Substance Use Trends in Maine

Central District
Epidemiological Profile 2018

Produced for Maine Department of Health and Human Services
State Epidemiological Outcomes Workgroup (SEOW)
www.maineseow.com

by Hornby Zeller Associates,
a Public Consulting Group Company

September 2018

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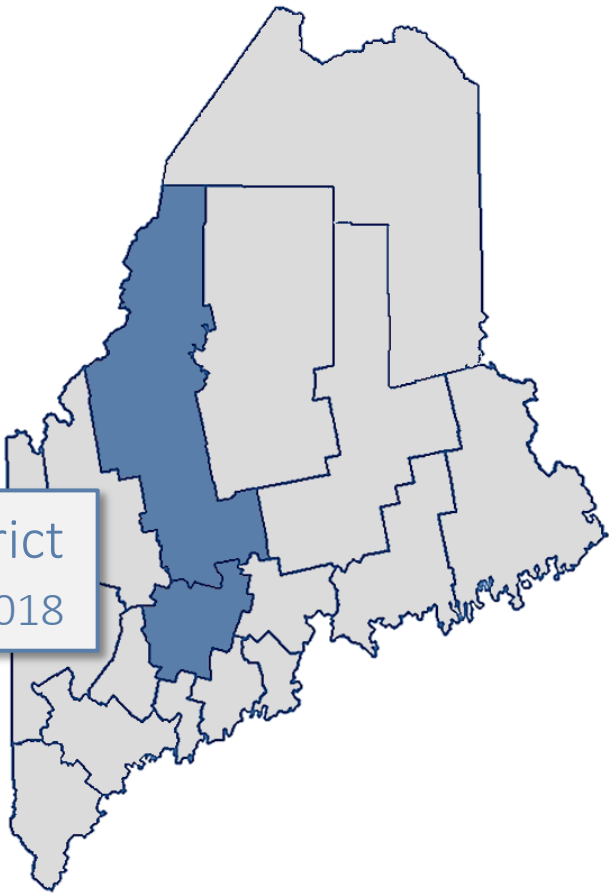

Central District

Epidemiological Profile 2018

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THE MAINE DEPARTMENT OF HEALTH AND HUMAN SERVICES
STATE EPIDEMIOLOGICAL OUTCOMES WORKGROUP (SEOW)

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Introduction

Overview of Central Public Health District

Central Public Health District (Central) consists of Somerset and Kennebec Counties which have a combined population of 172,447 people, representing approximately 13 percent of Maine's total population in 2017. There are 36 people per square mile, and just over two thirds of the people in this district reside in Kennebec County, home to the state's capital, Augusta. The State of Maine is considered an "aging" state, with 20 percent of the population aged 65 years old and over, a higher rate than the overall US population (15.6%). In Central, 20 percent of the population was 65 years old or older in 2016.

Approximately 95 percent of Central's population is Caucasian, followed by Hispanic (1.4%), Asian (0.9%), Black or African American (0.7%), and American Indian (0.5%). Central's median household income of $44,527 is the third lowest statewide, with 16 percent of the population living below the poverty level. Because this district includes both a comparatively rural, lower-income county (Somerset) and one with a higher-population, higher-income (Kennebec), the people served by the Central Public Health District (PHD) reflect a cross-representational demographic view of the State.

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

Purpose of this Report

This report takes into account the objectives of the Maine Department of Health and Human Services (DHHS), Maine Center of Disease Control (CDC), Division of Disease Prevention Tobacco and Substance Use Prevention and Control to: identify substance abuse patterns in defined geographical areas, establish substance abuse trends, detect emerging substances, and provide information for policy development and program planning. It also highlights all the prevention priorities identified in the Maine CDC's strategic plan: underage drinking, high-risk drinking, misuse of prescription drugs, and marijuana use. Finally, the report monitors many of the factors that contribute to substance use, such as access and perceptions of harm, as well as common negative consequences such as crime, car crashes and overdose deaths.

This report includes data available through July 2018. Older and unchanged data are included when more recent data were not available. Five major types of indicators are included: self-reported substance consumption, consequences of substance use, factors contributing to substance use, indicators about mental health and substance abuse, and treatment admissions.

For additional data and resources please visit the Maine State Epidemiological Outcomes Workgroup (SEOW) data dashboard at **www.maineseow.com**.

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Consumption of Substances

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

As demonstrated by the indicators presented in this profile, alcohol remains the substance most often used by youth and adults across the lifespan, both in Central and statewide. In particular, high-risk drinking among youth and younger adults continues to be a concern. About one-fifth of 18 to 25 year olds and more than one-quarter of 26 to 34 year olds reported binge drinking in the past month. One in five adults 18 and older in Central is considered a current smoker, with the District observing a decline in both youth and adult cigarette use. The prevalence of smoking cigarettes in Central's population is the same as the state average. Rates of abuse or misuse of prescription drugs, marijuana, and cocaine in Central are either lower or similar to the statewide average. Marijuana use among adults in Central has increased slightly over the past several years; this is consistent with statewide trends.

Alcohol

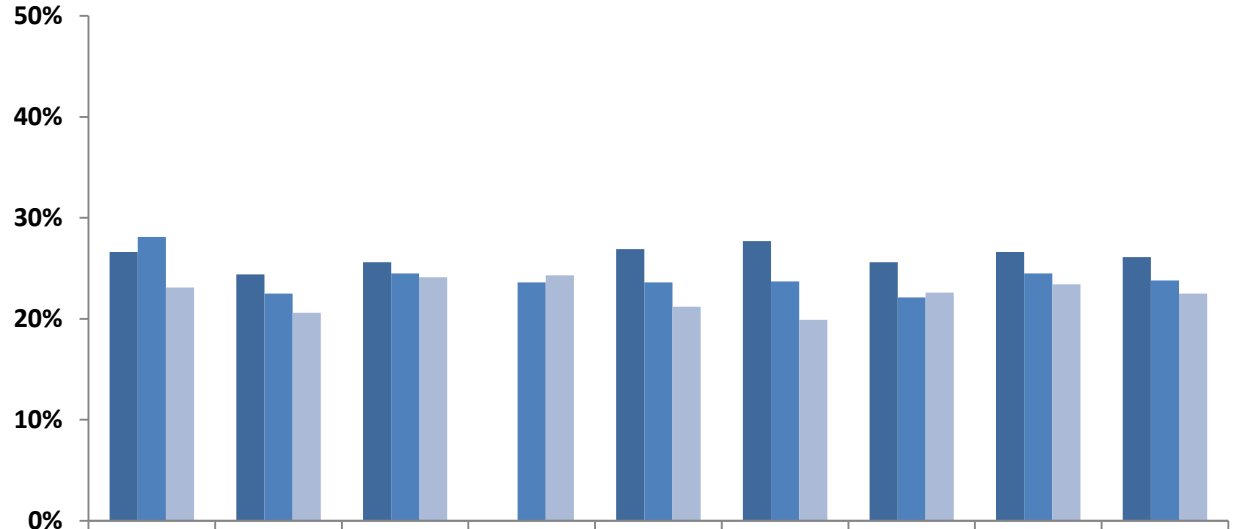
Indicator Description: ALCOHOL USE AMONG YOUTH. This measure shows the percentage of Maine high school students who reported having had one or more alcoholic drinks within 30 days prior to the survey.

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

Data Source(s): MIYHS, 2013–2017

Summary: In Central, the percentage of students who reported drinking in the past 30 days decreased from 24 percent in 2013 to 21 percent in 2017 as did the overall average for Maine which decreased from 26 percent to 23 percent, respectively.

Figure 1. Percent of high school students by Public Health District who had at least one drink of alcohol during past 30 days: 2013–2017



	Aroostook	Central	Cumber.	Downeast	Midcoast	Penquis	Western	York	Maine
2013	27%	24%	26%		27%	28%	26%	27%	26%
2015	28%	23%	25%	24%	24%	24%	22%	25%	24%
2017	23%	21%	24%	24%	21%	20%	23%	23%	23%

Source: MIYHS

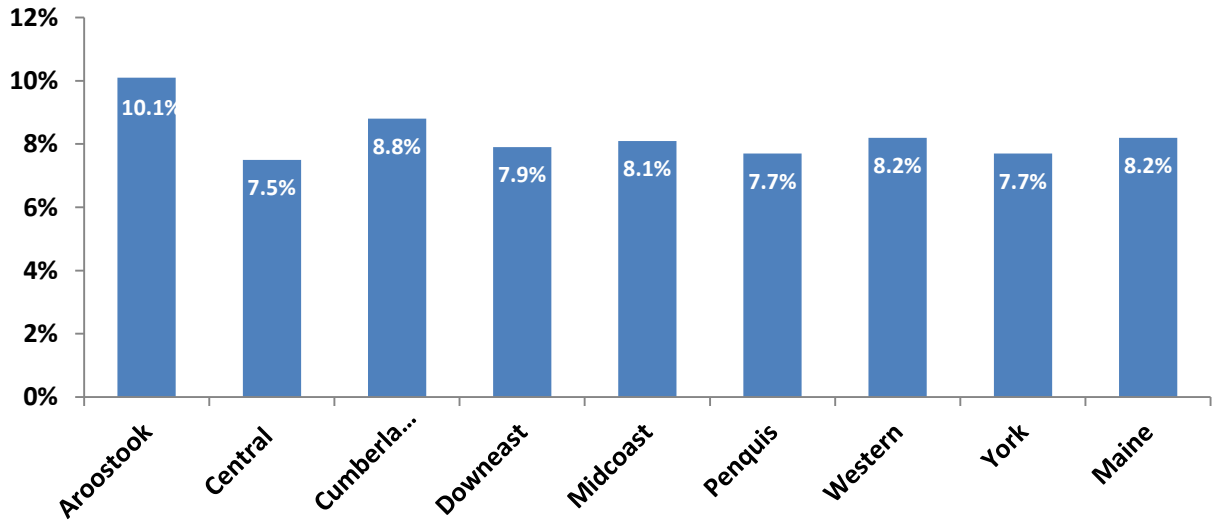
Indicator Description: HIGH-RISK ALCOHOL USE AMONG YOUTH. This indicator presents the percentage of Maine high school students who reported having had five or more alcoholic drinks in a row in one sitting at least once during the 30 days prior to the survey. In 2017, the MIYHS committee redesigned the question asked of students regarding the frequency of binge drinking. Therefore, 2017 data cannot be compared to previous years for trending.

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

Data Source(s): MIYHS, 2017, BRFSS 2013–2016

Summary: In 2017, 7.5 percent of Central high school students reported that they had at least five drinks in one sitting in the past month; this was the lowest rate among public health districts. Rates did not vary much across districts. Trending is not available at this time.

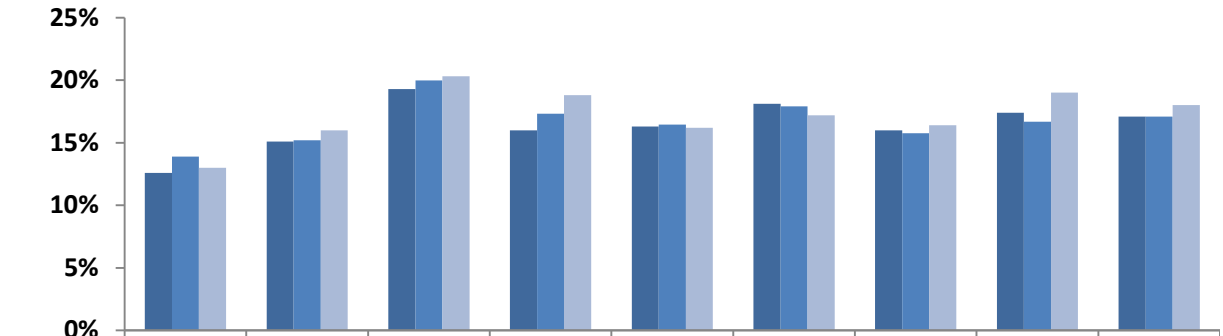
Figure 2. Percent of high school students by Public Health District who had at least five drinks in a row during past 30 days: 2017



Source: MIYHS

Summary: Binge drinking rates among adults 18 and over in Central have increased slightly from 15 percent in 2013-14 to 16 percent in 2015-16. Looking across all years of available data, the highest rate of binge drinking in Central PHD is observed among the 26 to 35 year old population, at 28 percent. Those between the ages of 18 and 25 years old and 36 to 49 years old had the second highest binge drinking rate in Central PHD (21%), followed by Mainers 50 and older (10%). In addition, adult males in Central observed a higher binge drinking rate than adult females (22% compared to 10%).

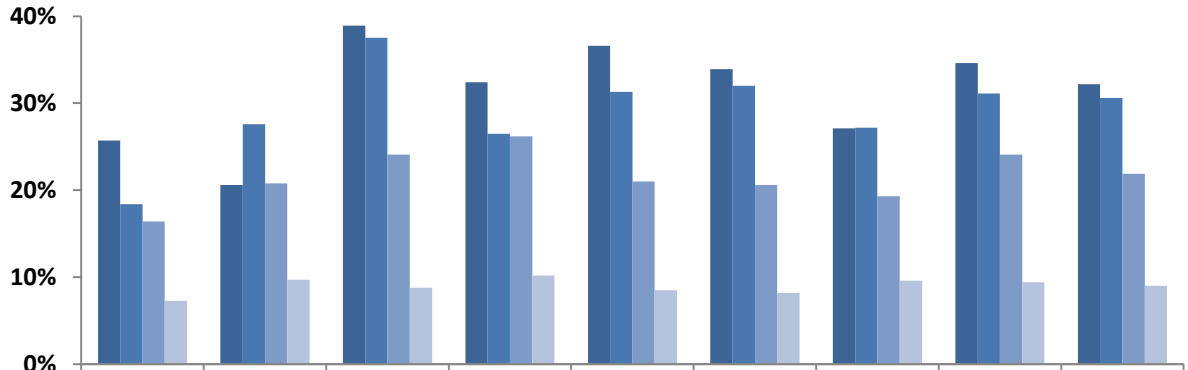
Figure 3. Percent of adults by Public Health District who reported binge drinking in past 30 days: 2013–14 to 2015–16



	Aroostook	Central	Cumber.	Downeast	Midcoast	Penquis	Western	York	Maine
2013-14	13%	15%	19%	16%	16%	18%	16%	17%	17%
2014-15	14%	15%	20%	17%	16%	18%	16%	17%	17%
2015-16	13%	16%	20%	19%	16%	17%	16%	19%	18%

Source: BRFSS 2013–16

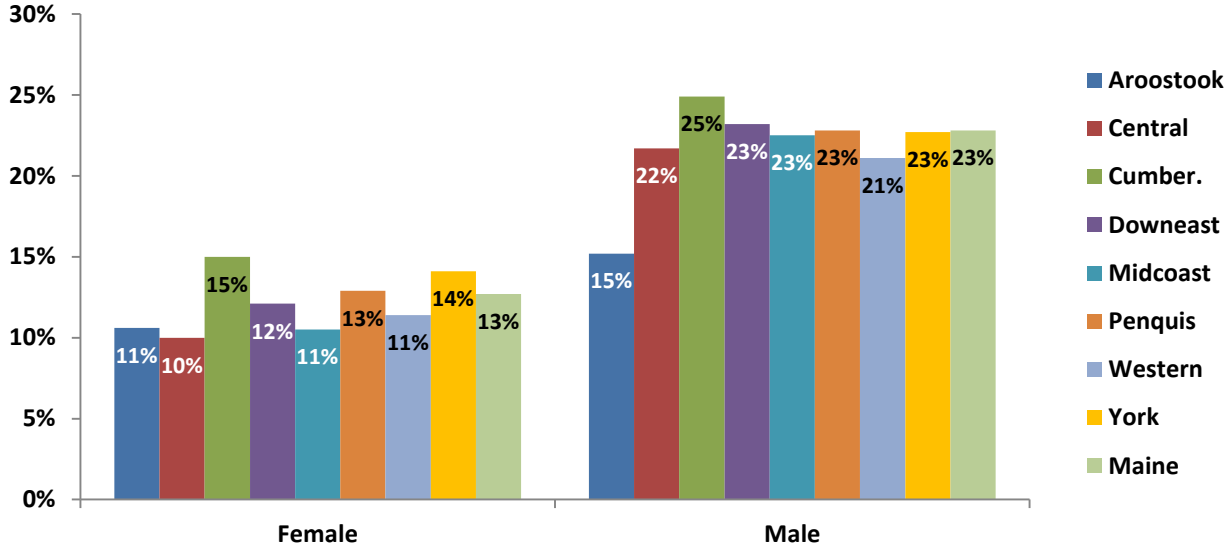
Figure 4. Percent of adults by Public Health District who reported binge drinking in past 30 days by age group: 2013–16



	Aroostook	Central	Cumber.	Downeast	Midcoast	Penquis	Western	York	Maine
18-25	26%	21%	39%	32%	37%	34%	27%	35%	32%
26-35	18%	28%	38%	27%	31%	32%	27%	31%	31%
36-49	16%	21%	24%	26%	21%	21%	19%	24%	22%
50+	7%	10%	9%	10%	9%	8%	10%	9%	9%

Source: BRFSS 2013–16

Figure 5. Percent of adults by Public Health District who reported binge drinking in past 30 days by gender: 2013–16



Source: BRFSS 2013–16

Tobacco

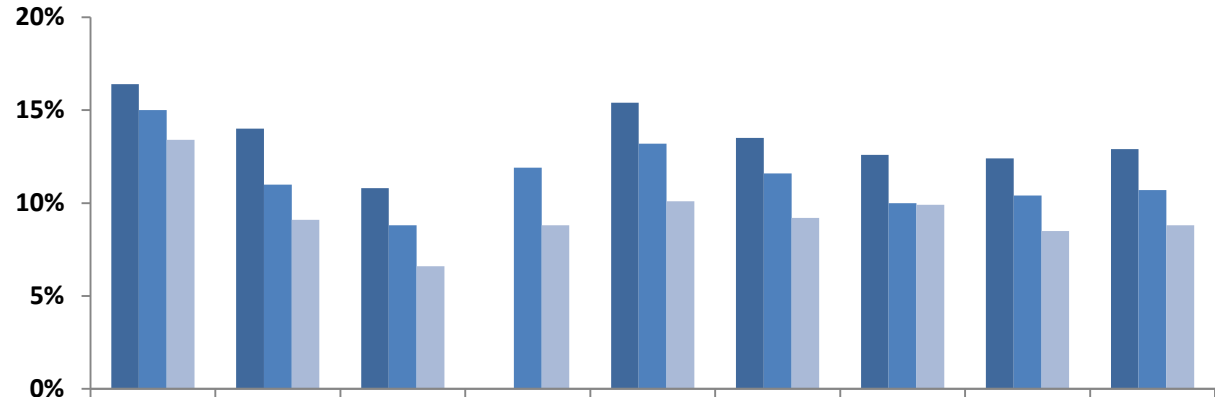
Indicator Description: SMOKING AMONG YOUTH. This indicator illustrates the percentage of Maine high school students who reported smoking a cigarette on at least one occasion within 30 days prior to the survey.

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

Data Source(s): MIYHS, 2013–2017

Summary: The percentage of Central high school students who smoked within the past 30 days (9%) has continued to decrease since 2013 (14%). The statewide average also decreased since 2013.

Figure 6. Percent of high school students by Public Health District who reported smoking one or more cigarettes during past 30 days: 2013–2017



	Aroostook	Central	Cumber.	Downeast	Midcoast	Penquis	Western	York	Maine
2013	16%	14%	11%		15%	14%	13%	12%	13%
2015	15%	11%	9%	12%	13%	12%	10%	10%	11%
2017	13%	9%	7%	9%	10%	9%	10%	9%	9%

Source: MIYHS

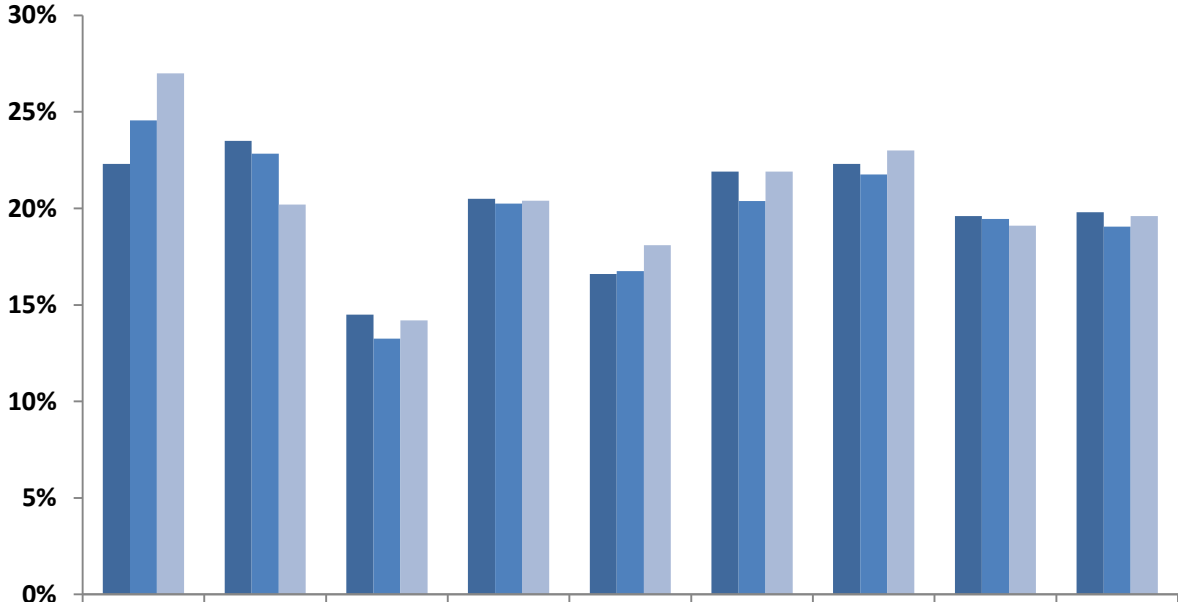
Indicator Description: SMOKING AMONG ADULTS. This indicator illustrates the percentage of Maine adults who reported using cigarettes on at least one occasion within 30 days prior to the survey, which is indicative of current use.

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

Data Source(s): BRFSS, 2013–2014 to 2015–16

Summary: In 2015–16, 20 percent of adults in Central indicated they had smoked cigarettes in the past 30 days; this was on par with the statewide average. During the 2013–16 period, 36 to 49 year olds had the highest rates in Central at 31 percent, followed by 26 to 35 year olds (30%), 18 to 25 year olds (23%), and adults 50 and older (16%). In addition, adult males in Central were more likely than adult females to smoke cigarettes (25% compared to 19%).

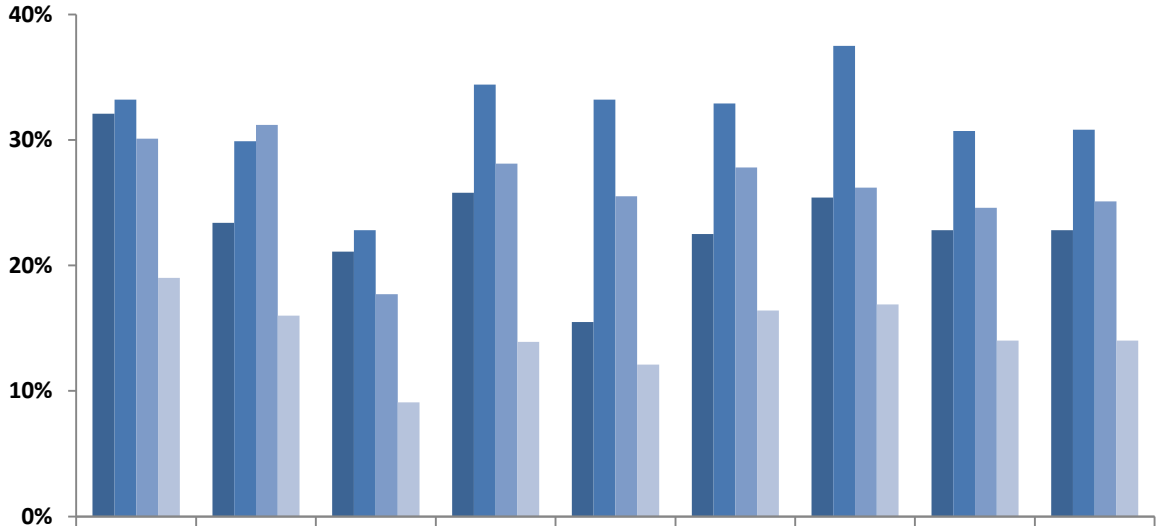
Figure 7. Percent of adults by Public Health District who reported as current smokers: 2013–14 to 2015–16



	Aroostook	Central	Cumber.	Downeast	Midcoast	Penquis	Western	York	Maine
2013-14	22%	24%	15%	21%	17%	22%	22%	20%	20%
2014-15	25%	23%	13%	20%	17%	20%	22%	19%	19%
2015-16	27%	20%	14%	20%	18%	22%	23%	19%	20%

Source: BRFSS 2013–16

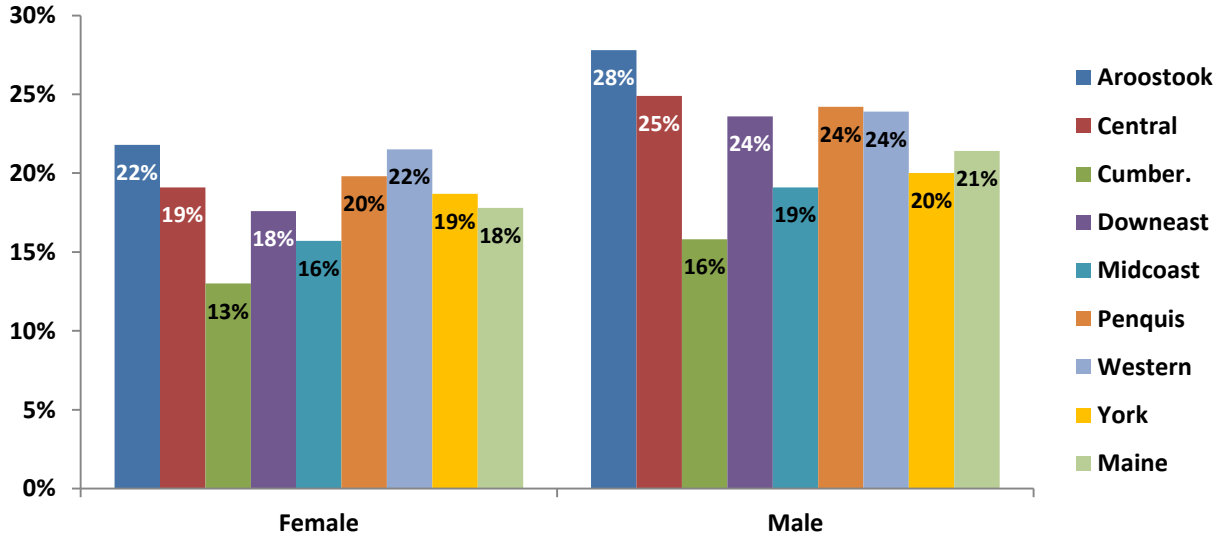
Figure 8. Percent of adults by Public Health District who reported as current smoker, by age group: 2013–16



	Aroostook	Central	Cumber.	Downeast	Midcoast	Penquis	Western	York	Maine
18-25	32%	23%	21%	26%	16%	23%	25%	23%	23%
26-35	33%	30%	23%	34%	33%	33%	38%	31%	31%
36-49	30%	31%	18%	28%	26%	28%	26%	25%	25%
50+	19%	16%	9%	14%	12%	16%	17%	14%	14%

Source: BRFSS 2013–16

Figure 9. Percent of adults by Public Health District who reported as current smoker, by gender: 2013–16



Source: BRFSS 2013–16

Prescription Drugs

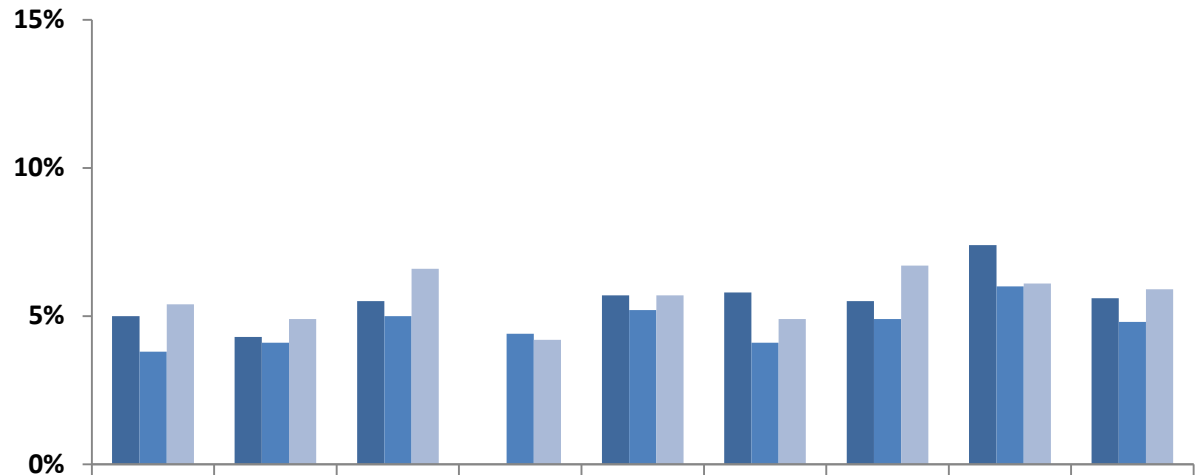
Indicator Description: MISUSE OF PRESCRIPTION DRUGS AMONG YOUTH. This indicator presents the percentage of Maine high school students who reported using prescription drugs that were not prescribed to them by a doctor within 30 days prior to the survey.

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

Data Source(s): MIYHS, 2013–2017

Summary: The percentage of Central high school students (5%) as well as the statewide average of students (6%) who took prescription drugs not prescribed to them in the past 30 days has remained similar to previous years.

Figure 10. Percent of high school students by Public Health District who have taken prescription drugs not prescribed to them by a doctor (past 30 days): 2013–2017



	Aroostook	Central	Cumber.	Downeast	Midcoast	Penquis	Western	York	Maine
2013	5%	4%	6%		6%	6%	6%	7%	6%
2015	4%	4%	5%	4%	5%	4%	5%	6%	5%
2017	5%	5%	7%	4%	6%	5%	7%	6%	6%

Source: MIYHS

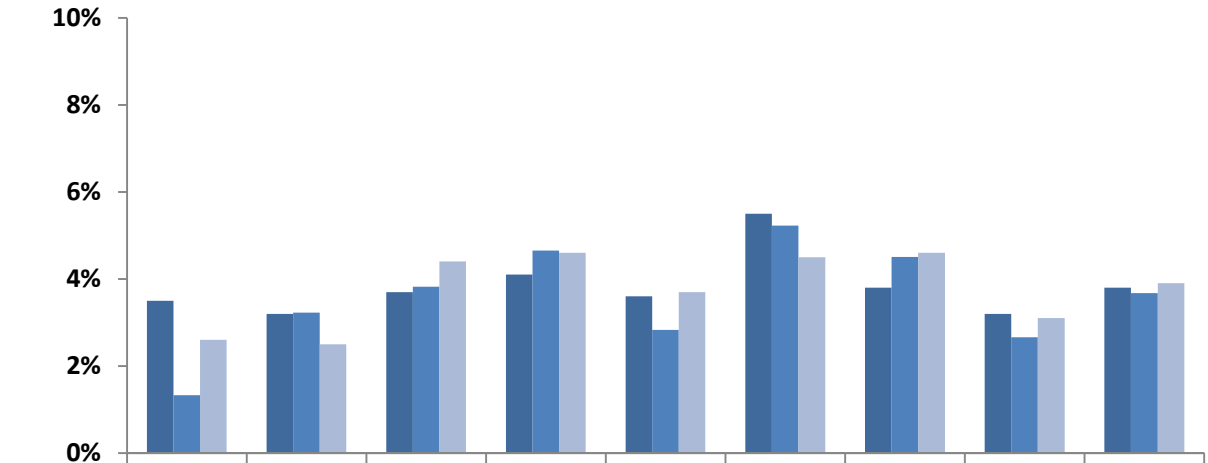
Indicator Description: MISUSE OF PRESCRIPTION DRUGS AMONG ADULTS. This measure reflects the percentage of adults in Maine who reported using prescription drugs not prescribed to them by a doctor or using them in a way other than the one prescribed, at least once in their lifetime. Because of small sample sizes, survey data from multiple years must be combined to produce this estimate.

Why Indicator is Important: Some Mainers misuse available prescription drugs (including stimulants and opiates) instead of illegal drugs to get high. Abuse of prescription drugs may lead to consequences such as unintentional poisonings, overdose, dependence and increased crime.

Data Source(s): BRFSS, 2012–14 to 2014–16

Summary: During 2014–16, 2.5 percent of the adults in Central reported that they had misused prescription drugs in their lifetime. This was lower than the statewide average (3.9%). When the years are combined (2013–16), Central residents 18 to 25 observed the highest rate of lifetime prescription drug misuse within the public health district. Like most other districts in Maine, adult males in Central were more likely to have misused prescription drugs in their lifetime as compared to adult females (4.3% compared to 1.4%).

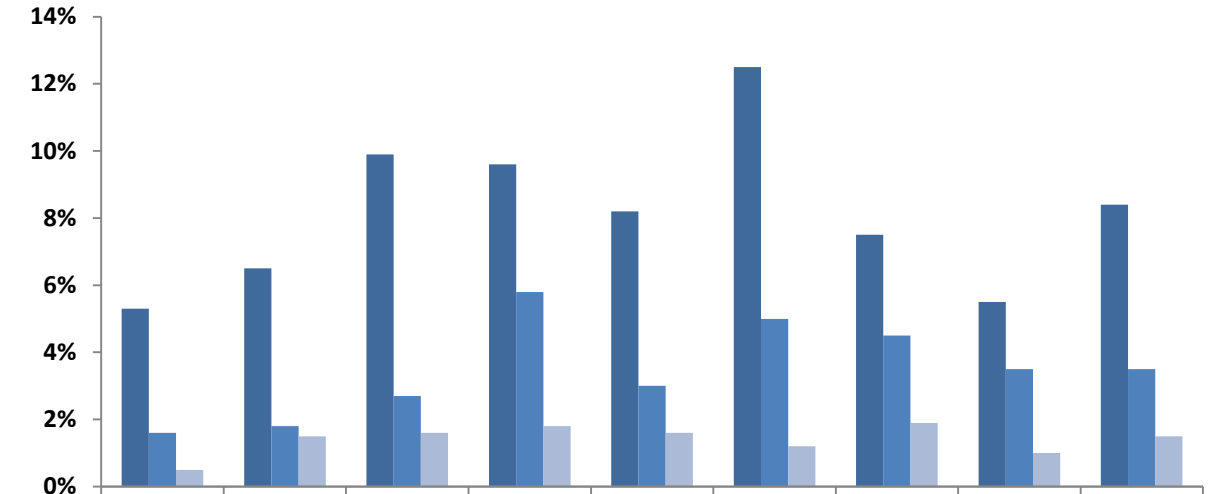
Figure 11. Misuse of prescription drugs among Maine residents (18 and older) in their lifetime, by Public Health District: 2012–14 to 2014–16



	Aroostook	Central	Cumber.	Downeast	Midcoast	Penquis	Western	York	Maine
2012-14	3.5%	3.2%	3.7%	4.1%	3.6%	5.5%	3.8%	3.2%	3.8%
2013-15	1.3%	3.2%	3.8%	4.7%	2.8%	5.2%	4.5%	2.7%	3.7%
2014-16	2.6%	2.5%	4.4%	4.6%	3.7%	4.5%	4.6%	3.1%	3.9%

Source: BRFSS 2012–2016

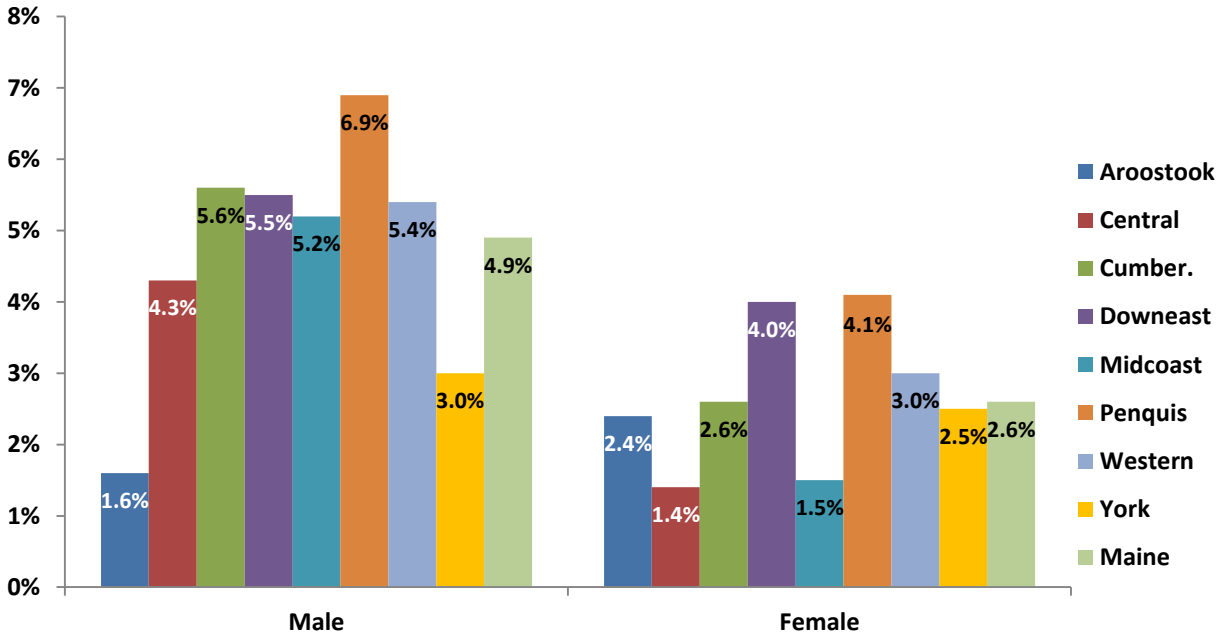
Figure 12. Lifetime misuse of prescription drugs among Maine adults, by age and Public Health District: 2013–16



	Aroostook	Central	Cumber.	Downeast	Midcoast	Penquis	Western	York	Maine
18-34	5.3%	6.5%	9.9%	9.6%	8.2%	12.5%	7.5%	5.5%	8.4%
35-54	1.6%	1.8%	2.7%	5.8%	3.0%	5.0%	4.5%	3.5%	3.5%
55+	0.5%	1.5%	1.6%	1.8%	1.6%	1.2%	1.9%	1.0%	1.5%

Source: BRFSS 2013–16

Figure 13. Lifetime misuse of prescription drugs among Maine adults, by gender and Public Health District: 2013–16



Source: BRFSS 2013–16

Marijuana

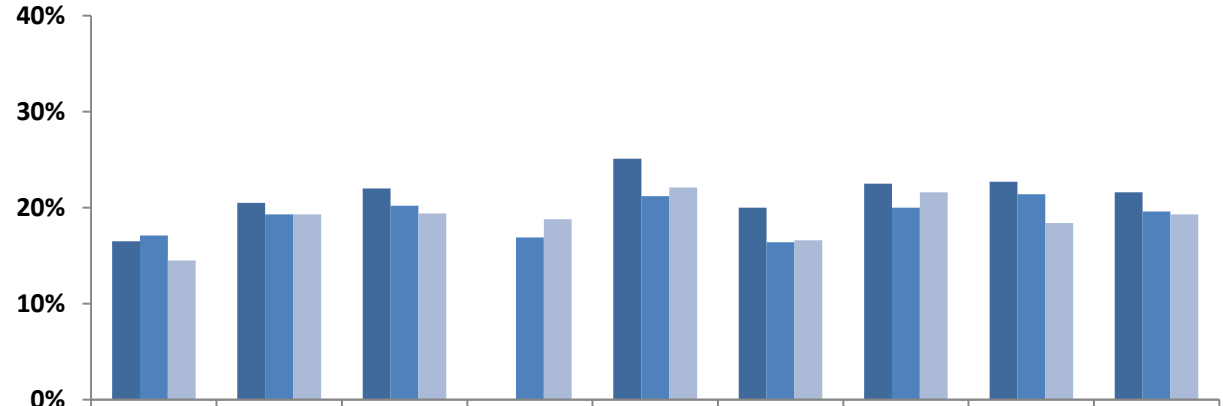
Indicator Description: CURRENT MARIJUANA USE. This measure shows the percentage of Maine residents who reported using marijuana in the past 30 days. This is presented for high school students and adults in Maine.

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

Data Source(s): MIYHS, 2013–2017; BRFSS, 2012–14 to 2014–16

Summary: In 2017, 19 percent of high school students in Central reported having used marijuana one or more times in the past 30 days. The rates for Central as well as the state of Maine have decreased slightly since 2013.

Figure 14. Percent of high school students by Public Health District who have used marijuana during past 30 days: 2013–2017

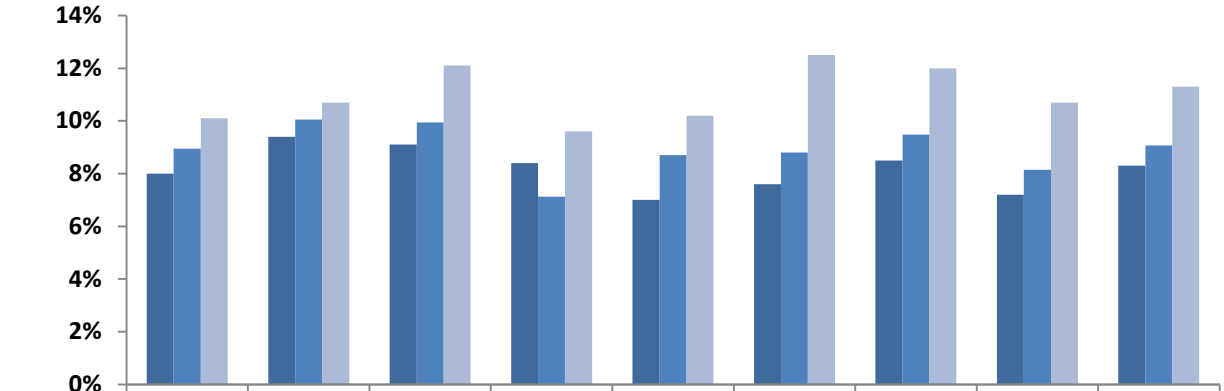


	Aroostook	Central	Cumber.	Downeast	Midcoast	Penquis	Western	York	Maine
2013	17%	21%	22%		25%	20%	23%	23%	22%
2015	17%	19%	20%	17%	21%	16%	20%	21%	20%
2017	15%	19%	19%	19%	22%	17%	22%	18%	19%

Source: MIYHS

Summary: Among Central adults, in 2014–16, 11 percent reported using any marijuana within the past 30 days. This was consistent with the statewide rate. The rate of Central's adults who have used marijuana in the past 30 days increased by two percentage points from 2012–14 to 2014–16. In 2013–16, past-month marijuana use rates were highest among 18 to 34 year olds at 17 percent; this was lower than the statewide average (19%). Central adult males were more than twice as likely as adult females to have used marijuana in the past month (15% compared to 6%).

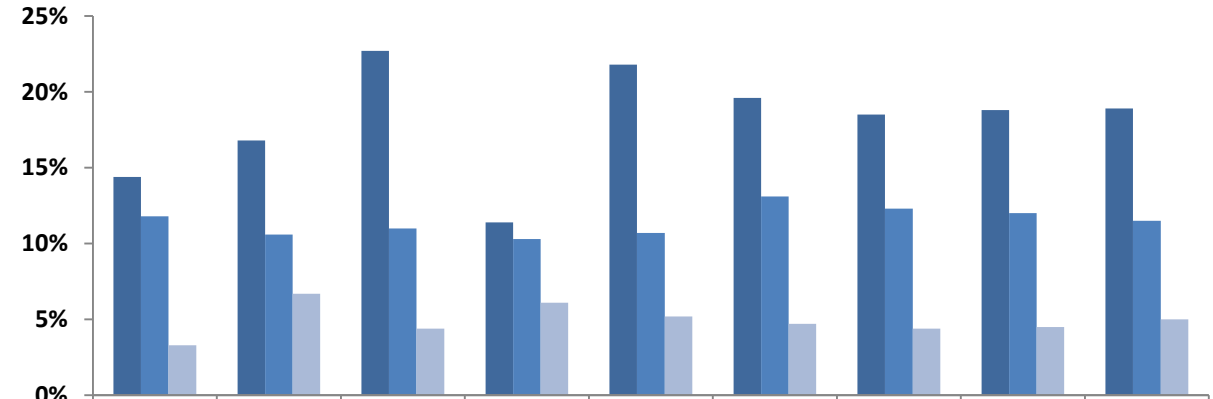
Figure 15. Percent of adults who have used marijuana during the past 30 days, by Public Health District: 2012–14 to 2014–16



	Aroostook	Central	Cumber.	Downeast	Midcoast	Penquis	Western	York	Maine
2012-14	8%	9%	9%	8%	7%	8%	9%	7%	8%
2013-15	9%	10%	10%	7%	9%	9%	9%	8%	9%
2014-16	10%	11%	12%	10%	10%	13%	12%	11%	11%

Source: BRFSS 2012–16

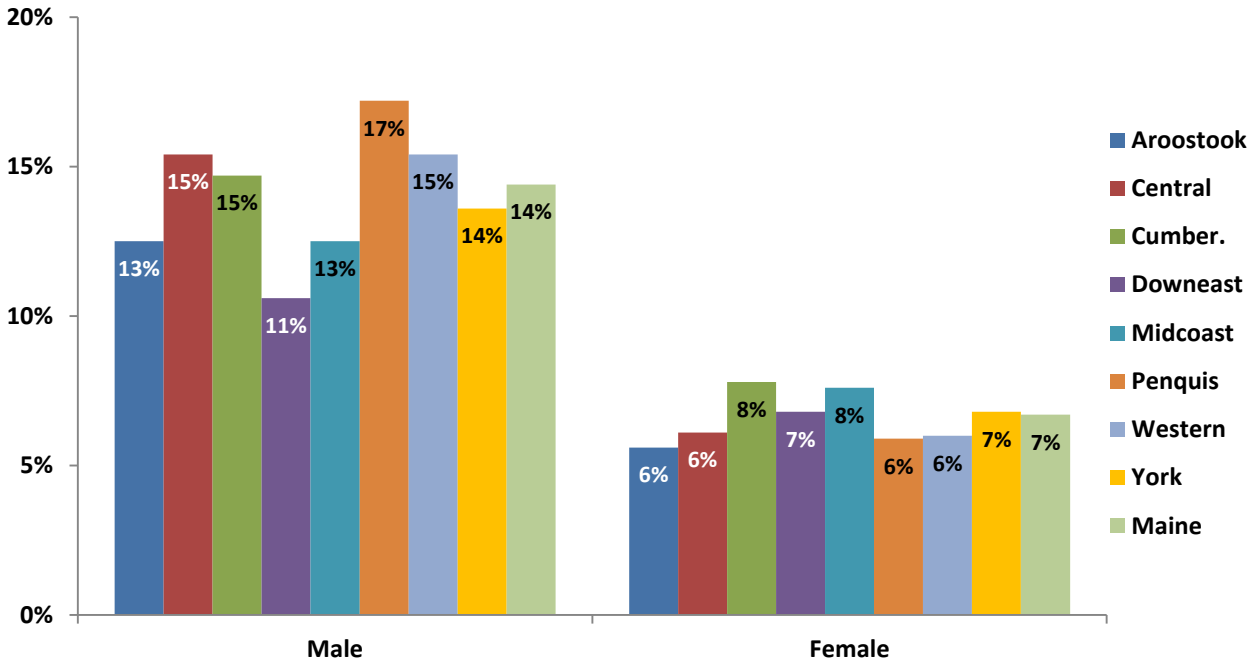
Figure 16. Percent of adults who have used marijuana during the past 30 days, by age and Public Health District: 2013–16



	Aroostook	Central	Cumber.	Downeast	Midcoast	Penquis	Western	York	Maine
18-34	14%	17%	23%	11%	22%	20%	19%	19%	19%
35-54	12%	11%	11%	10%	11%	13%	12%	12%	12%
55+	3%	7%	4%	6%	5%	5%	4%	5%	5%

Source: BRFSS 2013–16

Figure 17. Percent of adults who have used marijuana during the past 30 days, by gender and Public Health District: 2013–16



Source: BRFSS 2013–16

Other Illegal Drugs

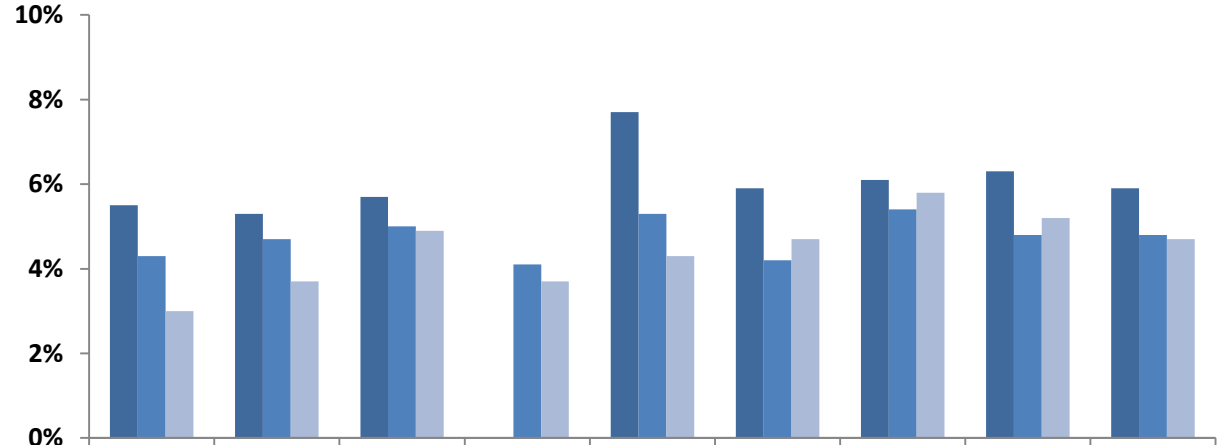
Indicator Description: LIFETIME COCAINE USE AMONG YOUTH. This indicator illustrates the percentage of Maine high school students who used cocaine at least once in their lifetime (*i.e.,* ever).

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

Data Source(s): MIYHS, 2013–2017

Summary: From 2013 to 2017, the rate of Central high school students reporting that they had used cocaine (in any form) during their lifetime decreased slightly from five percent to four percent. Since 2015, the statewide average for Maine has remained at five percent.

Figure 18. Percent of high school students by Public Health District that have used cocaine in any form during their lifetime: 2013–2017



	Aroostook	Central	Cumber.	Downeast	Midcoast	Penquis	Western	York	Maine
2013	6%	5%	6%		8%	6%	6%	6%	6%
2015	4%	5%	5%	4%	5%	4%	5%	5%	5%
2017	3%	4%	5%	4%	4%	5%	6%	5%	5%

Source: MIYHS

Consequences Resulting from Substance Use and Abuse

Both individuals and communities suffer the consequences of substance abuse, resulting in increased health care needs and criminal justice resource utilization. While a great deal of information regarding substance use can be obtained from the data described in the previous section, information on the effects of that use on individuals and communities can be derived from what has come to be called “consequence” data. Consequences are defined as the social, economic and health problems associated with the use of alcohol and drugs. Examples include, but are not limited to: drug overdoses, drug/alcohol-related arrests, substance-exposed newborns, poison center calls, and driving accidents involving alcohol and/or drugs.

When adjusted for population differences, Central shows a consistently higher prevalence of violent crimes and alcohol-related arrests when compared to the statewide average. Both arrest rates related to alcohol as well as those related to drugs have observed increases over the past several years. Furthermore, impaired driver crashes involving alcohol and/or drugs in Central have also observed a steady increase.

Central’s rate of calls to the Poison Center that were suspected to be substance-abuse-related was slightly higher than the statewide average, as was the proportion of live births with substance-exposed notifications. The number of naloxone administrations to residents of Central PHD given by Emergency Medical Service (EMS) responders nearly tripled since 2014, and Central also had the fourth-highest rate of overdose deaths observed among the districts; both figures are above statewide averages.

Substance Use and Pregnancy

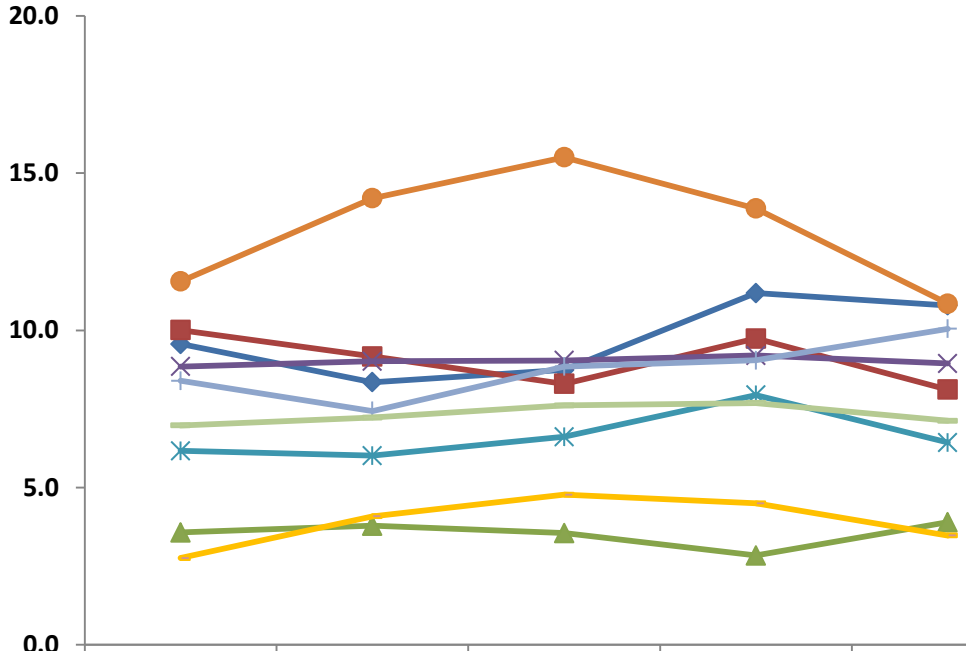
Indicator Description: BABIES BORN AFFECTED BY SUBSTANCES. This measure reflects the number of infants born in Maine where a healthcare provider reported to the Office of Children and Family Services (OCFS) that there was reasonable cause to suspect the baby may be affected by drugs or alcohol or demonstrating withdrawal symptoms resulting from prenatal drug exposure (illicit or prescribed) or who have fetal alcohol spectrum disorders. This measure potentially excludes instances where the infant was exposed to substances and did not show withdrawal symptoms after birth, instances where the birth of an infant affected by substances was not reported to OCFS, and any other instances in which there were discrepancies between reporters when interpreting Title 22, §4011-A, *notification of prenatal exposure to drugs or having fetal alcohol spectrum disorders*.

Why Indicator is Important: Prenatal exposure to alcohol, tobacco, and illicit drugs has the potential to cause a wide spectrum of physical, emotional, and developmental problems for these infants. The harm caused to the child can be significant and long-lasting, especially if the exposure is not detected and the effects are not treated as soon as possible.

Data Source(s): OCFS/MACWIS, 2013–2017

Summary: The rate of drug-affected baby (substance-exposed infant) reports in Central decreased from 2016 (9.7 per 10,000 residents) to 2017 (8.1 per 10,000 residents); the current rate was the fourth highest among the districts. The proportion of live births with substance-exposed infant reports in Central decreased from 10 percent in 2013 to nine percent in 2017; the current rate was one percentage point higher than the statewide proportion of eight percent.

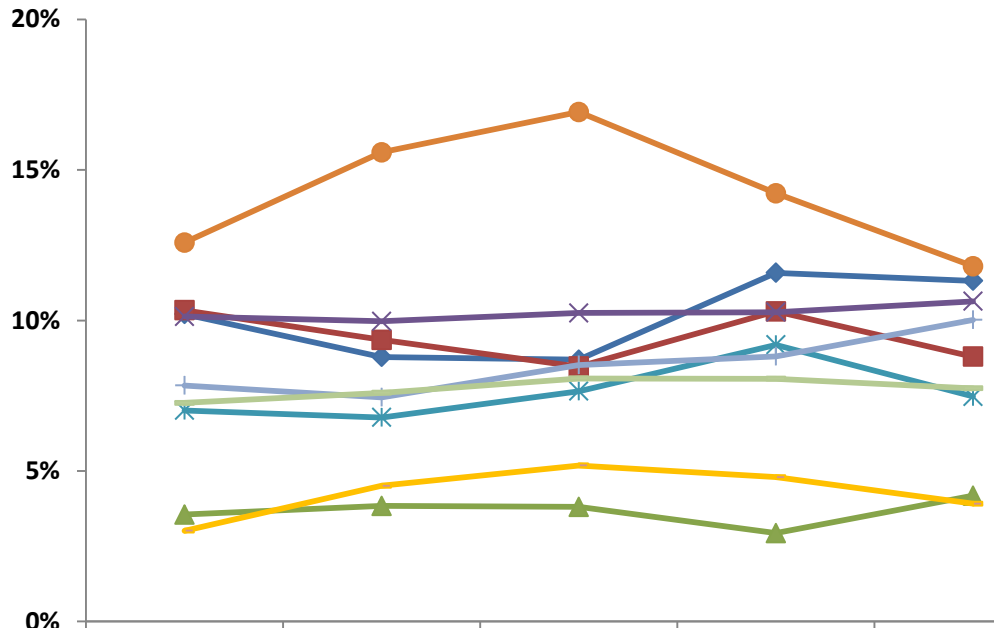
Figure 19. Number of drug-affected baby (substance-exposed infant) reports per 10,000 residents, by Public Health District: 2013–2017



	2013	2014	2015	2016	2017
Aroostook	9.6	8.4	8.7	11.2	10.8
Central	10.0	9.2	8.3	9.7	8.1
Cumberland	3.6	3.8	3.6	2.8	3.9
Downeast	8.8	9.0	9.0	9.2	8.9
Midcoast	6.2	6.0	6.6	7.9	6.4
Penquis	11.6	14.2	15.5	13.9	10.8
Western	8.4	7.4	8.8	9.0	10.0
York	2.8	4.1	4.8	4.5	3.5
Maine	7.0	7.2	7.6	7.7	7.1

Source: OCFS/MACWIS

Figure 20. Proportion of live births with drug-affected baby (substance-exposed infant) reports, by Public Health District: 2013–2017



	2013	2014	2015	2016	2017
Aroostook	10%	9%	9%	12%	11%
Central	10%	9%	8%	10%	9%
Cumber.	4%	4%	4%	3%	4%
Downeast	10%	10%	10%	10%	11%
Midcoast	7%	7%	8%	9%	7%
Penquis	13%	16%	17%	14%	12%
Western	8%	7%	9%	9%	10%
York	3%	5%	5%	5%	4%
Maine	7%	8%	8%	8%	8%

Source: OCFS/MACWIS

Referral Services

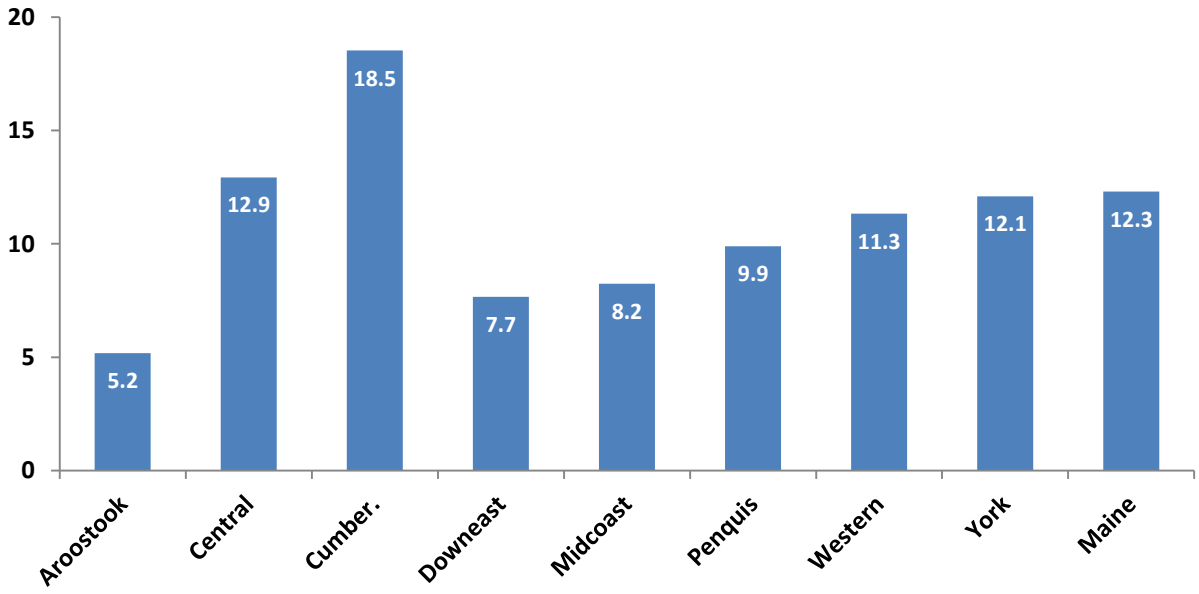
Indicator Description: INFORMATION CALLS FOR REFERRAL SERVICES. 2-1-1 Maine is a telephone and internet service that provides information and referrals to a wide range of health and human services. This indicator reflects the number of calls received by 2-1-1 Maine where the callers were seeking services related to the treatment of substance use. Callers are referred to support services such as alcohol anonymous meetings, residential treatment programs, outpatient counseling/certification programs, and medication assisted treatment programs. Virtually all callers are seeking treatment for themselves, family members, friends, or significant others.

Why Indicator is Important: The data collected provides valuable information serving as a barometer of health and human service needs related to substance use in the state.

Data Source(s): 2-1-1 Maine, 2017, 2013 to 2017

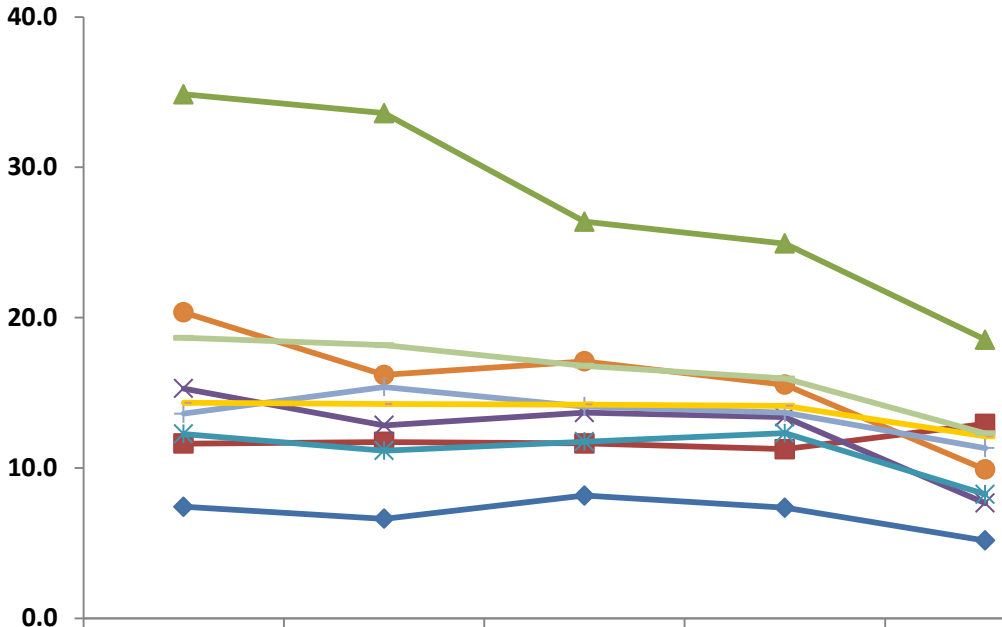
Summary: In 2017, Central observed 12.9 calls per 10,000 residents to 2-1-1 Maine related to substance use; this was slightly more than the state average (12.3 calls per 10,000). In 2017, Central held the second-highest rate of such calls among public health districts. Central's rate increased slightly from 11.6 in 2013 to 12.9 in 2017.

Figure 21. Number of 2-1-1 Maine referral calls relating to substance use per 10,000 residents, by Public Health District: 2017



Source: 2-1-1 Maine

Figure 22. Number of 2-1-1 referral calls relating to substance use per 10,000 residents, by Public Health District: 2013–2017



	2013	2014	2015	2016	2017
Aroostook	7.4	6.6	8.2	7.4	5.2
Central	11.6	11.7	11.6	11.3	12.9
Cumber.	34.9	33.6	26.4	24.9	18.5
Downeast	15.3	12.8	13.7	13.4	7.7
Midcoast	12.3	11.2	11.7	12.3	8.2
Penquis	20.4	16.2	17.1	15.5	9.9
Western	13.6	15.4	14.1	13.7	11.3
York	14.3	14.2	14.2	14.1	12.1
Maine	18.7	18.2	16.8	16.0	12.3

Source: 2-1-1 Maine

Criminal Justice Involvement

Indicator Description: ANNUAL VIOLENT CRIME RATE. This indicator shows the number of violent crimes reported to the police, per 10,000 people. Violent crimes include murder, rape, robberies, and aggravated assaults. The rate indicates only the rate of incidents reported to police and does not reflect the number of criminals who committed them or the number of injuries inflicted. The rate per 10,000 allows us to see frequency with which an occurrence shows up within a population over time, as well as make relative comparisons between small and large population areas.

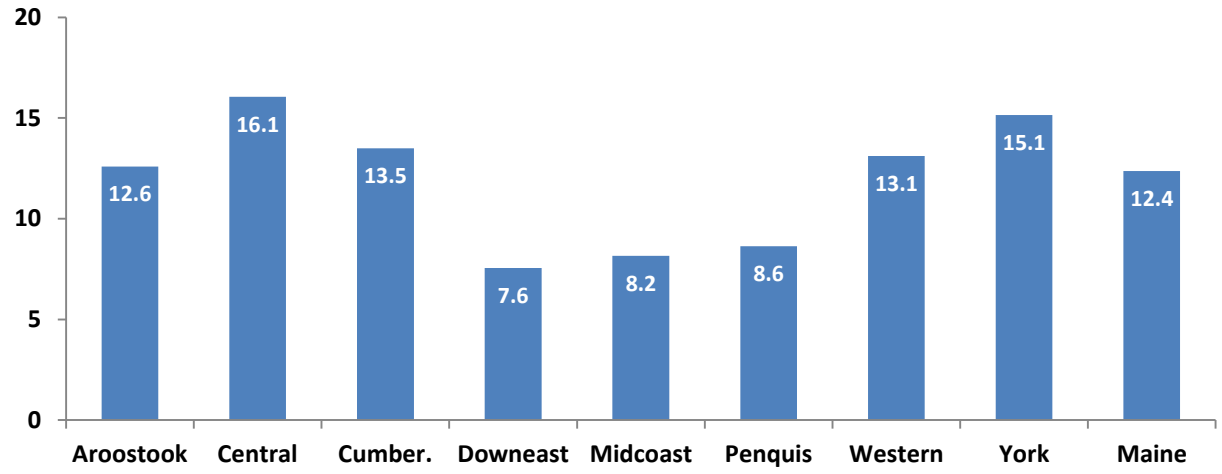
Operationalized as: $\left(\frac{\#\ of\ violent\ crimes}{population}\right) \times 10{,}000$

Why Indicator is Important: Violence has been associated with the use of alcohol/drugs, though the causal pathway is not completely understood. Drinking on the part of the victim or a perpetrator can increase the risk of assaults and assault-related injuries. Estimates have indicated that at least 23 percent of sexual assaults and 30 percent of physical assaults can be attributed to alcohol. Reported violent crimes are an under-report of the total number of actual violent crimes.

Data Source(s): DPS-UCR, 2015–16, 2012–13 to 2015–16

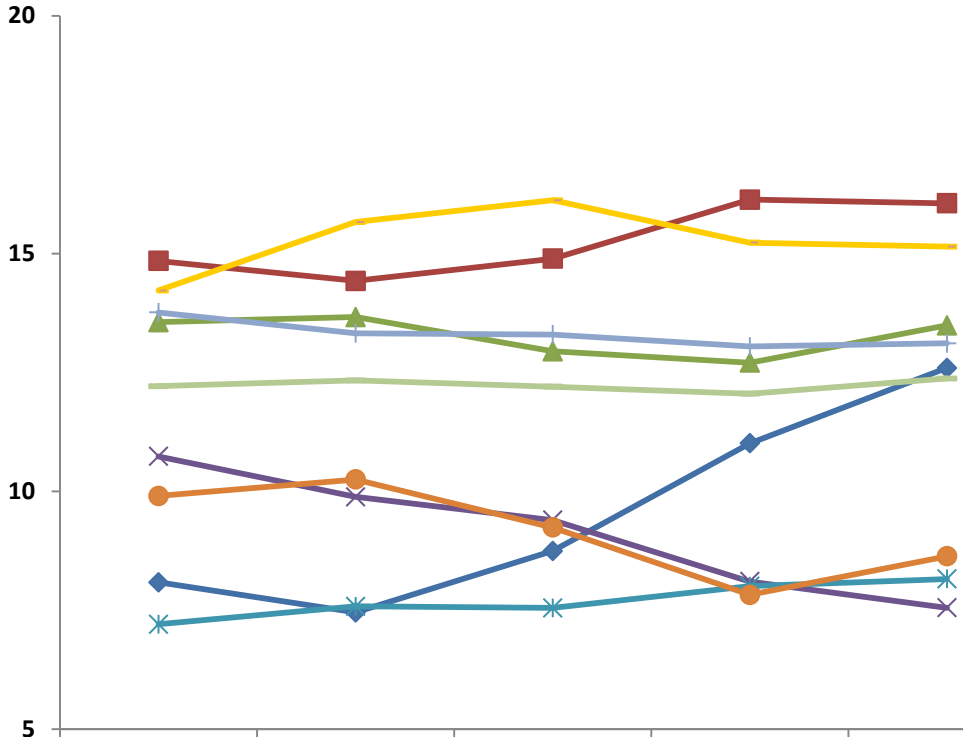
Summary: In 2015–16 (combined years), there were an average of 16.1 violent crimes per 10,000 people in Central, compared to the state average of 12.4 per 10,000 people. Central's rate has consistently been higher than the state rate for violent crime and has increased over the past several years. Although not shown, the number of violent crimes in Central increased slightly from 267 in 2012 to 277 in 2016.

Figure 23. Violent crime rate per 10,000 residents, by Public Health District: 2015–16



Source: DPS; UCR

Figure 24. Violent crime rate per 10,000 residents, by Public Health District: 2011–12 to 2015–16



	2011-12	2012-13	2013-14	2014-15	2015-16
Aroostook	8.1	7.5	8.7	11.0	12.6
Central	14.8	14.4	14.9	16.1	16.1
Cumber.	13.6	13.7	12.9	12.7	13.5
Downeast	10.7	9.9	9.4	8.1	7.6
Midcoast	7.2	7.6	7.5	8.0	8.2
Penquis	9.9	10.2	9.2	7.8	8.6
Western	13.8	13.3	13.3	13.0	13.1
York	14.2	15.7	16.1	15.2	15.1
Maine	12.2	12.3	12.2	12.1	12.4

Source: DPS; UCR

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

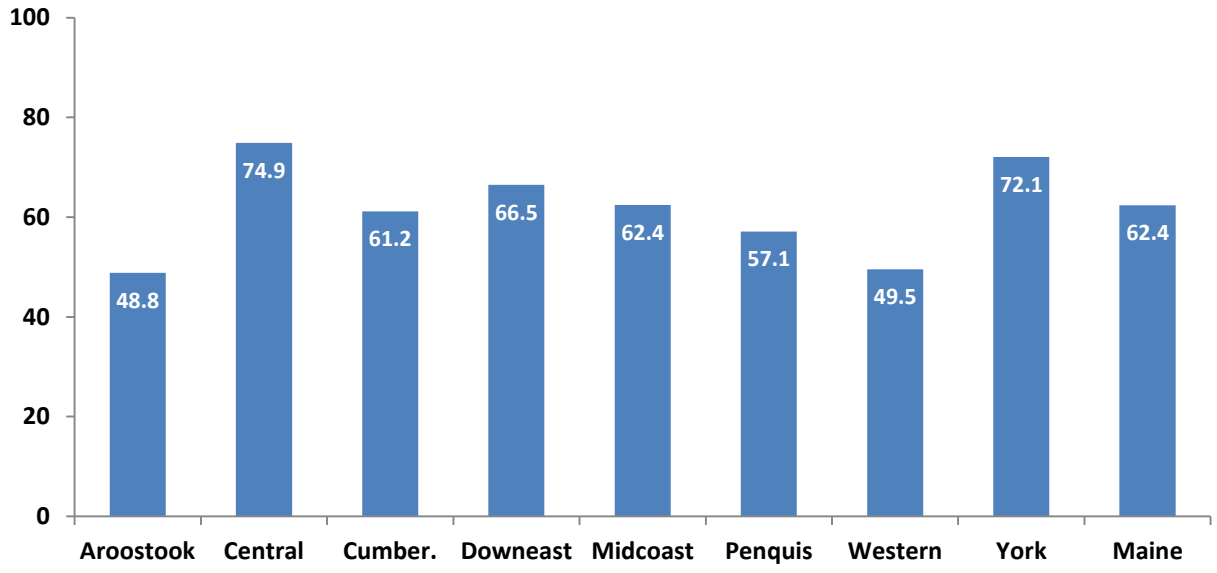
Operationalized as: $\left(\frac{\#\ of\ alcohol\ arrests}{population}\right) \times 10{,}000$

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

Data Source(s): DPS–UCR, 2015–16, 2011–12 to 2015–16

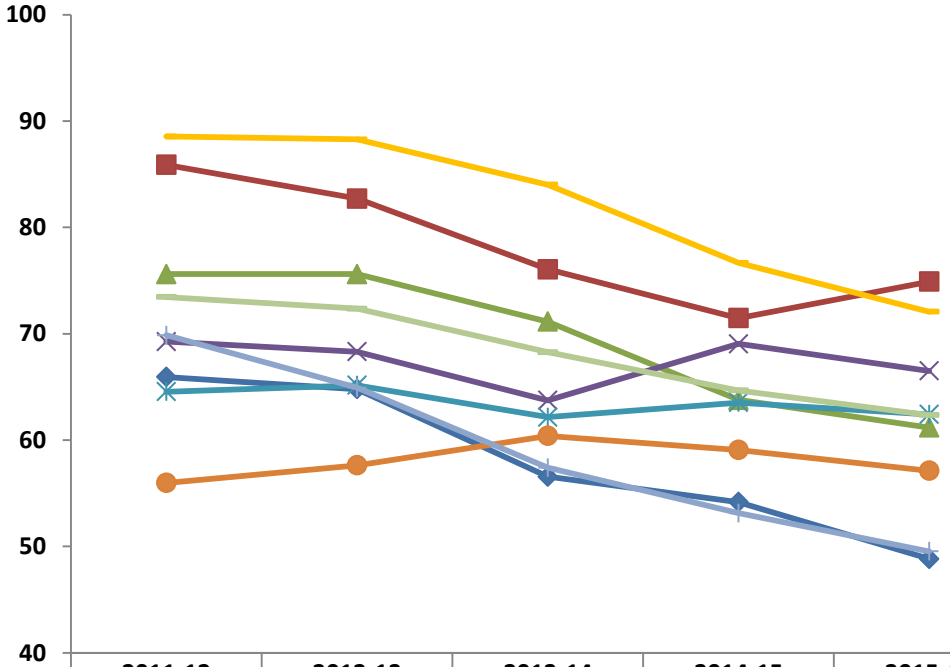
Summary: Central's alcohol-related arrest rate has decreased from 85.9 per 10,000 residents in 2011–12 to 74.9 per 10,000 residents in 2015–16; the current rate was higher than the statewide rate (62.4) and the highest observed among public health districts. Although not explicitly shown, Central's alcohol-related arrest rate dropped by nine percent from 2012 (1,447) to 2016 (1,317). Overall, most public health districts have observed a decline in alcohol-related arrests over the past several years.

Figure 25. Alcohol-related arrest rate per 10,000 residents, by Public Health District: 2015–16



Source: DPS; UCR

Figure 26. Alcohol-related arrest rate per 10,000 residents, by Public Health District: 2011–12 to 2015–16



	2011-12	2012-13	2013-14	2014-15	2015-16
Aroostook	65.9	64.8	56.6	54.2	48.8
Central	85.9	82.7	76.1	71.5	74.9
Cumber.	75.6	75.6	71.1	63.8	61.2
Downeast	69.3	68.3	63.7	69.0	66.5
Midcoast	64.5	65.2	62.2	63.5	62.4
Penquis	56.0	57.6	60.4	59.1	57.1
Western	69.9	64.9	57.4	53.1	49.5
York	88.6	88.3	84.0	76.7	72.1
Maine	73.5	72.4	68.3	64.7	62.4

Source: DPS; UCR

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

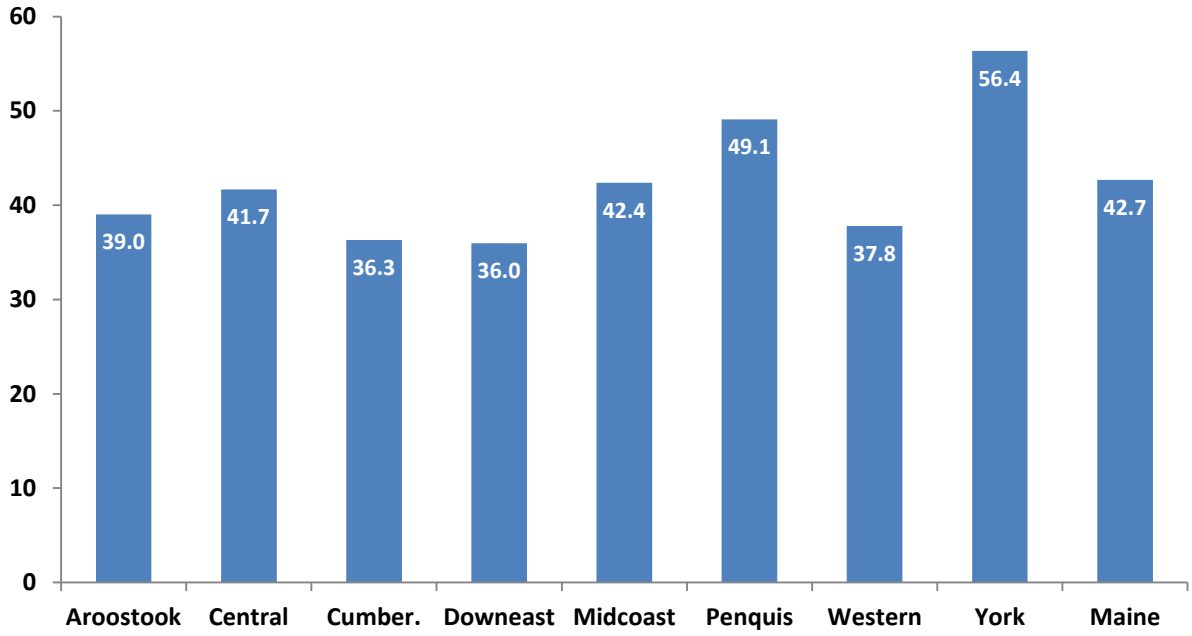
Operationalized as: $\left(\frac{\#\ of\ drug\ arrests}{population}\right) \times 10{,}000$

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

Data Source(s): DPS-UCR, 2015–16, 2011–12 to 2015–16

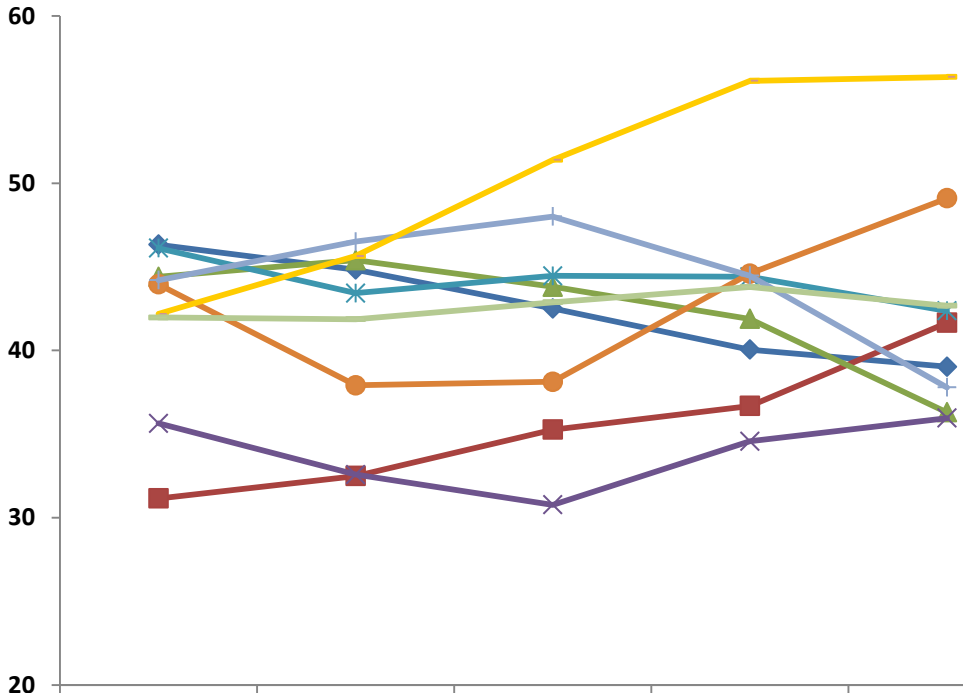
Summary: In 2015–16, Central experienced an average of 41.7 drug-related arrests per 10,000 people, compared to 42.7 per 10,000 people statewide. Central's drug-related crime rate has observed an overall increase since 2011–12 (31.2).

Figure 27. Drug-related arrest rate per 10,000 residents, by Public Health District: 2015–16



Source: DPS; UCR

Figure 28. Drug-related arrest rate per 10,000 residents, by Public Health District: 2011–12 to 2015–16

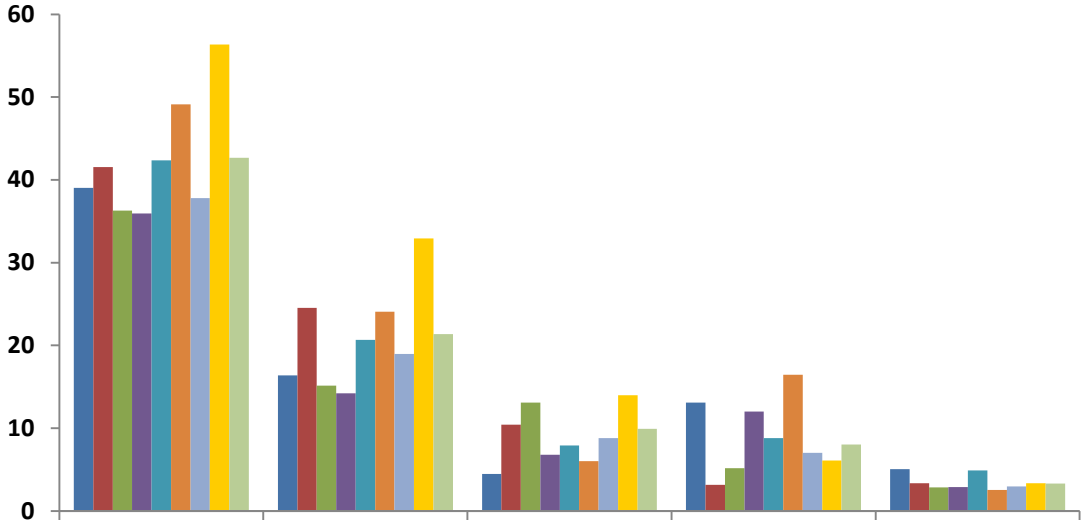


	2011-12	2012-13	2013-14	2014-15	2015-16
Aroostook	46.3	44.8	42.5	40.1	39.0
Central	31.2	32.5	35.3	36.7	41.7
Cumber.	44.4	45.4	43.8	41.9	36.3
Downeast	35.6	32.6	30.8	34.6	36.0
Midcoast	46.1	43.4	44.5	44.4	42.4
Penquis	44.0	37.9	38.1	44.6	49.1
Western	44.2	46.5	48.0	44.5	37.8
York	42.2	45.6	51.4	56.1	56.4
Maine	42.0	41.9	42.9	43.8	42.7

Source: DPS; UCR

Summary: In 2015–16, Central had an average rate of 10.5 drug-related arrests (including possession and sales/manufacturing) involving opium, cocaine, and derivatives per 10,000 residents; this was on par with the statewide rate (9.9). During the same period, Central observed 24.5 arrests per 10,000 residents for marijuana, 3.4 arrests per 10,000 residents for synthetic narcotics, and 3.2 arrests per 10,000 residents related to other dangerous non-narcotics.

Figure 29. Drug-related arrest rate per 10,000 residents, by drug type and Public Health District: 2015–16



	All drugs	Marijuana	Opium, cocaine, and derivatives*	Other dangerous non-narcotics**	Synthetic narcotics
Aroostook	39.0	16.4	4.5	13.1	5.1
Central	41.5	24.5	10.5	3.2	3.4
Cumber.	36.3	15.2	13.1	5.2	2.9
Downeast	36.0	14.2	6.8	12.0	2.9
Midcoast	42.4	20.7	7.9	8.8	4.9
Penquis	49.1	24.1	6.0	16.5	2.5
Western	37.8	19.0	8.8	7.0	3.0
York	56.4	32.9	14.0	6.1	3.3
Maine	42.7	21.4	9.9	8.0	3.3

Source: DPS; UCR

**Derivatives include cocaine/crack, codeine, heroin, and morphine.*
***Other dangerous non-narcotics include but are not limited to benzodiazepines, steroids, stimulants, synthetic cannabis, bath salts, methamphetamine, hallucinogens, and barbiturates.*

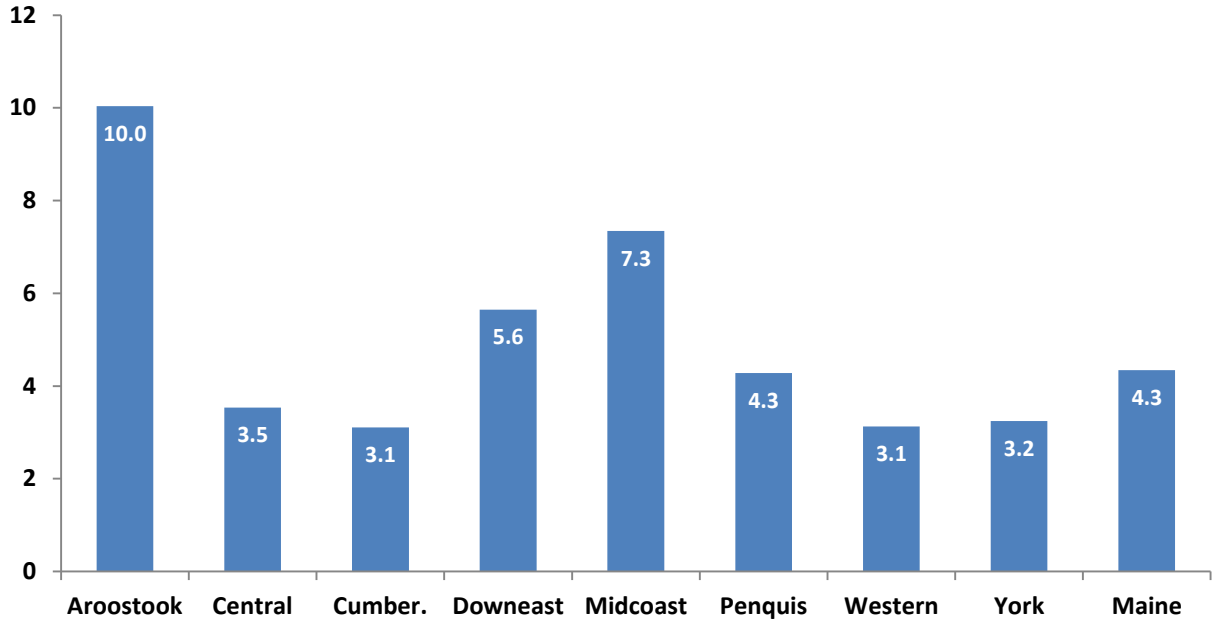
Indicator Description: MAINE DEA DRUG OFFENSE ARRESTS BY TYPE. This indicator reflects drug offense arrests made by the Maine's Drug Enforcement Agency (MDEA), overall and by drug type. The MDEA, through its eight regional multi-jurisdictional task forces, is the lead state agency in *confronting drug trafficking crime.* This indicator differs from the previous drug-related arrest data in that it only tracks MDEA efforts and does not encompass all activity within Maine law enforcement agencies.

Why Indicator is Important: Drug offense arrest rates can be an indication of the rate of criminal behavior, but it is important to note that they are also an indication of the level of law enforcement. Drug arrest rates are expected to increase with increased enforcement regardless of whether a decline in criminal behavior is observed.

Data Source(s): MDEA, 2016–17; 2012–13 to 2016–17; 2015–17

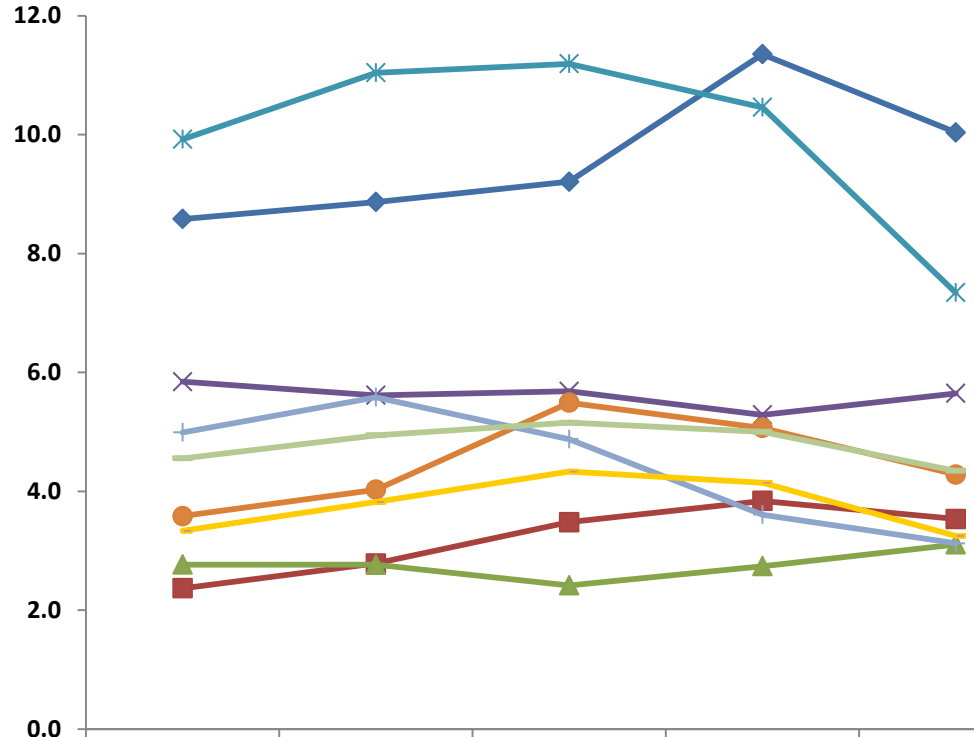
Summary: In 2016–17, there were 3.5 drug offense arrests per 10,000 residents in Central made by the Maine Drug Enforcement Agency (MDEA); this rate was slightly lower than the state average (4.3). After steadily increasing over several periods, the rate of MDEA drug arrests decreased from 2015–16 (3.8) to 2016–17 (3.5). MDEA drug offense arrest rates in Central have been driven primarily by those related to Heroin. During 2016–17, there was an average of two arrests per 10,000 people related to heroin in Central; this was on par with the state average.

Figure 30. Maine DEA drug trafficking and manufacturing arrests per 10,000 residents, by Public Health District: 2016–17



Source: MDEA

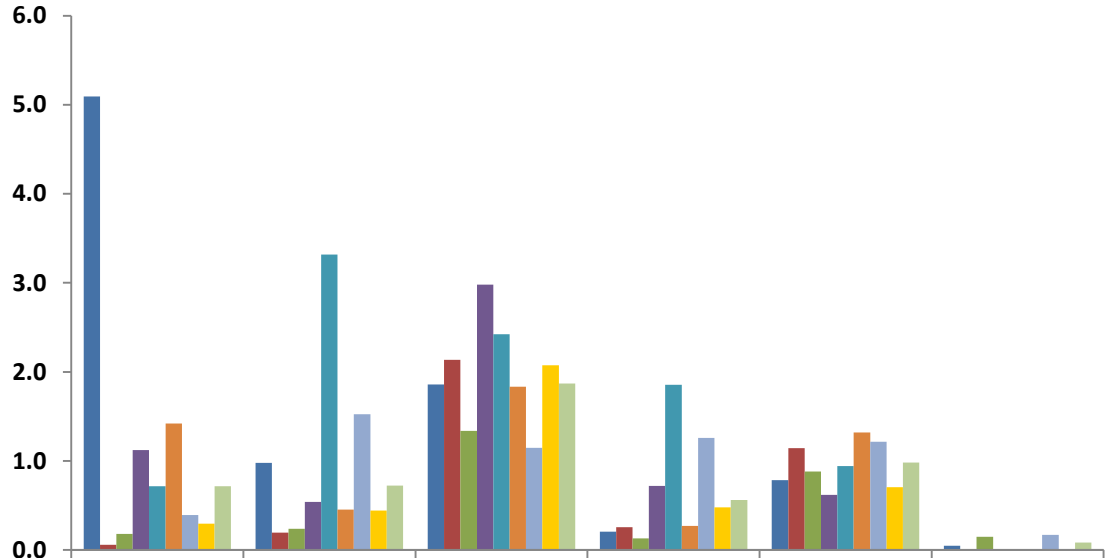
Figure 31. Maine DEA drug offense arrests per 10,000 residents, by Public Health District: 2012–13 to 2016–17



	2012-13	2013-14	2014-15	2015-16	2016-17
Aroostook	8.6	8.9	9.2	11.4	10.0
Central	2.4	2.8	3.5	3.8	3.5
Cumber.	2.8	2.8	2.4	2.7	3.1
Downeast	5.8	5.6	5.7	5.3	5.6
Midcoast	9.9	11.0	11.2	10.5	7.3
Penquis	3.6	4.0	5.5	5.1	4.3
Western	5.0	5.6	4.9	3.6	3.1
York	3.3	3.8	4.3	4.1	3.2
Maine	4.6	4.9	5.2	5.0	4.3

Source: MDEA

Figure 32. Maine DEA drug offense arrests per 10,000 residents, by drug type and Public Health District: 2015–17



	Methamphetamine	Pharm-narcotics	Heroin	Marijuana	Cocaine/crack	Fentanyl
Aroostook	5.1	1.0	1.9	0.2	0.8	0.0
Central	0.1	0.2	2.1	0.3	1.1	0.0
Cumberland	0.2	0.2	1.3	0.1	0.9	0.1
Downeast	1.1	0.5	3.0	0.7	0.6	0.0
Midcoast	0.7	3.3	2.4	1.9	0.9	0.0
Penquis	1.4	0.5	1.8	0.3	1.3	0.0
Western	0.4	1.5	1.1	1.3	1.2	0.2
York	0.3	0.4	2.1	0.5	0.7	0.0
Maine	0.7	0.7	1.9	0.6	1.0	0.1

Source: MDEA

Driving Under the Influence

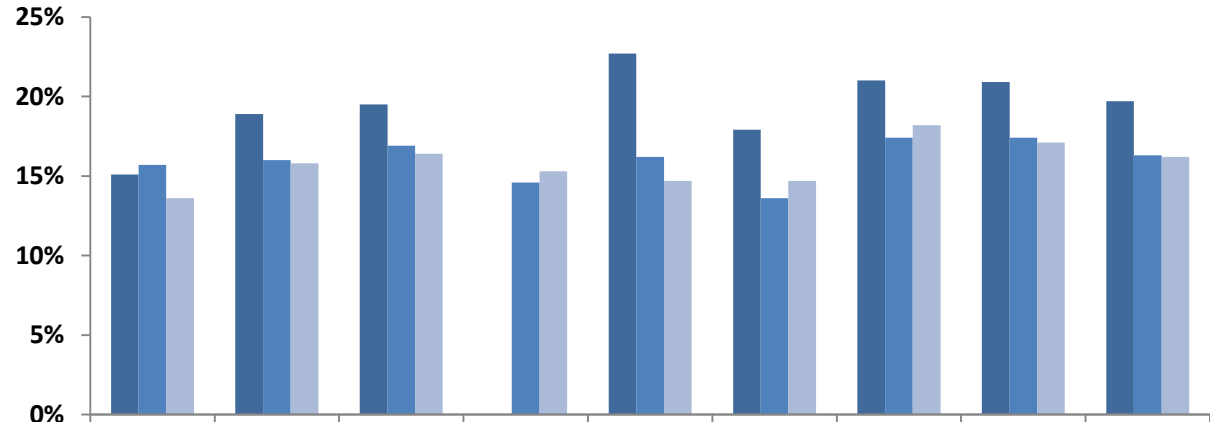
Indicator Description: YOUTH AS PASSENGERS IN VEHICLES DRIVEN BY INDIVIDUALS USING ILLEGAL DRUGS. This measure shows the proportion of high school students who reported that within 30 days prior to taking the survey they were a passenger in a car being operated by an individual who had consumed illegal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

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

Data Source(s): MIYHS, 2013–2017

Summary: The percentage of Central high school students who reported that, within the past 30 days, they had been passengers in a vehicle operated by someone who had taken illegal drugs remained the same from 2015 to 2017 (16%) as did the statewide average (16%).

Figure 33. Percent of high school students by Public Health District who rode in a vehicle driven by someone who had taken illegal drugs*: 2013–2017



	Aroostook	Central	Cumber.	Downeast	Midcoast	Penquis	Western	York	Maine
2013	15%	19%	20%		23%	18%	21%	21%	20%
2015	16%	16%	17%	15%	16%	14%	17%	17%	16%
2017	14%	16%	16%	15%	15%	15%	18%	17%	16%

Source: MIYHS

**The wording of the question changed slightly in 2015. In 2013, students were asked: During the past 30 days, how many times did you ride in a car or other vehicle driven by someone who had been taking illegal drugs such as marijuana? In 2015, students were asked: During the past 30 days, how many times did you ride in a car or other vehicle driven by someone who had been taking illegal drugs such as marijuana, cocaine, heroin, or LSD?*

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

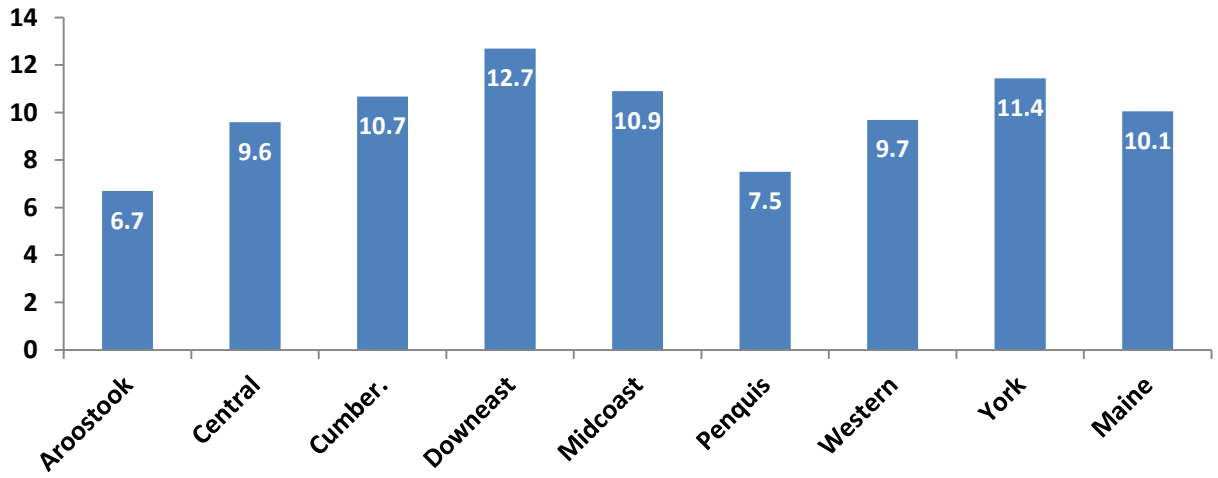
Operationalized as: $\left(\frac{\#\ of\ alcohol/drug-involved\ crashes}{population}\right) \times 10{,}000$

Why Indicator is Important: Motor vehicle crashes are the third-leading cause of traumatic brain injury (TBI) in the United States, with 14 percent of traumatic brain injuries occurring from motor vehicle crashes. Motor vehicle crashes were responsible for almost 20 percent of TBI-related deaths.[1] In 2009, the most recent data available, alcohol was attributed to 96 percent of the alcohol/drug-related crashes statewide.

Data Source(s): MDOT/MBHS, 2013–14 to 2016–17

Summary: Central's rate of alcohol and/or drug-related crashes increased from 2013–14 (7.9 crashes per 10,000 residents) to 2016–17 (9.6 crashes per 10,000 residents). Central has seen a steady increase in its rates of driver-impaired crashes in the past few years. Although not shown, the number of alcohol/drug-related car crashes increased by 29 percent from 2013 (124 crashes) to 2017 (160 crashes).

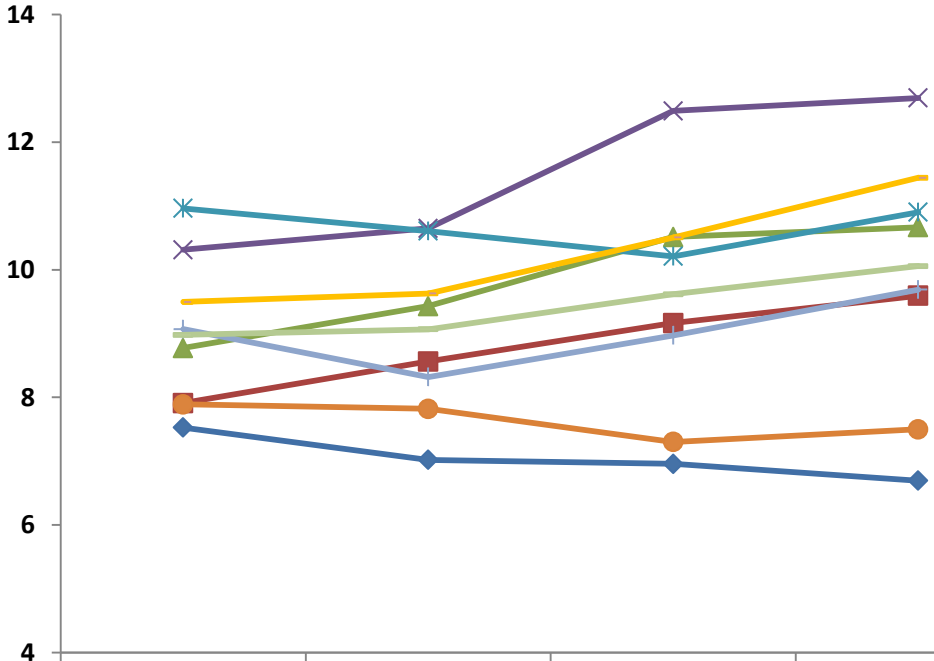
Figure 34. Alcohol/Drug-related motor vehicle crash rate per 10,000 residents, by Public Health District: 2016–17



Source: MDOT/MBHS

[1] US Centers for Disease Control and Prevention. Retrieved 9/11/2017 from https://www.cdc.gov/traumaticbraininjury/get_the_facts.html

Figure 35. Alcohol/Drug-related motor vehicle crash rate per 10,000 residents, by Public Health District: 2013–14 to 2016–17



	2013-14	2014-15	2015-16	2016-17
Aroostook	7.5	7.0	7.0	6.7
Central	7.9	8.6	9.2	9.6
Cumber.	8.8	9.4	10.5	10.7
Downeast	10.3	10.7	12.5	12.7
Midcoast	11.0	10.6	10.2	10.9
Penquis	7.9	7.8	7.3	7.5
Western	9.1	8.3	9.0	9.7
York	9.5	9.6	10.5	11.4
Maine	9.0	9.1	9.6	10.1

Source: MDOT/MBHS

Poison Center Calls

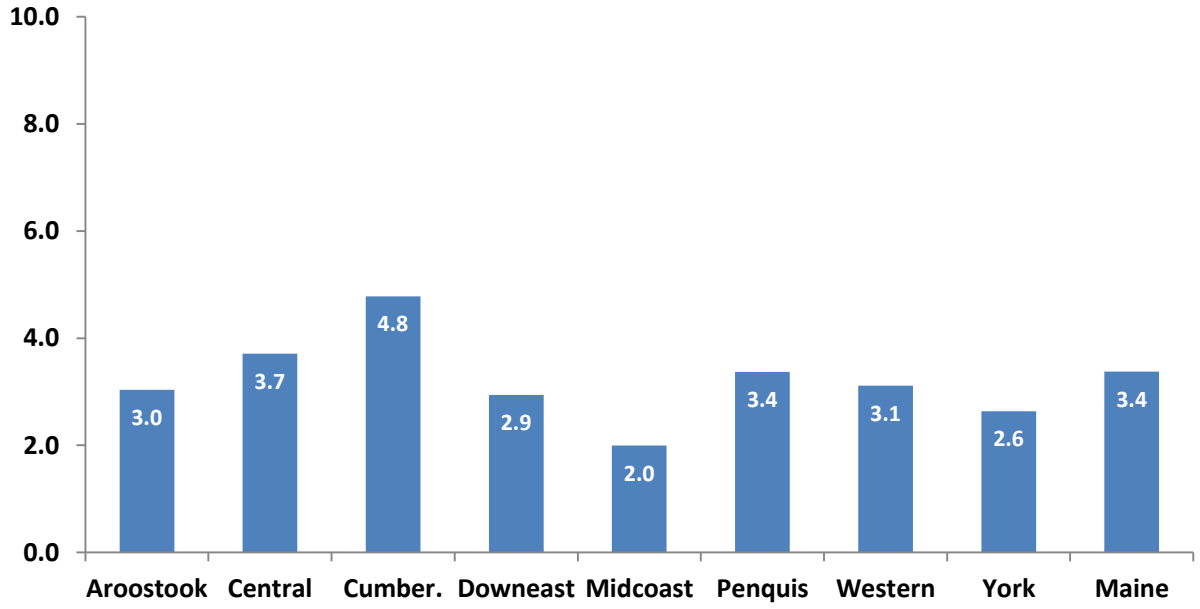
Indicator Description: POISONING CASES DOCUMENTED BY THE POISON CENTER. This measure reflects the rate of calls to the Northern New England Poison Center in which the Center determined that a poisoning occurred. These calls are for the state of Maine only. The Center reports poisonings in three categories: unintentional, meaning those that are accidental; suspected substance abuse cases, meaning cases where the Center believes the intent is for an individual to get high; and suspected suicides, meaning staff at the Center determine that the individual attempted suicide. The categories reflect the caller's self-report and are not considered clinical or medical diagnoses.

Why Indicator is Important: The exposure to and ingestion of damaging substances can have many physiologic side effects. Poisonings can be influenced by programs to prevent substance abuse, accidental poisoning, suicide and fatal interaction among medications.

Data Source(s): NNEPC, 2015–17, 2010–12 to 2015–17

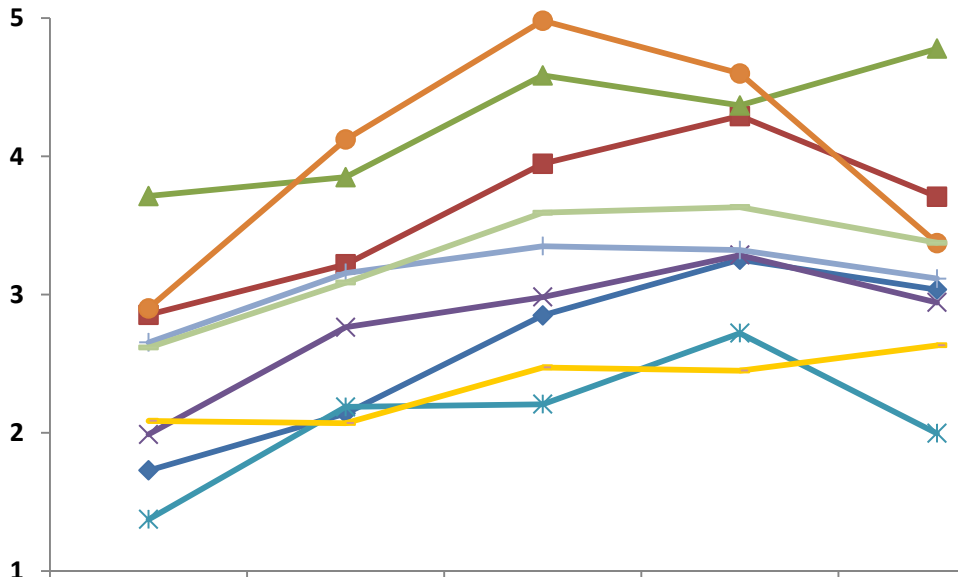
Summary: During the period of 2015–17, the Poison Center received 3.7 calls per 10,000 residents in Central that were suspected to be related to substance abuse; this rate was slightly higher than the statewide rate (3.4 calls per 10,000 residents). After steadily increasing for several years, the rate of poison center calls in Central suspected to involve substance abuse observed a slight decrease from 2014–16 (4.3 calls per 10,000 residents) to 2015–17 (3.7 calls per 10,000 residents).

Figure 36. Number of calls suspected to be substance abuse reported to New England Poison Center 10,000 residents, by Public Health District: 2015–17



Source: NNEPC

Figure 37. Number of calls suspected to be substance abuse reported to New England Poison Center per 10,000 residents, by Public Health District: 2010–12 to 2015–17



	2010-12	2012-14	2013-15	2014-16	2015-17
Aroostook	1.7	2.1	2.8	3.3	3.0
Central	2.9	3.2	3.9	4.3	3.7
Cumber.	3.7	3.8	4.6	4.4	4.8
Downeast	2.0	2.8	3.0	3.3	2.9
Midcoast	1.4	2.2	2.2	2.7	2.0
Penquis	2.9	4.1	5.0	4.6	3.4
Western	2.7	3.2	3.4	3.3	3.1
York	2.1	2.1	2.5	2.4	2.6
Maine	2.6	3.1	3.6	3.6	3.4

Source: NNEPC

Overdoses and Related Deaths

Indicator Description: OVERDOSES. This indicator shows the rate of persons receiving help from Emergency Medical Services (EMS) related to an overdose. Overdose is based on the primary impression given by the emergency responder.

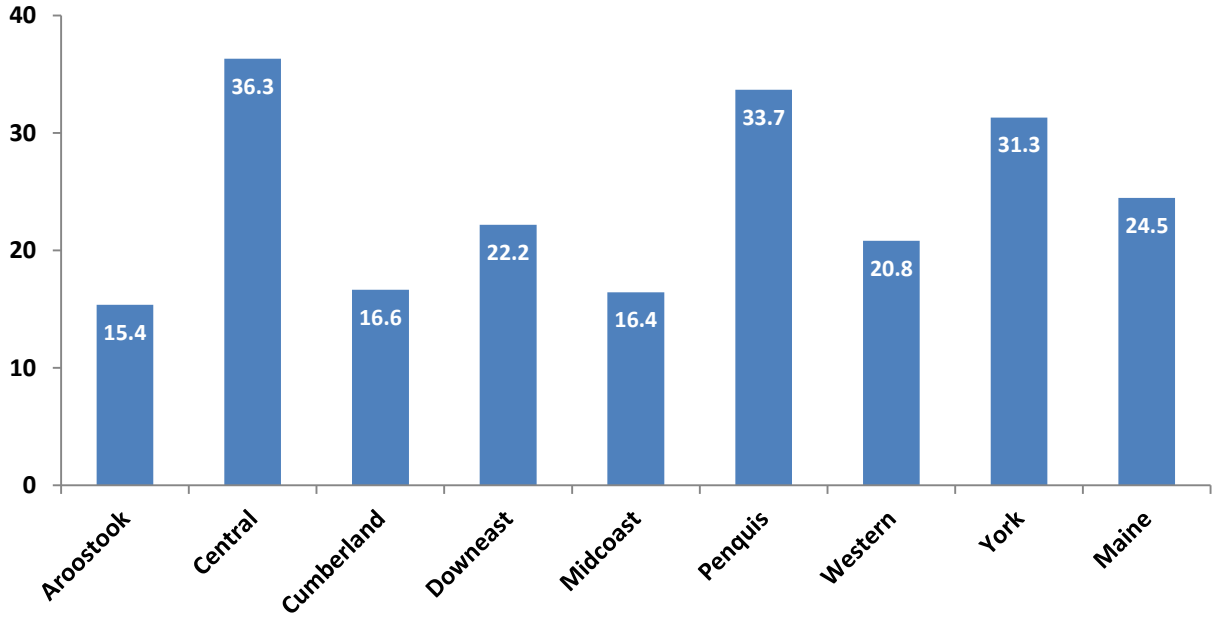
Why Indicator is Important: Overdosing on a substance can cause serious physical harm resulting in hospitalization and even death. Responding to overdoses also uses valuable EMS resources. The rate per 10,000 allows us to see the frequency with which an occurrence happens within a population over time, as well as make relative comparisons between small and large population areas. In this case, the base of 10,000 people was used due to small numbers.

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

Data Source(s): EMS, 2017, 2013–2017

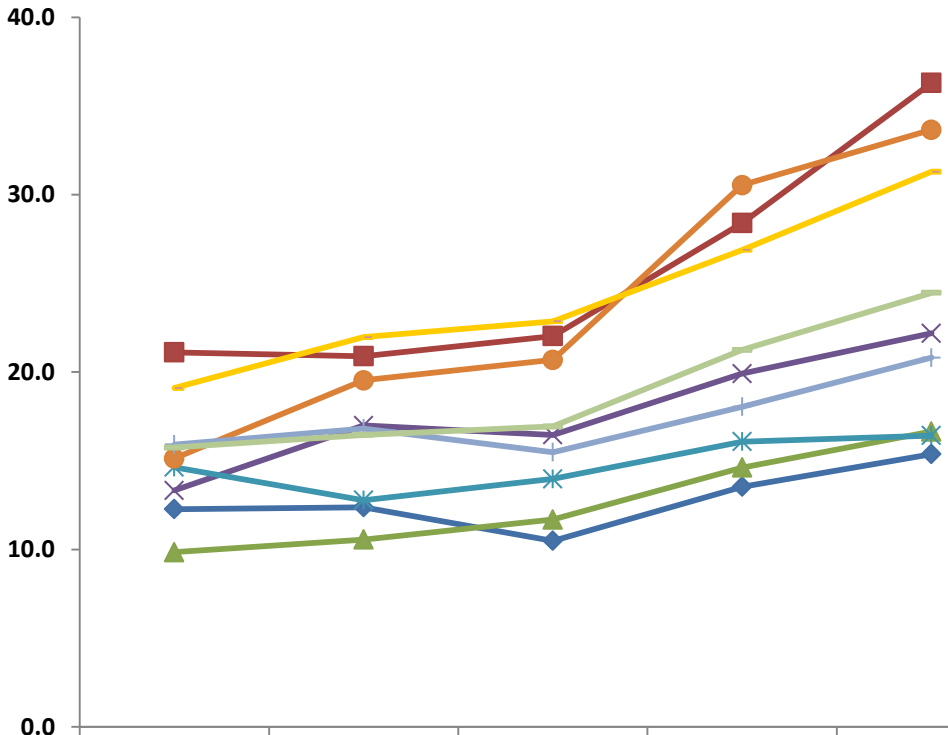
Summary: In 2017, Central had the highest rate of drug/medication overdose responses by EMS personnel among public health districts (36.3 per 10,000 residents). The statewide rate of 24.5 drug/medication responses per 10,000 residents is comparatively lower. The rate of overdose responses related to drug/medication in Central has continued to climb steadily over the past several years.

Figure 38. Number of drug and/or medication-related overdose EMS responses per 10,000 residents, by Public Health District: 2017



Source: Emergency Medical Services

Figure 39. Number of overdose EMS responses due to drug and/or medication per 10,000 residents, by Public Health District: 2013–2017



	2013	2014	2015	2016	2017
Aroostook	12.3	12.4	10.5	13.5	15.4
Central	21.1	20.9	22.0	28.4	36.3
Cumberland	9.8	10.6	11.7	14.6	16.6
Downeast	13.3	17.0	16.5	19.9	22.2
Midcoast	14.6	12.8	14.0	16.1	16.4
Penquis	15.1	19.5	20.7	30.5	33.7
Western	15.9	16.8	15.5	18.0	20.8
York	19.1	22.0	22.9	26.9	31.3
Maine	15.7	16.5	16.9	21.2	24.5

Source: Emergency Medical Services

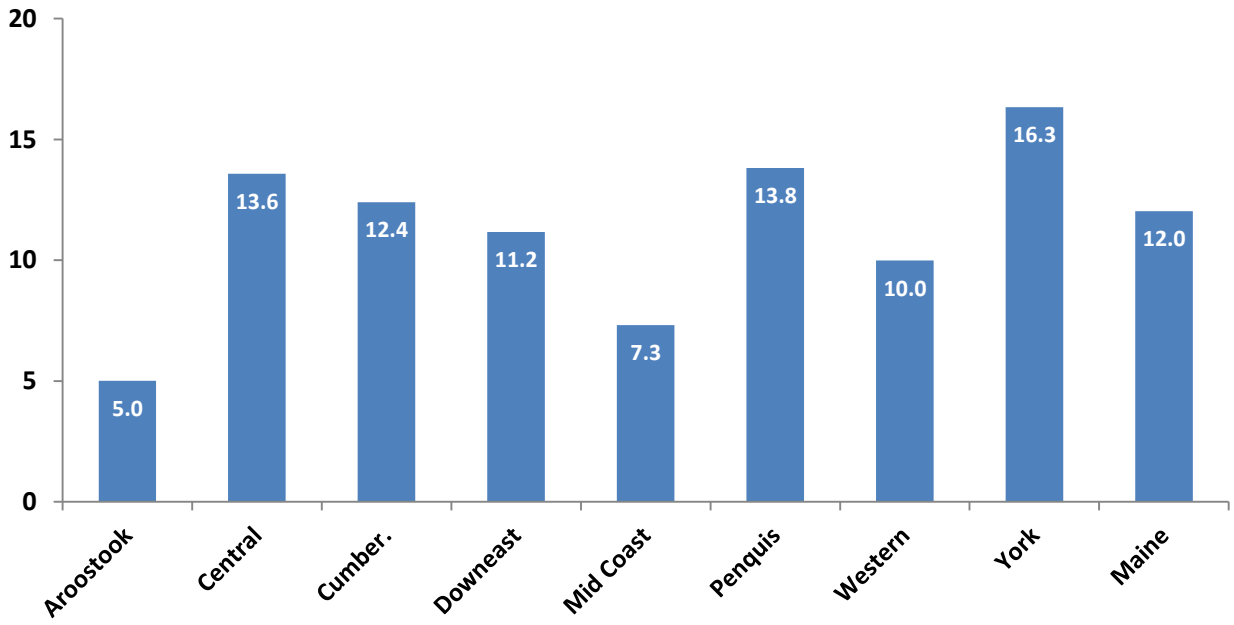
Indicator Description: NALOXONE ADMINISTRATIONS. This indicator shows the number of unique persons receiving naloxone administrations from Emergency Medical Services (EMS) related to an opioid overdose. Naloxone, also known as Narcan, is a medication administered to patients who have experienced an overdose related to an opioid (*e.g.*, prescription painkillers, heroin, or morphine). This indicator includes instances where the opioid overdose is accidental (that is, not a result of intentional or recreational misuse).

Why Indicator is Important: Overdosing on a substance can cause serious physical harm resulting in hospitalization and even death. Responding to overdoses also uses valuable EMS resources. It is worth stating that this indicator gives us a better sense of the overall prevalence of opioid overdoses, since it includes those that did not result in death.

Data Source(s): Emergency Medical Services, 2016-17, 2013–14 to 2016–17

Summary: In 2016–17, Central observed a rate of 13.6 individuals per 10,000 residents who were administered naloxone via overdose ambulance responses; this rate was higher than the statewide rate (12 individuals per 10,000 residents). Although not shown, naloxone administrations by EMS responders in Central have tripled from 2013 (78) to 2017 (240).

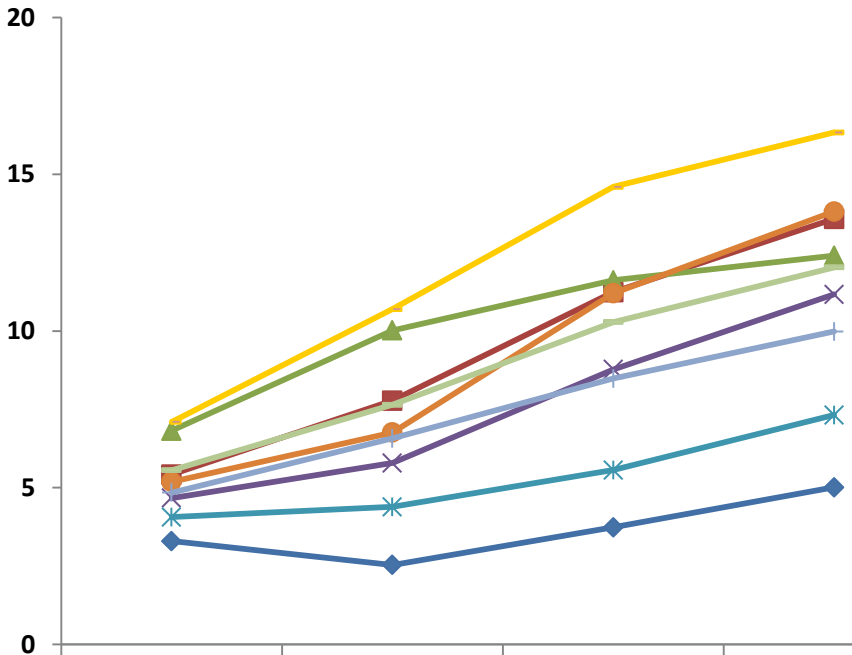
Figure 40. Individuals receiving EMS administered naloxone* administrations per 10,000 residents, by Public Health District: 2016–17



Source: Emergency Medical Services

**Naloxone, also known as Narcan, is a medication administered to counter the effects of an overdose due to opioids.*

Figure 41. Individuals receiving EMS administered naloxone* administrations per 10,000 residents, by Public Health District: 2013–14 to 2016–17



	2013-14	2014-15	2015-16	2016-17
Aroostook	3.3	2.5	3.7	5.0
Central	5.4	7.8	11.2	13.6
Cumber.	6.8	10.0	11.6	12.4
Downeast	4.7	5.8	8.8	11.2
Mid Coast	4.1	4.4	5.6	7.3
Penquis	5.2	6.8	11.2	13.8
Western	4.8	6.6	8.5	10.0
York	7.1	10.7	14.6	16.3
Maine	5.6	7.6	10.3	12.0

Source: Emergency Medical Services

**Naloxone, also known as Narcan, is a medication administered to counter the effects of an overdose due to opioids.*

Indicator Description: DEATHS DUE TO OVERDOSE. This measure reflects the number of deaths where the cause of death was directly related to the consumption of one or more substances. The measure excludes deaths where a substance may have been ingested prior to engaging in a behavior that resulted in death (*e.g.,* drunk driving) or where lifetime substance use and abuse may have impacted health (*e.g.,* alcohol-related cirrhosis). In order to preserve anonymity and strengthen validity, rates were calculated based on the sum of deaths per three-year interval. The rate per 10,000 allows us to see the frequency with which an occurrence happens within a population over time, as well as make relative comparisons between small- and large-population areas. In this case, the base of 10,000 people was used due to small numbers.

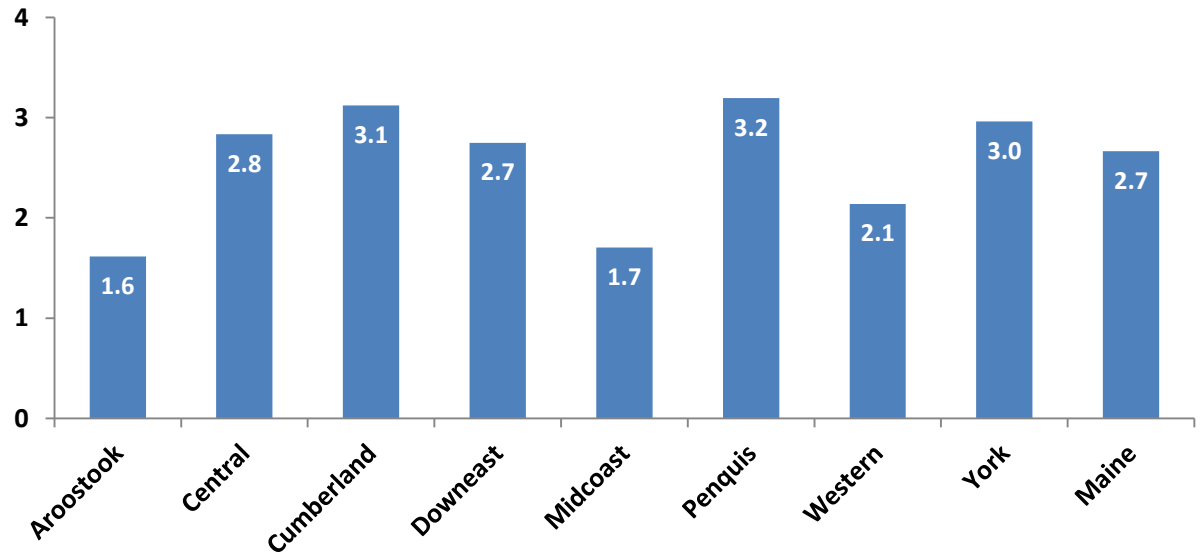
Operationalized as: $\left(\frac{\#\ of\ overdose\ deaths}{population}\right) \times 10{,}000$

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

Data Source(s): Dr. Marcella Sorg, Margaret Chase Smith Policy Center at University of Maine, Office of the Chief Medical Examiner, 2015–17, 2011–13 to 2015–17

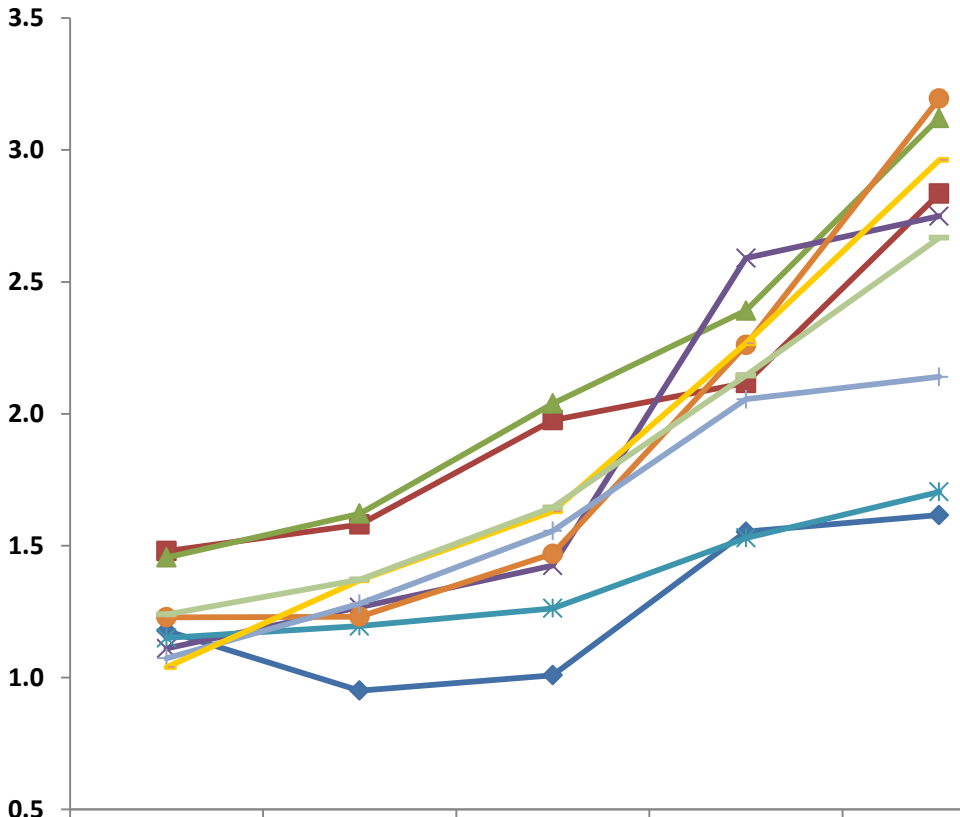
Summary: During 2015–17 (combined years), Central observed an average of 2.8 drug-related overdose deaths per 10,000 residents. Similar to those observed statewide, Central's rates have been steadily increasing over the past several years.

Figure 42. Drug-related death rate per 10,000 residents, by Public Health District: 2015–17



Source: Dr. Marcella Sorg, Margaret Chase Smith Policy Center at University of Maine, Office of the Chief Medical Examiner

Figure 43. Drug-related death rate per 10,000 residents, by Public Health District: 2011–13 to 2015–17



	2011-13	2012-14	2013-15	2014-16	2015-17
Aroostook	1.2	1.0	1.0	1.6	1.6
Central	1.5	1.6	2.0	2.1	2.8
Cumberland	1.5	1.6	2.0	2.4	3.1
Downeast	1.1	1.3	1.4	2.6	2.7
Midcoast	1.2	1.2	1.3	1.5	1.7
Penquis	1.2	1.2	1.5	2.3	3.2
Western	1.1	1.3	1.6	2.1	2.1
York	1.0	1.4	1.6	2.3	3.0
Maine	1.2	1.4	1.6	2.1	2.7

Source: Dr. Marcella Sorg, Margaret Chase Smith Policy Center at University of Maine, Office of the Chief Medical Examiner

Factors Contributing to Substance Use and Abuse

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

- Social Access (*e.g.,* getting drugs and alcohol from friends or family)
- Retail Availability (*e.g.,* retailer not carding properly)
- Pricing & Promotion (*e.g.,* two-for-one specials, industry sponsorships or signage)
- Social/Community Norms (*e.g.,* parental/community attitudes and beliefs)
- Enforcement (*e.g.,* lack of compliance checks)
- Perceptions of Harm (*e.g.,* individuals' belief that using a substance is harmful)[2]
- Perceived Risk of Being Caught (*e.g.,* individuals' belief that s/he will be caught by parents or police)[3]

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

Although most high school students in Central seem to perceive that regular use of alcohol poses a risk of harm, rates of perception of harm from smoking marijuana among youth and adults continues to decline. In addition, parental attitudes regarding their teen using marijuana have shifted to be more permissive. Accessibility of substances to youth remains a challenge. In fact, nearly two thirds of students in Central think it is easy to obtain alcohol and more than half felt marijuana would be easily accessible. In 2017, nearly one third of parents in Central PHD felt their teen could access alcohol in their house without their knowledge; more than one fifth felt prescription drugs could be accessed by their teen without them knowing. Central PHD has the highest rates of dispensed quantity of opiate agonists *per capita* across all public health districts. On a more positive note, Central PHD has the least number of active liquor licensees among all districts statewide, and observed increases in its high school students' perception of harm from binge drinking, misusing prescription drugs, and likelihood of getting caught by parents for drinking.

[2] Bonnie, R. J & O'Connell, M.E., Eds. (2004). *Reducing Underage Drinking: A Collective Responsibility.* The National Academies Press: Washington, DC.

[3] Birckmayer, J. D., Holder, H. D., Yacoubian, Jr., G. S., & Friend, K. B. (2004). A general causal model to guide alcohol, tobacco, and illicit drug prevention: assessing the research evidence. *Journal of Drug Education*, *34*(2), 121–153.

Availability and Accessibility

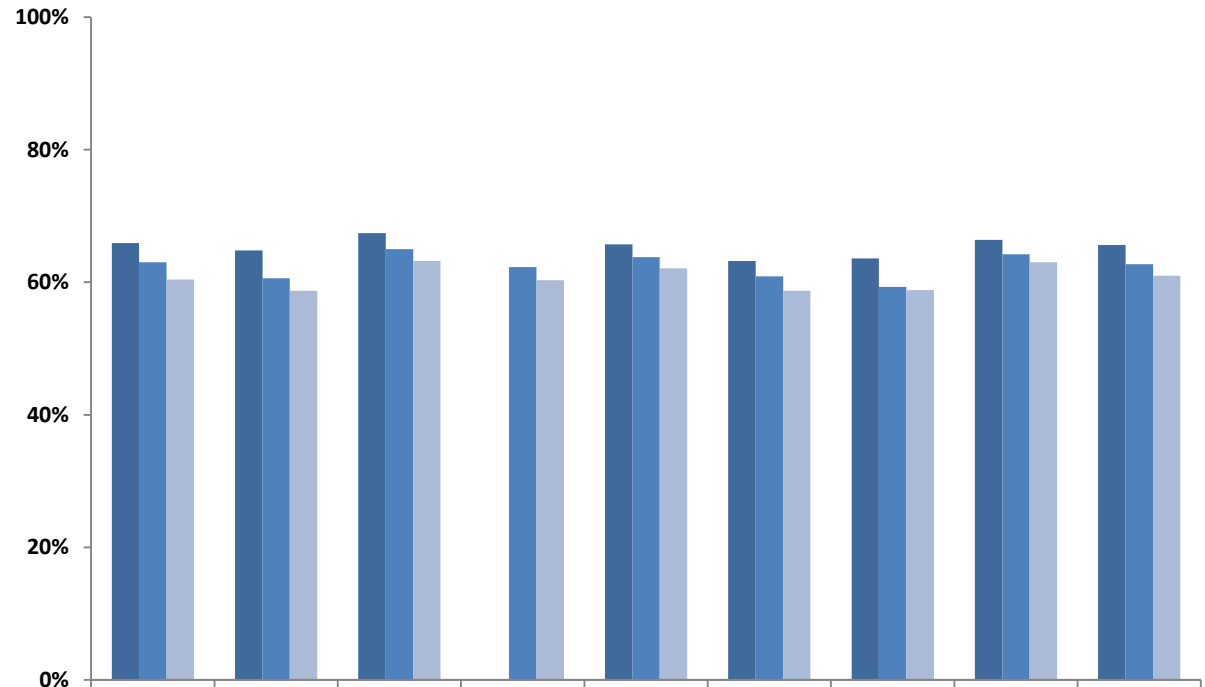
Indicator Description: PERCEIVED EASE OF OBTAINING ALCOHOL BY UNDERAGE YOUTH. This indicator reflects the percentage of high school students (grades 9 to 12) who reported that it would be easy or very easy for them to get alcohol if they wanted some.

Why Indicator is Important: In 2017, Maine high school students who reported that they thought alcohol was easy to obtain were nearly four times as likely to report consuming alcohol within the past month compared to students who did not think it was easy to obtain.

Data Source(s): MIYHS, 2013–2017

Summary: In 2017, 59 percent of Central high school students and 61 percent of Maine high school students reported that they find it easy to get alcohol. These rates represent a slight decline from previous years.

Figure 44. Percent of high school students by Public Health District who reported it was easy to get alcohol: 2013 to 2017



	Aroostook	Central	Cumber.	Downeast	Midcoast	Penquis	Western	York	Maine
2013	66%	65%	67%		66%	63%	64%	66%	66%
2015	63%	61%	65%	62%	64%	61%	59%	64%	63%
2017	60%	59%	63%	60%	62%	59%	59%	63%	61%

Source: MIYHS

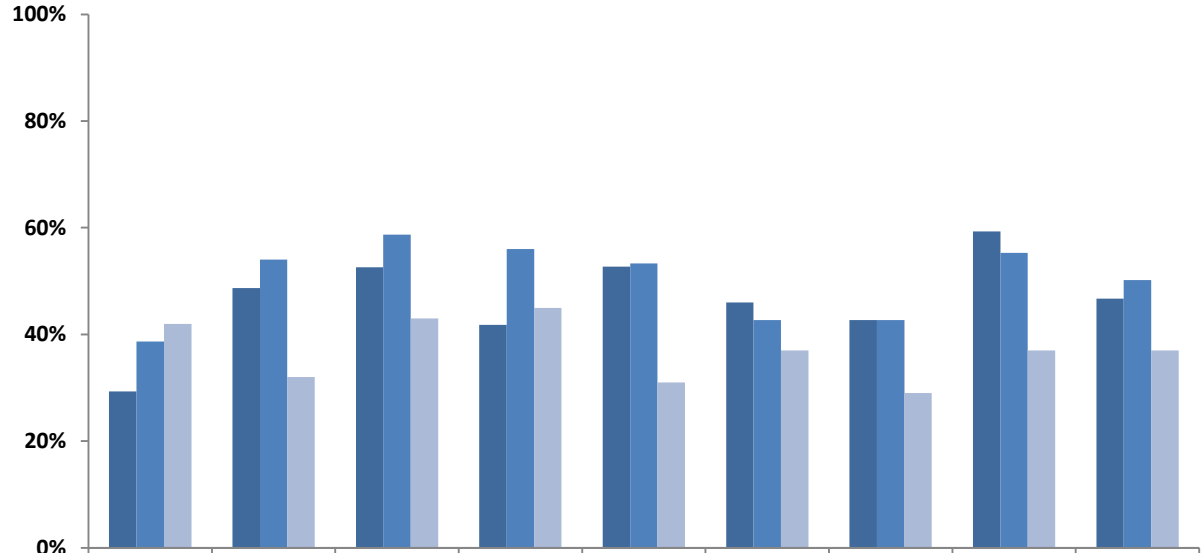
Indicator Description: PARENT PERCEPTION OF ACCESSIBILITY OF ALCOHOL AT HOME. This indicator measures the percentage of parents reporting that their teen would be able to access alcohol they had purchased without their knowledge. These data come from the Maine Parent Survey administered by Pan Atlantic for the Maine Office of Substance of Abuse and Mental Health Services.

Why Indicator is Important: Easy access to alcohol at home is a major contributing factor to underage drinking.

Data Source(s): Parent Survey 2013–17

Summary: In 2017, among parents of middle and high school youth, 32 percent felt it was possible for their children to access alcohol they had purchased without their knowledge; this result was five percentage points lower than the statewide average. Central's rate has decreased by 17 percentage points since 2013.

Figure 45. Parent perception of accessibility of parent purchased alcohol without parental knowledge: 2013 to 2017



	Aroostook	Central	Cumber.	Downeast	Midcoast	Penquis	Western	York	Maine
2013	29%	49%	53%	42%	53%	46%	43%	59%	47%
2015	39%	54%	59%	56%	53%	43%	43%	55%	50%
2017	42%	32%	43%	45%	31%	37%	29%	37%	37%

Source: Parent Survey 2013–17

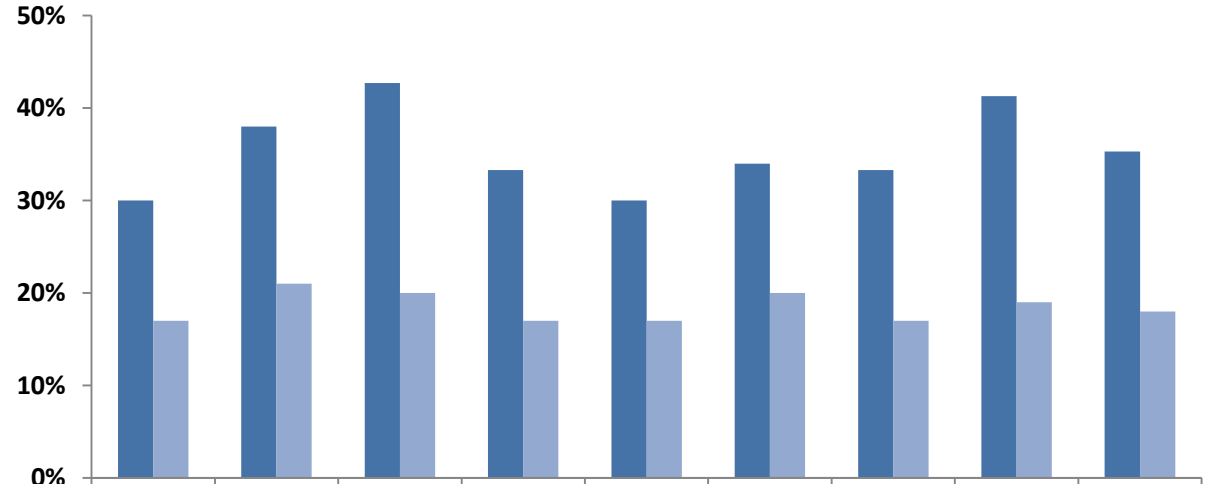
Indicator Description: PARENT PERCEPTION OF ACCESSIBILITY OF PRESCRIPTION DRUGS AT HOME. This indicator measures the percentage of parents reporting that their teen would be able to access prescription medication (not prescribed to their child) without their knowledge. This question was first asked in the 2015 Parent Survey. These data come from the Maine Parent Survey, administered by Pan Atlantic for the Maine Office of Substance of Abuse and Mental Health Services.

Why Indicator is Important: Easy access to prescription drugs at home is a major contributing factor to prescription drug misuse.

Data Source(s): Parent Survey 2015–17

Summary: In 2017, 21 percent of Central's parents felt that, at home, their child would be able to access prescription medications that were not prescribed to the child, without their parents' knowledge. This was a 17 percentage point decrease from 2015. Central's rate was slightly higher than the statewide average (18%), and the highest observed across public health districts.

Figure 46. Parent perception of teen accessibility of prescription drugs at home without parental knowledge: 2015 to 2017



	Aroostook	Central	Cumber.	Downeast	Midcoast	Penquis	Western	York	Maine
2015	30%	38%	43%	33%	30%	34%	33%	41%	35%
2017	17%	21%	20%	17%	17%	20%	17%	19%	18%

Source: Parent Survey 2015–17

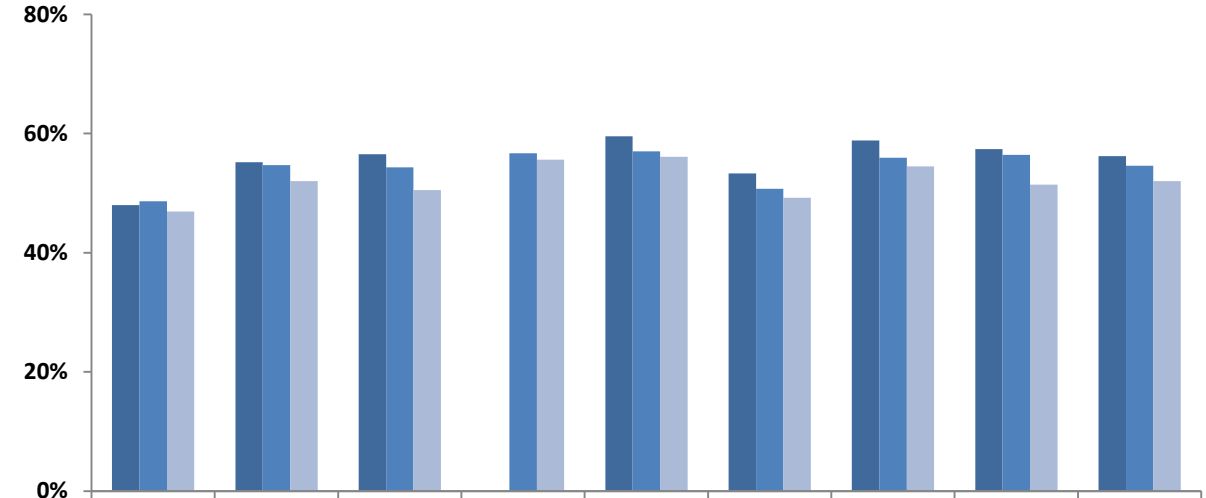
Indicator Description: PERCEIVED EASE OF OBTAINING MARIJUANA BY YOUTH. This indicator illustrates the percentage of high school students reporting it would be easy or very easy to obtain marijuana if they wanted it.

Why Indicator is Important: In 2017, Maine high school students who reported that they thought marijuana was easy to obtain were nearly nine times as likely to use marijuana in the past 30 days compared to their peers who thought it was difficult to obtain.

Data Source(s): MIYHS, 2013–2017

Summary: The percentage of high school students in Central who indicated that it would be easy to get marijuana decreased from 2015 (55%) to 2017 (52%). There was an identical trend with the statewide average for Maine.

Figure 47. Percent of high school students by Public Health District who reported it would be easy to get marijuana: 2013–2017



	Aroostook	Central	Cumber.	Downeast	Midcoast	Penquis	Western	York	Maine
2013	48%	55%	57%		60%	53%	59%	57%	56%
2015	49%	55%	54%	57%	57%	51%	56%	56%	55%
2017	47%	52%	51%	56%	56%	49%	55%	51%	52%

Source: MIYHS

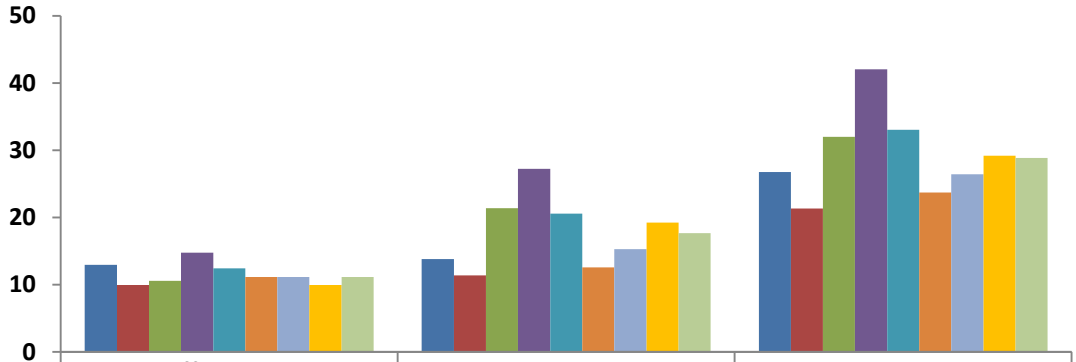
Indicator Description: NUMBER OF ALCOHOL OUTLETS PER CAPITA. This indicator reflects the number of active (as of July 2017) retail establishments selling alcohol per person. This includes both on-premise (*e.g.,* bars, restaurants) and off-premise (*e.g.,* convenience stores) establishments. It is calculated by dividing the number of retail establishments by the number of residents in the county (based on 2016 U.S. Census estimates).

Why Indicator is Important: National research shows that there is a correlation between the number of places that sell alcohol in an area (retail density) and the rate of alcohol-related crime.[4]

Data Source(s): DPS, Liquor Licensing and Compliance, 2017; U.S. Census, 2017

Summary: In 2017, Central observed a rate of 21.3 active liquor licensees per 10,000 people; this was below the statewide rate (28.8). Central's rate of on-premise liquor licenses was slightly higher than its rate for off-premise licensees (11.4 compared to 10); the difference is more pronounced among many of the other public health districts. Although not shown, as of August 2017, Central had 366 active liquor licensees (171 off-premise and 195 on-premise establishments).

Figure 48. Number of active liquor licensees per 10,000 residents, by premise type and Public Health District: 2017



	Off-premise	On-premise	Total
Arroostook	12.9	13.8	26.8
Central	10.0	11.4	21.3
Cumber.	10.6	21.4	32.0
Downeast	14.8	27.3	42.0
Midcoast	12.4	20.6	33.0
Penquis	11.1	12.6	23.7
Western	11.2	15.3	26.4
York	10.0	19.2	29.2
Maine	11.2	17.7	28.8

Source: DPS/U.S. Census

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

Indicator Description: DISPENSED QUANTITY OF SCHEDULE II-IV DRUGS PER CAPITA. These indicators reflect the dispensed quantity/doses of opiate agonists and stimulants through prescriptions in Maine. This includes only prescription drugs that are classified "Schedule II-IV" drugs, meaning those with a higher potential for abuse and addiction. It is important to note that the dispensed quantity does not indicate the size or dosage of the pills associated with the prescription. All pharmacies in Maine report to the Prescription Monitoring Program.

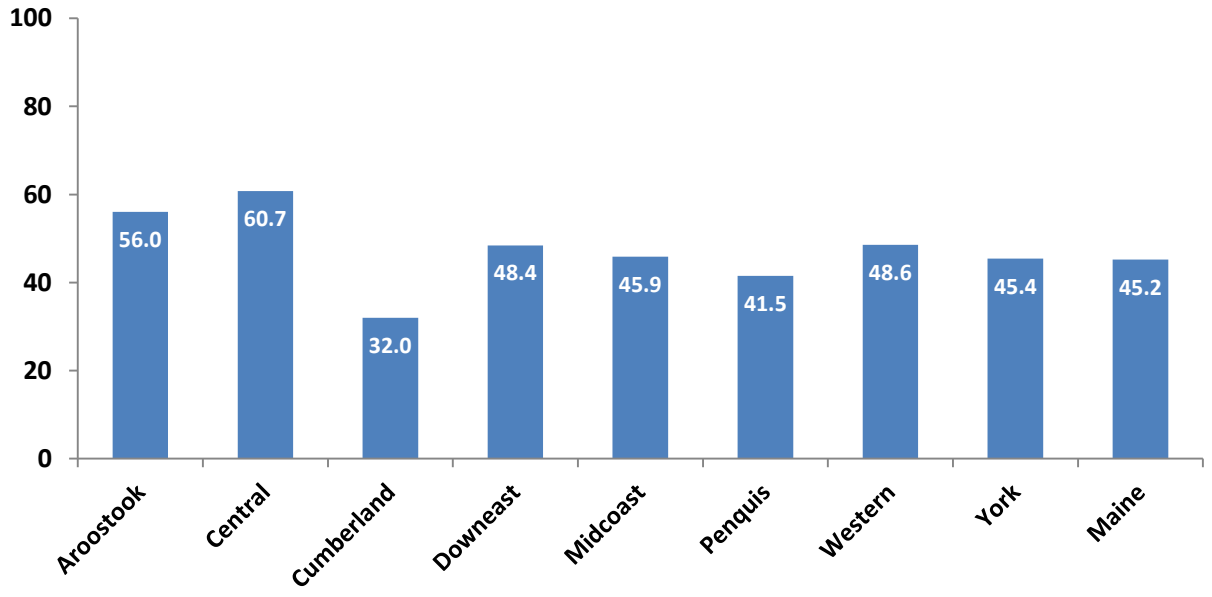
Note: 2017 figures are preliminary and subject to change.

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

Data Source(s): PMP, 2015–2017

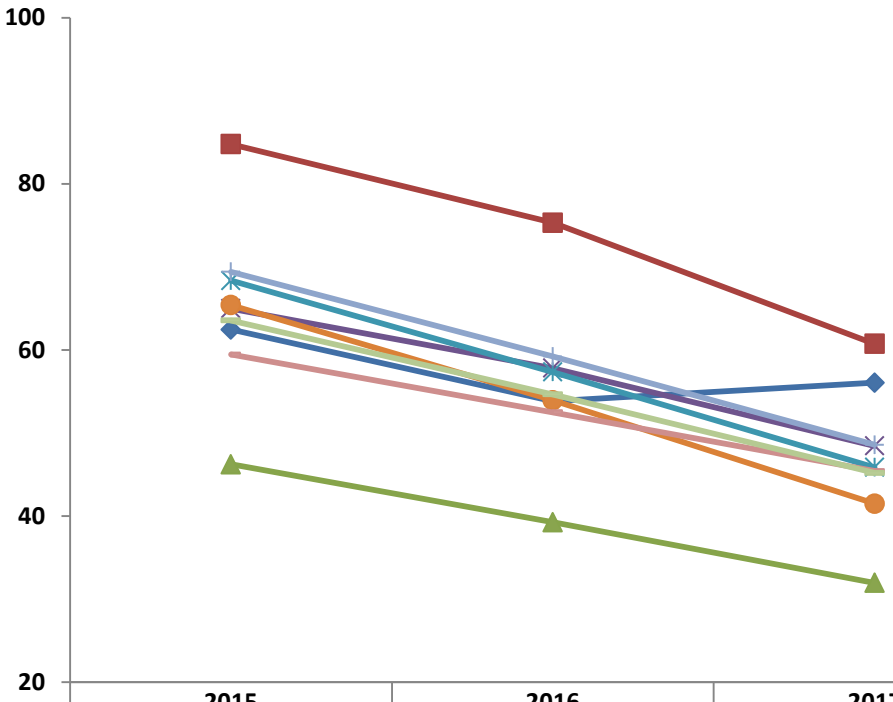
Summary: In 2017, the rate of dispensed quantity of opiate agonists *per capita* in Central was 60.7 units per person; this was substantially higher than the statewide rate (45.2) and highest among public health districts. Rates of dispensed units of opiate agonists in Central have steadily decreased since 2015 (84.8). Although not shown, the number of opiate agonist units dispensed in Central decreased by 12 percent from 2015 (4,286,404 units/doses) to 2017 (3,791,842 units/doses).

Figure 49. Dispensed doses of opiate agonists *per capita*, by Public Health District: 2017



Source: PMP

Figure 50. Dispensed doses of opiate agonists* *per capita*, by Public Health District: 2015–2017



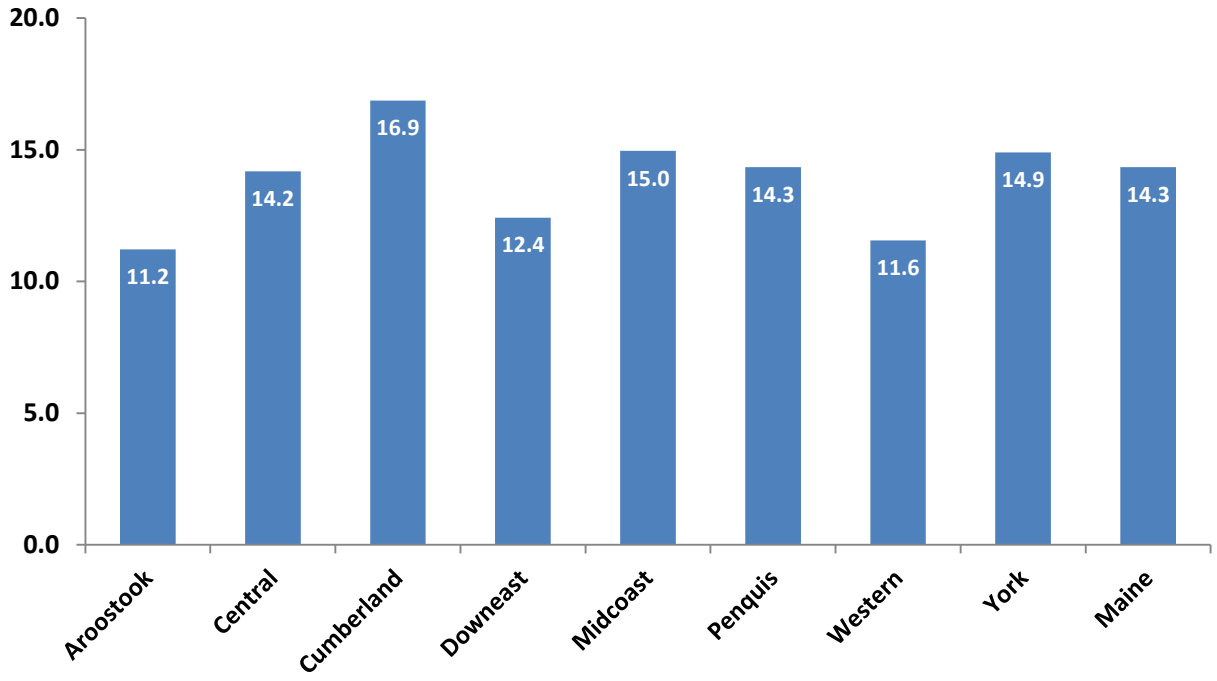
	2015	2016	2017
Aroostook	62.5	53.8	56.0
Central	84.8	75.3	60.7
Cumberland	46.2	39.3	32.0
Downeast	65.0	57.8	48.4
Midcoast	68.3	57.3	45.9
Penquis	65.4	53.9	41.5
Western	69.4	59.2	48.6
York	59.5	52.5	45.4
Maine	63.5	54.6	45.2

Source: PMP

**Opiate agonists include pain relievers and exclude medicated assisted prescriptions such as buprenorphine. In addition, opiate agonists in the form of powder were excluded from these analyses.*

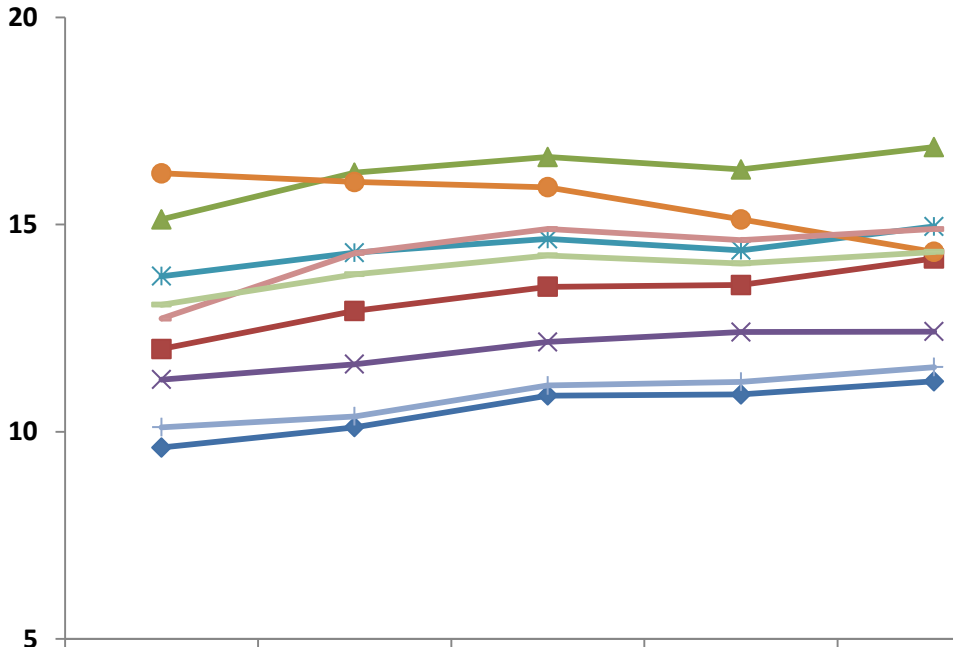
Summary: In 2017, the rate of the quantity/doses of stimulants dispensed in Central was 14.2 per person; this was on par with the state average (14.3). For the past several years, Central's rate for dispensed stimulant units *per capita* has increased overall. Although not shown, the number of units/doses of stimulants dispensed in Central has increased by 18 percent from 2013 (2,073,466 units/doses) to 2017 (2,445,711 units/doses).

Figure 51. Dispensed quantity of stimulants *per capita*, by Public Health District: 2017



Source: PMP

Figure 52. Dispensed quantity of stimulants *per capita*, by Public Health District: 2013 to 2017



	2013	2014	2015	2016	2017
Aroostook	9.6	10.1	10.9	10.9	11.2
Central	12.0	12.9	13.5	13.5	14.2
Cumberland	15.1	16.2	16.6	16.3	16.9
Downeast	11.3	11.6	12.2	12.4	12.4
Midcoast	13.8	14.3	14.7	14.4	15.0
Penquis	16.2	16.0	15.9	15.1	14.3
Western	10.1	10.4	11.1	11.2	11.6
York	12.7	14.3	14.9	14.6	14.9
Maine	13.1	13.8	14.3	14.1	14.3

Source: PMP

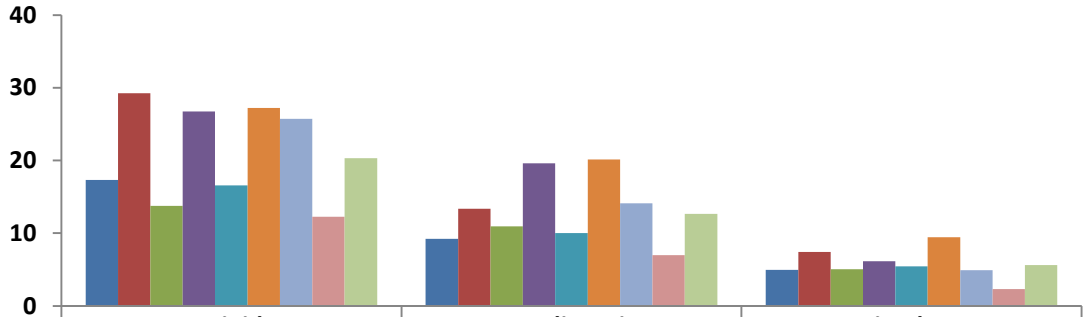
Indicator Description: SUBSTANCES REQUESTED FOR VERIFICATION. This indicator shows the rate of requests by non-law enforcement for medication verification through the Northern New England Poison Center (NNEPC). A person may call the NNEPC for many reasons, one being to help identify a medication or substance which another person has consumed or that has been found. The calls reflected in this indicator have been characterized by NNEPC as likely related to substance abuse, although NNEPC staff do not make a formal or clinical assessment.

Why Indicator is Important: The increased volume of medication verification calls suggests a greater availability of those drugs in the community. This measure also suggests that there is a higher awareness among the community and parents for potential misuse of prescription pills which is prompting calls.

Data Source(s): NNEPC, 2015–17

Summary: During the period of 2015–17**,** most calls to NNEPC within Central requesting substance verification involved opioids (29.3 calls per 10,000 residents), followed by benzodiazepines (13.4 calls per 10,000 residents), and stimulants (7.4 calls per 10,000 residents). These rates were all above the statewide averages. In 2015-17, Central observed the highest rate of calls among public health districts related to the verification of opioids.

Figure 53. Number of calls for medication verification reported to New England Poison Center per 10,000 residents, by drug type and Public Health District: 2015–17



	Opioids	Benzodiazepines	Stimulants
Aroostook	17.3	9.2	4.9
Central	29.3	13.4	7.4
Cumber.	13.8	10.9	5.1
Downeast	26.8	19.6	6.2
Midcoast	16.6	10.0	5.4
Penquis	27.2	20.2	9.4
Western	25.7	14.1	4.9
York	12.2	7.0	2.3
Maine	20.3	12.7	5.6

Source: NNEPC

Perceived Risk and Harm

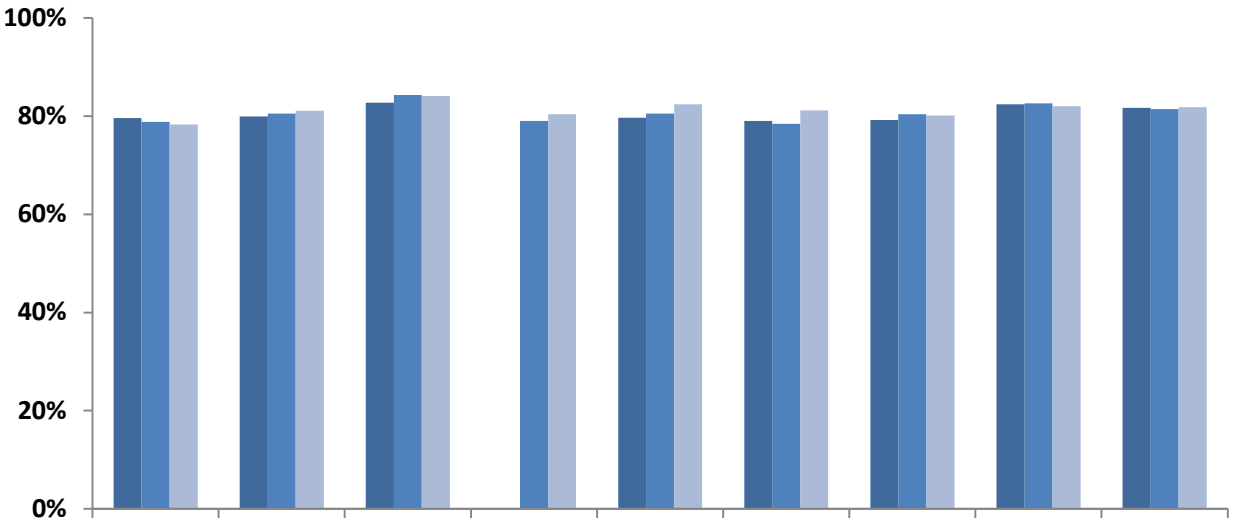
Indicator Description: **PERCEIVED RISK FROM BINGE DRINKING AMONG YOUTH.** This indicator reflects the percentage of individuals who perceive that there is moderate-to-great risk from drinking five or more drinks once or twice per week.

Why Indicator is Important: In 2017, Maine high school students who did not perceive a moderate to great risk of harm from binge drinking once or twice a week were twice as likely to drink in the past month as high school students who do perceive risk of harm.

Data Source(s): MIYHS, 2013–2017

Summary: The percentage of Central high school students who indicated that there is a moderate-to-great risk of harm if they consume five or more drinks regularly remained similar from 2013 (80%) to 2017 (81%). The statewide average also remained consistent at 82 percent.

Figure 54. Percent of high school students by Public Health District who reported consuming five or more drinks once or twice per week as harmful: 2013–2017



	Aroostook	Central	Cumber.	Downeast	Midcoast	Penquis	Western	York	Maine
2013	80%	80%	83%		80%	79%	79%	82%	82%
2015	79%	81%	84%	79%	81%	78%	80%	83%	81%
2017	78%	81%	84%	80%	82%	81%	80%	82%	82%

Source: MIYHS

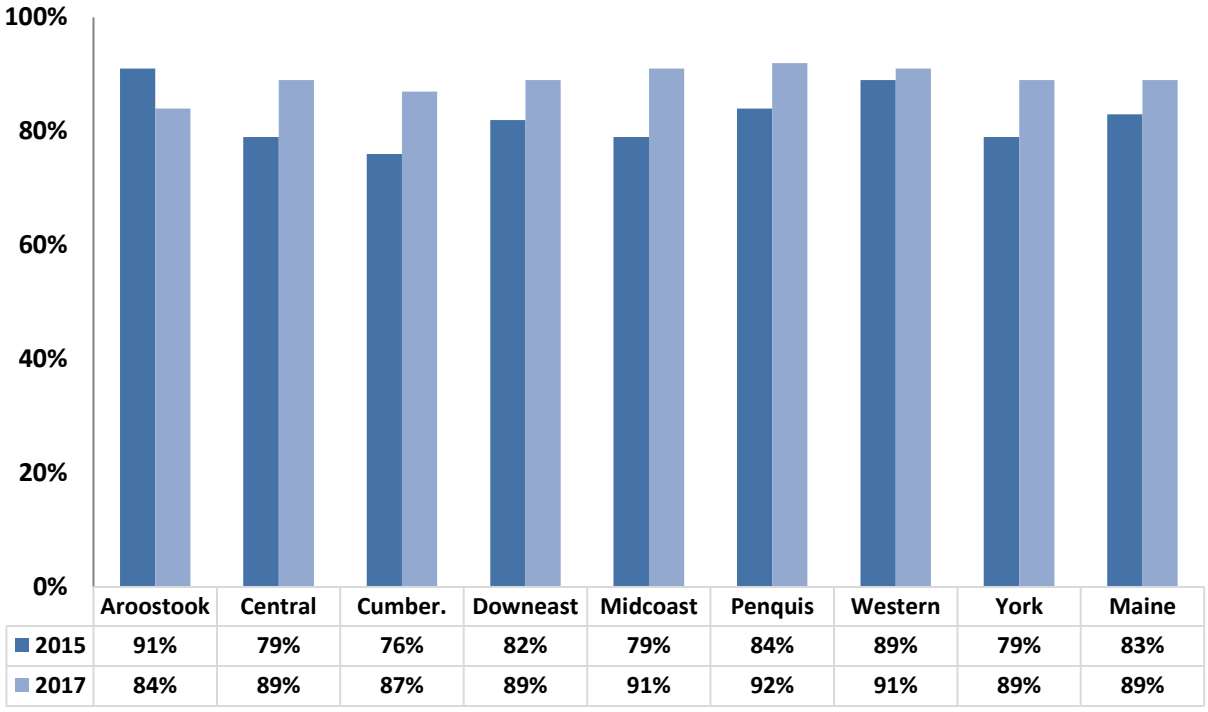
Indicator Description: PARENTAL ATTITUDE TOWARDS UNDERAGE DRINKING. This indicator reflects the percentage of Maine parents who believe that underage drinking is never okay for a variety of reasons, including the fact that it is illegal, not healthy, youth aren't mature enough, or that it might impact brain development.

Why Indicator is Important: The perception that consuming alcohol as risky indicates an individual is knowledgeable about health risks and other negative consequences.

Data Source(s): Parent Survey 2015–2017

Summary: The percentage of Central's parents who feel that underage drinking is never okay increased from 2015 (79%) to 2017 (89%). The statewide average increased from 83 percent to 89 percent during the same time frame.

Figure 55. Percent of parents who believe that underage drinking is never okay, by Public Health District: 2015 to 2017



	Aroostook	Central	Cumber.	Downeast	Midcoast	Penquis	Western	York	Maine
2015	91%	79%	76%	82%	79%	84%	89%	79%	83%
2017	84%	89%	87%	89%	91%	92%	91%	89%	89%

Source: Parent Survey 2015–2017

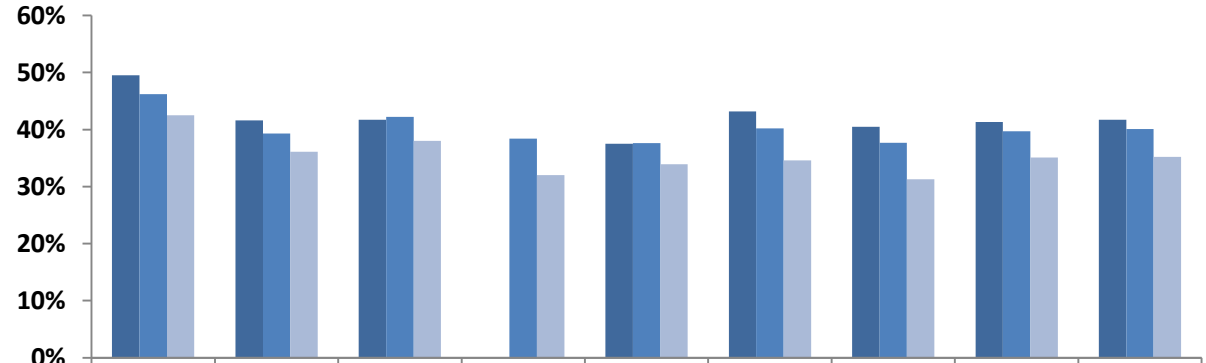
Indicator Description: PERCEIVED RISK OF REGULAR MARIJUANA USE AMONG YOUTH. This measure demonstrates the percentage of individuals who perceive a moderate-to-great risk of harm from smoking marijuana regularly.

Why Indicator is Important: High school students who do not believe there is moderate to great risk in smoking marijuana regularly are almost seven times as likely to smoke marijuana as their peers who do perceive risk of harm. A similar relationship exists between adult perceptions and consumption.

Data Source(s): MIYHS, 2013–2017

Summary: The percentage of high school students in Central who indicated that there is a moderate-to-great risk of harm if they smoke marijuana once or twice a week decreased from 2013 (42%) to 2017 (36%). This is on par with that observed statewide.

Figure 56. Percent of high school students by Public Health District who reported a risk of harm from smoking marijuana once or twice per week: 2013–2017



	Aroostook	Central	Cumber.	Downeast	Midcoast	Penquis	Western	York	Maine
2013	50%	42%	42%		38%	43%	41%	41%	42%
2015	46%	39%	42%	38%	38%	40%	38%	40%	40%
2017	43%	36%	38%	32%	34%	35%	31%	35%	35%

Source: MIYHS

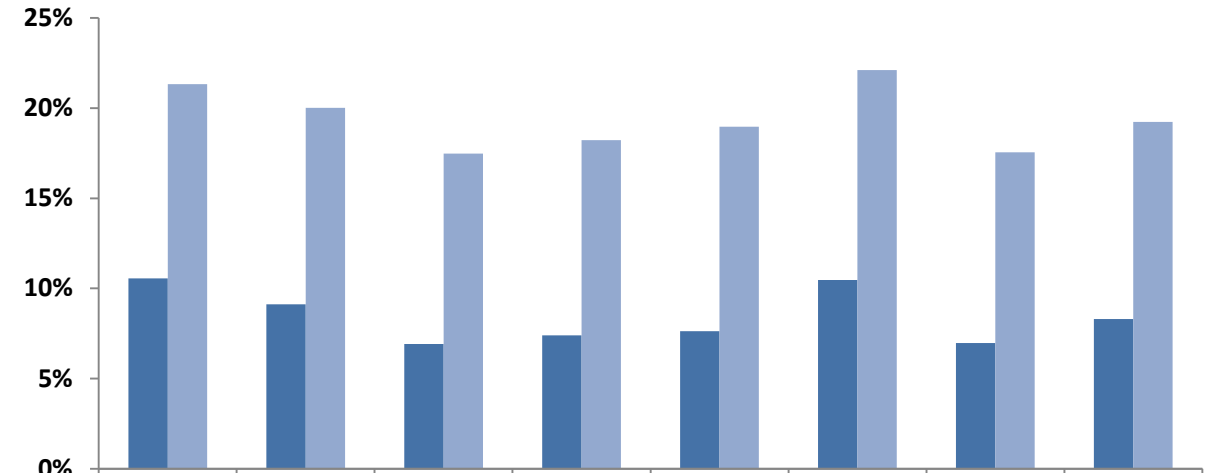
Indicator Description: PERCEIVED RISK OF MARIJUANA USE AMONG ADULTS. This measure demonstrates the percentage of adults in Maine who perceive a moderate-to-great risk of harm from smoking marijuana once a month. Because of small sample sizes, survey data from multiple years must be combined in order to produce this estimate. Due to a redesign in the survey, 2012–14 is the most recent available data for this indicator.

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

Data Source(s): NSDUH, 2012–14, 2008–10 to 2012–14

Summary: In 2012–14, Central residents 26 and older were twice as likely to perceive a risk of harm from smoking marijuana once a month when compared to those aged 18–25 years of age (20.0% compared to 9.1% of the younger cohort). Although not shown, the percentage of Central residents 18 to 25 who perceived a great risk from smoking marijuana once a month has steadily decreased since 2008–10 (currently 9.1%, down from 13.8%, a drop of almost five percentage points). Central's perception of risk is slightly above the state average in 2012–14.

Figure 57. Percent of adults who perceive a great risk from smoking marijuana once a month, by age group and Public Health District: 2012–14*



	Aroostook/ Downeast	Central	Cumber.	Midcoast	Penquis	Western	York	Maine
18-25	10.6%	9.1%	6.9%	7.4%	7.6%	10.5%	7.0%	8.3%
26+	21.3%	20.0%	17.5%	18.2%	19.0%	22.1%	17.6%	19.2%

Source: NSDUH

**Due to small sample sizes estimates for Aroostook and Downeast have been combined.*

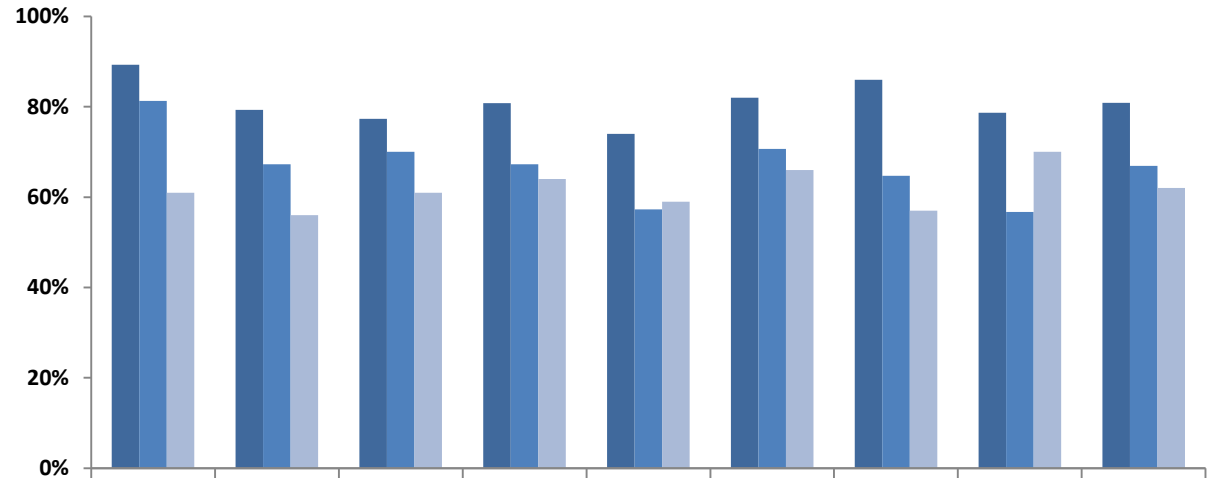
Indicator Description: PARENTAL ATTITUDES REGARDING MARIJUANA USE. This indicator reflects how parents felt about their teen using marijuana. Maine parents of teenagers (7th through 12th graders) were asked to select the response that best described their attitude about marijuana use by their child. Response options were mutually exclusive.

Why Indicator is Important: Parental perceptions and permissive attitudes towards substance use can have a major effect in their child's decision to use. As Maine observes changes in regulations and policies regarding marijuana use, shifts in cultural norms and beliefs around use are occurring as well.

Data Source(s): Parent Survey, 2013–17

Summary: In 2017, 56 percent of parents in Central felt it was never okay for their teen to use marijuana; this rate was lower than the statewide rate (62%). The rate of disapproval among parents concerning teen marijuana use has dropped by 23 percentage points since 2013 (79%).

Figure 58. Parental attitudes regarding their teen using marijuana: 2013 to 2017



	Aroostook	Central	Cumber.	Downeast	Midcoast	Penquis	Western	York	Maine
2013	89%	79%	77%	81%	74%	82%	86%	79%	81%
2015	81%	67%	70%	67%	57%	71%	65%	57%	67%
2017	61%	56%	61%	64%	59%	66%	57%	70%	62%

Source: Parent Survey 2013–17

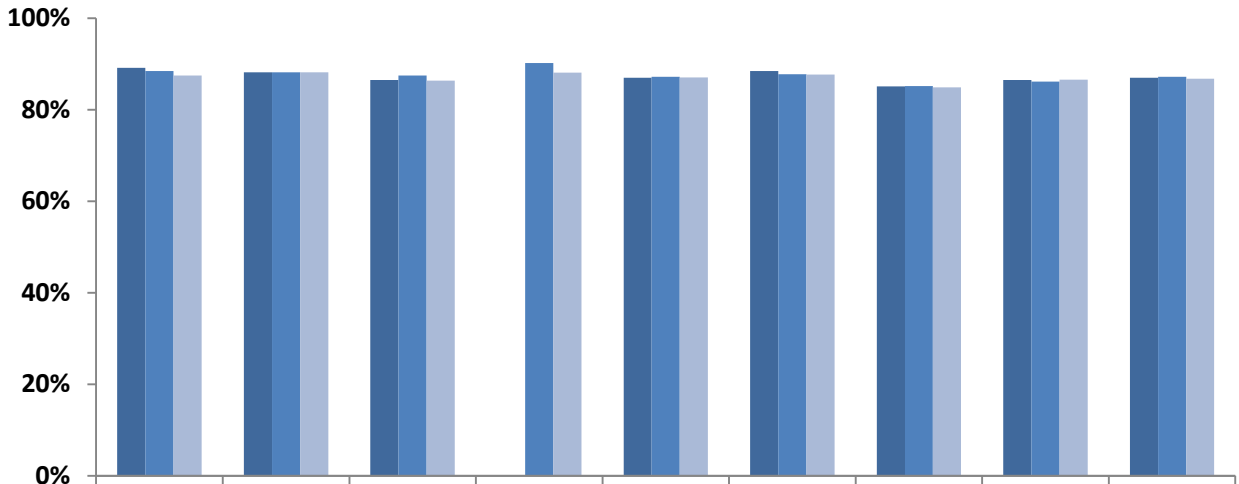
Indicator Description: PERCEIVED RISK OF PRESCRIPTION DRUG MISUSE AMONG YOUTH. This measure demonstrates the percentage of high school students who perceive a moderate-to-great risk of harm from taking a prescription drug that was not prescribed to them.

Why Indicator is Important: According to the 2017 statewide MIYHS, high school students who do not believe there is moderate-to-great risk in misusing prescription drugs are three times as likely to have ever misused prescription pain relievers compared to their peers who do perceive risk of harm associated with misusing prescription drugs.

Data Source(s): MIYHS, 2013–2017

Summary: The perception of risk from misusing prescription drugs among high school students in Central remained consistent from 2013 to 2017 (88%); the statewide average has also remained unchanged (87%).

Figure 59. Percent of high school students who reported a risk of harm from misusing prescription drugs, by Public Health District: 2013–2017



	Aroostook	Central	Cumber.	Downeast	Midcoast	Penquis	Western	York	Maine
2013	89%	88%	87%		87%	89%	85%	87%	87%
2015	89%	88%	88%	90%	87%	88%	85%	86%	87%
2017	88%	88%	86%	88%	87%	88%	85%	87%	87%

Source: MIYHS

Perceived Enforcement

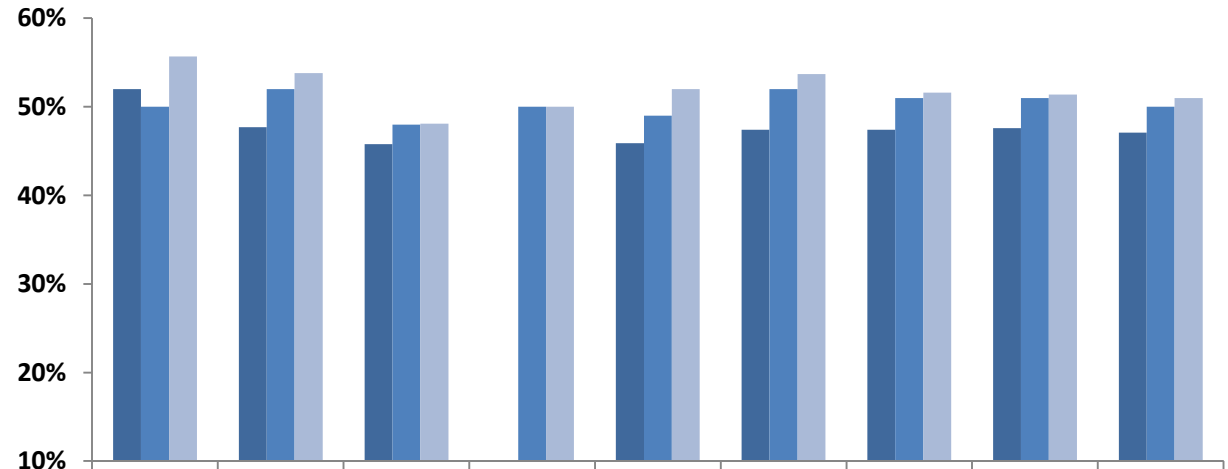
Indicator Description: PERCIEVED RISK OF BEING CAUGHT FOR DRINKING ALCOHOL AMONG YOUTH. This indicator reflects the percentage of high school students who reported that they would be caught by their parents or by police if they drank alcohol.

Why Indicator is important: According to the 2017 statewide MIYHS, high school students who believe they would not be caught by their parents are more than five times as likely to drink in the past month as compared to students who do think they will be caught.

Data Source(s): MIYHS, 2013–2017

Summary: In 2017, over half (54%) of Central's high school students thought they would be caught by their parents if they drank without their parent's knowledge. This percentage is higher than the statewide average (51%).

Figure 60. Perceived risk among high school students in Central of being caught by parents for drinking alcohol: 2013–2017



	Aroostook	Central	Cumber-land	Downeast	Midcoast	Penquis	Western	York	Maine
2013	52%	48%	46%		46%	47%	47%	48%	47%
2015	50%	52%	48%	50%	49%	52%	51%	51%	50%
2017	56%	54%	48%	50%	52%	54%	52%	51%	51%

Source: MIYHS

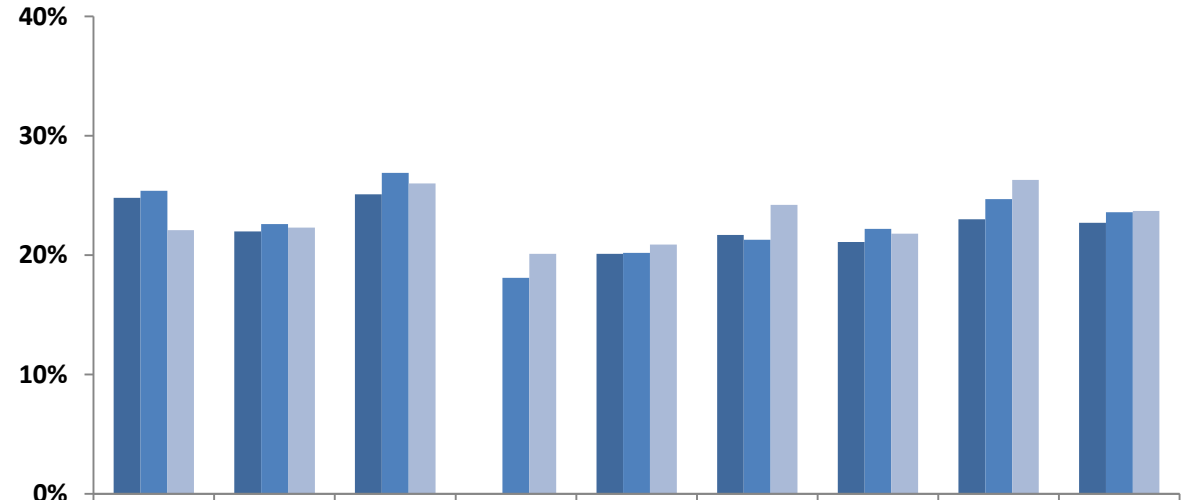
Indicator Description: PERCEIVED RISK OF BEING CAUGHT FOR SMOKING MARIJUANA AMONG YOUTH. This measure shows the percentage of high school students who reported that they thought they would be caught by police if they smoked marijuana.

Why Indicator is Important: High school students who believe they would be caught by the police were nearly three times as likely to smoke marijuana compared to their peers.

Data Source(s): MIYHS, 2013–2017

Summary: Central's high school students who indicated that they thought they would be caught by the police if they smoked marijuana remained consistent between 2013 and 2017 (22%); the percentage is lower than the statewide rate (24%). Alternatively, this means that nearly four out of five of Central's high school students do *not* perceive a risk of being caught by the police for smoking marijuana.

Figure 61. Perceived risk among high school students of being caught by police for smoking marijuana, by Public Health District: 2013–2017



	Aroostook	Central	Cumber.	Downeast	Midcoast	Penquis	Western	York	Maine
2013	25%	22%	25%		20%	22%	21%	23%	23%
2015	25%	23%	27%	18%	20%	21%	22%	25%	24%
2017	22%	22%	26%	20%	21%	24%	22%	26%	24%

Source: MIYHS

Mental Health, Suicide and Co-occurring Disorders

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

More than one-fifth of adults in the Central Public Health District reported having ever been diagnosed with an anxiety disorder or a depression disorder. Nearly a third of the adults ages 26 to 35 in Central reported that they had been diagnosed with anxiety and more than one in four adult females in Central reported having ever been diagnosed with depression. In addition, more than one in four high school students felt sad or hopeless every day for two weeks in 2017 and about one in seven high school students seriously considered attempting suicide within the past year. The rate of referral calls related to mental health services in Central is lower than the statewide average in 2017, and has decreased gradually over the past several years. Central observed the highest rate of deaths related to suicide among public health districts in recent years.

Depression and Anxiety

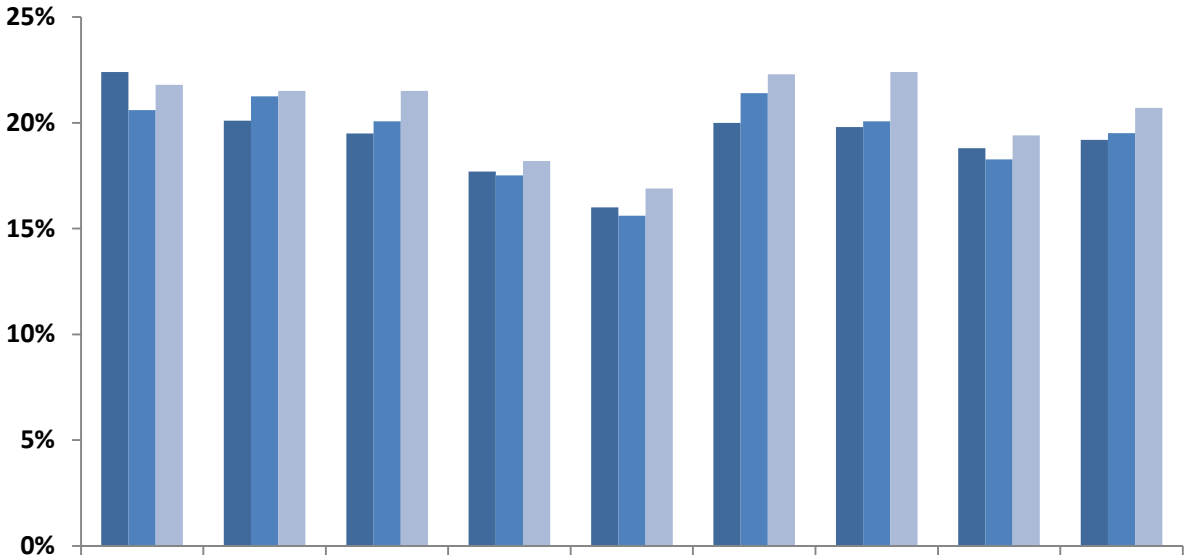
Indicator Description: DIAGNOSIS OF ANXIETY AND DEPRESSION AMONG ADULTS. This indicator examines the percentage of Maine residents age 18 and older who have ever been told by a doctor that they have a depressive or anxiety disorder.

Why Indicator is Important: The link between mental health and substance abuse is well documented. Experiencing mental health disorders (*e.g.*, anxiety or depression) is associated with higher rates of substance abuse. [5]

Data Source(s): BRFSS, 2012–14 to 2014–16

Summary: In the 2014–16 period, about one in five (22%) of Central's adults reported that they had been told they had an anxiety disorder. This rate is similar to that observed statewide (21%). Rates of anxiety diagnoses in Central were highest among adults 26 to 35 (29%), followed by 36 to 49 year olds (27%), 18 to 25 year olds (20%), and those 50 and over (17%). Anxiety disorder diagnoses were more prevalent among adult females than adult males in Central (26% compared to 15%).

Figure 62. Percent of adults who have ever been told they have an anxiety disorder, by Public Health District: 2012–14 to 2014–16

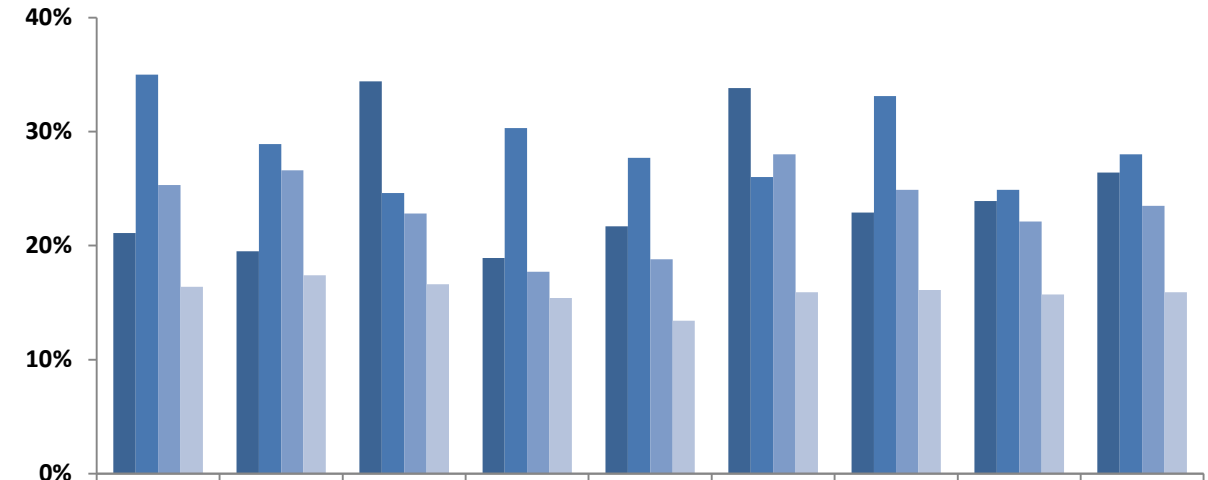


	Aroostook	Central	Cumber.	Downeast	Midcoast	Penquis	Western	York	Maine
2012-14	22%	20%	20%	18%	16%	20%	20%	19%	19%
2013-15	21%	21%	20%	18%	16%	21%	20%	18%	20%
2014-16	22%	22%	22%	18%	17%	22%	22%	19%	21%

Source: BRFSS 2012–16

[5] Footnote: Kessler, R. C. (2004). The epidemiology of dual diagnosis. *Biological psychiatry*. *56*(10), 730–737.

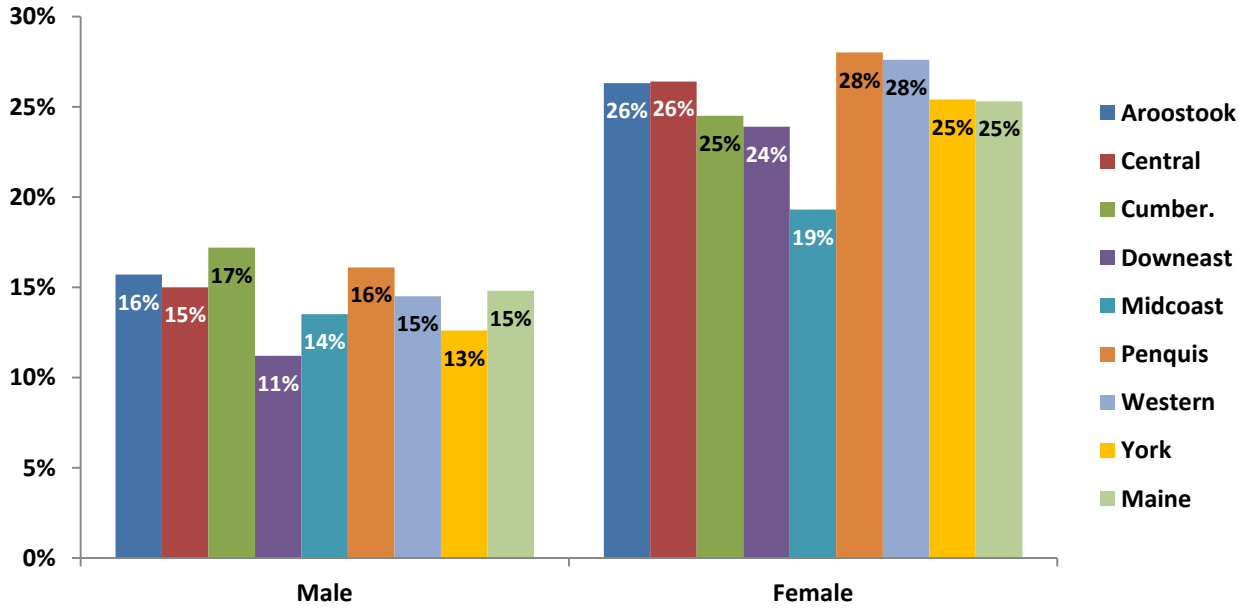
Figure 63. Percent of adults who have ever been told they have an anxiety disorder, by age and Public Health District: 2013–16



	Aroostook	Central	Cumber.	Downeast	Midcoast	Penquis	Western	York	Maine
18-25	21%	20%	34%	19%	22%	34%	23%	24%	26%
26-35	35%	29%	25%	30%	28%	26%	33%	25%	28%
36-49	25%	27%	23%	18%	19%	28%	25%	22%	24%
50+	16%	17%	17%	15%	13%	16%	16%	16%	16%

Source: BRFSS 2013-16

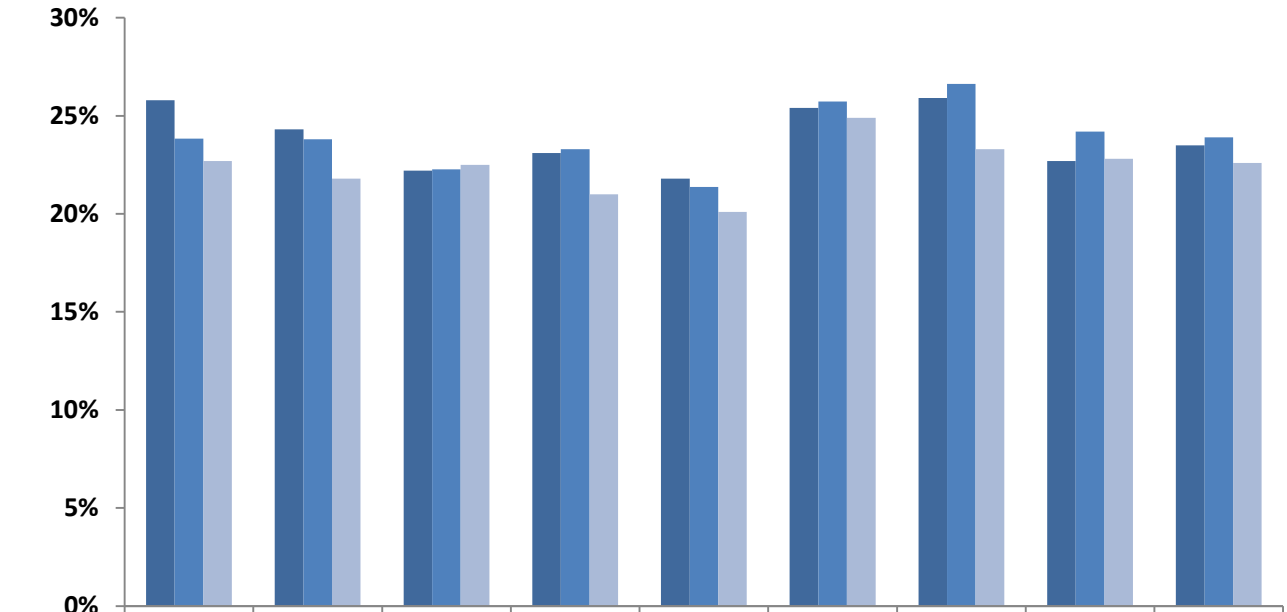
Figure 64. Percent of adults who have ever been told they have an anxiety disorder, by gender and Public Health District: 2013–16



Source: BRFSS 2013–16

Summary: The rate of Central's adults reporting they had been diagnosed with a depression disorder decreased slightly from 2013–14 (24%) to 2015–16 (22%); this was on par with the statewide trend. Depression rates were highest among 36 to 45 year olds (32%), followed by 26 to 35 year olds (24%), those 50 and over (20%), and 18 to 25 year olds (19%). Depression disorder diagnoses were more prevalent among adult females (28%) than adult males (17%) in Central.

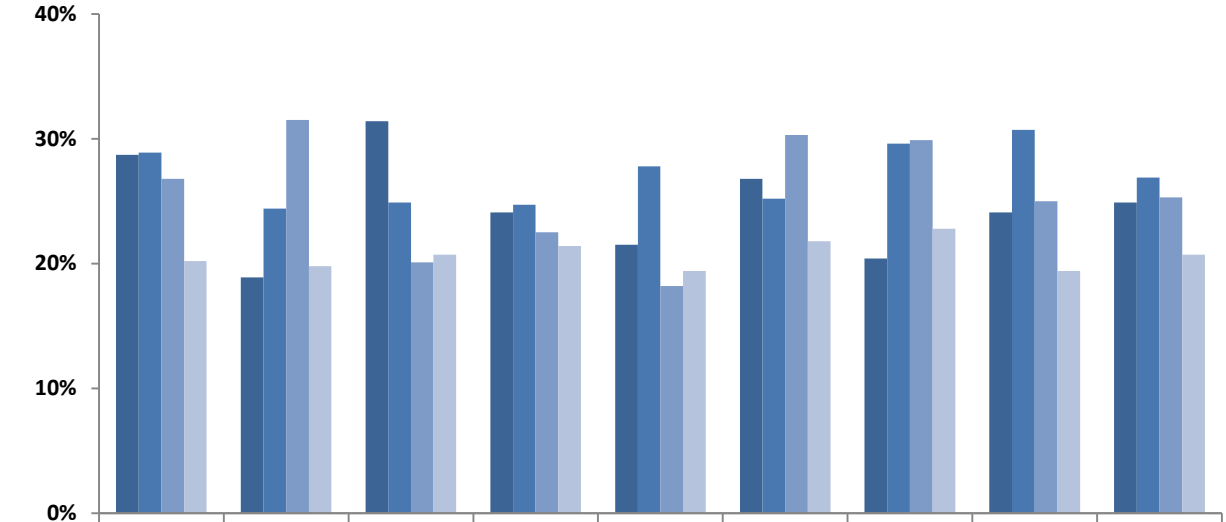
Figure 65. Percent of adults who have ever been told they have a depression disorder, by Public Health District: 2013–14 to 2015–16



	Aroostook	Central	Cumber.	Downeast	Midcoast	Penquis	Western	York	Maine
2013-14	26%	24%	22%	23%	22%	25%	26%	23%	24%
2014-15	24%	24%	22%	23%	21%	26%	27%	24%	24%
2015-16	23%	22%	23%	21%	20%	25%	23%	23%	23%

Source: BRFSS 2013–16

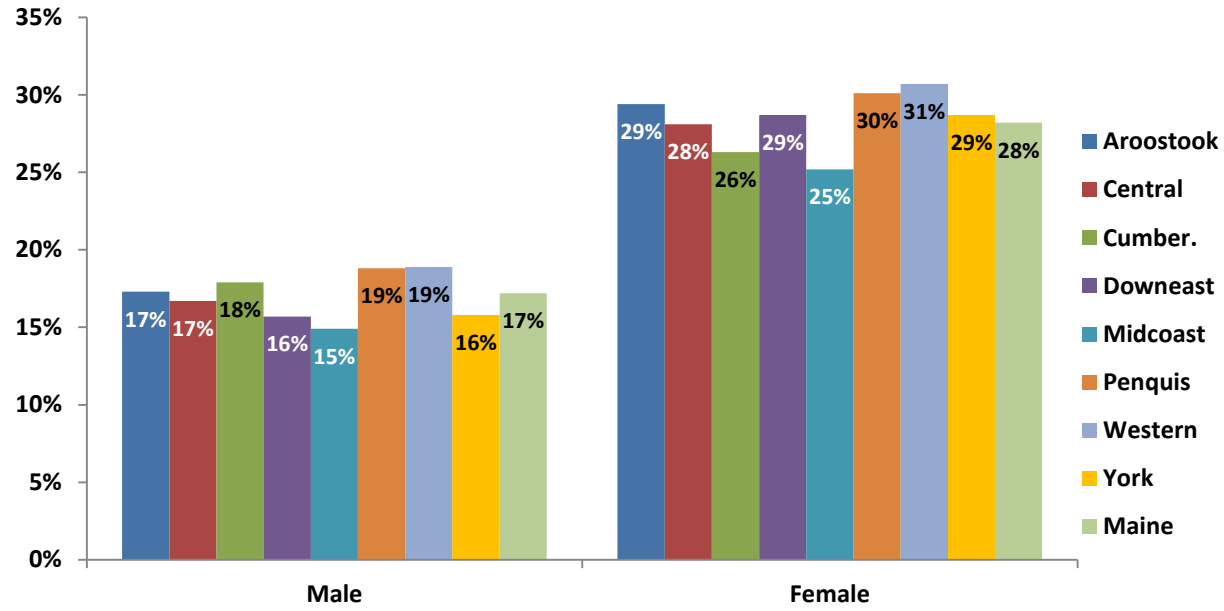
Figure 66. Percent of adults who have ever been told they have a depression disorder, by age and Public Health District: 2014–16



	Aroostook	Central	Cumber.	Downeast	Midcoast	Penquis	Western	York	Maine
18-25	29%	19%	31%	24%	22%	27%	20%	24%	25%
26-35	29%	24%	25%	25%	28%	25%	30%	31%	27%
36-49	27%	32%	20%	23%	18%	30%	30%	25%	25%
50+	20%	20%	21%	21%	19%	22%	23%	19%	21%

Source: BRFSS 2014–16

Figure 67. Percent of adults who have ever been told they have a depression disorder, by gender and Public Health District: 2014–16



Source: BRFSS 2014–16

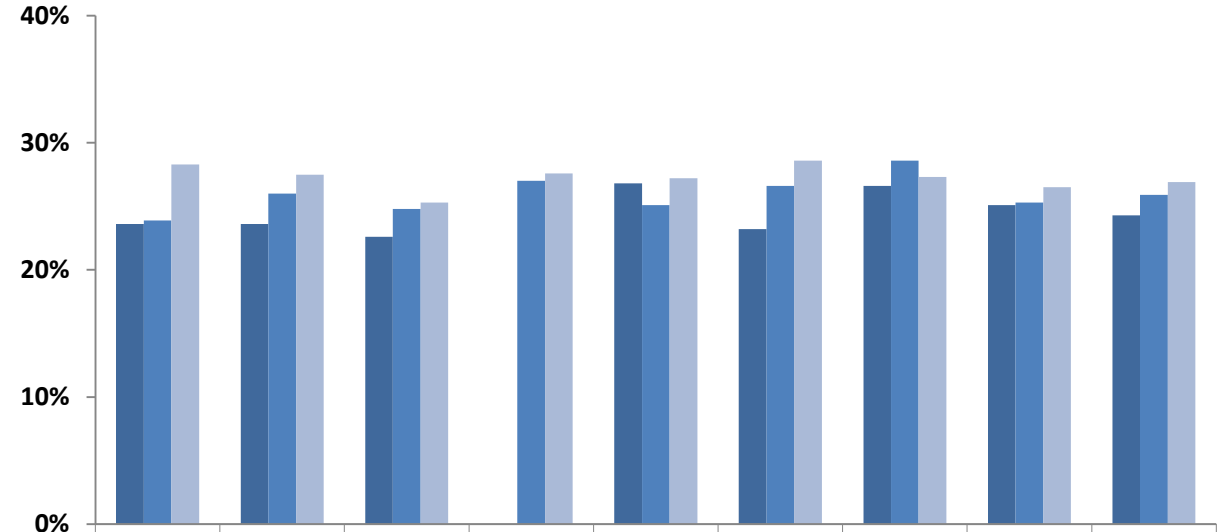
Indicator Description: DEPRESSION AMONG YOUTH. This indicator measures the percentage of high school students reporting they felt sad or hopeless almost every day for two weeks in a row during the past year.

Why Indicator is Important: Experiencing depression in the past year is associated with higher rates of substance abuse. According to the 2017 MIYHS, students who reported feeling hopeless or sad for at least two weeks within the past twelve months were almost twice as likely to have used marijuana or to have engaged in binge drinking in the past 30 days, and three times as likely to have misused prescription drugs during the past 30 days. Among youth, depression is also associated with problems with relationships and academic achievement.

Data Source(s): MIYHS, 2013–2017

Summary: The percent of Central's high school students who indicated that they felt sad or hopeless every day for two weeks or more during the past year increased from 2013 (24%) to 2017 (28%). This is in line with the statewide trend (increasing from 24% to 27%, respectively).

Figure 68. Felt sad or hopeless almost every day for two weeks or more in a row during the past year, by Public Health District: 2013–2017



	Aroostook	Central	Cumber.	Downeast	Midcoast	Penquis	Western	York	Maine
2013	24%	24%	23%		27%	23%	27%	25%	24%
2015	24%	26%	25%	27%	25%	27%	29%	25%	26%
2017	28%	28%	25%	28%	27%	29%	27%	27%	27%

Source: MIYHS

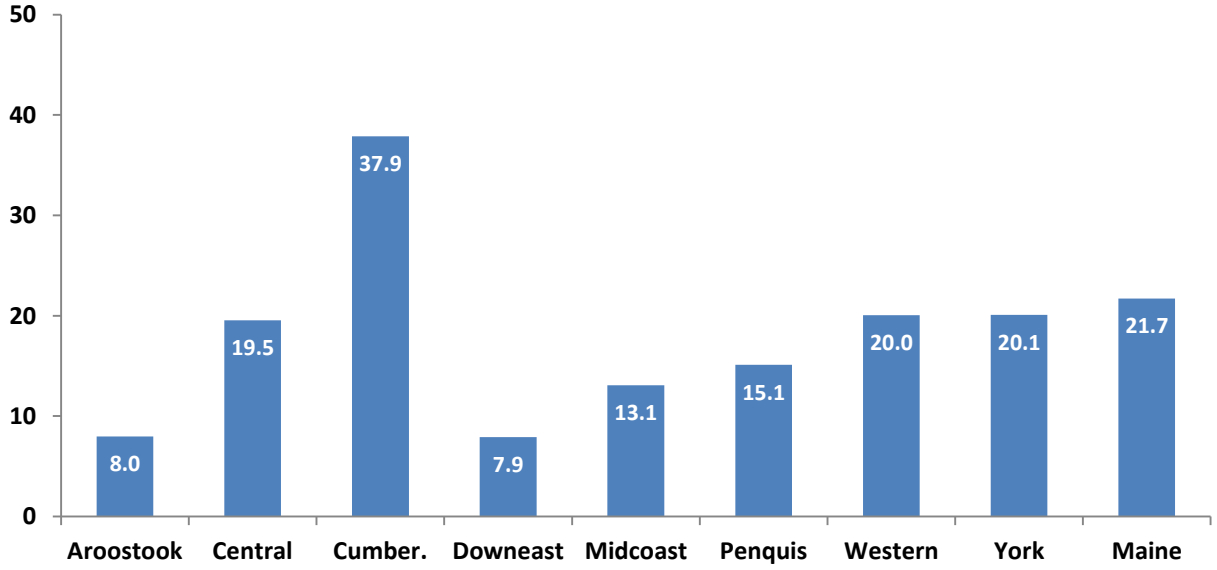
Indicator Description: INFORMATION CALLS FOR MENTAL HEALTH AND HUMAN SERVICES. 2-1-1 Maine is a telephone and internet service that provides information and referrals to health and human services. This indicator reflects the number of calls received by 2-1-1 Maine by the type of service requested.

Why Indicator is Important: The data collected from each call provides valuable information serving as a barometer of health and human service needs in the state.

Data Source(s): 2-1-1 Maine, 2017, 2013–2017

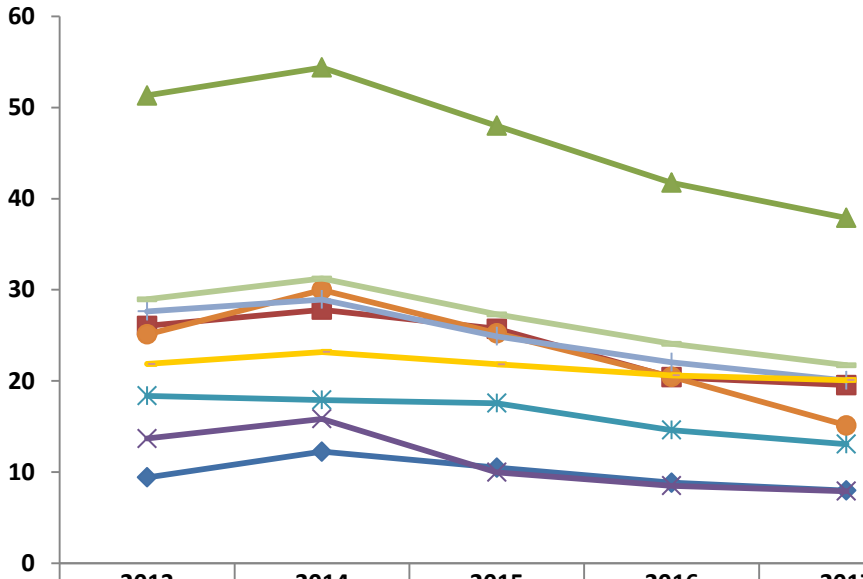
Summary: In 2017, Central observed 19.5 2-1-1 Maine referral calls related to mental health services per 10,000 residents; this rate was slightly lower than the statewide rate (21.7 calls per 10,000 residents). Central's rate of such calls has declined since 2013.

Figure 69. Number of 2-1-1 Maine referral calls related to mental health services per 10,000 residents, by Public Health districts: 2017



Source: 2-1-1 Maine

Figure 70. Number of 2-1-1 Maine referral calls related to mental health services per 10,000 residents, by public health districts: 2013–2017



	2013	2014	2015	2016	2017
Aroostook	9.4	12.2	10.5	8.8	8.0
Central	26.0	27.8	25.7	20.4	19.5
Cumber.	51.3	54.4	48.0	41.7	37.9
Downeast	13.7	15.8	10.0	8.5	7.9
Midcoast	18.4	17.9	17.6	14.6	13.1
Penquis	25.1	30.0	25.2	20.5	15.1
Western	27.6	28.9	24.9	22.1	20.0
York	21.9	23.2	21.8	20.6	20.1
Maine	29.0	31.2	27.3	24.1	21.7

Source: 2-1-1 Maine

Suicide and Suicidal Ideation

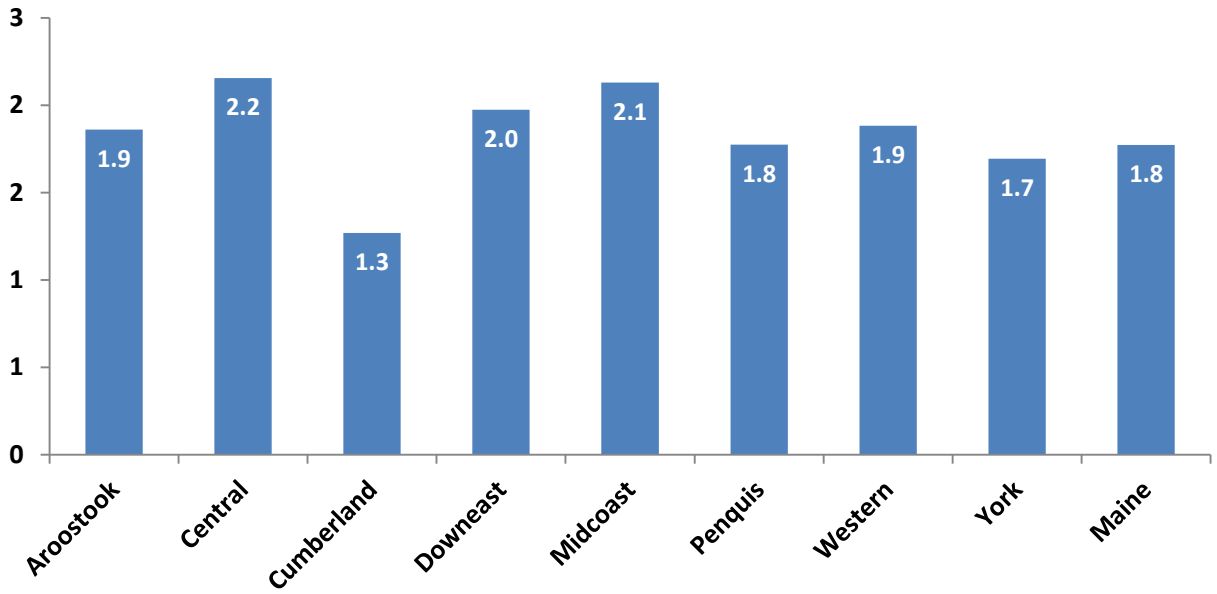
Indicator Description: RATE OF SUICIDE DEATHS. Every death in Maine has a recorded cause. This indicator examines deaths that were classified as a suicide. In this case, a rate per 10,000 residents is used to compare the prevalence across the public health districts.

Why Indicator is Important: Although not the leading cause of death, substance use and abuse is often a factor in suicides. For example, the CDC's National Violent Death Reporting System has estimated that nationally, 14 percent of suicides are attributable to alcohol.[6]

Data Source(s): ODRVS, 2015–17, 2013–15 to 2015–17

Summary: During the three-year period 2015–17, Central reported an average of 2.2 suicide deaths per 10,000 residents per year; this was slightly higher than the statewide rate (1.8). Suicide rates in Central have observed a slight increase since 2014–16 (1.9). Although not shown, there were 45 suicide deaths in Central in 2017.

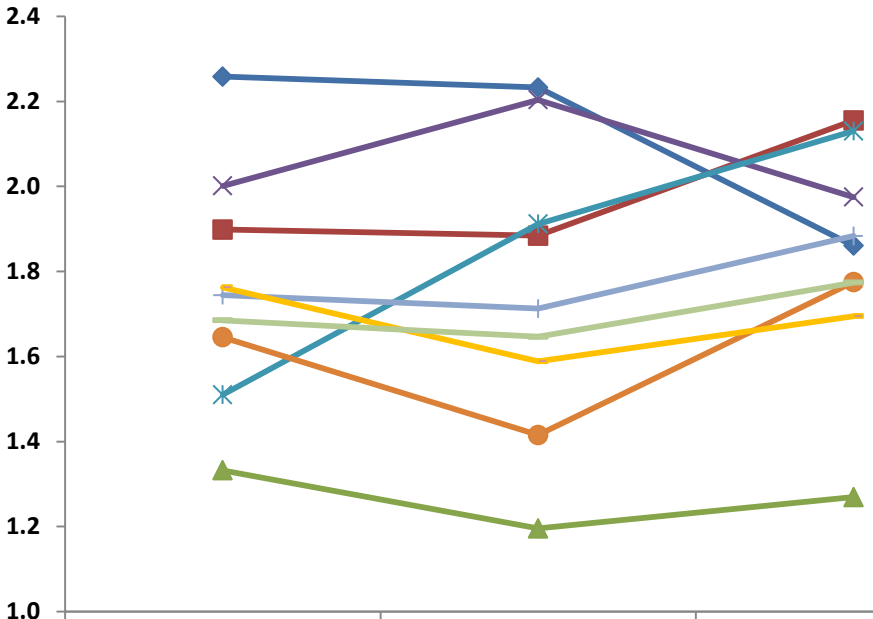
Figure 71. Number of suicide deaths per 10,000 residents, by Public Health District: 2015–17



Source: ODRVS

[6] Centers for Disease Control and Prevention. (2011). Suicides due to alcohol and/or drug overdose: a data brief from the National Violent Death Reporting System. *Atlanta (GA): The Centers*.

Figure 72. Number of suicide deaths per 10,000 residents, by Public Health District: 2013–15 to 2015–17



	2013-15	2014-16	2015-17
Aroostook	2.3	2.2	1.9
Central	1.9	1.9	2.2
Cumberland	1.3	1.2	1.3
Downeast	2.0	2.2	2.0
Midcoast	1.5	1.9	2.1
Penquis	1.6	1.4	1.8
Western	1.7	1.7	1.9
York	1.8	1.6	1.7
Maine	1.7	1.6	1.8

Source: ODRVS

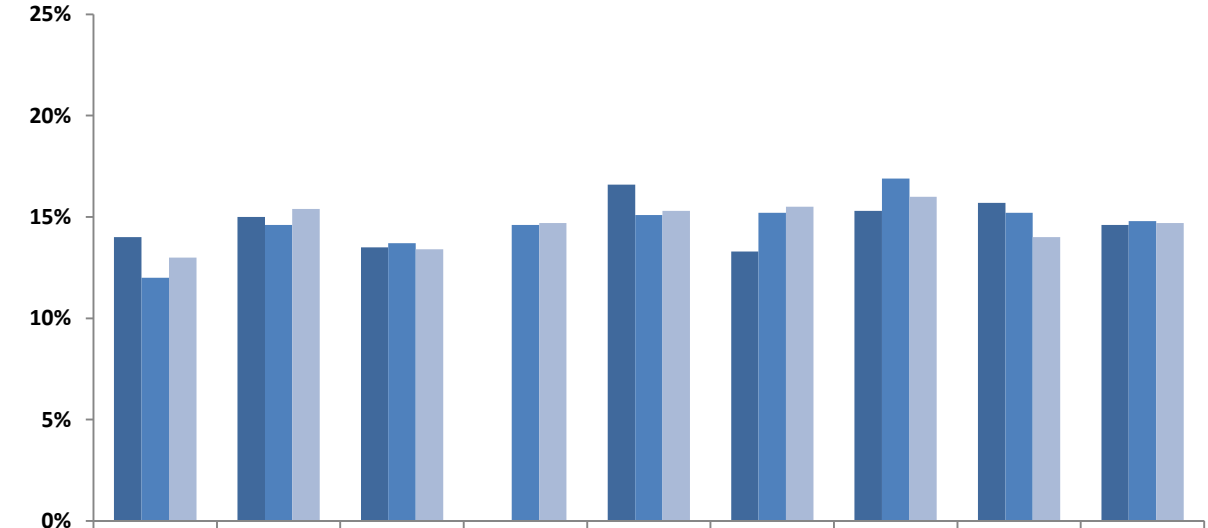
Indicator Description: SUICIDAL IDEATION AMONG YOUTH. This measure examines the percentage of high school students who reported that they seriously considered attempting suicide during the past year.

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

Data Source(s): MIYHS, 2013–2017

Summary: The percentage of Central's high school students who seriously considered attempting suicide during the past year has remained unchanged from 2013 to 2017 (15%). This result is the same as that observed statewide.

Figure 73. Percent of high school students who considered suicide during the past year, by Public Health District: 2013–2017



	Aroostook	Central	Cumber.	Downeast	Midcoast	Penquis	Western	York	Maine
2013	14%	15%	14%		17%	13%	15%	16%	15%
2015	12%	15%	14%	15%	15%	15%	17%	15%	15%
2017	13%	15%	13%	15%	15%	16%	16%	14%	15%

Source: MIYHS

Treatment Admissions for Substance Abuse

Mainers continue to seek out treatment for abuse involving a wide array of substances besides alcohol. In 2017, the state of Maine observed 3,045 clients admitted for alcohol as the primary substance, followed by heroin (2,414) and synthetic opiates (1,227). Data were retrieved in July of 2018.

In Central, over one third of primary treatment admissions were for alcohol and just over one quarter were related to heroin/morphine. Central's rates of primary admissions involving heroin/morphine, synthetic opiates, as well as alcohol were markedly higher than the statewide rates. After observing an increase in primary admissions related to alcohol, Central has observed a steady rate of primary admissions related to alcohol for the past few years.

Treatment Admissions

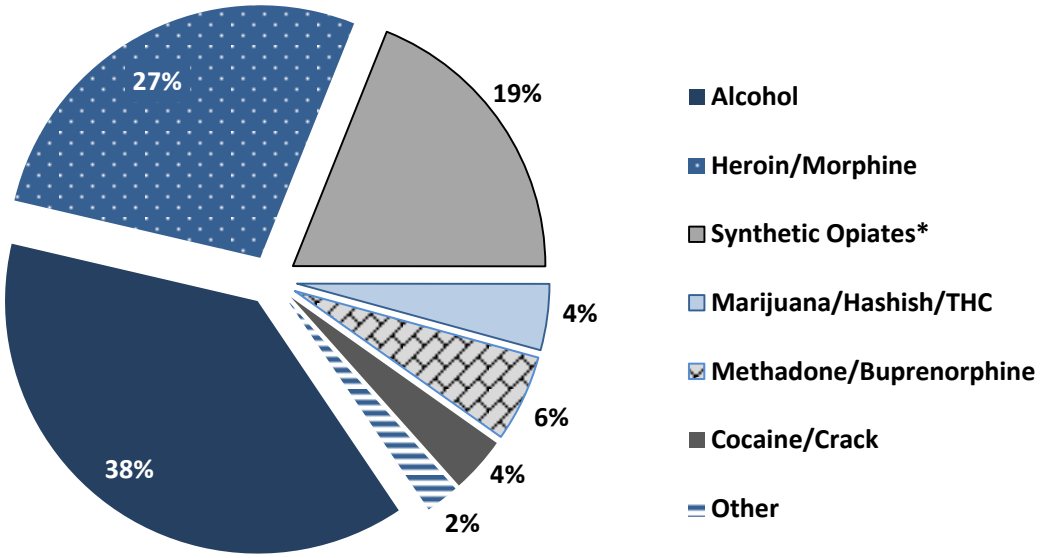
Indicator Description: **PRIMARY TREATMENT ADMISSIONS.** This indicator reflects substance abuse treatment admissions in which a substance was listed as the primary reason for admission. The following analysis excludes admissions for shelter/detoxification services as well as those who were identified as co-affected or codependents (*e.g.*, spouse, child, sibling) of the client who was receiving treatment. The following data include duplicate admissions, meaning that a unique individual/client could be counted multiple times if they were admitted more than once during the year.

Why Indicator is Important: Treatment admissions data provide an indication of service usage and the impact of substance use on the behavioral healthcare system. Treatment admissions data are not a good indicator of substance use, abuse or dependence.

Data Source(s): WITS, 2013–2017

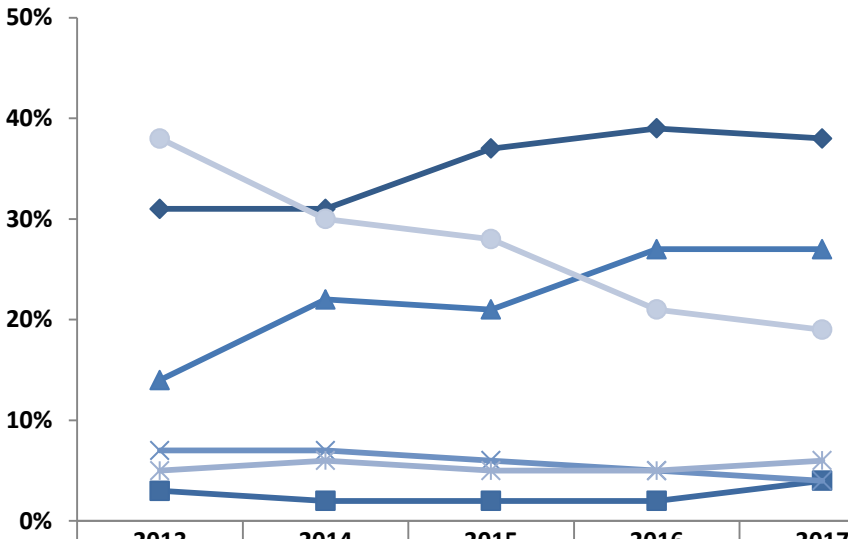
Summary: In 2017, the largest portion of primary treatment admissions in Central were related to alcohol (38%), followed by heroin/morphine (27%), synthetic opiates (19%), marijuana/ hashish/THC (4%), methadone/buprenorphine (6%), marijuana (4%) and cocaine/crack (4%). The proportion of primary admissions related to heroin/morphine has gradually increased in recent years while those related to synthetic opiates have steadily decreased.

Figure 74. Percentage of primary drug admissions in Central, by drug type: 2017



Source: WITS 2017
**Synthetic Opiates excludes methadone/buprenorphine*
***WITS system is not static; therefore 2017 numbers may be lower than true counts. Data were retrieved 7/8/2018*

Figure 75. Percentage of primary drug admissions in Central, by drug type: 2013–2017



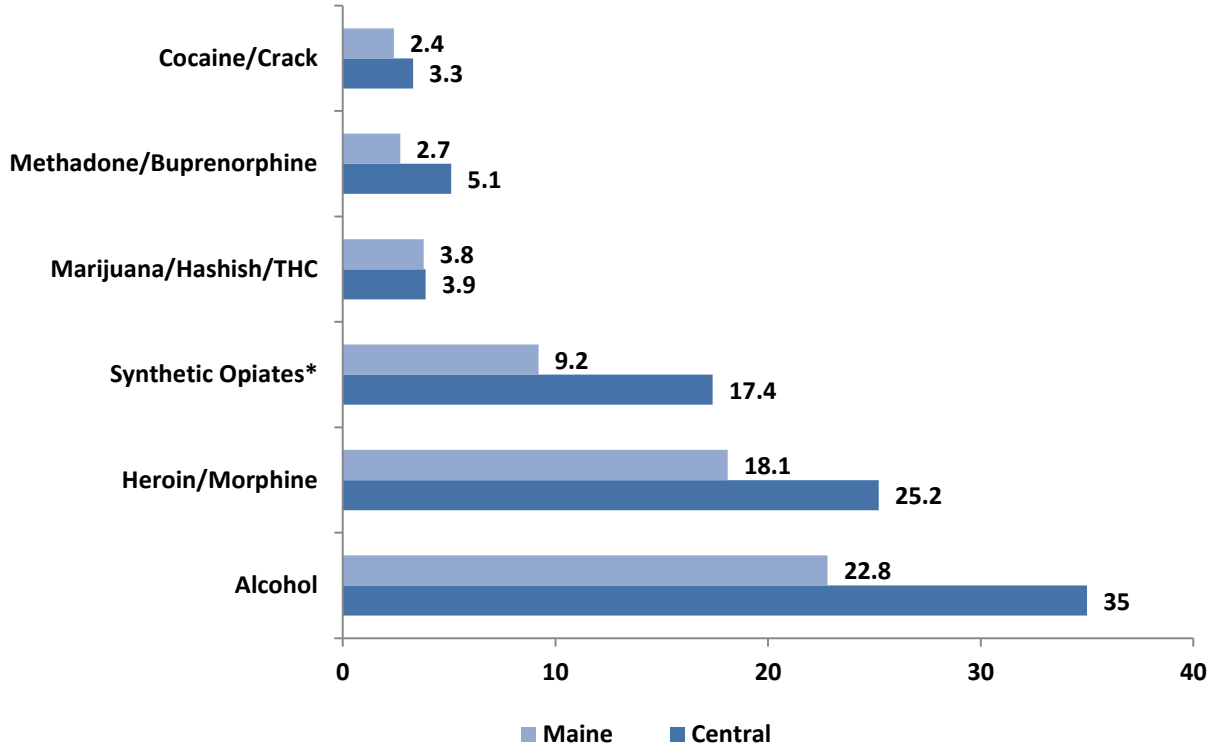
	2013	2014	2015	2016	2017
Alcohol	31%	31%	37%	39%	38%
Cocaine/Crack	3%	2%	2%	2%	4%
Heroin/Morphine	14%	22%	21%	27%	27%
Marijuana/Hashish/THC	7%	7%	6%	5%	4%
Methadone/Buprenorphine	5%	6%	5%	5%	6%
Synthetic Opiates*	38%	30%	28%	21%	19%

Source: WITS 2013–2017

**Synthetic Opiates excludes methadone/buprenorphine*
***WITS system is not static; therefore 2017 numbers may be lower than true counts. Data were retrieved 7/8/2018.*

Summary: In 2017, Central observed 35 primary admissions per 10,000 residents related to alcohol; this rate was followed by admissions for heroin/morphine (25.2 per 10,000), synthetic opiates (17.4 per 10,000), methadone/buprenorphine (5.1 per 10,000), marijuana/hashish/THC (3.9 per 10,000), and cocaine/crack (3.3 per 10,000). Central had higher rates for all substances shown when compared to the state as a whole.

Figure 76. Primary treatment admissions per 10,000 residents in Central and Maine: 2017

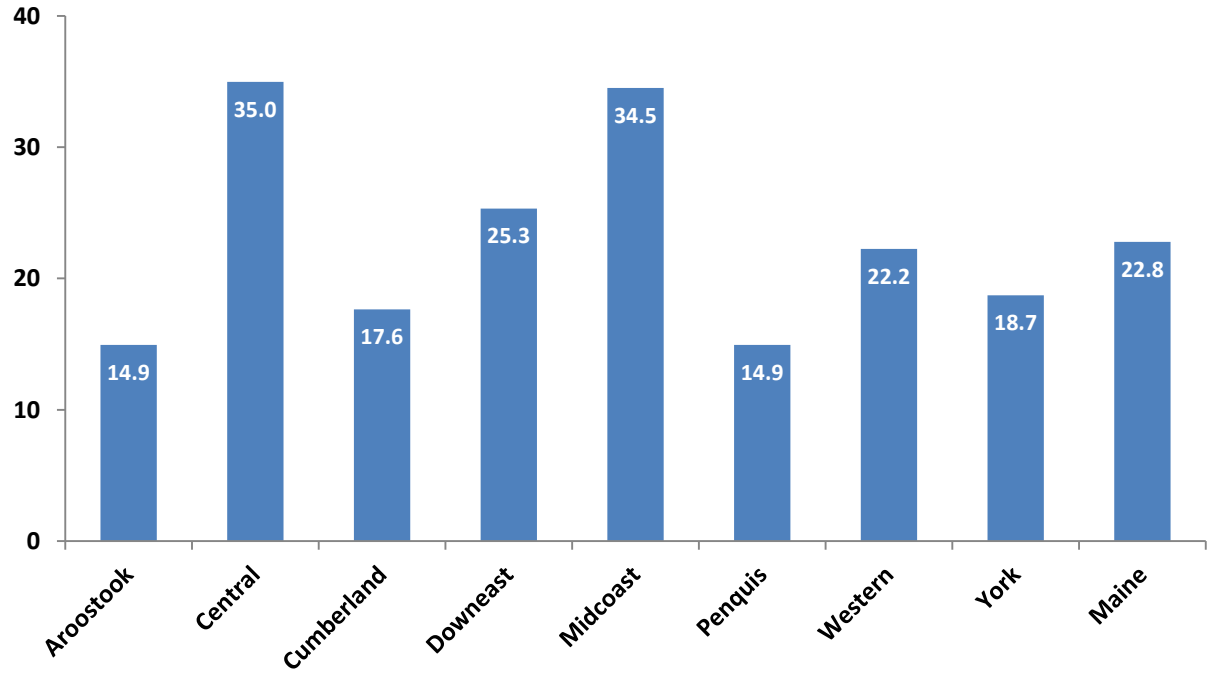


Source: WITS 2017

**Excludes methadone/buprenorphine*
***WITS system is not static; therefore 2017 numbers may be lower than true counts. Data were retrieved 7/8/2018.*

Summary: In 2017, Central experienced the highest rate among public health districts of primary treatment admissions due to alcohol (35 admissions per 10,000 residents).

Figure 77. Primary admissions related to alcohol per 10,000 residents, by Public Health District and drug type: 2017

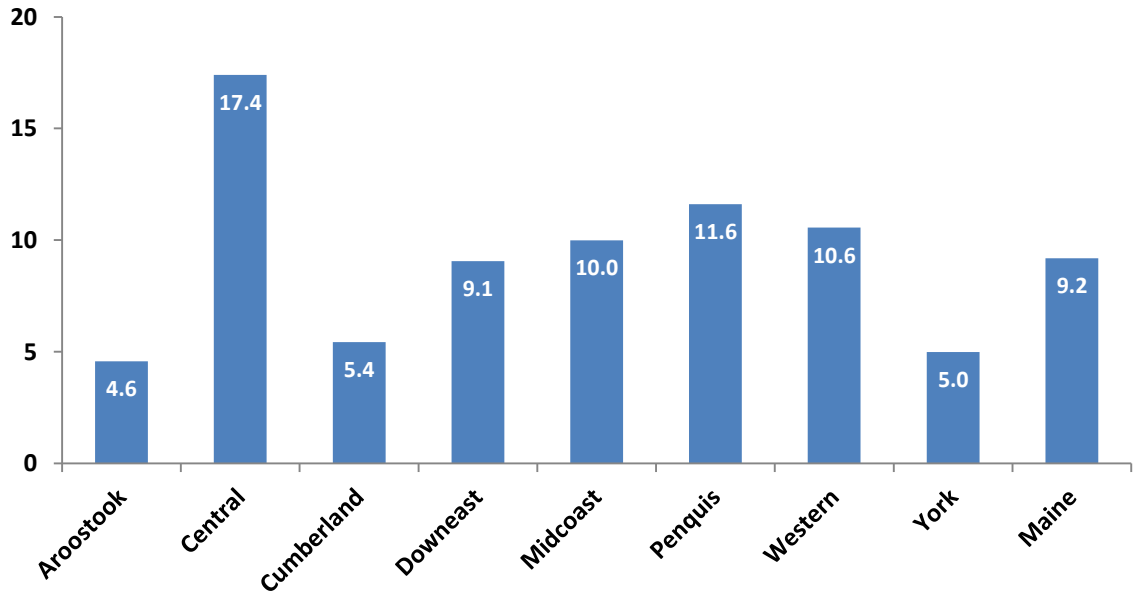


Source: WITS 2017

**WITS system is not static; therefore 2017 numbers may be lower than true counts. Data were retrieved 7/8/2018.*

Summary: In 2017, Central observed a rate of 17.4 primary admissions related to synthetic opiates per 10,000 residents. Central has the highest rate among public health districts for synthetic opiate admissions in the state.

Figure 78. Primary admissions related to synthetic opiates* per 10,000 residents, by Public Health District: 2017

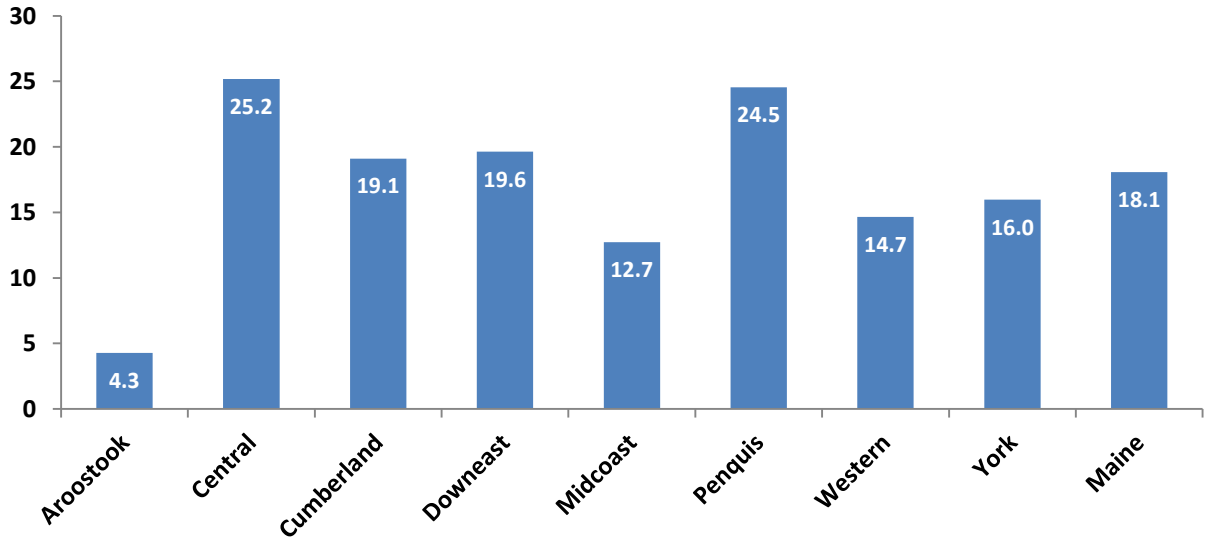


Source: WITS 2017

***Synthetic opiates exclude methadone, but include buprenorphine.*
***WITS system is not static; therefore 2017 numbers may be lower than true counts. Data were retrieved 7/8/2018.*

Summary: In 2017, Central observed the highest rate of primary admissions related to heroin/morphine in the state (25.2 admissions per 10,000 residents).

Figure 79. Primary admissions related to heroin/morphine per 10,000 residents, by Public Health District and drug type: 2017

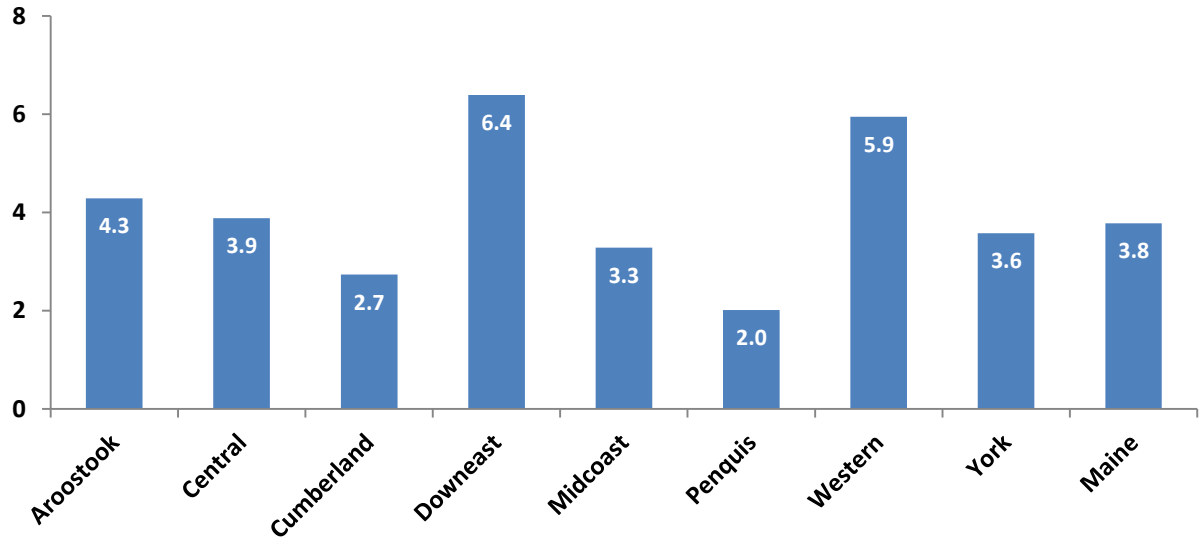


Source: WITS 2017

**WITS system is not static; therefore 2017 numbers may be lower than true counts. Data were retrieved 7/8/2018.*

Summary: In 2017, Central observed the fourth-highest rate among public health districts of primary treatment admissions related to marijuana.

Figure 80. Primary admissions related to marijuana per 10,000 residents, by Public Health District and drug type: 2017



Source: WITS 2017

**WITS system is not static; therefore 2017 numbers may be lower than true counts. Data were retrieved 7/8/2018.*

Appendix: Data Sources

This report includes data that was gathered from a number of data sources. A detailed description of each source is provided below, consisting of information about the data included in each source, and retrieval or contact information. The report includes data that were available through July 2018.

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

Description of Data Sources

Behavioral Risk Factor Surveillance System (BRFSS). The BRFSS is a national survey administered on an ongoing basis by the National Centers for Disease Control and Prevention (CDC) to adults in all 50 states, several districts and territories. The instrument collects data on adult risk behaviors, including alcohol and drug abuse. The most recent data available are from 2016. Due to methodological changes in weighting and sampling, data prior to 2011 cannot be trended with more current data. In some instances, due to smaller sample sizes, multiple years of data are combined in efforts to produce more reliable estimates. **Contact:** Melissa Damren, Maine BRFSS Coordinator; melissa.damren@maine.gov; (207) 287-1420.

Maine Department of Public Safety (DPS), Bureau of Highway Safety (BHS), Maine Department of Transportation (MDOT). The Bureau of Highway Safety is responsible for tracking all fatalities that occur on Maine's highways and reporting this information through the Fatal Analysis Reporting System (FARS). The data represented provides information on highway crashes and fatalities. Much of this information is gathered from the FARS system, which records data on fatal crashes in Maine for input into a larger national record-keeping system of statistical data. FARS data is also used by BHS and the Maine State Police to analyze enforcement priorities and schedules. Impaired driving is one of the most serious traffic risks facing the nation, killing thousands every year. **Contact:** For FARS data/fatal crashes, contact Lauren Stewart, Highway Safety Director; lauren.v.stewart@maine.gov; (207) 626-3841. For all other crash data, contact the Maine DOT; (207) 624-3000.

Maine Department of Public Safety (DPS), Uniform Crime Reports (UCR). UCR data includes drug and alcohol arrests. Drug arrests include sale and manufacturing as well as possession of illegal substances. Liquor arrests include all liquor law violations. OUI arrests are arrests for

operating a motor vehicle under the influence of a controlled substance. DPS data are now available from 2016. Arrest data may reflect differences in resources or focus of law enforcement efforts, so may not be directly comparable from year to year.
Retrieval: http://www.maine.gov/dps/cim/crime_in_maine/cim.htm

For UCR statistical purposes, "arrests" also include those persons cited or summonsed for criminal acts in lieu of actual physical custody. These forms categorize the arrests by offense classification (both Part I and Part II crimes), and by age, sex and race. The same individual may be arrested several times over a period of time; each separate arrest is counted. A person may be arrested on several charges at one time; only one arrest is counted and is listed under the most serious charge. For UCR purposes, a juvenile is counted as "arrested" when the circumstances are such that if he or she were an adult, an arrest would result; in fact, there may not have been a formal charge.

Maine Drug Enforcement Agency (MDEA). The MDEA through its regional multi-jurisdictional task forces is the lead state agency in confronting drug trafficking crime. The data included in this report represents those arrested for a drug offense but does not indicate what other drug(s) may have been seized. For example, a person may be arrested for the sale of cocaine but also be in possession of oxycodone and marijuana. It is important to note that arrests and multi-jurisdictional drug enforcement are resource-dependent; such funds fluctuate from year to year, and must be reallocated to combat highest priority threats. **Contact:** Roy E. McKinney, Director; roy.e.mckinney@maine.gov; (207) 626-3852.

Maine Emergency Medical Services (EMS). Maine EMS is a bureau within the Maine Department of Public Safety (DPS) and is responsible for the coordination and integration of all state activities concerning Emergency Medical Services and the overall planning, evaluation, coordination, facilitation and regulation of EMS systems. EMS collects data statewide from the 272 licensed ambulance and non-transporting services. It is mandated that services submit an electronic patient care report to Maine EMS within one business day of patient contact. Data are compiled upon request. **Contact:** Timothy Nangle, Maine Emergency Medical Services; timothy.e.nangle@maine.gov; (207) 626-3860.

Maine Integrated Youth Health Survey (MIYHS). The MIYHS is a statewide survey administered biennially since 2009 through a collaborative partnership between Maine Department of Health and Human Services and Maine Department of Education. Its purpose is to quantify health-related behaviors and attitudes of 5th through 12th graders by direct student survey. The survey collects information on student substance use, risk factors related to substance use, as well as consequences, perceptions and social risk factors related to substances, and collects information on many other health factors. MIYHS defines binge-drinking as consuming five or more drinks in a row. As of the date of this report, the most recent data available are from 2015. **Contact:** Reid Plimpton, Center for Disease Control and Prevention reid.plimpton@maine.gov; (207) 287-5084

Maine Office of the Chief Medical Examiner. The Maine Office of the Chief Medical Examiner investigates all deaths associated with drug overdose. Analysis of these cases is currently funded by the Office of Attorney General. The death data are reported on a quarterly and an annual basis after cases are finalized, and released through the Attorney General's Office. Drug categories reported to SEOW include methadone, cocaine, benzodiazepines, oxycodone, fentanyl, and heroin/morphine. **Contact**: Dr. Marcella Sorg, Director, Rural Drug & Alcohol Research Program, Margaret Chase Smith Policy Center, University of Maine mhsorg@maine.edu.

National Survey on Drug Use and Health (NSDUH). The NSDUH is a national survey administered annually by the Substance Abuse and Mental Health Services Administration (SAMHSA) to youth grades 6 through 12 and adults ages 18 and older. The instrument collects information on substance use and health at the national, regional and state levels. The advantage of NSDUH is that it allows comparisons to be made across the lifespan (that is, ages 12 and up). However, NSDUH is not as current as other data sources; as of this report, data at the state level are available from 2015–16.

Older data are included for trending and comparative purposes. In 2016, a number of changes were made to the NSDUH questionnaire and data collection procedures resulting in the establishment of a new baseline for a number of measures. Therefore, estimates for several measures included in prior reports are not available. For details, see Section A of the "20152016 National Survey on Drug Use and Health: Guide to State Tables and Summary of Small Area Estimation Methodology" at https://www.samhsa.gov/data/report/2015-2016-nsduhguide-state-tables-and-summary-sae-methodology

NSDUH defines Illicit Drugs as marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or any prescription-type psychotherapeutic used non-medically; Binge Alcohol Use as drinking five or more drinks on the same occasion (*i.e.,* at the same time or within a couple of hours of each other) on at least one day in the past 30 days; Dependence or abuse based on definitions found in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-V); and Serious Mental Illness (SMI) as a diagnosable mental, behavioral, or emotional disorder that met the criteria found in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) and resulted in functional impairment that substantially interfered with or limited one or more major life activities. Retrieval: https://www.samhsa.gov/data/report/2016-national-survey-drug-use-and-healthmethodological-summary-and-definitions

Northern New England Poison Center (NNEPC). The Northern New England Poison Center provides services to Maine, New Hampshire, and Vermont. A poisoning case represents a single individual's contact with a potentially toxic substance. Intentional poisoning includes those related to substance abuse, suicide and misuse. Data include the number of confirmed cases where exposures are judged to be substance abuse-related (*i.e.*, an individual's attempt to get high). NNEPC collects detailed data on specific substances involved in poisonings, including the

categories of stimulants/street drugs, alcohol, opioids, asthma/cold and cough, benzodiazepines, antidepressants, and pharmaceuticals, as well as other substances.

The category of stimulants/street drugs includes marijuana and other cannabis, amphetamine and amphetamine-like substances, cocaine (salt and crack), amphetamine/dextroamphetamine, caffeine tablets/capsules, ecstasy, methamphetamine, GHB, and other/unknown stimulants/street drugs. The category alcohol includes alcohol-containing products such as mouthwash. The opioid category includes Oxycodone, Hydrocodone, buprenorphine, methadone, tramadol, morphine, propoxyphene, codeine, hydromorphone, stomach opioids, Meperidine (Demerol), heroin, Fentanyl, and other/unknown opioids. Data available from the poison center are reported on a continual daily basis and are included through December 2015. These data are only reflective of cases in which the Poison Center was contacted. **Contact:** Colin Smith, Northern New England Poison Center; SMITHC12@mmc.org; (207) 662-7085.

Office of Child and Family Services (OCFS), Maine Automated Child Welfare Information System (MACWIS). The Office of Child and Family Services (OCFS) assists Maine's children and families by providing Child Welfare, Children's Behavioral Health , Early Childhood, and Preventive services and supports. The Maine Child Welfare Information System (MACWIS) is the single electronic repository for Maine child welfare information and aides in the recording, tracking, and processing of all child welfare duties and functions. **Contact:** Lori Geiger, Information Service Manager; lori.geiger@maine.gov; (207) 624-7911.

Data, Research and Vital Statistics (DRVS). DRVS is an office within the Maine CDC. Death certificates are the source documents for the data on the vital events in Maine. The data include either all deaths occurring in Maine or only deaths to Maine residents depending upon the indicator, based on the death certificate database's ICD10 codes for alcohol- or drug-related deaths. Data include unintentional, self-inflicted, assault and undetermined intent deaths. **Contact:** Anne Rogers, Data, Research and Vital Statistics; anne.rogers@maine.gov; (207) 287-5468.

Parent Survey. In 2006, the Maine Office of Substance Abuse and Mental Health Services (SAMHS) commissioned Pan Atlantic Research, a Maine-based marketing research and consulting firm, to conduct baseline quantitative market research with parents of teenagers throughout the state on a range of issues related to underage drinking. The 2006 research was a component of a broader project being conducted in preparation for a parent social marketing campaign, the objective of which was to reduce teenage drinking in the State of Maine through improved parenting techniques and enhanced parental involvement. Pan Atlantic Research has subsequently conducted benchmarking research on this project for SAMHS and the Maine Center for Disease and Control in 2007, 2008, 2009, 2011, 2013, 2015 and now in 2017. Since 2008, the research has been designed to be more directly comparable to the 2009 (and future) Maine Integrated Youth Health Surveys (MIYHS). Also since 2008, the sample has been stratified on a statewide basis according to Maine's eight public health districts (150 completed surveys per PHD). Additionally, the sample composition since 2008 includes parents of 7th to 12th graders (200 per grade–1,200 total). The survey was redesigned in 2017 to increase the

emphasis on questions relating to teenage use of marijuana and prescription drugs. **Contact:** Jason Edes, Director of Research, Pan Atlantic Research; jedes@panatlanticresearch.com; (207) 221-8877 ext. 100.

Pregnancy Risk Assessment Monitoring System (PRAMS). PRAMS is an ongoing, population-based surveillance system designed to identify and monitor selected maternal behaviors and experiences before, during, and after pregnancy among women who have recently given birth to a live infant. Data are collected monthly from women using a mail/telephone survey. **Contact:** Thomas Patenaude, PRAMS Coordinator, Maine CDC; Thomas.Patenaude@maine.gov; (207) 287-5469.

Prescription Monitoring Program (PMP). PMP maintains a database of all transactions for class C-II through C-IV drugs dispensed in the state of Maine. Drug categories used in this report include opiates, sedatives, and stimulants. The counts included in this report represent the number of prescriptions and doses dispensed between 2013 and 2017. **Contact:** Office of Substance Abuse and Mental Health Services; SAMHS.PMP@maine.gov; (207) 287-2595.

Web Infrastructure for Treatment Services (WITS). WITS does not capture data from all treatment facilities or services provided in Maine and therefore is not a complete representation of ALL substance use treatment services provided in Maine. WITS is the State system that all licensed substance abuse treatment agencies are required by licensing rule to submit all data on substance abuse treatment services rendered. However, there are many organizations and private practitioners, such as primary care practitioners and independent substance use licensed counselors, who are not mandated to enter data in to the system. Analyses in this report are based on client-reported primary, secondary and tertiary drug(s) of choice as well as other demographic and background information that is collected at intake. It is important to note that the WITS system is not static; therefore, 2017 numbers may be artificially low. Drug categories included in this report are alcohol, marijuana, cocaine, heroin, synthetic opiates, methadone/buprenorphine and benzodiazepines. **Contact:** Office of Substance Abuse and Mental Health Services; SAMHS.PMP@maine.gov; (207) 287-2595.

2-1-1 Maine. 2-1-1 Maine is a free, confidential resource for individuals to connect to thousands of health and human services in Maine. 2-1-1 Maine maintains a statewide directory of resources including services for substance abuse, mental health, gambling addiction, housing, childcare and more. Individuals can contact 2-1-1 Maine and access needed information and referrals by calling 2-1-1 and speaking with a trained specialist in Maine, by texting their zip code to 898-211 and communicating with a Maine-based specialist, or by visiting www.211maine.org. 2-1-1 Maine's Contact Center operates 24 hours a day, seven days a week, 365 days a year. 2-1-1 Maine is a collaborative effort of the Maine Department of Health and Human Services, the United Ways of Maine, and The Opportunity Alliance as the Contact Center partner. **Contact:** info@211maine.org; Dial 2-1-1 or 1-866-811-5695; Text your zip code to 898-211.

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