marijuana use. Objective 2: Increase parent perception that their attitudes and behaviors related to marijuana use influence their children's decisions to use marijuana and increase parent knowledge of how to influence their children. Objective 3: Increase community knowledge about youth mental health issues and the increased risk for substance abuse among youth with unidentified/untreated mental health problems.	1. Collaborate with youth, parents and other stakeholders to develop public education and social marketing campaigns.	-CADET -Drug Free Communities -Myrth Schwartz MicMac Band -Link for Hope	Criterion referenced increase in youth and adult designation of "great risk" as a response to MYDAUS and ASAP Survey questions about risk associated with marijuana use. Time Frame: Years 3, 4, 5 Criterion referenced increase in youth report of parent attitudes toward marijuana use as "very wrong". Time Frame: 4 years Criterion referenced increase in parent perception that their attitudes influence their children's decisions (as compared to baseline from ASAP
	2. Collaborate with schools/student assistance groups to communicate information to youth and parents. (time frame: Year 2 and ongoing)	-CADET -Drug Free Communities -Link for Hope	
	3. Collaborate with early intervention programs to reach high risk families. (time frame: Year 2 and ongoing) (Resource: Maliseet Head Start)	-Drug Free Communities	

	4. Collaborate and work with community leaders and groups to communicate information to community members. (time frame: Year 2 and ongoing)	-AMHC Obj. 3 -Drug Free Communities -Myrth Schwartz MicMac Band -Link for Hope	Survey). Time frame: 3 years Outcome: Increase in community knowledge (need to obtain baseline data for this). Time Frame: 5 years
	5. Approach media to gain their support and to obtain donations of media resources for the public education and social marketing campaigns.	-AMHC Obj. 3 -CADET -Drug Free Communities -Link for Hope	
	6. Disseminate public education and social marketing campaign information. (time frame: Year 2 and ongoing)	-AMHC Obj. 3 -CADET -Drug Free Communities -Link for Hope	
Objective 4: Increase use of recommended parental monitoring practices to prevent marijuana misuse.	1. Collaborate with youth, parents and other stakeholders to develop public education and social marketing campaigns based on the Search Institute's 40 Developmental Assets.	-CADET -Drug Free Communities -Link for Hope	1. Criterion referenced decrease in risk of substance abuse due to family management. Time Frame: 4 years 2. Criterion referenced decrease in % of youth reporting marijuana use in the past 30 days. Time Frame: 4 years
	2. Collaborate with schools, media, parent groups, medical providers, businesses and others to communicate information to parents. (time frame: Year 2 and ongoing)	-Drug Free Communities -Link for Hope	
	3. Collaborate with early intervention programs to reach high risk families. (time frame:	-Drug Free Communities -Myrth	

	Year 2 and ongoing)	Schwartz MicMac Band	
	4. Collaborate and work with community leaders and groups to communicate information to community members. (time frame: Year 2 and ongoing)	-AMHC -Drug Free Communities -Myrth Schwartz MicMac Band -Link for Hope	
	5. Dissemination of public education and social marketing campaigns. (time frame: Year 2 and ongoing)	-AMHC -Link for Hope	
Objective 5: Create communities that provide the support and resources necessary to decrease youth risk of abusing marijuana.	1. Implementation of the 40 Developmental Assets approach in 5 communities throughout the County. (time frame: 5 years)	-CADET -Drug Free Communities -Link for Hope	1. Criterion referenced decrease in % of youth reporting marijuana use in the past 30 days. Time Frame: 4 years
	2. Assess whether there is a need for additional social activities for youth, particularly evening/night activities (resource: local recreation departments).	-CADET -Drug Free Communities -Link for Hope	
	3. If there is a need, identify what would be needed to increase activities (i.e. volunteers, funding, transportation, promotions) and engage in a planning process. (time frame: Year 2)	Substance abuse collaborative will review.	

Problem Statement: Abuse of inhalants, stimulants and over-the-counter drugs by youth and young adults.

Goal 5: Decrease abuse of inhalants, stimulants and over-the-counter medicines.

Objectives	Strategies	Who will implement strategy:	Benchmarks
Objective 1: Increase youth and parent perceptions of risk related to inhalant, stimulant and over-the-counter drug use. Objective 2: Increase parent perception that their attitudes and behaviors related to substance use influence their children's decisions to use substances and increase parent knowledge of how to influence their children. Objective 3: Increase community knowledge about youth mental health issues and the increased risk for substance abuse among youth with unidentified/untreated mental health problems.	1. Collaborate with youth, parents and other stakeholders to develop public education and social marketing campaigns.	-CADET -Drug Free Communties -Myrth Schwartz MicMac Band -Link for Hope	Criterion referenced increase in youth and adult designation of "great risk" as a response to MYDAUS and ASAP Survey questions about inhalant, stimulant and over-the-counter medicine use. Time Frame: Years 3, 4 and 5 Criterion referenced increase in parent perception that their attitudes influence their children's decisions (as compared to baseline from ASAP Survey). Time Frame: 3 years Increase in community knowledge (need to obtain baseline data for this).
	2. Collaborate with schools/student assistance groups to communicate information to youth and parents. (time frame: Year 2 and ongoing)	-CADET -Drug Free Communities -Link for Hope	
	3. Collaborate with early intervention programs to reach high risk families. (time frame: Year 2 and ongoing) (Resource: Maliseet Head Start)	-Drug Free Communities	

	4. Collaborate and work with community leaders and groups to communicate information to community members. (time frame: Year 2)	-AMHC Obj. 3 -Drug Free Communities -Myrth Schwartz MicMac Band -Link for Hope	Time Frame: 5 years
	5. Approach media to gain their support and to obtain donations of media resources for the public education and social marketing campaigns.	-AMHC Obj. 3 -Drug Free Communities -Link for Hope	
	6. Disseminate public education and social marketing campaign information. (time frame: Year 2 and ongoing)	-AMHC Obj. 3 -Drug Free Communities -Link for Hope -TAMC	
Objective 4: Increase use of recommended parental monitoring practices to prevent inhalant, stimulant and over-the-counter medicine misuse.	1. Collaborate with youth, parents and other stakeholders to develop public education and social marketing campaigns based on the Search Institute's 40 Developmental Assets.	-CADET -Drug Free Communities -Link for Hope	1. Criterion referenced decrease in risk of substance abuse due to family management. Time Frame: 4 years 2. Criterion referenced decrease in % of youth reporting ever using inhalants and stimulants. Time Frame: 4 years 3. Criterion referenced decrease in number of substance abuse related poisonings involving over-
	2. Collaborate with schools, media, parent groups, medical providers, businesses and others to communicate information to parents. (time frame: Year 2 and ongoing)	-Drug Free Communities -Link for Hope	

	3. Collaborate with early intervention programs to reach high risk families. (time frame: Year 2 and ongoing) (Resource: Maliseet Head Start)	-Drug Free Communities -Myrth Schwartz MicMac Band	the-counter medicines. Time Frame: Years 3 and 5
	4. Collaborate and work with community leaders and groups to communicate information to community members. (time frame: Year 2 and ongoing)	-AMHC -Drug Free Communities -Myrth Schwartz MicMac Band -Link for Hope	
	5. Dissemination of public education and social marketing campaigns. (time frame: Year 2 and ongoing)	-AMHC -Drug Free Communities -Link for Hope -TAMC	
Objective 5: Create communities that provide the support and resources necessary to decrease youth risk of abusing inhalants, stimulants and over-the-counter medicines.	1. Implementation of the 40 Developmental Assets approach in 5 communities throughout the County. (time frame: 5 years)	-CADET -Drug Free Communities -Link for Hope	Outcomes: 1. Criterion referenced decrease in % of youth reporting ever using inhalants and stimulants. Time Frame: 4 years
	3. Assess whether there is a need for additional social activities for youth, particularly evening/night activities (resource: local recreation departments).	-CADET -Drug Free Communities -Link for Hope	
	4. If there is a need, identify what would be needed to increase activities (i.e. volunteers, funding,	-Substance abuse collaborative will review	

	transportation, promotions) and engage in a planning process. (time frame: Year 2)		

Problem Statement: High level of need for comprehensive, coordinated and local substance abuse intervention resources.

Goal 6: Establish comprehensive, coordinated and local substance abuse intervention resources.

Objectives	Strategies	Who will implement strategy:	Benchmarks
Objective 1: Establish local long term inpatient treatment facility. Objective 2: Establish local after-care support services in three communities countywide.	1. Initiate a collaborative with Aroostook County substance abuse treatment agencies, hospitals and community stakeholders to assess feasibility of (1) establishing a long-term inpatient treatment facility in the County, (2) establishing after-care support services and (3) integrating specialized medical care into a long-term inpatient treatment facility program.	-Drug Free Communities -Cary Medical Center -Link for Hope -Maliseet Health Department	1. Local, long term inpatient treatment facility. Time Frame: 4 years (if feasible) 2. After-care support services in three communities countywide. Time Frame: 9 years (3 years for each community)
	2. Engage in planning process: review best practice and planning research literature.	**To be determined upon completion of strategy 1**	
	3. Write strategic and funding plans.	**To be determined upon completion of strategy 1**	
	4. Seek resources and funding needed to establish programs.	**To be determined upon completion of strategy 1**	
Objective 3: Create strategic and funding plans to establish an Aroostook County drug	1. Initiate a collaborative with the Aroostook County judiciary, District Attorney, Probation/Parole, and treatment providers to develop and write a plan for implementation of a treatment drug court in the	-Drug Free Communities	1. Completed drug court grant application. Time Frame: 6 months

court.	County.		
	2. Engage in planning process: review drug court best practice and planning research literature.	-Drug Free Communities	
	3. Write strategic plan for implementation of drug court that includes a funding plan.	-Drug Free Communities	
	4. Apply for funding for drug court.	-Drug Free Communities	
Objective 4: Establish a countywide treatment network. Capacity Building Actions:	1. Create a workgroup that includes mental health/substance abuse treatment providers, medical providers, judiciary and corrections.	**To be completed if funding for drug court is received**	
	2. Identify and record network structure, practices and policies.		
	3. Establish and record guidelines for maintenance of ongoing communication and coordination between all groups represented.		
	4. Develop and record a method for maintaining coordination of types of treatment available; record types of treatment currently available (update annually).		

Additional Capacity Building Priorities

There are no additional capacity building priorities.

Year 1 Action Plan

Note: DFC means Drug Free Communities

Goal	Objectives	Activities	Timeline	Who is responsible	Measures
Goal 1	Objective 1: Increase community readiness	1. Conduct visits and/or presentations with community leaders, members and groups; schools, law enforcement and other stakeholders to encourage participation in addressing the problem.	6 months	-AMHC -Community Voices -CADET -DFC -Link for Hope	1. Documentation of visits/presentations 2. Documentation of people will to assist in address the problem
		2. Approach and engage local educational and health outreach programs to assist in the effort with flyers, posters, or brochures.	6 months	-AMHC -Community Voices -CADET -Betsy – Houlton Band of Maliseets -DFC -Link for Hope -TAMC	Documentation of commitment to assist in the effort
		3. Point out media articles that describe local critical incidents.	Ongoing through year	-Community Voices -CADET -DFC -Link for Hope -TAMC	Documentation of information sharing
		4. Prepare and submit articles for church bulletins, local newsletters,	Ongoing through	-CADET -Myrth	Copies of articles

		etc.	year	Schwartz MicMac Band -DFC -Link for Hope -TAMC	
		5. Present information at local community events and to unrelated community groups.	Ongoing through year	-Northern and Southern HMPs -CADET -Myrth Schwartz MicMac Band -Maliseet Health Department -DFC -Link for Hope -TAMC	Documentation of visits/presentations
		6. Post flyers and posters.	Ongoing through year	-AMHC -Community Voices -Betsy – Houlton Band of Maliseets -Myrth Schwartz MicMac Band -DFC -Link for Hope -TAMC	Copies of flyers and posters and documentation of date posted

		7. Publish newspaper editorials/articles with general information and local implications.	Ongoing through year	-AMHC -Community Voices -Betsy – Houlton Band of Maliseets -Myrth Schwartz MicMac Band -CADET -DFC -Link for Hope -TAMC	Copies of articles/editorials
		8. Disseminate information about prevention activities in multiple formats (newspaper, newsletters, web site, television, blog).	Ongoing through year	-AMHC -Community Voices -Betsy – Houlton Band of Maliseets -CADET -DFC -Link for Hope -TAMC	Copies of information disseminated, dates of television appearance
	Obj 1-1 Capacity Building Explore locally relevant methods to engage diverse community members and groups as leaders in prevention planning and	1. Obtain technical assistance from the Prevention Centers about how to effectively engage diverse community groups as leaders in prevention planning and implementation and how to expand and improve efficacy of dissemination. Share information	9 months	-DFC	Documentation of technical assistance and information sharing

	implementation.	with collaborative partners.			
	Obj 1-2 Capacity Building Expand and improve the efficacy of dissemination.		1 year	-DFC	
	Obj 1-3 Capacity Building Identify differences in communities and how communities can help each other to advance prevention efforts throughout the County.	1. Work with collaborative partners to identify differences in communities and how communities can help each other advance prevention efforts.	6 months	-CADET -DFC -Link for Hope -TAMC	Documentation of differences and how communities can help each other
	Objective 2: Increase the substance abuse prevention workforce in Aroostook County.	1. Provide field supervision to at least one Bachelor's or Master's level college student per year.	1 year	-DFC -TAMC (2.3 only)	Documentation of completion of field supervision at the end of the year
		2. Initiate dialog with OSA, Aroostook's two University of Maine campuses, and health care providers to develop educational opportunities to build the prevention workforce in Aroostook County.	1 year		Documentation of dialogue
		3. Promote and disseminate information about prevention training and education.	1 year		Documentation of promotion/dissemination activities
	Objective 3: Facilitate countywide collaboration in strategic plan implementation.	1. Review the strategic plan and progress toward achieving goals with County partners at countywide CCHC meetings held six times per year.	Six times per year	-Northern and Southern HMPs -CADET -AMHC -Community	Documentation from meetings

				Voices -Link for Hope	
		2. Choose a name and develop a logo for the countywide collaborative (to be put on all materials distributed etc.)	3 months	-Substance abuse collaborative	Copy of logo
		3. Identify barriers to ongoing, sustainable countywide involvement and strategies to overcome barriers.	6 months	-DFC	Documentation of barriers and strategies
		4. Facilitate ongoing attendance of diverse groups at County meetings by addressing barriers to attendance.	8 months	-DFC	Documentation of actions
		5. Identify and address barriers to engagement of diverse community groups.	1 year	-DFC	
		6. Continually work to engage diverse groups in prevention activities.	Ongoing	-DFC	
		7. Organize a network of community members committed to providing human and financial resources to prevent substance abuse.	1 year	-Community Voices -Northern and Southern HMPs -CADET -Link for Hope	Documentation of resources
		8. Obtain technical assistance about how to effectively facilitate and maintain collaborative efforts.	6 months	-DFC	Documentation of technical assistance
	Objective 4: Establish a Youth Advisory Council	1. Recruit youth from existing YAP, ATLC, and Native American youth groups.	3 months	-Northern and Southern HMPs	Documentation of youth representatives and youth feedback

	Capacity Building Actions:	2. Coordinate with youth groups to get youth feedback.	3 months	-AMHC -Myrth Schwartz MicMac Band -Link for Hope	
		3. Seek youth representative's guidance at countywide CCHC meetings.	Ongoing		
	Objective 5: Develop a sustainability plan that identifies non-grant funded sustainability strategies.	1. Complete the Finance Project Sustainability Planning Workbook.	1 year	-DFC	Written sustainability plan
		2. Explore potential collaboration with Northern Maine Development Commission on issues related to substance abuse and poverty.	6 months		
	Obj. 5-2 Capacity Building Build capacity to identify and obtain resources necessary to implement sustained evidence-based prevention efforts.	1. Seek technical assistance from the Prevention Centers.	1 year	-DFC	Documentation of technical assistance and information sharing with collaborative members
	Obj. 5-3 Capacity Building Build capacity to diversify sustainable and consistent funding sources.				
	Objective 6: Increase awareness about substance abuse prevention.	1. Complete phases 1-5 of the CDC CDCynergy social marketing planning system.	1 year	-DFC	Social marketing materials developed
		2. Substance abuse prevention collaborative will coordinate awareness efforts.	Ongoing	-Northern and Southern HMPs -AMHC	Documentation of coordination from meeting minutes

				-CADET -Community Voices -Betsy – Houlton Band of Maliseets -Myrth Schwartz MicMac Band -Link for Hope	
	Objective 7: Conduct ongoing assessments and evaluations of collaborative functioning.	1. Seek technical assistance from the Prevention Centers to increase capacity in identified areas and to develop a method to assess group functioning (see Strategy 3).	6 months	-DFC	1. Documentation of technical assistance 2. Method to assess group functioning
	Obj. 7-1 Capacity Building Build capacity to gather local data.	2. Collaborate with the Prevention Centers to assess cultural competence and design a plan to improve cultural competency.	6-12 months		Plan to assess cultural competence
	Obj. 7-2 Capacity Building Build capacity to conduct systematic evaluation and monitoring.	3. Twice annually assess collaborative partners' perceptions of the internal and external functioning of the collaborative group.	2x per year and ongoing		Completed assessments

Goals 2, 3, 5

Goal	Objectives	Activities	Timeline	Who is responsible	Measures
Goal 2	Objective 1: Increase effectiveness of enforcement policies and practices for underage drinking and drug abuse.	1. Collaborate with local law enforcement to establish underage drinking as shared priority. (Resource: Maliseet Tribal Police)	6 months	-Community Voices -Chief Gahagan -DFC -Link for Hope	Documentation of contacts with law enforcement
		2. Use media to increase support for enforcement.	Ongoing	- Northern HMP -DFC -Link for Hope	Copies/documentation of media pieces
		3. Initiate collaborative with courts/justice system to assess barriers to more stringent enforcement of legal consequences.	6 months	- Northern HMP -DFC	Documentation of contacts
		4. Initiate contact with schools and youth to develop and implement uniform policies and enforcement procedures.	6 months	-CADET -DFC -Link for Hope	Documentation of contacts
		5. Educate parents about the dangers of furnishing or hosting underage drinking parties.	1 year	-Southern HMP -Community Voices -DFC	Documentation of educational efforts
		6. Publicize penalties for furnishing alcohol to minors or hosting underage drinking parties. (Resource: Maliseet Tribal Police)	4 times per year and ongoing	- Community Voices -Link for Hope	Documentation of publications

		7. Work with law enforcement to establish a department policy for underage drinking enforcement. (Resource: Maliseet Tribal Police)	- 1 year	- Northern and Southern HMPs	Documentation of work
		8. Provide training to law enforcement officers around best practices and model policy implementation. (Resource: Maliseet Tribal Police)	- 1 year	-Southern HMP	Documentation of work
		9. Initiate work with the State to mandate liquor enforcement training for law enforcement.	1 year and ongoing	-Southern HMP	Documentation of contacts
		10. Initiate a conversation with judges and probation/parole officers about concerns related to decreasing consequences for substance related violations.	6 months	-DFC	Documentation of contacts
		11. Initiate work at the State level to decrease the amount of judicial and probation/parole officer flexibility to decrease consequences for substance related violations.	1 year and ongoing	-DFC	Documentation of contacts
Goals 2-5 **Goals 2-5**	Objective 2: Increase youth and parent perceptions of risk related to underage and high risk drinking and prescription drug, marijuana, inhalant, stimulant and OTC abuse. Objective 3: Increase parent perception that their attitudes	1. Collaborate with youth, parents and other stakeholders to develop public education and social marketing campaigns.	1 year	-Northern and Southern HMP School Health Coordinators (alcohol only) -AMHC for Objective 4 -CADET	1. Documentation of contacts 2. Campaign materials developed

Goals 2-5	and behaviors related to substance use influence their children's decisions to use substances and increase parent knowledge of how to influence their children. Objective 4: Increase community knowledge about youth mental health issues and the increased risk for substance abuse among youth with unidentified/untreated mental health problems.			-DFC -Link for Hope	
		2. Initiate collaborative and planning process with early intervention programs to reach high risk families. (Resource: Maliseet Head Start)	6-12 months	-Northern and Southern HMPs (alcohol only) -AMHC for Objective 4 -Myrth Schwartz MicMac Band -DFC	Documentation of contacts and plans
		3. Initiative collaborative and planning process to work with community leaders and groups and schools/student assistance groups to communicate information to community members.	6-12 months	-Northern and Southern HMPs (alcohol only) -AMHC for Objective 4 -CADET -Myrth Schwartz MicMac Band -DFC -Link for Hope	Documentation of contacts and plans
		4. Approach media to gain their support and to obtain donations of media resources for the public education and social marketing campaigns.	6-12 months	-Northern and Southern HMPs (alcohol only) -AMHC for Objective 4 -CADET -DFC -Link for Hope	Documentation of contacts and commitments to provide donations

Goals 2-5		5. Initiate collaborative with hospitals and medical providers to educate patients about the risks and side effects of prescription drug abuse.	1 year	-CADET -DFC	
	Objective 5: Increase use of recommended parental monitoring practices to prevent alcohol, prescription drug, marijuana, stimulant, inhalant and OTC abuse.	1. Collaborate with youth, parents and other stakeholders to develop public education and social marketing campaigns based on the Search Institute's 40 Developmental Assets and OSA's Parent Campaign.	1 year	-CADET -DFC -Link for Hope	1. Documentation of participation and outcomes 2. Campaign materials
		2. Initiate collaborative with schools, media, parent groups, medical providers, businesses and others to communicate information to parents (one possible tool: public signs).	6-12 months	- Northern and Southern HMPs (alcohol only) -DFC -Link for Hope	Documentation of contacts and outcomes
		3. Initiate collaborative with early intervention programs to reach high risk families.	6-12 months	-Northern and Southern HMPs (alcohol only) -Myrth Schwartz MicMac Band -DFC	Documentation of contacts and outcomes
		4. Initiate collaborative with community leaders and groups.	6-12 months	-Northern and Southern HMPs (alcohol only) --Myrth Schwartz MicMac Band -AMHC	Documentation of contacts and outcomes

				-DFC -Link for Hope	
		5. Assess legal ramifications and policies related to school and police department notification of parents for suspicions of substance abuse or if the youth is caught with substances.	1 year	-DFC	Completed assessment
Goals 2-5	Objective 6: Create communities that provide the support and resources necessary to decrease youth risk of underage and high risk drinking and risk of using prescription drugs, marijuana, inhalants, stimulants and OTC drugs.	1. Recruit 2-3 communities to implement the 40 Developmental Assets approach.	1 year	-CADET -DFC -Link for Hope	Documentation of recruitment efforts and outcomes
		2. Work with communities to determine if lack of social activities is a concern; if it is, develop and conduct an assessment.	1 year	-CADET -DFC -Link for Hope	1. Documentation of work with communities 2. Documentation of assessment findings
		3. Initiate work at the State level to set standards for outdoor advertising of alcohol.	1 year	-Pete McCorison – AMHC -Community Voices	Documentation of contacts and activities
		4. Initiate work at the State level to set standards for placement of alcohol in stores.	1 year	-Pete McCorison – AMHC -Community Voices	Documentation of contacts and activities

Goal 2	Objective 7: Increase effectiveness of retailers' policies and practices that restrict access to alcohol by underage youth.	1. Conduct retailer training.	1 year	-Northern and Southern HMPs	Documentation of activities and outcomes
		2. Initiate work with the State on establishing a policy mandating responsible beverage service training for all new employees. (time frame: Years 2-5)	1 year	-DFC	Documentation of contacts and activities
		3. Initiate work with the State on re-establishing a liquor enforcement officer. (time frame: Years 2-5)	1 year	-CADET	Documentation of contacts and activities
		4. Initiate work with the State to mandate 100% compliance checks. (time frame: Years 2-5)	1 year	-DFC	Documentation of contacts and activities
Goals 2-5	Objective 8: Build connections with Canadian border communities involved in prevention work to address substance abuse issues that cross the border for Maine and Canada.	1. Identify substance abuse prevention groups in Canadian border towns.	6 months	-DFC	Documentation of groups with contact information
		2. Initiate dialogue about alcohol and drug abuse issues.	6 months	-DFC	Documentation of contacts and outcomes
		3. Establish a system to maintain communication with Canadian prevention groups.	6 months	-DFC	Documentation of plan
		4. Evaluate the potential for collaboration on substance abuse prevention.	1 year	-DFC	Documentation of evaluation

Goal 2	Objective 9: Decrease access to alcohol in Canada.	1. Collaborate with US Border and Customs to establish underage drinking as shared priority.	1 year	-DFC	Documentation of contacts and outcomes
		2. Collaborate with US Border and Customs to identify and address issues related to access to alcohol in Canada and underage youth bringing alcohol into the US.	1 year	-DFC	Documentation of contacts and outcomes
		3. Begin modifying the Border Binge Drinking Reduction Program.	1 year	-DFC	Documentation of modifications
Goal 2	Objective 10: Increase retailers' use of policies and practices that discourage high risk drinking.	1. Collaborate with retailers to limit promotions that encourage high-risk drinking.	1 year	-Northern and Southern HMPs	Documentation of contacts and outcomes
		2. Educate merchants about the negative impacts of low pricing and promotion.	1 year	-Northern and Southern HMPs	Documentation of contacts and outcomes
		3. Use media to increase awareness of negative impacts of low pricing and promotion.	1 year	-Northern and Southern HMPs	Documentation of media
		4. Initiate work at the State level to establish policies at bars and college or workplace parties to limit high risk drinking.	1 year	-DFC	Documentation of contacts and outcomes

		5. Initiate work at the State level to establish a system to conduct bar checks and leverage penalties for service to visibly intoxicated persons of legal age.	1 year	-DFC	Documentation of contacts and outcomes
Goal 3	Objective 6: Increase medical provider readiness to participate in solving the prescription drug abuse problem. (Resource: Maliseet Health Department – Larry Tonzi)	1. Educate medical providers about the prescription drug problem (magnitude, who is using, harms) in the County through one-on-one visits or at pre-scheduled hospital group meetings.	6 months	-DFC -Link for Hope	Documentation of contacts and outcomes
		2. Educate medical providers about the risks of prescribing controlled substances through one-on-one visits or at pre-scheduled hospital group meetings.	6-9 months	-DFC -Link for Hope	Documentation of contacts and outcomes
		3. Discuss descriptive *local* incidents related to the issue.	Ongoing throughout year	-DFC	Documentation of contacts
		4. Prepare and submit articles for hospital and other medical newsletters circulated in the County.	Ongoing throughout year	-DFC -Link for Hope	Copies of articles
		5. Discuss how medical providers can be involved in solving the problem.	1 year	-DFC -Link for Hope	Documentation of contacts

		6. Establish a medical provider workgroup to participate in strategy implementation in each region.	1 year	-DFC	Documentation of workgroup members and contacts
Goal 3	Objective 7: Decrease promotion of prescription drugs.	1. Initiate collaboration with hospitals and medical providers to establish policies, if none exist, around prescription drug advertisement.	6-12 months	-DFC -Maliseet Health Department -Link for Hope	Documentation of contacts and outcomes
		2. Initiate work at the State and/or Federal level to put limits on promotion of Rx drugs to doctors and through the media.	Ongoing	-CADET -Maliseet Health Department	Documentation of contacts and outcomes
Goal 3	Objective 8: Increase use of the Prescription Monitoring Program.	1. Educate pharmacists, medical providers and hospitals about the PMP.	1 Year	-Northern HMP -DFC -Link for Hope	1. Documentation of contacts and outcomes
		2. Collaborate with pharmacists, medical providers and hospitals to identify and address barriers to regular use of the PMP.	1 Year	-Northern HMP -DFC	Documentation of contacts and outcomes
		3. Initiate work at the State and Tribal level to require pharmacists and/or doctors to check the PMP prior to filling a prescription for a controlled substance.	1 Year	-DFC -Maliseet Health Department	Documentation of contacts and outcomes
		4. Initiate work at the State level to increase the frequency of pharmacy uploads to the PMP.	1 Year	-DFC	Documentation of contacts and outcomes

Goal 3	Objective 9: Increase medical provider use of policies and practices that safeguard against prescription drug abuse.	1. Expand dialog with medical providers about monitoring and screening practices (what are they currently doing?). (Resource: Maliseet Health Department – Larry Tonzi)	1 Year	-DFC -Maliseet Health Department	Documentation of contacts and outcomes
		2. Identify and address barriers to implementation of policies and practices.	1 Year	-DFC -Maliseet Health Department	Documentation of barriers and actions taken
		3. Initiate work at the State level to mandate use of specific monitoring and screening practices and address barriers to such a strategy.	1 Year	-DFC	Documentation of contacts and outcomes
		4. Initiate work at the State level to require prescription of non-controlled substance alternatives prior to prescribing controlled substances.	1 Year	-DFC	Documentation of contacts and outcomes
Goal 3	Objective 10: Increase awareness of and access to alternative treatments for pain management.	1. Identify alternative treatments for pain management that are available in the County (resource: collaborative with alternative treatment groups).	6 months	-DFC	Documentation of alternative treatments
		2. Assess accessibility (financial, geographic, and availability) of treatments (see assistance from UMAINE Prevention Center)	6-12 months	-DFC	Written assessment findings

		3. Initiate work at the State level to increase coverage of alternative treatments by health insurance carriers.	1 Year	-DFC	Documentation of contacts and outcomes
		4. Initiate work at the State and Tribal level to create policies requiring use of alternative treatments concurrent with initial use of prescribed painkillers and prior to *long term* prescribing of painkillers (with exceptions where appropriate).	1 Year	-DFC -Maliseet Health Department	Documentation of contacts and outcomes
Goal 3	Objective 11: Decrease access to prescription drugs.	1. Initiate conversation with hospitals around current community education initiatives around prescription drugs.	6 months	-DFC	Documentation of contacts and outcomes
		2. Work with communities to establish a place for people to dispose of prescription drugs.	1 Year	-Northern and Southern HMPs -Maliseet Health Department (promotion)	Documentation of contacts and outcomes
Goal 3	Objective 12: Increase medical provider knowledge of addiction and pain management.	1. Provide ongoing educational opportunities for medical providers (such as research-based pain and addiction assessment methods, effective pain management practices, how to work with addicted patients, issues related to their identified concerns about	Ongoing	-AMHC -DFC -Maliseet Health Department (send staff to opportunities)	Documentation of contacts and outcomes

		prescribing and not prescribing painkillers).			
		2. Initiate a conversation with hospitals about establishing a system through which to provide information to new providers who come to the County.	1 Year	-DFC	Documentation of system
Goal 6	Objective 1: Establish local long term inpatient treatment facility. Objective 2: Establish local after-care support services in three communities countywide.	1. Initiate a collaborative with Aroostook County substance abuse treatment agencies, hospitals and community stakeholders to assess feasibility of (1) establishing a long-term inpatient treatment facility in the County, (2) establishing after-care support services and (3) integrating specialized medical care into a long-term inpatient treatment facility program.	1 Year	-DFC -Maliseet Health Department -Link for Hope	1. Documentation of contacts and outcomes 2. Documentation of assessment
Goal 6	Objective 3: Create strategic and funding plans to establish an Aroostook County drug court.	1. Initiate a collaborative with the Aroostook County judiciary, District Attorney, Probation/Parole, and treatment providers to develop and write a plan for implementation of a treatment drug court in the County.	2 months	-DFC	
		2. Engage in planning process: review drug court best practice and planning research	3 months	-DFC	

		literature.			
		3. Write strategic plan for implementation of drug court that includes a funding plan.	4 months	-DFC	
		4. Apply for funding for drug court.	5 months	-DFC	

Sustainability

Continuation of collaborative strategic planning process:

The Aroostook Substance Abuse Prevention Collaborative will designate a coordinator to coordinate implementation of strategies which will enhance the functioning of the collaborative (i.e. identification of barriers to ongoing, sustainable countywide involvement and strategies to overcome barriers; identification of barriers to ongoing attendance and engagement of diverse groups at County meetings; and evaluation of collaborative functioning). The collaborative will have countywide meetings at least six times per year as part of the Comprehensive Community Health Coalition meetings.

Funding plan:

Aroostook Substance Abuse Prevention partners will develop and attain the resources needed to implement the Strategic Plan through:

1. Increased, ongoing coordination of existing resources.
2. Ongoing notification of partners about available funding opportunities.
3. Negotiation regarding which partner agency should apply for specific funding opportunities.
4. Initiation of contact with hospital and business leaders to get them engaged in collaboration and to elicit additional in-kind and/or financial support.
5. Public education about the need for prevention resources as a means to increase the pressure on public officials to provide funding for prevention.
6. Development of a sustainability plan that identifies non-grant funded sustainability strategies.
7. Implementation of the sustainability plan.
8. Ongoing grantseeking and writing performed by the Aroostook Substance Abuse Prevention Collaborative Coordinator.

Appendix 1: Countywide Comprehensive Assessment

Strategic Planning and Environmental Programming Grant Assessment Findings:

Aroostook County

August 2007

Prepared by:

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Aroostook County SPEP Grant Coordinator

Aroostook Substance Abuse Prevention

Cary Medical Center

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Executive Summary

The Aroostook County Substance Abuse (ASAP) Collaborative Project (funded by the Maine Office of Substance Abuse) completed a comprehensive assessment of substance abuse consumption and consequences and the factors contributing to the problem of substance abuse in Spring, 2007. This document summarizes the findings from the assessment.

Due to the large geographic size of the County and resulting cultural and community differences, ASAP divided the County into the four regions currently designated for each Aroostook County Healthy Maine Partnership. ASAP reviewed both county and regional level data. Key findings are summarized below.

County Level Key Findings

Consumption and consequences

1. Substances most frequently abused by youth and adults are alcohol, marijuana and prescription drugs, all of which were associated with harms such as domestic violence, child abuse/neglect, hospitalizations and arrests.

2. Youth use of alcohol, marijuana, prescription drugs, inhalants, cocaine and heroin *surpassed or was comparable* to national consumption rates for most grade levels.

3. Adult abuse of prescription drugs, stimulants (such as methamphetamine) and hallucinogens was higher than state levels.

4. The percentage of substance abuse treatment admissions for alcohol, marijuana and prescription drugs were *higher* than state and national percentages for youth and adults with the exception of adult admissions for alcohol, which equaled state admissions. Stimulant (example: methamphetamine) admissions were also higher than the state.

5. Harms caused by alcohol misuse were *more frequent* than harm caused by *any other* substance.

6. Child Abuse: Alcohol/drugs were involved in 55% of substantiated child abuse/neglect cases. Increased prescription drug abuse is partly responsible for an increase in child abuse/neglect cases throughout the County.

7. Domestic Violence: Alcohol, marijuana, prescription drugs and cocaine/crack were all primary substances of abuse reported by domestic violence offenders admitted for treatment. An average of 76% of domestic violence cases in the County had substance abuse involved in the violent incident preceding arrest.

8. Drug and Alcohol-Induced Deaths: Since 1999, alcohol-induced deaths *increased* from 4.0 to 10.9 while drug-induced deaths *increased* from 1.3 to 13.7 per 100,000. The County has a *higher average rate* of alcohol induced deaths (4.9) than the state (4.5).

9. Aroostook County Maine Drug Enforcement Agency Cases: Prescription drugs were most frequently involved in MDEA cases, followed by marijuana and methamphetamine, cocaine (8%), heroin (6%) and ecstasy (1%). The County MDEA recently identified YABA (methamphetamine) tablets as a substance creeping into Aroostook County from Canada.

10. Prescription Monitoring Program: Narcotics as the most frequently prescribed scheduled drugs in Aroostook County, representing 56% of all County scheduled drug prescriptions filled, followed by tranquilizers and stimulants. Aroostook County is the 5th highest county in Maine for average number of scheduled drug prescriptions filled. The County average scheduled drug scripts per person (1.58) surpassed the state average (1.50).

Contributing factors

1. Ease of access to alcohol and prescription drugs
2. Lack of consequences for adults who sell or provide alcohol to minors
3. Lack of consequences for youth arrested for substance related violations
4. Community norms (especially related to alcohol, marijuana and prescription drug use)
5. Cultural acceptance of and preference for use of prescription drugs to manage pain
6. Limited use of preventive screening and monitoring practices by medical providers
7. Limited access to or awareness of alternative methods of pain care and management (example: acupuncture, massage therapy, biofeedback, chiropractic care)
8. Youth perceptions of availability of drugs
9. Inaccurate perceptions of harm related to alcohol, marijuana, prescription drug, inhalant, stimulant, and over-the-counter drug use
10. Youth perceptions of parental attitudes favorable to drug use and anti-social behavior
11. Family management (parental monitoring and involvement, rule-setting and discipline)
12. Limited community readiness
13. Limited community resources to address the problem

Regional Level Differences

Northern Region

Data consistently suggested that abuse of prescription and illicit drugs are less prevalent than in other County regions. Data on alcohol-related harms indicated a higher frequency of alcohol-related harms (child abuse, arrests) than in other regions, where the frequency of drug-related harms was more prevalent. Regional hospital data suggests that the Northern region may have less prescription drug misuse than other regions.

The community level risk factor for which Northern Region youth were at greatest risk for using substances was community laws and norms favorable to substance use while the family climate factors for which they were most at risk were poor family management and parent attitudes favorable to anti-social behavior.

Northern Region and Central Region 1

Poison data reveals several similarities between the Northern Region and Central Region 1 which distinguish them from the Southern Region and Central Region 2.

1. Abuse related poison exposures: Alcohol or alcohol-containing products were the substances most frequently involved, followed by prescription drugs.
2. Diversion calls: Muscle relaxants and non-opioid analgesics followed opioids as substances most frequently involved in diversion calls to the Northern New England Poison Center.

Central Region 1

Data consistently suggested that prescription drug abuse is more prevalent among individuals under 50-years-old in Central Region 1 than in other regions. In contrast to the other three regions, youth in Central Region 1 report using alcohol, prescription drugs and inhalants more frequently than marijuana. The percentage of youth reporting stimulant use in Central Region 1 is also somewhat higher than the State. For hospital discharges, prescription drug related diagnoses were second to alcohol. The arrest rate for prescription drug violations among 10-17 year-olds was significantly higher in Central Region 1 than in the other regions. Unlike other regions, the prescription drug arrest rate for 21-29 year-olds was higher than the rate for marijuana violations.

Youth in Central Region 1 were at less risk for substance abuse due to community level risk factors than youth in other regions. The family climate risk factor for which Central Region 1 youth were most at risk was parental attitudes favorable to anti-social behavior.

Central Region 2

Data suggested that illicit and prescription drug abuse is more prevalent in Central Region 2 than in the Northern and Southern Regions. The percentage of youth reporting stimulant use in Central Region 2 is also somewhat higher than the State. In contrast to Central Region 1, Central region 2 had a significantly higher rate of 18-20

year-olds arrested for prescription drug violations than other regions. This may be due to the fact that the region has a university. Central Region 1 had the second highest combined rate of arrests for alcohol-related violations (following the Northern Region).

Central Region 2 youth consumption of substances and level of risk for abusing substances was generally higher than the other regions. In Central Region 2, the community level risk factor for which youth were most at risk was perceived availability of substances. The family climate risk factor for which youth were most at risk was poor family management and parental attitudes favorable to anti-social behavior.

Central Region 2 and Southern Region

Poison data reveals several similarities between Central Region 2 and the Southern Region which distinguish them from the other two regions.

1. Abuse related poison exposures: Prescription drugs were the substances most frequently involved, followed by alcohol.
2. Diversion calls: Non-opioid analgesics and benzodiazepines/benzo-like substances followed opioids as substances most frequently involved in diversion calls to the Northern New England Poison Center from both regions.

Southern Region

Data suggested that while illicit and prescription drug use is more prevalent in the Southern Region than in the Northern Region, the magnitude of use may not be as great as the Central Regions. Like the two Central regions, youth in the Southern Region report higher levels of stimulant use than at the State level. In contrast to other regions, methamphetamine was identified in a key informant interview as a substance used by adults and youth in the Southern Region, suggesting it may be more visible in the Southern Region.

In the Southern Region, the community level risk factor for which youth were most at risk community laws and norms favorable to drug use. The family climate risk factor for which youth were most at risk was parental attitudes favorable to anti-social behavior.

Resources and Readiness

Resource assessment findings suggest that Aroostook County has very few resources to comprehensively address substance abuse prevention and that County residents have limited access to comprehensive treatment and after-care support services. This lack of resources leaves many areas of the County without access to ongoing, comprehensive and coordinated prevention and treatment services, thereby limiting the overall efficacy of current efforts.

Readiness assessment findings indicated that regional levels of readiness to address substance abuse are relatively low. The Southern Region and Central Regions 1 and 2 were at level 4 of 9 while the Northern Region was at level 5 of 9.

Data Reviewed:

Consumption Data:

1. Maine General Population Survey
    - Source: Maine Office of Substance Abuse
    - 2004
2. Maine Youth Drug and Alcohol Use Survey (MYDAUS)
    - Source: Maine Office of Substance Abuse
    - 2006
3. Poisonings by Substance Type
    - Source: Northern New England Poison Center
    - 2006 Diversion Poison Calls – Law Enforcement and General Public
    - 2001-2006 Substance Abuse Related Poison Exposures
4. Prescription Monitoring Program
    - Source: Maine Prescription Monitoring Program
    - July 2004-June 2006
5. Treatment Admissions by Age, Substance Type, Domestic Violence Offender, Disability, and Employment Status
    - Source: Maine Treatment Data System
    - 2003-2005

Consequence Data:

1. Child Abuse/Neglect Cases Related to Substance Abuse
    - Source: Maine Department of Health and Human Services, Child and Family Services
    - 2004-2006
2. Domestic Violence Related to Substance Abuse
    - Source: Maine Treatment Data System
        - 2003-2005
    - Source: Domestic Violence Report, Maine Office of the Attorney General
        - 2003-2004
    - Source: Aroostook County District Attorney
        - 2007 Caseloads
3. Drug and Alcohol Induced Deaths by Age
    - Source: Maine Vital Records Mortality Files
    - 1999-2005 (2005 is preliminary data)
4. Uniform Crime Reports
    - Source: Maine Department of Public Safety
    - 2003-2005
6. Maine Drug Enforcement Agency - Aroostook County Cases
    - Source: Maine Drug Enforcement Agency
    - 2005-2006
7. Maine General Population Survey
    - Source: Maine Office of Substance Abuse
    - 2004

Intervening Variables Data:

1. Maine Youth Drug and Alcohol Use Survey (MYDAUS)
    - Source: Maine Office of Substance Abuse
    - 2006
2. Community Health Needs Assessment for County Health Link
    - Source: Public Health Resource Group, Inc. for County Health Link
    - 2001
3. Link for Hope Coalition Focus Groups
    - Source: Link for Hope Coalition
    - 2005
4. "Listening to Aroostook" Community Needs Assessment
    - Source: United Way
    - 2006
5. Adult & Youth Intervening Variables Survey
    - Source: Aroostook Substance Abuse Prevention
    - Summer 2007
6. Medical Provider Chronic Pain Treatment Survey
    - Source: Aroostook Substance Abuse Prevention
    - Summer 2007
7. Key Informant Interviews
    - Adult and juvenile probation (n=4), pharmacists (n=4), child protective workers (n=3), elder care worker (n=2), US Customs and Border Protection supervisor (n=1); treatment foster care therapist (1)
    - Source: Aroostook Substance Abuse Prevention
    - Summer 2007

Alcohol

Alcohol is the most frequently consumed substance among Aroostook County residents of all ages and is connected to more harms than any other substance.

Consumption

Maine General Population Survey

Alcohol was the most frequently referenced substance of abuse among respondents to the Maine General Population Survey: 43% of Aroostook respondents reported alcohol consumption at least once in the last thirty days. 16% of respondents reported binge drinking one or more times in the past thirty days. This suggests approximately 8,720 County residents 18 and over participated in binge drinking one or more times in the past thirty days.

State/National Comparison: Prior 30-day alcohol use and binge drinking were **below** State and National percentages (57% and 20% respectively).

MYDAUS

Alcohol use was reported by more MYDAUS participants in Aroostook County than any other substance of abuse. 27.5% of Aroostook County school-age youth who participated in the MYDAUS reported use of alcohol within the last thirty days. This is comparable to alcohol use reported at the State level, which was 29%. 13.1% of Aroostook County participants reported binge-drinking in the past 2 weeks. Prior 2-week binge-drinking was 14.6% at the State level.

State/National Comparison: Prior 30 day use of alcohol by Aroostook youth is **lower** than the State and **higher** than the Nation. National data was not available for binge drinking. The percentage of 8th grade youth reporting binge drinking in the prior 2 weeks is higher than the Maine percentage.

Table 1 Alcohol Prior 30 Day Use - Youth

Grade	County MYDAUS	Maine MYDAUS	Monitoring the Future
8th	21.1%	20.5%	17.2%
10th	36.3%	38.2%	33.8%
12th	45.4%	49.1%	45.3%

Table 2 Prior 2 Weeks Binge Drinking - Youth

Grade	County MYDAUS	Maine MYDAUS	Monitoring the Future
8th	9.2%	7.7%	N/A
10th	17.4%	19.7%	N/A
12th	25.1%	29.4%	N/A

Regional differences: Alcohol was the most frequently used substance among youth in all regions of the County, and was followed by binge drinking in 3 of the 4 regions. However, Central Region 1 (Caribou and surrounding area) had higher frequency of prescription drug and inhalant use than binge drinking.

Poisonings

Alcohol and alcohol-containing products (e.g. mouthwash, hair spray) were **one of two most frequently** reported substances involved in *countywide* substance abuse related poison exposures, representing 18% of substances reported. Such products were the **third most frequently** reported in Maine.

Regional differences: At the regional level, alcohol was the most frequently reported substance in the Northern Region and Central Region 1. However in the Southern Region and Central Region 2, alcohol was second to prescription drugs.

Treatment Admissions

Alcohol was the most frequently reported primary substance of abuse for Aroostook County residents over 17-years-old. For residents under 18-years-old, alcohol was the second most frequently reported primary substance of abuse.

State/National Comparison: Treatment admissions for alcohol use were **higher** than National admissions for comparable age groups. Alcohol accounted for 63% of resident treatment admissions for adults (National – 41%, Maine - 60%) and 36% of admissions for 10-17 year-olds (National – 18.4%; Maine – 33%).

Aroostook County treatment admission rates for alcohol were **higher** than Maine rates for all age groups except 50-64 year-olds.

Consequences

Child Abuse

Combined data from 2004 and 2005 indicated that alcohol abuse was the primary substance abused in 28% of child abuse and neglect cases in Aroostook County. 2007 interviews with child protective workers confirmed that alcohol is the substance most frequently abused by parents involved with the child welfare system.

Regional differences: One regional difference noted was that alcohol abuse seems to be increasing among young parents in the Fort Kent area. The interviewee said that there are an increasing number of young teen parents who are severe alcoholics.

Domestic Violence

According to a review of current domestic violence cases filed with the Aroostook County District Attorney, an average of 76% (88% in the Central and Northern regions of the County and 64% in the Southern region) of domestic violence cases in Aroostook County have substance abuse involved in the violent incident that preceded arrest. In all County regions, alcohol is the substance most frequently involved in the violent incident that preceded arrest.

Between 2003 and 2005, there were 200 patients admitted to substance abuse treatment who identified themselves as domestic violence offenders. Alcohol was the primary substance of abuse for 65% of those patients.

Alcohol-Induced Deaths

Since 1999, there was an increase in the number of alcohol-induced deaths in Aroostook County. In 1999 there were 3 alcohol-induced deaths while in 2005 there were 8. The rate per 100,000 deaths was 4.0 in 1999 while the rate in 2005 was 10.9. The average alcohol-induced death rate between 1999 and 2004 in Aroostook County (4.9) was higher than the State average (4.5).

Between 1999 and 2004 in Aroostook County and Maine, 50-64 year-olds had the highest number and rate of alcohol-induced deaths – followed by adults over 65-years-old and 30-49 year-olds. The rate of alcohol induced deaths for 50-64 year-olds was higher in Aroostook County (10.6) than in Maine (9.2).

Arrests: Uniform Crime Reports

Alcohol violations represented an average of 78% of substance-related arrests in Aroostook County for residents over 10-years-old. Alcohol violations were the only substance-related violations for which adults over 65-years-old were arrested. Nevertheless, the rate of alcohol violation arrests in age categories over 20-years-old decreased with age.

Residents 18-20 years-old had the highest rate of alcohol violation arrests (125.4 per 1,000 18-20 year-olds) followed by 21-29 year-olds (rate = 63.5), 10-17 year-olds (rate = 20.8), 30-49 year-olds (rate = 16), and 50-64 year-olds (rate = 5). The alcohol violation arrest rate for adults over 64-years-old was less than 5.

Interviews with adult and juvenile probation workers confirmed that alcohol is among the top three substances abused by individuals on their caseloads. One **regional difference** was that alcohol **was not** noted among the top four substances for juveniles in the Southern region of the County.

State Comparison: Aroostook County alcohol violation arrest rates were lower than Maine rates for all age groups except 21-29 year-olds. The Maine rate for 21-29 year-olds was 61.9 while the County rate was 63.5.

Regional Differences: In all regions, there were higher arrest rates for alcohol related violations than for other drug related violations across all age groups. However, the **Northern Region** had the **highest combined rate** of alcohol related violations for 18-20 year-olds (153) followed by Central Region 2 (117), Central Region 1 (91) and Southern Region (89).

Regional Hospitalizations

Note: Data were obtained from the four hospitals in the County. Each hospital has different methods of collecting and retrieving discharge data. The data is not comparable due to limitations on what could be accessed although some patterns emerged. Also, although tobacco-related diagnoses were included in the total number of drug-related diagnoses, only the most frequent diagnoses for other drugs are reported here.

In all hospitals, alcohol-related diagnoses were the most frequent. Data from three hospitals indicated that alcohol-related diagnoses were given more frequently to adults than youth. Youth were more frequently discharged with diagnoses related to drug abuse.

The second most frequently given diagnosis varied by hospital. In the Northern region, marijuana was the second most frequently given diagnosis (18%) followed by prescription drugs (14%). In contrast, at Cary Medical Center prescription drug diagnoses were second to alcohol for discharges. Cary Medical Center also provided Emergency Room data; prescription drugs were the substance most frequently involved in Emergency Room cases. At Houlton Regional Hospital, the most frequently given drug diagnosis was 'unspecified drug dependence or addiction' (37%) followed by opioids (8%) and other drugs (3%).

Data provided by two hospitals (TAMC and Cary Medical Center) suggested that adults over 30 are being discharged with drug-related diagnoses as much as or more than youth and young adults under 30-years-old.

Central Region 1 – Cary Medical Center
A higher number of adults over 30-years-old were treated at Cary Medical Center for substance related problems than young adults under 30-years-old. 67% of adults over 30 were given an opioid-related diagnosis (compared to 33% of individuals under 30) and 57% were given a non-specified drug-related diagnosis (compared to 43% of individuals under 30).

Central Region 2 – The Aroostook Medical Center
31% of inpatient discharges were given a drug-related diagnosis. Approximately half of those patients were 18-29 years-old while half were 30 or older.

Drug Abuse

Consequences

Child Abuse

Combined data from 2004 and 2005 indicated that 27% of substantiated child abuse/neglect cases were related to drug abuse. Interviews with child protective workers indicated that prescriptions drugs are the most frequently involved drug, followed by marijuana. However, according to one worker interviewed, Child Protective Services does not generally pursue referred cases in which parents abuse only marijuana.

Drug-Induced Deaths

Since 1999, the number of drug-induced deaths in Aroostook County increased. In 1999, there was 1 drug-induced death while in 2005 there were 10 drug-induced deaths. The rate of drug-induced deaths was 1.3 in 1999 and 13.7 in 2005.

The average drug-induced death rate between 1999 and 2004 for Aroostook County was 5.2 while the average rate for Maine was 8.8. In Aroostook County, the age specific drug-induced death rate was lower across all age groups than in the State.

Between 1999 and 2004, 21-29 year-olds in Aroostook County had a higher rate of drug-induced deaths (9.8) than other age groups in the County. 30-49 year olds had the highest number of drug-induced deaths (n = 8); the drug-induced death rate for this age group was 6.3. The frequency and rate of drug-induced deaths among adults over 50-years-old was less than 5.

Marijuana

Marijuana is the most frequently consumed illegal drug among County residents of all ages and is connected to multiple harms.

Consumption

Maine General Population Survey

Marijuana was the most frequently reported drug of abuse among Aroostook County adults. 4% of respondents reported they abused marijuana within the last 12 months. This suggests approximately 2,180 County residents abused marijuana within the last 12 months.

State/National comparison: Prior adult thirty day use in the County (2%) was **lower** than use reported at National (5.9%) and State levels (4%).

MYDAUS

Marijuana was the most frequently referenced drug of abuse in the MYDAUS. 10.7% of Aroostook County school-age youth who participated in the MYDAUS reported use of marijuana within the last thirty days. This is **lower** than use reported at the State level, which was 14.1%.

State/National comparison: **Higher** percentages of County youth in 10th and 12th grades reported prior 30 day marijuana use than 10th and 12th graders Nationally.

Table 3 Marijuana Prior 30 Day Use - Youth

Grade	County MYDAUS	Maine MYDAUS	Monitoring the Future
8th	4.6%	6.6%	6.6%
10th	15.7%	20.4%	14.2%
12th	19.9%	27.2%	18.3%

Regional differences: Marijuana was the **most frequently** used drug among youth in **3** regions of the County. However, Central Region 1 (Caribou and surrounding area) had higher frequency of prescription drug and inhalant use and binge drinking.

Poisonings

Marijuana was involved in 1.7% of County substance abuse poison exposures reported to the NNEPC. This is **lower** than involvement reported at the State level (2.9%).

Treatment Admissions

Treatment admissions of County residents for marijuana were more frequent than for other drugs. However, marijuana was not consistently the most frequently cited primary substance of abuse for age specific treatment admission rates.

Aroostook County residents 17 and under admitted for treatment had higher admission rates for marijuana abuse than any other substance, including alcohol. Rates for 18- 30-years-old were **less than** alcohol and prescription drugs but greater than the admission rates for cocaine/crack and heroine/morphine. Rates for 30-64 year-olds were **less than** alcohol and higher than other substances.

Aroostook County residents17 and under admitted for substance abuse treatment had **higher** admission rates for marijuana abuse than any other substance.

- The 10-14 year-old admission rate for marijuana abuse was 5.21 while the alcohol rate was 1.4.
- The admission rate of 15-17 year-olds for marijuana abuse was 34.3 while the rate for alcohol was 23.6.

The rate of treatment admissions for marijuana in age categories over 29-years-old decreased with age.

State/National comparison: Aroostook County treatment admission *rates* for marijuana were **higher** than Maine rates for all age categories except adults over 65-years-old, for whom no treatment admissions were reported.

Total resident admissions for marijuana were **higher** than admissions at National and State levels. Marijuana was the primary substance of abuse for admissions of 15.5% of adults (National – 11.7%; Maine – 9.2%) and 58% of 10-17 year-olds (National – 44% (youth 12-17); Maine – 54%).

Consequences

Domestic Violence

Between 2003 and 2005, there were 200 patients admitted to substance abuse treatment who identified themselves as domestic violence offenders. Marijuana was the primary drug of abuse for 20% of those patients and was the **most frequently** reported primary *drug* of abuse.

Arrests: Uniform Crime Reports

Marijuana violations represented an average of 12.8% of substance-related arrests in Aroostook County for residents over 10-years-old. The rate of marijuana violation arrests in age categories over 20-years-old decreased with age.

Residents 18-20 years-old had the highest rate of marijuana violation arrests (31.4 per 1,000 18-20 year-olds) followed by 21-29 year-olds (rate = 17.4), and 10-17 year-olds (rate = 7.3). The rate of arrests for marijuana violations among adults over 29-years-old was below 5.

State comparison: Aroostook County had **lower** marijuana violation arrest rates than Maine.

Regional differences: Two of the interviews with adult and juvenile probation workers confirmed that marijuana is among the top three substances abused by individuals on their caseloads. However, marijuana **was not** noted for adults in the St. John Valley and Southern regions of the County.

Arrest rates for marijuana were second highest for all age groups in two County regions. However, in both Central Region 1 and 2, marijuana arrest rates were third highest (following synthetic narcotics) among one age group in each region (Central Region 1 – 21-29 year-olds; Central Region 2 – 18-20 year-olds) but were second highest for all other age groups. Marijuana arrest rates in the Northern Region were lower than the other three regions for all age groups except 18-20 year-olds for which the lower rate was found in Central Region 2.

Arrests: Maine Drug Enforcement Agency – Aroostook County Cases

Marijuana was the **second most frequently** involved substance in cases handled by the Maine Drug Enforcement Agency in Aroostook County and represented 16% of Aroostook County cases.

Prescription Drugs

Prescription drug abuse follows marijuana in frequency of abuse for adults. Both prescription drugs and inhalants are the third most frequently abused substance by youth. Data suggests the level of harm it causes may be greater than marijuana.

Note: Opioids are a family of *synthetic* drugs used to treat pain. They are similar to opiates such as morphine and codeine.[2]

Consumption

Maine General Population Survey

Opioids were the second most frequently reported drug of abuse among respondents: 2% reported abusing opioids within the last 12 months. This suggests approximately 1,090 County residents abused opioids within the last 12 months.

State/National comparison: 1.7% of adult residents reported prescription drug abuse in the last thirty days. This is **less** than National levels (1.8% for pain relievers, 2.6% for psychotherapeutics) and **more** than State levels (.7%).

MYDAUS

4.2% of Aroostook County survey participants reported using prescription drugs in the past 30 days. Results from the Maine MYDAUS revealed that 6% of state-level participants reported prescription drug use.

State/National comparison: The percentage of youth in 12th grade who used prescription drugs in the prior 30 days was higher for Aroostook County than the Nation.

Table 4 Prescription Drug Prior 30 Day Use - Youth

Grade	County MYDAUS	Maine MYDAUS	Monitoring the Future
8th	3.7%	3.8%	N/A
10th	5%	8.1%	N/A
12th	5.7%	9.4%	3.8%

Regional differences: Prescription drug abuse was reported less frequently than alcohol, binge drinking, marijuana and inhalants in 3 County regions. However, in Central Region 1 (Caribou and surrounding area), prescription drug abuse was reported more frequently than inhalants, binge drinking, and marijuana.

Poisonings

Six of the top 10 substances involved in substance abuse related poison exposures in Aroostook County were prescription drugs - opioids, benzodiazepines, anti-depressants, non-opioid analgesics, anti-psychotics, and anti-consultants. Opioids,

[2] www.seniormag.com/conditions/cancer/cancerglossary/o.htm

benzodiazepines, and anti-depressants were **among the top five** substances most frequently involved in substance-abuse related poison exposures. 47% of substances involved in substance abuse related poisonings were prescription drugs.

State comparison: County and State frequencies of abuse related poison exposures for different kinds of prescription drugs were comparable. Opioids represented 14% of exposures (Maine – 16.7%), benzodiazepines represented 13% (Maine – 14.5%), and anti-depressants represented 10% (Maine – 10%).

Regional differences: Prescription drugs were the substances most frequently involved in abuse related poison exposures in the Southern Region and Central Region 2. In the Northern Region and Central Region 1, prescription drugs were second to alcohol.

Regional Diversion Calls: Northern New England Poison Center

Note: Diversion calls are made to the NNEPC by either law enforcement or individuals. The caller contacts NNEPC in order to have pills identified. Law enforcement call for identification of confiscated pills while individuals usually call for identification of a pill they intend to or have abused. Diversion calls are considered a reliable indicator for the types of prescription drugs being abused.

Opioids were the substance most frequently referenced in diversion calls made to the NNEPC from all County regions.

Regional differences: Muscle relaxants and non-opiod analgesics (such as Aspirin or Tylenol) followed opioids in the Northern Region and Central Region 1. In contrast, non-opioid analgesics and benzodiazepines/benzo-like substances followed opioids in the Southern Region and Central Region 2.

Prescription Monitoring Program

Opioids are the most frequently prescribed scheduled drugs in Aroostook County and represent 56% of all scheduled drug prescriptions filled in the County. Opioids were followed by tranquilizers (34.5%) stimulants (9%) and other scheduled drugs (<1%).

In the year beginning July, 2005, Aroostook County moved from 10th in the State to 5th highest in the State for average number of scheduled drug prescriptions filled. The County average scheduled drug scripts per person (1.58) **surpassed** the State average scheduled drug scripts per person (1.50).

Aroostook County also ranked:

- 8th highest for number of scripts written per person for narcotics
- 4th highest for number of scripts written per person for tranquilizers
- 7th highest for number of scripts written per person for stimulants

Treatment Admissions

Opioids were consistently among the top three primary substances of abuse among Aroostook County residents over 14-years-old who were admitted for treatment. Other forms of prescription drugs were not consistently identified as primary substances of abuse across multiple age categories and in numbers greater than 5.

The rate of opioid admissions was second only to alcohol admission rates among 18-29 year-olds. Opioid admission rates were the third highest, following alcohol and marijuana, for 15-17 year-olds and 30-64 year-olds.

State/National comparison: County treatment admission rates were higher than Maine rates for 18-29 year-olds and lower for all other age groups. Aroostook County admission rates were 24.91 (per 1,000 18-20 year-olds) for 18-20 year-olds, 27.96 for 21-24 year-olds, and 29.75 for 25-29 year-olds.

Aroostook County had higher percentages of admissions with other opiates and synthetic narcotics as the primary substance of abuse than National and State levels for all age groups except adults over 29-years-old. Admission percentages for County children 17 and under were 8% (National – 1.3%; Maine - 4.3%) while adult admissions were 14% (National – 4.6%; Maine – 12%).

Consequences

Child Abuse and Neglect

All child protective workers interviewed said that the reason for the recent increase in substantiated cases in which parents are abusing *drugs* is an increase in prescription drug abuse.

Domestic Violence

Between 2003 and 2005, there were 200 patients admitted to substance abuse treatment who identified themselves as domestic violence offenders. Opioids were the primary drugs of abuse for 11% of those patients.

Arrests: Uniform Crime Reports

Opioid violations represented an average of 9% of substance-related arrests in Aroostook County for residents over 10-years-old. The rate of opioid violation arrests in age categories over 20-years-old with age.

Aroostook County residents 18-20 years old had the highest rate of opioid violation arrests (41 per 1,000 18-20 year-olds). The opioid violation arrest rate for this age group surpassed the marijuana violation arrest rate (31). The age group with the second highest rate of opioid violation arrests was 21-29 year-olds (rate = 6) followed by 10-17 year-olds (rate = 1.4) and 30-49 year-olds (rate = .89). There were no arrests for opioid violations among adults over 49-years-old.

State comparison: Aroostook County opioid violation arrest rates were **higher** than Maine rates for 10-29 year-olds and **lower** than Maine rates for adults over 29-years-old. Maine opioid violation arrest rates were .70 for 10-17 year-olds, 3.91 for 18-20 year-olds, and 3.2 for 21-29 year-olds.

Regional differences: Probation workers interviewed consistently identified opiates/prescription drugs among the top three substances abused by individuals on their caseloads. Opiates are reportedly the **most frequently** abused substance by individuals from the St. John Valley involved with the adult probation system.

According to arrest data, there were no arrests for synthetic narcotics between 2003 and 2005 in the Northern Region. In the three other regions, synthetic narcotic arrest rates for adults 30-49 years-old were third highest (following marijuana). Synthetic narcotic arrest rates were also third highest for 18-29 year-olds in the Southern Region and 10-17 year-olds in Central Region 1. When compared to the other three regions, **Central Region 1** had a **significantly higher arrest rate of youth 10-17** for synthetic narcotics while **Central Region 2** had a **significantly higher arrest rate of 18-20 year-olds** for synthetic narcotics. Synthetic narcotics had the second highest arrest rate among one age group in each of the Central Regions (Central Region 1 – 21-29 year-olds; Central Region 2 – 18-20 year-olds).

Arrests: Maine Drug Enforcement Agency – Aroostook County Cases

Prescription drugs were the substances **most frequently** involved in cases handled by the Maine Drug Enforcement Agency and represented 53% of Aroostook County cases.

Inhalants

Inhalants are primarily being used by youth and are used as frequently as prescription drugs. Inhalant abuse was not reported by adults who participated in the Maine General Population Survey.

Consumption

MYDAUS

Inhalants are the fourth most frequently used substance by youth (following alcohol, marijuana and prescription drugs); 4.2% of Aroostook County MYDAUS respondents reported using inhalants at least once in the past thirty days.

Table 5 Inhalant Prior 30 Day Use - Youth

Grade	County MYDAUS	Maine MYDAUS	Monitoring the Future
8th	6.9%	7.1%	4.1%
10th	4.5%	4.7%	2.3%
12th	1.3%	2.3%	1.5%

State/National comparison: County youth inhalant use is **higher** than National levels and **lower** than State levels (2.6% and 4.7%).

Regional differences: In 3 county regions, inhalant abuse was reported more frequently than prescription drugs and stimulants and less frequently than alcohol, binge drinking and marijuana. In Central Region 1 (Caribou and surrounding area), inhalant abuse was reported more frequently than marijuana abuse and binge drinking and less frequently than alcohol and prescription drug abuse.

Poisonings

Chemicals, hydrocarbons, paints, varnishes and lacquers were among the top 10 substances involved in abuse related exposures in Aroostook County, accounting for 4% of exposures. Inhalants were not among the top 3 substances at the regional level.

State comparison: Inhalants were not among the top 10 substances at the State level.

Treatment Admissions

There were no resident treatment admissions for inhalants.

Consequences

Consequence data reviewed (child abuse/neglect, domestic violence, and arrests) did not reveal any data related to inhalant abuse.

Cocaine/Crack

Cocaine/crack use among Aroostook County youth and adults was low relative to use of alcohol, marijuana, prescription drugs and inhalants (for youth only). Harms caused by cocaine/crack use did not have the same consistent level of magnitude as harms caused by alcohol, marijuana and prescription drugs.

Consumption

Maine General Population Survey

There were no reports of cocaine/crack use in the last thirty days among Aroostook County adult respondents to the Maine General Population Survey.

MYDAUS

2.1% of Aroostook County youth reported cocaine/crack use in the last thirty days.

Table 6 Cocaine/Crack Prior 30 Day Use - Youth

Grade	County MYDAUS	Maine MYDAUS	Monitoring the Future
8th	.6%	1.1%	1.6%
10th	2%	1.9%	2.2%
12th	3.6%	3.3%	3.4%

State/National comparison: County 10th and 12th grade youth cocaine use was comparable to National and State levels.

Poisonings

Cocaine was involved in 1.7% of abuse related poison exposures in Aroostook County.

State comparison: Cocaine was involved in fewer abuse related poison exposures in Maine (3.7%) than in the County.

Treatment Admissions

There were no treatment admissions for cocaine among residents under 18-years-old.

State/National Comparison: Treatment admissions of County residents for cocaine as the primary substance of abuse were lower than National and State statistics: 3% of County adult resident admissions had cocaine as primary substance of abuse (National - 14.8%; Maine - 4.7%). County resident treatment admission rates for cocaine/crack were slightly lower than Maine rates for all age groups.

County resident admissions with cocaine as primary substance of abuse constituted 2.3% of 18-20 year-olds (National – 3.3%; Maine – 4.4%), 3.3% for 21-24 year-olds (National – 7.2%; Maine – 4.7%), 5.2% for 25-29 year-olds (National – 11.5%; Maine – 5.8%), and 3% for 30-49 year-olds (National - 17.2%; Maine - 5.3%).

Consequences

Domestic Violence

Cocaine/crack was the primary drug of abuse for 4% of Aroostook County domestic violence offenders admitted for treatment.

Arrests: Uniform Crime Reports

Enforcement violations for cocaine were not distinguished in the data from arrests for opium and derivatives (i.e. heroin). Arrests for the combined category accounted for 3% of County arrests. County arrest rates for the combined category were lower than Maine rates except for arrests of 18-20 year-olds (County - 16.4; Maine - 6.86).

Arrests for opium, cocaine and derivatives were third highest (following marijuana) among 30-45 year-olds in the Northern and Southern Regions. When compared to the other three regions, **Central Region 2** had **significantly higher arrest rates of 18-20 year olds for opium, cocaine and derivatives**.

Arrests: Maine Drug Enforcement Agency – Aroostook County Cases

Cocaine/crack was the **third most frequently** involved substance in cases handled by the Maine Drug Enforcement Agency in Aroostook County and represented 8% of Aroostook County cases.

Heroin

Heroin use among Aroostook County youth surpassed National levels while adult use was below State and National levels. Nevertheless, heroin consumption was reported less frequently than cocaine/crack, alcohol, marijuana, prescription drugs and inhalants.

The magnitude of harms caused by heroin was slightly less than cocaine/crack and did not have the same consistent level of magnitude as harms caused by alcohol, marijuana and prescription drugs.

Consumption

Maine General Population Survey

There were no reports of heroin use among adult survey respondents to the Maine General Population Survey.

MYDAUS

1% of Aroostook County MYDAUS respondents reported use of heroin in the last thirty days.

Table 7 Heroin Prior 30 Day Use - Youth

Grade	County MYDAUS	Maine MYDAUS	Monitoring the Future
8th	.7%	.8%	.3%
10th	.9%	1%	.5%
12th	1.4%	1.2%	.4%

State/National comparison: Reported County youth heroin consumption is **higher** than National levels and equals State levels (.4% and 1%).

Poisonings

Heroin was involved in 2.3% of abuse related poison exposures in Aroostook County, which is more frequent than cocaine/crack poisonings.

State comparison: Heroin was involved in more abuse related poisoning exposures in Aroostook County than in Maine (1.7%).

Treatment Admissions

There were no treatment admissions for heroin among Aroostook County residents under 18-years-old. Heroin/morphine was the primary substance of abuse for 1.9% of adult admissions.

State/National comparison: County adult admissions for heroin/morphine are lower than National (14.9%) and State (7.8%) levels.

Heroin/morphine was the primary substance of abuse for 2.7% of 18-20 year-olds, 3.3% of 21-29 year-olds, and 1% of 30-49 year-olds. These percentages are lower than National and State levels. Treatment admission rates of Aroostook County

residents for heroin/morphine were lower than Maine admissions rates for all age groups (18-20 year-olds: 2.49, 7.4; 21-24 year-olds: 3.75, 13.64; 25-29 year-olds: 2.47, 8.23; 30-49 year-olds: .38, 1.95).

Consequences

Domestic Violence

Heroin use was not reported by domestic violence offenders.

Arrests: Uniform Crime Reports

Enforcement violations for heroin were not distinguished in the data from arrests cocaine/crack. See the Arrest summary for cocaine/crack for information about heroin related arrests.

Arrests: Maine Drug Enforcement Agency – Aroostook County Cases

Heroin was the **fourth most frequently** involved substance in cases handled by the Maine Drug Enforcement Agency in Aroostook County and represented 6% of Aroostook County cases.

Stimulants (methamphetamine, other amphetamines)

Youth and adult stimulant use is higher than State and National levels for some use patterns. There are regional differences in reports of stimulant use, with urban areas having higher levels of stimulant use than rural areas. Like cocaine and heroin, harms caused by stimulant use are more difficult to identify due to data limitations and have less magnitude than those caused by alcohol, marijuana and prescription drugs. However, stimulant use seems to be a growing problem that is spreading from South to North and that is linked to Aroostook County's location on the Canadian border.

Consumption

Maine General Population Survey

County adult prior thirty day use of stimulants was higher than Maine (Aroostook County - .8%; Maine - .1%). National data was only available that combined data for both youth and adults; prior thirty day methamphetamine use for persons age 12 or older at the national level was .2%.

MYDAUS

State/National comparison

County youth stimulant use in the last thirty days was lower than National levels and comparable to State levels. However, there were several areas in the County at which youth reports of ever using stimulants **surpassed** State levels (there was no comparable National data) by 1% or more (Maine = 3.3%).

Table 8 Stimulant Prior 30 Day Use - Youth

Grade	County MYDAUS	Maine MYDAUS	Monitoring the Future
8th	.9%	.9%	2.1%
10th	1.6%	2%	3.5%
12th	2.3%	2.2%	3.7%

Regional differences: Throughout the County, more urbanized areas have higher percentages of youth reporting ever having used stimulants. Over 4% of youth in more urbanized areas of Central Region 1 (Caribou and surrounding area), Central Region 2 (Presque Isle and surrounding area) and Southern Region (Houlton and surrounding area) reported ever using stimulants. Although there was more stimulant use reported by youth in the more urban areas of the Northern region, the frequency did not surpass 2%. This pattern was noted in all but two of the rural areas of the other county regions. However, there were two exceptions: one rural area in Central Region 2 had 3.4% of youth reporting ever using stimulants and one rural area in the Southern region had 2.7% of youth reporting ever using stimulants.

Poisonings

Stimulants were involved in 1.7% of abuse related poison exposures in Aroostook County and .4% of exposures in Maine.

Treatment Admissions

There were no treatment admissions for stimulants among residents under 25-years-old. Stimulants were the primary substance of abuse for 1.2% of all adults over 24-years-old. Adults 25-29 years-old were treated more frequently for stimulants (2.6% of admissions) than adults
30-49 year-olds (1.6% of admissions).

Treatment admission rates for stimulants were higher for Aroostook County than for Maine. Rates for 25-29 year-olds were 1.9 and .36, respectively. Rates for 30-49 year-olds were .61 and .11.

State/National comparison: County adult treatment admissions for stimulants were higher than Maine (.31%) and lower than the Nation (9.5%).

Consequences

Child Abuse/Neglect

Child protective workers did not identify methamphetamine as a substance frequently abused by parents involved in the child welfare system. However, it was noted that in the Southern region methamphetamine carries a stigma for substance abusers, who have indicated that within the substance abusing community prescription drug abuse is more acceptable than methamphetamine abuse. Hence, substance abusers are more likely to admit to prescription drug abuse than methamphetamine abuse, even if they are abusing methamphetamine. Therefore, there may be under reporting of methamphetamine abuse in the Southern region.

Arrests: Uniform Crime Reports

Arrest data from local police departments did not distinguish stimulant arrests, which were placed under the general category “other non-narcotic drugs.” Arrest rates for other non-narcotic drugs were third highest (following marijuana) among 10-29 year-olds in the Northern region, 10-17 year-olds in the Southern region, and 21-49 year olds in Central Region 2. Nevertheless, when compared to the other three regions, Central Region 2 had significantly higher arrest rates of 18-20 year olds for other non-narcotic drugs. The arrest rate of 10-17 year-olds for other non-narcotic drugs in the Northern region surpassed the rates in the three other regions while the rate for 18-20 year-olds was higher than two other regions.

Regional differences: Methamphetamine was specifically identified as a substance used by adults and youth involved in the criminal justice system in the Southern region, suggesting that the problem of methamphetamine may be more visible in that region than in other County regions.

Arrests: Maine Drug Enforcement Agency – Aroostook County Cases

Along with marijuana, methamphetamine was the second most frequently involved substance in cases handled by the County Maine Drug Enforcement Agency (MDEA) (16% of cases). The County MDEA also recently identified YABA tablets, which typically contain both methamphetamine and caffeine, as a substance creeping into Maine through the County. According to the MDEA, all YABA tablets seized in the County originate in Canada. YABA tablets are very inexpensive and are particularly popular with "long haul" truck drivers. YABA tablets are highly addictive and carry the same risks to users as methamphetamine[3]. YABA tablets pose a particular threat to youth because they are deliberately marketed to young people[4]; and are typically brightly colored, candy flavored tablets that have appealing insignias – such as the Pepsi and Coca-Cola logos, the Nestle Quik Bunny or a steaming teapot[5].

Arrest data specifically for YABA was not available because it is included with methamphetamine arrests. Nevertheless, a report issued by the County MDEA indicated that seizures increased in 2006.

[3] National Drug Intelligence Center. (2003). YABA fast facts: Questions and answers. Retrieved April 4, 2007 from http://www.usdoj.gov/ndic/pubs5/5048/5048p.pdf

[4] See iii

[5] Maine Drug Enforcement Agency – Aroostook County. (2007). Maine Drug Enforcement Agency Summary of YABA Abuse. Provided to CADET by the County MDEA Commander.

Hallucinogens

Consumption

Maine General Population Survey

.4% of Aroostook County adult respondents to the Maine General Population Survey reported use of hallucinogens in the last 30 days.

State/National comparison: County adult use is higher than Maine (.2%) and lower than the Nation (1.7%).

MYDAUS

1.5% of County 12th graders reported hallucinogen use.

State/National comparison: County youth reported lower prior thirty day hallucinogen use than youth Nationally and in Maine.

Table 9 Hallucinogen Prior 30 Day Use – Youth

	County MYDAUS	Maine MYDAUS	Monitoring the Future
8th	.7%	1.2%	.9%
10th	1%	2.4%	1.5%
12th	1.5%	3%	1.5%

Poisonings

Hallucinogens were involved in .4% of abuse related poison exposures in the County and .2% of Maine exposures

Treatment Admissions

There were no treatment admissions for hallucinogens among Aroostook County residents.

Consequences

Hallucinogens were not specifically identified as a substance involved in most of the consequence data reviewed.

Arrests: Uniform Crime Reports

Arrest data from local police departments did not distinguish hallucinogen arrests, which were placed under the general category “other non-narcotic drugs.” See arrest summary in the Stimulants section.

Arrests: Maine Drug Enforcement Agency – Aroostook County Cases

Ecstasy is the substance least frequently involved in MDEA cases. It was involved in 1% of cases.

Over-the-Counter Medicines

Poison data is the only data source monitoring abuse of over-the-counter medicines. Over-the-counter medicines did not show up in any consequence data.

Poisonings

Note: The Northern New England Poison Center groups asthma, cold/cough, eye, ear, nose and throat medicines in one category. However, the director of the Poison Center reported that medicines these mostly represent dextromethorphan abuse.

Over-the-counter medicines were among the top 5 substances involved in substance abuse related poisonings in Aroostook County between 2001 and 2006, accounting for 13% of substances.

State comparison: Over-the-counter medicines accounted for 11% of substances involved in abuse related poisonings at the State level and were also among the top 5 substances.

Employment and Substance Abuse

According to data from the Treatment Data System and the Maine General Population Survey, reports of unemployment or lack of involvement in the workforce were more frequent among individuals involved in drug abuse than alcohol abuse. However, employed respondents to the Maine General Population Survey who reported binge drinking one or more times in the past month more frequently reported they felt the effects of their alcohol abuse at work than employed respondents who abused drugs.

Intervening Variables Data

Community Level Risk Factors

MYDAUS

The MYDAUS data communicate level of risk for using substances for three research-based community level risk factors: (1) community laws and norms favorable to substance use, (2) perceived availability of drugs and (3) perceived availability of handguns.

County 42% of County youth are at risk for using substances because of community laws and norms that are favorable to substance use. This was slightly lower than youth at the State level (44%).

Regional differences All County regions had 30% or more youth in two or more schools at risk for using substances **because of all three** community level risk factors. However, risk was higher in the Northern Region and Central Region 2 (Presque Isle and surrounding area), where 40% or more youth in two or more schools were at risk because of community level factors.

Northern Region Youth are at greater risk (>40% in 2 or more schools) because of laws and norms favorable to drug use and perceived availability of drugs than because of perceived availability of handguns.

Central Region 1 Youth risk is approximately the same for all three community level risk factors - >30% at risk in 2 or more schools for all three factors, but not reaching 40% or more at risk in 2 or more schools.

Central Region 2 Youth are at greatest risk because of perceived availability of drugs (>50% in 2 or more schools) and were also at greater risk because of laws and norms favorable to drug use and perceived availability of handguns (>40% in 2 or more schools).

Southern Region Youth are at greater risk (>40% in 2 or more schools) because of laws and norms favorable to drug use, although they were still at risk due to perceptions of the availability of drugs and handguns (both >30% in 2 or more schools).

Findings from ASAP Surveys and Interviews

Alcohol One interviewee suggested that in many rural areas the only place for adults to go to socialize is the local bar. Similarly, two interviewees said that teens associate recreation and social bonding with alcohol use.

Rx Drugs

Awareness of alternatives treatments Most adult survey participants were either not aware (34%) or aware to some extent (32%) of alternative, non-medicine pain management treatments available in their area. Some awareness of alternative methods for mental and physical pain management was reported by 37% of adult participants while 19% said they were not aware of alternative methods.

Two medical providers identified lack of knowledge about alternative treatments as a barrier to patient use of such treatments. A need for patient education about alternative treatments of pain management was identified.

Affordable alternative treatments Approximately 44% of the adult sample responded to a question about how affordable alternative treatments are. 55% of those who responded said that alternative treatments are affordable to some extent while 26% responded yes and 19% responded no.

45% of medical providers identified financial barriers (such as cost or lack of insurance coverage) as preventing patient use of alternative treatments.

Access to alternative treatments Approximately 43% of the adult sample responded to a question about how easy it is to access alternative treatments. 54% of those who responded said that alternative treatments are "to some extent" easy to access while 39% responded yes and 7% no.

Seven survey participants identified lack of alterative treatment resources (i.e. pain management programs that include non-medication treatments, pain management consultants, mental health treatment programs, alternative therapies) as a reason for the high number of controlled substance prescriptions filled in 2005-2006.

Medical providers said that lack of alternative treatment resources (25%) and transportation (25%) are barriers to patient use of alternative treatments for pain management.

Advertising of alternative treatments Lack of advertisement and marketing of non-medication pain management treatments was identified by two participants as a reason for the high number of controlled substance prescriptions filled in 2005-2006.

Inefficacy and time Several medical providers indicated that lack of effectiveness for some types of pain and time are barriers to patient use of alternative treatments.

Patient preferences and behavior Patient expectations and demands for narcotics, responses when narcotics are not provided, attitudes towards alternative treatments and non-compliance with alternative treatments were identified as factors contributing to the high number of controlled substance prescriptions filled in 2005-2006.

40% of medical provides also identified patient lack of motivation, attitudes towards alternative treatments and non-compliance with alternative treatments as barriers to patient use of alternative treatments to manage pain. Two medical providers identified time as a barrier to the use of alternative treatments.

Several interviewees noted that people abuse substances to escape problems. Use of controlled substances to address problems is a legal way of escaping through the use of substances. This problem is further compounded by the fact that, according to interviewees, youth and elders tend be resistant to mental health treatment.

Cultural acceptance A number of participants identified cultural acceptance and validation of use of prescription drugs to address problems as a factor contributing to the high number of controlled substance prescriptions filled in 2005-2006

Community lack of support Community apathy, denial of alcohol and substance abuse problems, hopelessness and resistance to changing policies were identified by

several participants as factors contributing to the prevalence of substance abuse, and in particular prescription drug abuse, in the County.

Community Education Several assessment participants identified patient and community member lack of education about the risks and side effects of using controlled substances as a reason for the high number of prescriptions filled in the County for controlled substances. A need for patient and community education about permanent solutions to chronic pain was identified.

Medical Provider Education Three participants identifies medical provider lack of education about addiction and the substance abuse problem in the County as a factor contributing to the high number of prescriptions filled in the County for controlled substances.

Medical providers responded to questions on the Medical Provider Survey about previous education and educational needs. Findings are described below:

1. Previous educational experiences (number responding: 35): Lack of education in several key areas related to prescribing narcotics was reported by between 31% and 50% of participants.

Table 10

Subject area	**% who have not received education subject area**
Use of alternative methods to manage chronic, non-malignant pain	50%
Use of narcotics to manage chronic non-malignant pain	36%
Side effects and consequences of using narcotics	31%
Chronic non-malignant pain (in general)	28%

2. Educational needs identified by medical providers: The top 3 educational needs identified by medical providers are:
    a. alternative methods to manage or treat pain
    b. assessment methods (pain, compliance with treatment, diversion and identification of drug seeking behaviors)
    c. management of pain (chronic and co-morbid mental health and physical pain)

   Areas identified by 2-3 medical providers are:
    a. use of narcotics for pan management
    b. chronic pain management
    c. chronic non-malignant pain
    d. side effects and consequences of using narcotics
    e. addiction and substance abuse
    f. long term monitoring of people taking controlled substances for an extended period of time

   Areas identified by 1 participant are:

a. working with patients with fibromyalgia
b. patient education
c. managing drug dependency
d. regular CME related to use of narcotics
e. long term treatment vs. long term pain control
f. not prescribing based on patient history alone
g. need for clinical evidence of cause/severity of pain prior to prescribing narcotics
h. monitoring and treatment planning for patients prescribed narcotics
i. options if medicine and alternative treatments do not work

3. Barriers to ongoing knowledge acquisition. The top five barriers identified by medical providers are:
   a. lack of interest or perception of need for additional education
   b. lack of local education opportunities and access to experts
   c. time away from medical practice
   d. distance from educational institutions and opportunities
   e. cost
4. Confidence in effectiveness of alternative treatments for pain. 48% of medical providers said they have confidence in alternative treatments while 33% indicated that have some confidence and 10% said they have no confidence in alternative treatments.

Medical provider primary concerns about prescribing/not prescribing narcotics

Primary concerns about prescribing narcotics are:

Table 11

Primary concern	**%**
Patients abusing prescription	80%
Addiction	75%
Patients selling the prescription to others	47%
Side effects	31%
Tolerance build up	19%
Interaction with other medications	14%

Primary concerns about not prescribing narcotics:

Table 12

Inadequate pain management/undue patient suffering	**52%**
Addiction/abuse	14%
Patient dissatisfaction	10%
Selling/diversion	7% (n=2)
Lawsuits/liability	7% (n=2)

Link for Hope Coalition Focus Groups

Focus group participants identified several major issues/concerns related to substance abuse in the community:

- Adult use patterns modeled for children
- Belief that alcohol use is okay
- Social acceptance
- Distance to services
- Established sub-culture of prescription drug use – it is socially accepted and expected
- Community apathy, denial, ignorance
- Community sense of powerlessness
- Poverty fuels diversion of prescription drugs
- Lack of community activities

"Listening to Aroostook"
Assessment participants identified a need to address community values that encourage, or do not discourage, alcohol misuse and abuse.

Community Health Needs Assessment – County Health Link
Assessment participants expressed concern about the number of elderly prescribed psychotropic medications that are not always appropriate.

Enforcement

MYDAUS
See Community Norms.

Findings from ASAP Surveys and Interviews

Alcohol

Border Customs and Border Protection does not currently apprehend youth who consume alcohol in Canada and cross the border smelling of alcohol or intoxicate. Action is taken when the driver is impaired or when the youth have alcohol bottles in their vehicle.

Selling/providing alcohol to minors Most adult survey participants thought it somewhat unlikely or very unlikely that they would be arrested for selling (64%) or providing (70%) alcohol to minors

Selling alcohol to an intoxicated person Most adult survey participants (70%) thought it somewhat unlikely or very unlikely that a person would be arrested for selling alcohol to an intoxicated person.

Stopped if driving with a BAC above the legal limit 35% of adults participants said it would be somewhat unlikely or very unlikely that they would be caught if driving with a BAC above the legal limit.

Note about youth More youth than adults said it would be very likely or somewhat likely for (1) a person selling/providing alcohol to minors to be arrested, (2) a person selling alcohol to an intoxicated person to be arrested and (3) that they would be stopped if driving with a BAC above the legal limit.

Sobriety check point Significantly fewer adults than youth reported having been through a sobriety checkpoint at least once in the last 12 months (5.1% yes vs. 21% yes).

Differential enforcement 63% of adults and 35% of youth strongly agreed or agreed somewhat with the statement that legal consequences for drug/alcohol violations are enforced differently for people of lower socio-economic status than people of higher socio-economic status.

Marijuana

One child protective services worker reported that Child Protective Services does not pursue cases in which the only reason for referral is that the parent uses marijuana.

Link for Hope Coalition Focus Groups
Focus group participants identified several major issues related to substance abuse:

- minimal law enforcement
- minimal legal consequences
- failure of the legal system to take parents

Family Climate

MYDAUS

MYDAUS risk factors "Family History of Anti-Social Behaviors", "Poor Family Management", and "Parental Attitudes Favorable Towards Drug Use" communicate some information about Family Norms.

Family History of Anti-Social Behavior

Responses to these questions reveal whether survey participants have siblings that drink, smoke marijuana, smoke cigarettes, have been expelled, or have taken a handgun to school; and the number of adults they know who have used and/or dealt drugs, gotten drunk or high, or have engaged in illegal activities.

Poor Family Management

Responses to these questions reveal the extent to which respondents report that their parents would catch them if they drank liquor, carried a handgun, or skipped school, as well as the extent to which respondents report that there are clear family rules, that parents know the whereabouts of their children, that there are rules about alcohol and drug use, and that parents monitor homework completion.

Parental Attitudes Favorable to Drug Abuse

Responses to these questions indicate the degree to which survey participants report their parents would feel it is wrong if they (the participants) drink liquor, smoke marijuana, or smoke cigarettes.

Parental Attitudes Favorable to Anti-Social Behavior

Responses to these questions indicate the degree to which survey participants report their parents would feel it is wrong if they (the participants) steal, draw graffiti, or fight.

County The percentage of County youth at risk because of family norms was **lower** than the State in two of the three risk areas (family history of anti-social behavior [County 33%; State 35%] and poor family management [County 39%; State 42%]) and **slightly higher** than the State in one area (parental attitudes favorable to drug abuse [County 32%; State 31%]).

Regional differences All County regions had 30% or more youth in two or more schools at risk for using substances because of the two of the four family climate risk factors: poor family management and parental attitude favorable to anti-social behavior.

Northern Region Youth are at greater risk because of poor family management and parental attitudes favorable to anti-social behavior (>40% in 2 or more schools) and are also at risk because of parental attitudes favorable to drug use (>30% in 2 or more schools).

Central Region 1 Youth are at greater risk because of parental attitudes favorable to anti-social behavior (>40% in 2 or more schools) and are also at risk because of poor family management and family history of anti-social behavior (>30% in 2 or more schools).

Central Region 2 Youth are at greatest risk because of poor family management and parental attitudes favorable to anti-social behavior (>50% in 2 or more schools) and at risk because of family history of anti-social behavior and parental attitudes favorable to drug use (both >30% in 2 or more schools).

Southern Region Youth are at greater risk because of parental attitudes favorable to anti-social behavior (>40% in 2 or more schools) and at risk because of poor family management, family history of anti-social behavior and parental attitudes favorable to drug use (all >30% in 2 or more schools).

Findings from ASAP Surveys and Interviews

Alcohol

Alcohol consumption: Family and community events Attendance at family events at which alcohol was served was reported more frequently by youth and adults than attendance at community events where alcohol was served. See Tables 13 and 14 below for more information.

Table 13

Number of times in the past year attended family event at which alcohol was served	**Frequency**
1-5 times	41% adult, 35% youth
6-10 times	10% adult, 7% youth
11+ times	4% adult, 2% youth

Table 14

Number of times in the past year attended community event at which alcohol was served	**Frequency**
1-5 times	46% adult, 28% youth
6-10 times	10% adult, 2% youth
11+ times	5% adult, 2% youth

Alcohol consumption: Adults Most adult survey participants who reported drinking alcohol said they usually do so at home (39%). Other places where adults said they usually drink alcohol is at a restaurant/banquet hall (12%), bar/club (4%), another person's home (3%) or a family event (3%).

Parent education of children 59% of parents reported talking to their children about using alcohol responsibly while 91% of youth reported their parents had such a discussion with them. It should be noted that not all adult respondents with children had teenage children, so the data does not accurately reflect the number of adults

speaking with their teenagers about alcohol use. There is concern that parents should be discussing the dangers associated with alcohol use and telling their children not to use alcohol, instead of telling them how to use it responsibly.

Parent perceptions of their influence on their children 59% of parents who participated in the adult survey said they strongly agree they their attitudes towards alcohol/drugs impacts their child's decision to use alcohol/drugs.

Link for Hope Coalition Focus Groups

Focus group participants identified several major issues/concerns related to substance abuse in the community:

- Lack of parenting knowledge/skills
- Lack of guidance
- Dysfunctional families
- Lack of supervision
- Lack of discipline at home
- Lack of parental involvement in children's lives
- Parental apathy
- Children are not given enough boundaries and limits

"Listening to Aroostook"

Assessment participants identified a need to address family values that encourage, or do not discourage, alcohol misuse and abuse.

Perceptions of Risk

MYDAUS

Responses to these questions reveal the extent to which survey participants believe people risk harm to themselves if they smoke cigarettes, drink or smoke marijuana.

County 36% of County youth are at risk for substance abuse based upon their reported perceptions of harm related to substance abuse. This was lower than perceptions of harm reported at the State level (39%).

Regional differences Youth in three of four County regions (Northern, Central 2, and Southern) are at risk for abusing substances because of perceived risk of drug abuse. This was not the case in Central Region 1, where the percentage of youth at risk did not meet the selection criteria.

Northern Region Youth are at greater risk for substance abuse because of misperceptions of risk of drug abuse (>40% in 2 or more schools).

Central Region 2 Youth are at greater risk for substance abuse because of misperceptions of risk of drug abuse (>40% in 2 or more schools).

Southern Region Youth are at risk for substance abuse because of misperceptions of risk of drug abuse (>30% in 2 or more schools).

Findings from ASAP Surveys and Interviews

Youth and adult perceptions of risk for binge drinking, regular alcohol and marijuana use, and use of over-the-counter drugs, inhalants and stimulants were lower than perceptions of risk for other illicit drugs. Nevertheless, youth perceptions of risk were consistently lower than adult perceptions for all substances.

Alcohol

23% of adults and 65% of youth responded yes or to some extent that it is less harmful for youth to use alcohol than illegal drugs.

Moderate alcohol use and harm to the brain 30% of youth said moderate alcohol use cannot cause biological harm to the (developing) brain while 26% of adults said it can cause harm “to some extent” and 9% said it cannot cause harm.

Daily binge drinking 77% of adults and 51% of youth said consuming 4-5 drinks of alcohol per day poses great risk.

Weekly binge drinking 33% of adults and 7% of youth said consuming 4-5 drinks of alcohol 1-2 times per week poses great risk.

Rx Drugs

78% of adults and 44% of youth said that abusing prescription drugs poses great risk of harm. According to several interviewees, youth and adults are not aware the risk of addiction associated with taking controlled substances when they either take the medicine as prescribed or experiment with it. Consequently, they easily become addicted. One interviewee said that elders and their caregivers/family members also do not fully understand either the risk of addiction associated with taking controlled substances or how to identify signs and symptoms of side effects and dependency.

Self reported knowledge of risks/side effects 26% of adults and 19% of youth reported "much knowledge" of the health risks and side effects associated with prescription drug abuse.

Marijuana

42% of adult and 74% of youth participants responded yes or to some extent that marijuana use is less harmful than other drug use while 29% of adults and 44% of youth said smoking marijuana once per month poses no risk or slight risk.

Legal to use for medical reasons 61% of youth and 23% of adults said that their attitudes about the risk of using marijuana are influenced at least to some extent by the legality of marijuana use for medical reasons.

Legal to purchase paraphernalia 54% of youth and 11% of adults said that their attitudes about the risk of using marijuana are influenced at least to some extent by the fact that it is legal to purchase marijuana paraphernalia.

Inhalants

83% of adults and 72% of youth said abusing inhalants poses great risk of harm.

Stimulants

76% of adults and 42% of youth said abusing stimulants poses great risk of harm.

Over-the-counter medicines

50% of adults and 33% of youth said abusing OTC medicines poses great risk of harm.

Alcohol-containing products

70% of adults and 54% of youth said that abusing alcohol-containing products poses great risk of harm.

Link for Hope Coalition Focus Groups

Focus group participants identified lack of education about substance use/abuse as a major issue.

Price/Promotion

Findings from ASAP Surveys and Interviews

Rx Drugs

Pricing Several participants attributed the high number of prescriptions filled in the County for controlled substances to the fact that Medicaid pays for the prescriptions while others suggested that prescription drugs are cheaper than other drugs.

Promotion

Pharmaceutical companies Pharmaceutical company promotion and advertising of prescriptions drugs, to both medical providers and the general public, was identified by a number of participants as a factor contributing to the high number of prescriptions filled in the County for controlled substances.

Advertisements in medical offices 67% of youth and 73%adult participants noticed advertisements for prescription drugs on their most recent visit to a medical office.

Belief that advertisements influence youth decisions to abuse prescription drugs Adult and youth beliefs that advertisements for prescription drugs influence youth decisions to abuse prescription drugs were lower than beliefs about the influence of media on alcohol and other drug use. Beliefs about the influence of clothing promotion on decisions to use alcohol/substances were also lower. Participants were asked to respond "yes", "no" or "don't know" to questions about their beliefs about the influence of media and advertising.

Table 15

Substance	**Adult % responding Yes**	**Youth % responding Yes**
Prescription drug advertisements	**42%**	**57%**
Alcohol promotion targets youth	74%	67%
Media promoting alcohol influences decision	78%	73%
Media promoting substance use influences decision	71%	73%
Clothing promoting alcohol/substance abuse influences decision	**60%**	**57%**
Other substances	71%	73%

Community Health Needs Assessment – County Health Link

Assessment participants expressed concern about stores that advertise the sale of large quantities of alcohol through prominent displays and promotion.

Retail Access/Availability

MYDAUS

The data from the MYDAUS communicate the degree to which respondents think it is easy for youths to get alcohol, cigarettes, and illicit drugs. See Community Level Risk Factors for a breakdown by region.

County 41% of County youth were at risk for substance abuse because of perceived availability of substances. This was **higher** than perceived availability at the State level (37%).

Findings from ASAP Surveys and Interviews

Alcohol

Access in Canada 27% of underage youth surveyed reported they get the alcohol they consume in Canada. An interview with a border and customs supervisor confirmed that a lot of underage youth go to drink alcohol in Canada. 37% of youth participants said they were not asked to show proof of age when purchasing alcohol in Canada.

Access in the United States

ID Checks Survey findings suggest that retail outlets selling alcohol may inconsistently ask for proof of age for adults under 30-years-old and youth under 21-years-old. Only 17 adults and youth survey participants responded "yes" or "no" to the question about being asked to show proof of age if under 30-years-old or under 21-years-old. However, 9 said they were asked while 8 said they were not asked to show proof of age.

Sale refused due to age Only 6 youth answered the survey question about whether the sale of alcohol was refused to them because of their age. All six said it was not.

Sale refused due to intoxication 4 adults and youth said they were served alcohol when they had already had too much too drink. This represents 2% of the total survey sample. A higher percentage of youth than adults (33% vs. 14%) reported seeing people served alcohol when already drunk. The low percentage of adults may under represent the problem due sample bias caused by the sampling method.

Rx Drugs

Data indicates that controlled substances, particularly narcotics, are easy for County residents to access because of medical practice and system issues.

Availability The narcotics prescribed by all medical providers most frequently in the past month are:

Table 16

Narcotic	**% medical providers prescribing in past month**
Oxycodone products	69%
Hydrocodone with acetaminophen	60%
Propoxyphene products	49%

Codeine with products	40%
Fentanyl patch	29%
Morphine products	26%
Hyrdromorphone	23%

Dentists Seven dentists responded to an additional question about the narcotics they most frequently prescribe. Narcotics identified by 2 or more dentists are:

a. Vicodin products
b. Tylenol #3
c. Hydrocodone products
d. Percocet

Medical practice issues

Prescribing Practices A large number of participants (n=30) from multiple data sources (key informant interviews, adult surveys, medical provider surveys) identified medical provider readiness to prescribe controlled substances and "overprescribing" of controlled substances as a contributing factor for retail access to prescription drugs. Prescriptions for large amounts of controlled substances at one time or prescribing controlled substances for an extended period of time were also identified as contributing factors by two respondents.

Monitoring Practices Over 40% of medical providers responded that they do not use the monitoring practices specified on the survey to monitor patients prescribed narcotics. See Table 14 below.

Table 17

Monitoring Practice	**% Responding "No"**
Contracts	48%
Urine toxicology screening of all chronic pain patients prior to treating with narcotics	86%
Random toxicology screening 1-2 times per year for chronic pain patients prescribed chronic narcotic therapy	48%
Use of Prescription Monitoring Program or other system prior to prescribing narcotics to patients	47%
Policy for after hours narcotics replacement	55%
System to track narcotics samples provided to patients	43%

Referral to Alternatives Although a large number of medical providers (73%) reported frequently prescribing non-narcotic pain medication prior to prescribing narcotics, only 39% said they frequently have patients try alternative pain management

techniques while 21% said they do so somewhat frequently and 39% said they **infrequently or never** do so. There was some feedback from an interviewee and a survey participant indicating that doctors do not refer patients to alternative pain management treatments or only do so as a last resort. One interviewee said that some patients often only receive pain management treatment when they also need mental health treatment to fully address their problem.

System Issues

Prescription Monitoring Program Use of the Maine Prescription Monitoring Program was not reported by all pharmacists interviewed. In fact, two pharmacists and a survey respondent said there is currently no way to track all people who go from pharmacy to pharmacy or physician to physician to get controlled substances. One pharmacist believed that in order to be recorded on the Prescription Monitoring Program, the patient had to have Mainecare. Participants in the surveys also In fact, the Prescription Monitoring program tracks all prescriptions filled by every pharmacy in Maine and even pharmacies serving Maine that are located outside the state. Patients going from pharmacy to pharmacy can be tracked by using the PMP.

Medical Practice Related

1. High physician turnover, which was identified as potentially leading to decreased familiarity with patient history and decreased likelihood of becoming involved with patients or searching for non-prescription alternative treatments.
2. Shortage of medical providers in the County and consequent (1) time constraints imposed on their practice and (2) patient over use of the ER.
3. Absence of system through which medical providers or Emergency Room personnel can communicate with one another about shared patients.
4. Absence of a system through which doctors can be notified of how many pills patients get in the mail.

Policy Concerns about legal liability for not prescribing narcotics were expressed by a small number of assessment participants. One participant identified JHACO and Maine quality practice expectations as contributing to concerns about not managing pain properly.

Proximity to Canadian Border A border and customs supervisor interviewed reported that transport of prescription drugs, especially Oxycontin, into the United States from Canada is a problem.

"Listening to Aroostook"

Assessment participants expressed concern about:

- Ease of access to alcohol in Canada

Social Access/Availability

MYDAUS
See Retail Access/Availability

Findings from ASAP Surveys and Interviews

Alcohol

Most youth survey participants (37%) gained access to alcohol through an unrelated person over 21-years-old and usually drank alcohol at another person's home (43%). Other suppliers included "someone else" (35%), someone under 21-years-old (19%), restaurant/bar/public place (16%) and family member over 21-years-old (9%). Other places in which youth reported usually drinking alcohol were at another person's home (35%), at a bar, pub or public place (28%), at home (26%), at a family event (9%) and at a restaurant or banquet hall (5%).

Purchaser There were 33 youth responses to the question about who purchases alcohol for them. If alcohol was purchased for the youth, it was purchased by someone the youth knows who is 21 or older (37%), someone under age 21 (9%) or a family member (7%).

Rx Drugs

Survey responses indicate that the primary source for prescription drugs for survey participants who took prescription drugs they were not prescribed was family members. 13 adult and youth participants reported taking prescription drugs not prescribed to them. Almost half of these participants (n=6) got the prescription drug from a family member while about one-third (n=4) got them from someone unrelated and 2 got them from a parent/guardian.

Disposal Findings from adult and youth survey responses suggest that County residents are not properly disposing of excess prescription drugs (among those who responded to the question (n = 84) 52% flush them, 32% throw them away, 29% keep them). Both throwing prescription drugs in the trash and keeping them can provide a way for people addicted to controlled substances to access them. However, 63% of adult participants **were not aware** of a place in their geographic area to dispose of prescription drugs.

Link for Hope Coalition Focus Groups
Focus group participants identified several major issues/concerns related to prescription drug abuse in the community:

- Easy access to drugs
- Medical provider difficulty distinguishing between people in real pain and those seeking drugs
- Medical provider fears that they have to treat the patient or be sued
- Poor quality screening
- Lack of communication among medical providers in a large geographic area
- Confidentiality as a legal and small town barrier

Community Health Needs Assessment – County Health Link

Assessment participants expressed concern about:

- Lack of trained staff in schools to administer medications
- Parents of children with psychiatric challenges who "doctor shop" and barriers to information sharing between physicians and agencies.
- Complexities of prescribing psychotropic medications by primary care physicians and a need for training in this area.

Resources

Treatment services

Several interviewees identified barriers to achieving sobriety for those who are already addicted to substances. These included:

1. Limited access to inpatient treatment both inside and outside the County, which is compounded by long waiting lists, transportation issues and financial constraints.
2. Lack of outpatient treatment for children affected by substance abuse.

Support/aftercare services

Several barriers to maintaining sobriety were identified by interviewees:

1. Limited availability of support and aftercare services, especially services that allow people to get away from the people and places they frequented when abusing substances.
2. Lack of sobriety among support groups and aftercare services participants.

Youth programming

Lack of social opportunities, events and programming for youth and adults was identified by a number of participants as a factor contributing the prevalence of substance abuse in the County.

Social and Geographic Issues

Labor

A number of survey participants identified employment related issues, such as unemployment, seasonal jobs, prevalence of physically laborious jobs and lack of service jobs as factors contributing to the high number of controlled substance prescriptions filled in the County in 2005-2006.

Socio-economic

Poverty was identified by a number of survey participants as a factor contributing to the high number of controlled substance prescriptions filled in 2005-2006.

Age

19 participants identified the high number of elderly represented in the County population contributing to the high number of controlled substance prescriptions filled in the County in 2005-2006.

Prevalence of illness

20 participants identified high rates of cancer, chronic illness, disability and mental health problems as contributing to the high number of controlled substance prescriptions filled in the County in 2005-2006.

Disability Several participants attributed ease of getting approved to receive disability benefits as a factor contributing to the high number of controlled substance prescriptions filled in the County in 2005-2006.

Common chronic pain diagnoses for which narcotics are prescribed Medical providers identified the most common chronic pain diagnoses for which they prescribe narcotics. The diagnoses are placed into general categories below:

Table 18

Type of pain	**%**
Back pain	42%
Arthritis (includes osteo and rheumatoid)	19%
Neuralgic/neuropathic pain	19%
Pain related to surgery	11%
Trauma/injury	11%
Malignancy/cancer related	8% (n=3)
Dental pain	6% (n=2)
Migraine/headache	6% (n=2)

Obesity and lack of physical activity Several participants identified the consequences of obesity and lack of physical activity as contributing to the high number of controlled substance prescriptions filled in the County in 2005-2006.

Geography

Several participants identified the large, rural geography of the County, and consequent isolation, as a factor contributing to the prevalence of substance abuse.

Community Readiness

The Tri-Ethnic Center for Prevention Research's Community Readiness Assessment was used to assess community readiness throughout Aroostook County. SPEP grant partners conducted 5-8 interviews in each of the four regions of the County. The end result, is a unique readiness score for each region. The findings are described below by region. A low score is 1 and a high score is 9. There are six dimensions of readiness, for which an individual score is calculated (community efforts, community knowledge of efforts, leadership, community climate, community knowledge about the issue, and resources related to the issue). The score that places the community's **stage of readiness** is the average of the scores from all of the dimensions of readiness combined.

Southern Region
The overall community readiness score for the Southern Region is 4.30 – Preplanning Stage

1. Dimension A – Community Efforts: 7.4
2. Dimension B – Community Knowledge of Efforts: 4
3. Dimension C – Leadership: 4.6
4. Dimension D – Community Climate: 2.4
5. Dimension E – Community Knowledge about the Issue: 3.4
6. Dimension F – Resources Related to the Issue: 4.2

Central Region 2 (Presque Isle and surrounding area)
The overall community readiness score for Central Region 2 is 4.67 – Preplanning Stage

1. Dimension A – Community Efforts: 7
2. Dimension B – Community Knowledge of Efforts: 4.25
3. Dimension C – Leadership: 4.50
4. Dimension D – Community Climate: 2.75
5. Dimension E – Community Knowledge about the Issue: 4.50
6. Dimension F – Resources Related to the Issue: 5.0

Central Region 1 (Caribou and surrounding area)
The overall community readiness score for Central Region 1 is 4.92 – Preplanning Stage

1. Dimension A – Community Efforts: 7
2. Dimension B – Community Knowledge of Efforts: 4.50
3. Dimension C – Leadership: 5.50
4. Dimension D – Community Climate: 4
5. Dimension E – Community Knowledge about the Issue: 4.25
6. Dimension F – Resources Related to the Issue: 4.25

Northern Region

The overall community readiness score for the Northern Region is 5 – Preparation Stage.

7. Dimension A – Community Efforts: 7.25
8. Dimension B – Community Knowledge of Efforts: 4.25
9. Dimension C – Leadership: 5.88
10. Dimension D – Community Climate: 4.14
11. Dimension E – Community Knowledge about the Issue: 4.63
12. Dimension F – Resources Related to the Issue: 6.13

Based upon the readiness assessment findings, readiness efforts will initially target increasing community awareness about the problem and mobilizing community members and groups in solving the problem.

Appendix 2: Planning Models

Planning Model Goal 1: Countywide prevention implementation

Problem Statement:	**Priority Goal 1:**	**Objectives:**	**Strategies:**
1. Lack of a sustainable, comprehensive, countywide approach to prevention that includes consistent, ongoing implementation of strategies targeting both individual, environmental and community level change. 2. Limited community readiness to address substance abuse	Build a sustainable, comprehensive, countywide approach to prevention that includes consistent, ongoing implementation of strategies targeting both individual and environmental/community level change.	Objective 1: Increase community readiness to address substance abuse by one Phase in each region. Objective 2: Increase the substance abuse prevention workforce in Aroostook County. Objective 3: Facilitate countywide collaboration in strategic plan implementation. Objective 4: Establish a Youth Advisory Council Objective 5: Develop a sustainability plan that identifies non-grant funded sustainability strategies. Objective 6: Increase awareness about substance abuse prevention. Objective 7: Conduct ongoing assessments and evaluations of collaborative functioning.	1. Increase community awareness of the problem. 2. Engage communities in addressing the problem. 3. Bring communities together to work on the problem. 4. Provide educational and internship opportunities to increase the workforce. 5. Solidify the ASAP brand, its collaborative partners and its policies and practices. 6. Seek out and maintain youth involvement in addressing the problem. 7. Develop and write a sustainability plan. 8. Develop a marketing campaign to increase awareness about substance abuse prevention. 9. Assess cultural competency and collaborative functioning.

Capacity Components: Increase capacity to disseminate information; engage and maintain involvement of diverse community groups; facilitate and maintain collaborative efforts; gather, analyze and monitor data; and achieve sustainability.

Planning Model Goal 2: Alcohol misuse

Problem Statement:	**Priority Goal 2:**	**Objectives:**	**Strategies:**
Misuse of alcohol by youth and adults. Harms associated with alcohol misuse (domestic violence, child abuse, substance-induced deaths, arrests, poisonings, treatment admissions) were *more frequent* than harm caused by *any other* substance.	Reduce youth and adult misuse of alcohol. Decrease harms associated with alcohol misuse.	Objective 1: Increase effectiveness of enforcement policies and practices for underage drinking and drug abuse. Objective 2: Increase youth and parent perceptions of risk related to underage and high risk drinking. Objective 3: Increase parent perception that their attitudes and behaviors related to alcohol use influence their children's decisions to use alcohol and increase parent knowledge of how to influence their children. Objective 4: Increase community knowledge about youth mental health issues and the increased risk for substance abuse among youth with unidentified/untreated mental health problems. Objective 5: Increase use of recommended parental monitoring practices for underage drinking. Objective 6: Create communities that provide the support and resources necessary to decrease youth risk of underage and high risk drinking. Objective 7: Increase effectiveness of retailers' policies and practices that restrict access to alcohol by underage youth. Objective 8: Build connections with Canadian border communities. Objective 9: Decrease access to alcohol in Canada. Objective 10: Increase retailers' use of policies and practices that discourage high risk drinking.	1. Collaborate with law enforcement, courts, corrections, schools, parents, youth, retailers and community groups. 2. Educate parents about the dangers of furnishing and hosting underage drinking parties. 3. Establish policies for underage drinking enforcement. 4. Train law enforcement officers around best practices and model policy implementation. 5. Work at the State level to make relevant policy changes. Assess current policies. 4. Use media for public education and social marketing campaigns. 5. Implement the 40 Developmental Assets in 5 communities. 6. Assess whether there is a need for additional social activities for youth, particularly evening/night activities. 7. Train and educate retailers.

Capacity Components: Increase capacity to achieve sustainability in order to dedicate staff to strategy implementation.

Planning Model Goal 3: Prescription drug abuse

Problem Statement:	**Priority Goal 3:**	**Objectives:**	**Strategies:**
Misuse of prescription drugs by youth and adults. Harms associated with prescription drug misuse (domestic violence, child abuse, arrests, poisonings, treatment admissions) are prevalent and increasing.	Reduce youth and adult misuse of prescription drugs. Decrease harms associated with prescription drug misuse.	**Objective 1**: Increase community members' (youth, adults, elders and their family members and caregivers) perceptions of risks related to prescription drug abuse. **Objective 2**: Increase parent perception that their attitudes and behaviors influence their children's decisions to use prescription drugs and increase parent knowledge of how to influence their children. **Objective 3**: Increase community knowledge about youth mental health issues and the increased risk for substance abuse among youth with unidentified/untreated mental health problems. **Objective 4**: Increase use of recommended parental monitoring practices to prevent prescription drug misuse. **Objective 5**: Create communities that provide the support and resources necessary to decrease youth risk of abusing prescription drugs. **Objective 6**: Increase medical provider readiness to participate in solving the prescription drug abuse problem. **Objective 7**: Decrease promotion of prescription drugs. **Objective 8**: Increase use of the Prescription Monitoring Program. **Objective 9**: Increase medical provider use of policies and practices that safeguard against prescription drug abuse. **Objective 10:** Increase awareness of and access to alternative treatments for pain management. **Objective 11**: Decrease access to prescription drugs. **Objective 12**: Increase medical provider knowledge of addiction and pain management.	1. See **Planning Model: Alcohol misuse** for strategies related to Objectives 1-5. 2. Educate medical providers about the problem and risks associated with prescribing controlled substances. 3. Establish a medical provider workgroup to assist in addressing the problem. 4. Publish articles in local media and newsletters. 5. Work to establish relevant policies (see Strategic Plan). 6. Educate medical providers in relevant areas (see Strategic Plan). 7. Increase awareness and access to alternative treatments for pain. 8. Increase awareness of where to store and dispose of prescription drugs. 9. Establish a system through which to provide information to new providers who come to the County.

Capacity Components: Increase capacity to achieve sustainability in order to dedicate staff to strategy implementation.

Planning Model Goal 4: Marijuana abuse

Problem Statement:	**Priority Goal 2:**	**Objectives:**	**Strategies:**
Misuse of marijuana by youth and adults. Harms associated with marijuana misuse (domestic violence, child abuse/neglect, arrests, treatment admissions) are prevalent.	Reduce youth and adult misuse of marijuana. Decrease harms associated with marijuana misuse.	Objective 1: Increase youth and parent perceptions of risk related marijuana use. Objective 2: Increase parent perception that their attitudes and behaviors related to marijuana use influence their children's decisions to use marijuana and increase parent knowledge of how to influence their children. Objective 3: Increase community knowledge about youth mental health issues and the increased risk for substance abuse among youth with unidentified/untreated mental health problems. Objective 4: Increase use of recommended parental monitoring practices to prevent marijuana misuse. Objective 5: Create communities that provide the support and resources necessary to decrease youth risk of abusing marijuana.	1. Collaborate with law enforcement, courts, corrections, schools, parents, youth, retailers and community groups. 2. Work at the State level to make relevant policy changes. Assess current policies. 3. Use media for public education and social marketing campaigns. 4. Implement the 40 Developmental Assets in 5 communities. 5. Assess whether there is a need for additional social activities for youth, particularly evening/night activities.

Capacity Components: Increase capacity to achieve sustainability in order to dedicate staff to strategy implementation.

Planning Model Goal 5: Inhalant, stimulant and OTC abuse

Problem Statement:	**Priority Goal 2:**	**Objectives:**	**Strategies:**
Abuse of inhalants, stimulants and over-the-counter drugs by youth and young adults. .	Decrease abuse of inhalants, stimulants and over-the-counter medicines . .	Objective 1: Increase youth and parent perceptions of risk related inhalant, stimulant and OTC abuse. Objective 2: Increase parent perception that their attitudes and behaviors related to substance use influence their children's decisions to use substances and increase parent knowledge of how to influence their children. Objective 3: Increase community knowledge about youth mental health issues and the increased risk for substance abuse among youth with unidentified/untreated mental health problems. Objective 4: Increase use of recommended parental monitoring practices to prevent substance abuse. Objective 5: Create communities that provide the support and resources necessary to decrease youth risk of abusing inhalants, stimulants and OTC medicines.	1. Collaborate with law enforcement, courts, corrections, schools, parents, youth, retailers and community groups. 2. Work at the State level to make relevant policy changes. Assess current policies. 3. Use media for public education and social marketing campaigns. 4. Implement the 40 Developmental Assets in 5 communities. 5. Assess whether there is a need for additional social activities for youth, particularly evening/night activities.

Capacity Components: Increase capacity to achieve sustainability in order to dedicate staff to strategy implementation.

Planning Model Goal 6: Preventive treatment strategies

Problem Statement:	**Priority Goal 2:**	**Objectives:**	**Strategies:**
High level of need for comprehensive, coordinated and local substance abuse intervention resources. .	Establish comprehensive, coordinated and local substance abuse intervention resources. . .	Objective 1: Establish local long term inpatient treatment facility. Objective 2: Establish local after-care support services in three communities countywide. Objective 3: Create strategic and funding plans to establish an Aroostook County drug court. Objective 4: Establish a countywide treatment network.	1. Initiate a collaborative with Aroostook County substance abuse treatment agencies, hospitals and community stakeholders to assess feasibility of (1) establishing a long-term inpatient treatment facility in the County, (2) establishing after-care support services and (3) integrating specialized medical care into a long-term inpatient treatment facility program. 2. Initiate a collaborative with the Aroostook County judiciary, District Attorney, Probation/Parole, and treatment providers to develop and write a plan for implementation of a treatment drug court in the County. 3. Engage in planning process: review best practice and planning research literature. 4. Write strategic and funding plans. 5. Seek resources and funding needed to establish programs.

Capacity Components: Increase capacity to achieve sustainability in order to dedicate staff to strategy implementation.

Appendix 3: Memoranda of Understanding