# 2020
# COMMUNITY NEEDS ASSESSMENT & GAP ANALYSIS

## Aroostook Rural Communities Opioid Response Program

Aroostook County, Maine

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## Aroostook Rural Communities Opioid Response Program
Aroostook County, Maine

### Grantee Organization
AMHC - Aroostook Mental Health Services, INC.

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G25RH40023

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*The consortium would like to acknowledge Erik Lamoreau, Project Coordinator for his efforts in completing this report.*

# NEEDS ASSESSMENT & PRIORITY SETTING

## Executive Summary

In September 2020, Aroostook Mental Health Services, Inc. was awarded a $200,000, 18-month planning grant from the Human Resources and Services Administration (HRSA) Rural Communities Opioid Response Program (RCORP). A consortium, known as Aroostook Rural Communities Opioid Response Program (ACORP), was formed to reduce the morbidity and mortality of substance use disorder (SUD), including opioid use disorder (OUD).

ACORP is a consortium of stakeholders, champions, and people in recovery. In addition to Aroostook Mental Health Services, Inc., the consortium includes the Aroostook County Sheriff's Office, Cary Medical Center, Northern Light AR Gould Hospital, Houlton Regional Hospital, Northern Maine Medical Center, and a person in recovery. The consortium engaged stakeholders representing many sectors of the community (healthcare, law enforcement, tribal, social service, business, municipal, education) and, in particular, individuals with SUD/OUD who are in treatment and recovery; individuals who actively use substances; as well as affected others.

The community needs assessment results were developed through multiple strategies to achieve the qualitative and quantitative data necessary to reflect an accurate assessment of SUD/OUD prevalence, existing services, and gaps in service.

### Local Data

- Non-fatal opioid overdose responses are on pace to double in 2020 compared to 2019, specifically in northern and central Aroostook County. There were 43 overdoses in CY2019, and in the first six months of CY2020, there were 39[1].
- Fatal overdose rates have increased 81% in Aroostook County from 2019 to 2020. There were 11 fatal outcomes in CY2019, and in the first six months of CY2020, there were nine[2].
- The number of drug-related arrests has risen in the last three years, including a 61% increase in southern Aroostook County[3].
- Aroostook has the highest increase rate of new acute and chronic cases of Hepatitis C (HCV) per capita in Maine, with acute cases up from 18.4 cases per 100,000 residents in 2013 to 30.3 cases per 100,000 residents in 2017. Chronic cases are up from 24.8 cases per 100,000 in 2013 to 70.3 cases per 100,000 in 2017. 80% of new acute HCV cases can be accredited to injection drug use[4].

### Community Survey

ACORP's community survey included a total of 21 questions. The length of the survey did not deter strong community participation, with a total of 477 respondents. This suggests that Aroostook County residents are motivated to address the opioid epidemic. The majority of respondents indicated they are open to additional services like Syringe Service Programs (SSPs) and the expansion of Medication Assisted Treatment (MAT) but rated the overall community as less open-minded. The favorable response to new and expanded services may be an indication that the broader community is more ready than previously thought. The highlights include:

#### Prevention

- 91% believe there is a need for improved adolescent prevention programs.
- 78% would like to see the expansion of naloxone distribution through jails, treatment centers, emergency rooms, first responders, etc.
- 75% felt that expansion of Syringe Service Programs (SSPs) is needed.
- 41% are unfamiliar with the Good Samaritan Law (GSL).
- 81% are in favor of accessible HCV/HIV testing.

1 *2020, Aroostook Emergency Medical Services*
2 *Ibid*
3 *2020, Aroostook County Sheriff's Department*
4 *2018, https://www.maine.gov/dhhs/mecdc/infectious-disease/epi/hepatitis/index.shtml*

### Treatment

» 72% believe transportation is a barrier to treatment.

» 41% of persons in recovery (PIR) believe telehealth is a reliable alternative to in-person treatment compared to 60% of active using individuals who disagree in its reliability.

» 62% believe residents in smaller, more rural towns lack access to services than those who live closer to hub towns (Presque Isle, Caribou, Houlton.)

» Waitlists are the number one reason respondents believe the using community does not seek help.

### Recovery

» 63% agree in expanding peer recovery services including recovery coaching.

» 89% agree in expanding safe housing options, such as recovery residences.

### Stigma

» Stigma is the number two reason respondents believe the using community does not seek help.

## Key Findings

Through local data, the community survey, one-on-one interviews, focus groups, and community readiness tools, ACORP has identified the following needs:

### Prevention

» Opportunities for innovative engagement with youth.

» Improvements in screening youth at risk of SUD/OUD.

» Expansion of harm reduction services, including education and awareness about the services and their benefits.

» More support for affected others.

### Treatment

» Additional Medication-Assisted Treatment (MAT) services, including access to MAT for pregnant women.

» Increase access to services, particularly for individuals living in smaller, more rural towns.

» Opportunities for more engagement with people who use drugs (PWUD), including access to screening and treatment for HIV/HEP C and other infectious diseases.

### Recovery

» More recovery coaches to target populations, including individuals with SUD/OUD seeking support from the emergency department (ED), incarcerated/newly released, tribal members, and shelters.

» More recovery coaches in general, particularly in northern Aroostook.

» More recovery residences (sober houses) throughout Aroostook.

### Stigma

» Substantial efforts in education and outreach are required to reduce the stigma associated with SUD/OUD.

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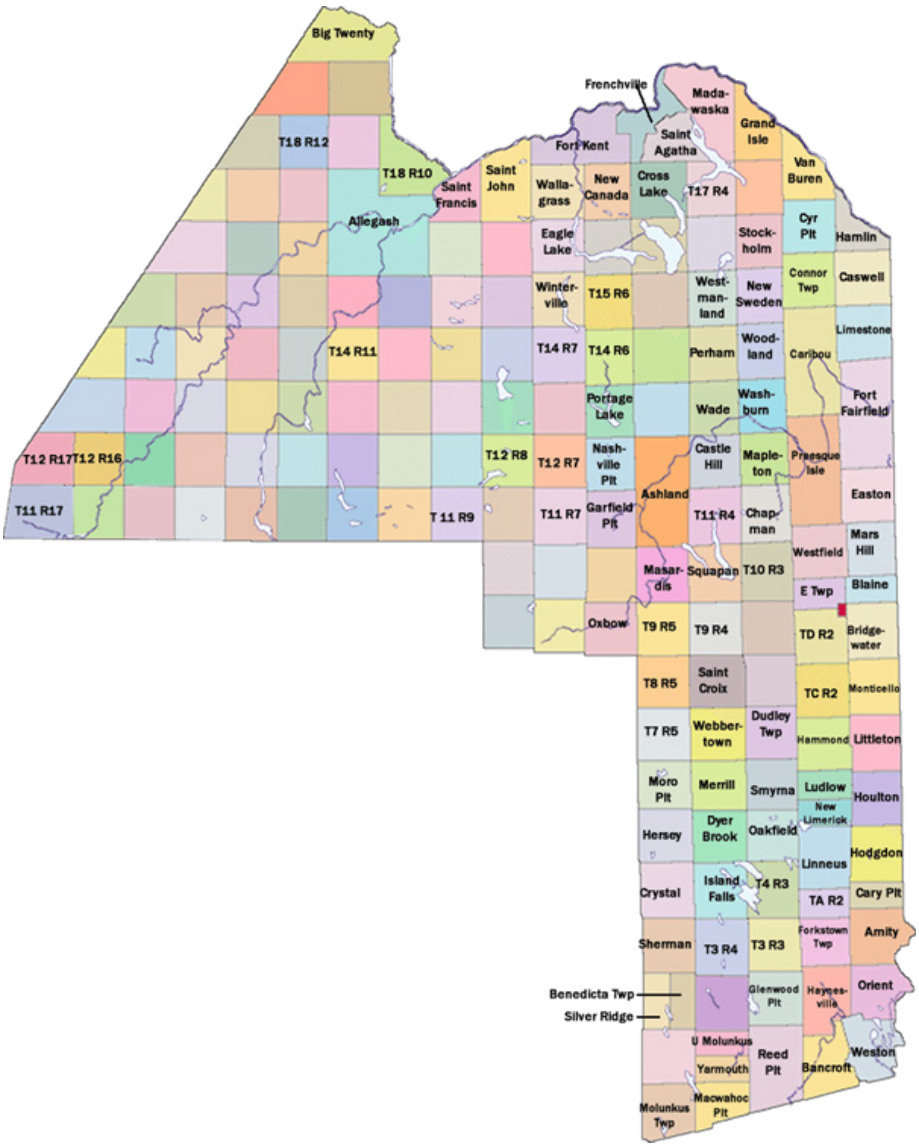
*Source: Google, 2018*

## Geographic Overview

Maine's Aroostook County is a sparsely populated area known as the "crown" of Maine. It is often referred to as simply "the County." Aroostook County is 6,453 square miles which are 21.2% of Maine's total area. As the largest county in Maine, it is the size of Connecticut and Rhode Island combined and the largest county east of the Mississippi River. Aroostook has two cities, 54 towns, 11 plantations (an organized territory with no formal local government), and 108 unorganized territories with 10.8 individuals per square mile[5]. Unfortunately, the region has experienced relative deprivation, including sustained outmigration by younger adults, which has halved the population since the 1970s. With 24% of residents over 65 years of age, Aroostook is one of the oldest counties in the nation. 80% of residents live in rural communities with little access to services. To travel from the town of Weston in the south to Fort Kent in the north, is a drive of nearly 217 non-highway miles. It is a challenge for the smaller towns to connect to the larger communities where the majority of services are available.




*Source: Google, 2016*

5 2010, *https://www.census.gov/quickfacts/aroostookcountymaine*

## Culture & History of Aroostook County

Aroostook can be characterized in three sections or districts: Northern, Central, and Southern Aroostook. Each community has a unique culture, history, and background.

### Northern Aroostook

With an estimated population of 15,598[6], Northern Aroostook is known for its strong Acadian and Swedish cultures. Many residents are bilingual, speaking both English and French. The most prominent industry is forestry. A good portion of employment comes from what it is referred to as "the woods." Fort Kent, with a population of 3,856, is the largest community. The town offers the University of Maine at Fort Kent, Northern Maine Medical Center, and a sizable outdoor heritage center for year-round activities. Fort Kent is also the home of the annual Can-Am International Sled Dog race which draws thousands of visitors each year.

*2019 Can-Am Sled Dog Race, Fort Kent*

Madawaska, with a population of 3,735, is 20 miles east of Fort Kent. It is the second-largest community and has a large paper mill, Twin Rivers Paper Mill, and is home to the annual Acadian Festival. Madawaska is the most bilingual community in Aroostook, with over 83% of residents fluent in French. The Acadian Festival brings people from all over the world who are part of the Acadian culture. Ploys, a traditional meal, are served freely among the participants. This Festival is Maine's largest cultural Festival. It is not uncommon to see the French or Acadian flag flown year-round in this part of the county. Northern Aroostook is also home to many lakes, waterways, and groomed trails, making it a very popular year-round destination.

*2019 Acadian Festival, Madawaska*

### Central Aroostook

With an estimated population of 35,869[7], Central Aroostook makes up the largest populated area of Aroostook County. Central Aroostook is known for its large potato crop and processing facilities. The agriculture industry employs the most individuals in Aroostook. According to the USDA, more than 51,300 acres of potatoes are grown annually. After years of decline, the industry is seeing a resurgence in acreage planted each year. Central Aroostook comes with an "early to rise" and hardworking ethic. As a farming culture, it contributes 1,650 jobs with annual revenues of $233,500,000.

*Aroostook Band of Micmac's 24th Annual Mawiomi*

Central Aroostook is also home to one of the two tribes in the county. The Aroostook Band of Micmacs has an estimated population of 562[8]. The tribe has its own health center, prevention services, drug task force, trout farm, vegetable farm, housing units, and homes across Aroostook County. They also have an active youth program known as the Boys and Girls Club of Border Towns. Nearly 70% of the tribe lives within a 20-mile radius of Presque Isle[9].

Considered the hub of Aroostook, Presque Isle is the county's largest city. It has the University of Maine at Presque Isle, Northern Maine Community College, a large business district, and Northern Light A.R. Gould Hospital. Presque Isle also has the only passenger airport in Aroostook, the Presque Isle International Airport. Caribou, the second-largest city, borders Presque Isle. Caribou has a new state-of-the-art community school, Cary Medical Center, and a large business district. Presque Isle and Caribou combined have an estimated population of 16,600, making up almost 25% of the population for the whole county.

6 2010, https://www.census.gov/quickfacts/aroostookcountymaine
7 2010, https://www.census.gov/quickfacts/aroostookcountymaine
8 2020, http://micmac-nsn.gov/
9 2020, http://micmac-nsn.gov/

*The Northern Maine Fair, Presque Isle*

*Maine Potato Blossom Festival, Fort Fairfield*

Central Aroostook is also the home to the Northern Maine Fair, a tradition for more than 150 years. The Potato Blossom Festival held in Fort Fairfield is another staple in the county, with more than 100 events over nine days. It is a large attraction in Maine for visitors to come and experience the farming culture. The 74th Annual Potato Blossom Festival will be held in 2021.

## Southern Aroostook

With an estimated population of 15,588[10], Southern Aroostook is slightly lower in population than northern Aroostook. Southern Aroostook has many camping opportunities, clear lakes, hiking, snowmobiling trails, and some of Maine's most beautiful scenery. At the end of the I95 corridor is the largest town, Houlton, which serves as the primary access point to the rest of Aroostook County. The town also sees a large number of visitors traveling to Canada. Due to its proximity to the Canadian border, a large portion of the southern Aroostook economy is a result of Canadians coming to Houlton to purchase less expensive fuel, groceries, and other essential supplies.

*Top: Houlton River Front Park*
*Bottom: "Million Dollar View" in Weston*

Southern Aroostook is known to be very proud of its English rural roots. So much so that Houlton is known as the "Shiretown." With an estimated population of 5,752, Houlton is the third-largest town in Aroostook. It has large truck stops, Houlton Regional Hospital, Houlton Higher Education Center, and is home to the Aroostook County Jail. Established in 1807, it is the oldest town in Aroostook. Hodgdon is southern Aroostook's second-largest town, with an estimated population of 1,267[11]. The region includes plants or divisions of national or international corporations, including LP (Louisiana Pacific), Smith and Wesson, and Tate and Lyle. Southern Aroostook could be characterized as a "little of everything" as it has both potato farms and a lumber industry, both staples of the other districts of Aroostook.

Due to COVID-19, the border is currently closed to the public. This has hurt the economy of Southern Aroostook which relies on its Canadian neighbors to support local business and commerce. Southern Aroostook is home to the Houlton Band of Maliseet Indians. The tribe has a population of 869 and has been recognized by the U.S. government since 1980[12]. The Maliseets are a smaller band of a much larger tribe across the Canadian border. They have many of their own services including vocational rehabilitation, education, a health center, and an economic development program.

## Summary

Aroostook County has a diverse culture. In 2019, it had an estimated population of 67,055. In 1960, Aroostook had 106,064 residents[13]. The large number of seniors mixed with the outmigration of young adults has depleted the workforce, resulting in less income and causing rural areas to be even less densely populated. With its large size and shrinking population, staying connected is more challenging than ever. Aroostook has two active tribes. The two most populated cities (Caribou and Presque Isle) border each other and provide the most resources and services. This makes it challenging for smaller rural communities who are not near those service areas to access what they need to live well and thrive as communities.

10 2010, https://www.census.gov/quickfacts/aroostookcountymaine
11 2010, https://www.census.gov/quickfacts/aroostookcountymaine
12 2020, http://www.maliseets.com/index.htm
13 2010, https://www.census.gov/quickfacts/aroostookcountymaine

# VISION, MISSION, & PLANNING VALUES

## Mission

Aroostook Rural Communities Opioid Response Program (ACORP) aims to reduce the morbidity and mortality of substance use disorder (SUD), including opioid use disorder (OUD), by improving the capacity and infrastructure for prevention, treatment, and recovery services in northern, central, and southern Aroostook County.

## Vision

ACORP will provide education, decrease systemic cultural stigma, and reduce barriers to improve the accessibility and availability of services to those affected by SUD/OUD in Aroostook County.

## ACORP Values

The ACORP consortium is a compassionate partnership focused on solutions that provide hope and healing for anyone affected by substance use disorder or the opioid epidemic. ACORP members demonstrate integrity, equality, transparency, dignity, and community input to achieve our mission and vision.

# NEEDS ASSESSMENT METHODOLOGIES

ACORP has employed a variety of resource strategies to ensure an accurate account of the needs of its county as it relates to SUD and OUD. Using quantitative and qualitative data, ACORP collected as much region-specific data as possible from northern, central, and southern Aroostook County. As demonstrated below, both primary and secondary data were used to develop the needs assessment.

ACORP methodologies for collecting primary (qualitative) data:

- CDC community readiness tool
- One-on-one interviews
- Focus groups
- Community survey (both qualitative and quantitative data)

ACORP methodologies for collecting secondary (quantitative) data:

- Regional: local hospitals, EMS (Emergency Medical Services), law enforcement, social service organizations, and community stakeholders
- County-wide: SEOW (State Epidemiological Outcome Workgroup), Community Health Needs Assessment
- County and statewide: U.S. Census Bureau, SEOW, statewide service partners including Maine Office of Behavioral Health (MBOH) and Maine Center for Disease Control (MCDC)

# Primary Data Strategies

## CDC Community Readiness Tool

Members of the ACORP consortium conducted a group assessment prior to asking the community what they believe are the gaps in services. The community readiness tool outlines evidence-based practices that help combat the opioid epidemic. The practices were evaluated by consortium members and close colleagues to gain insight on what our communities may be ready to adopt for strategies. It also highlighted the need for education about the existing services that were previously unknown by the consortium and other community members.

The community readiness tool was provided to law enforcement representatives, healthcare workers, and current/past using individuals. Twenty unique individuals returned their evaluation. While there were ten evidence-based strategies in this tool, ACORP focused on four, naloxone access and distribution, medication-assisted treatment (MAT), Good Samaritan Laws (GSL), and syringe service programs (SSP). The strategies chosen were based on the previous gap analysis conducted early on in the process. The strategies measured the following: which services already exist in our regions, one's own awareness of the services and what they offer, our perception of our community's awareness, the need to expand, and the level of buy-in we believe our community has for each strategy. A copy of the community readiness tool is included in this document's addendum.

### One-on-One Interviews

Interviews were conducted over two months with multiple stakeholders, representatives, allies, people in recovery, and actively using individuals. Interviewees were asked a series of questions about their perceptions of opioid use disorder and substance use disorder in Aroostook County. They were asked for input on needs, gaps, and solutions. Many professionals donated their valuable time to participate. Despite the daily challenges they face dealing with COVID-19, they were eager to join a Zoom call to discuss their concerns about the opioid epidemic. Aroostook's recovery community also willingly participated by Zoom or in-person where allowed. They were interested in the needs and particularly helpful in identifying the gaps. There were some challenges in encouraging the homeless and active population to participate. The incentive of a gift card increased their willingness to share their opinions. As a result, we had ten homeless and actively using individuals participate in the county-wide interview process. While interview questions varied by population, a sample interview guide and a list of interviewees are included in this document's addendum.

### Focus Groups

One of the most challenging parts of this needs assessment was organizing and completing focus groups. COVID-19 prevented in-person meetings with incarcerated individuals, healthcare workers, or any group with more than five people. Digital platforms were available, and many agreed to join an on-line focus group. Unfortunately, many were no-shows. The time and effort to schedule digital focus groups and then not get the expected participation was frustrating but understandable. With the uptick in people needing support in our communities, service providers rarely were able to help organize or get individuals together long enough to perform a focus group. Thankfully there were some successes, including consortium member participation and local residential SUD counselors, residential treatment clients, and the local recovery community. ACORP consortium helped develop the list of questions asked at the focus groups. Depending on the particular audience, each group was asked a form of the same question. Populations represented in the focus groups are noted below, and results will be reflected throughout this needs assessment. A copy of the focus group questions is included in this document's addendum.

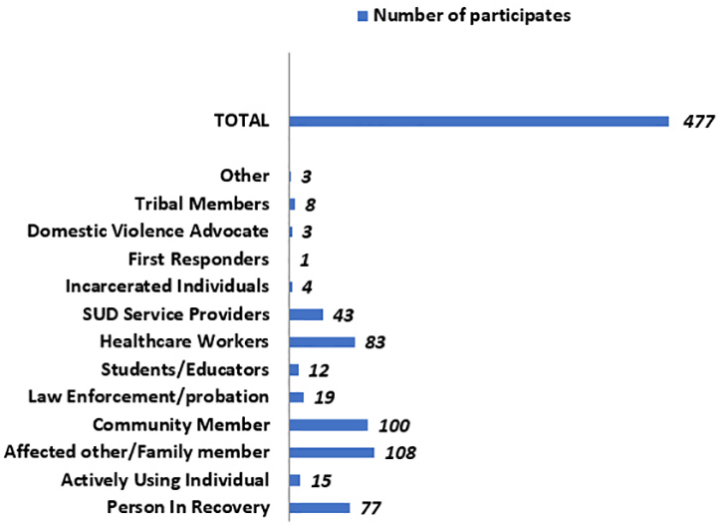
### Community Survey

One of the great successes of this needs assessment was the participation in the community survey. The survey was developed in a manner that would allow any community member to share their perceptions on stigma, evidence-based strategies, future hopes, needs, and gaps and assesses their understanding of what services already exist. The community readiness tool noted earlier provided the launching point for what to ask in the community survey. Naloxone services, syringe services, MAT services, and Good Samaritan Laws were highlighted in the survey. These focal points provided us with a clear picture of our community's knowledge of evidence-based practices. Surveys were distributed across Aroostook County through a variety of methods. The AMHC website, AMHC facilities, social media, community flyers posted at various businesses, and local media were utilized as partners in distributing the survey as widely as possible. The survey was open for 30 days and closed on December 20, 2020. Surveys took an average time of 14 minutes to complete. If an individual chose to offer their contact information, they were placed in a drawing for four gift cards of $50 each. This incentive helped increase participation. (Please note: contact information was optional, and an individual could remain anonymous.)

The survey was created on Microsoft Forms and easily accessible with a QR Code or direct link. In closing, 477 participants have completed the survey, which provided

reliable qualitative and quantitative data from each region of Aroostook. The survey data has been collected in a format that allows us to drill down on the specific population, region, age, ethnicity, and level of need for all evidence-based models presented in the survey. This allows Aroostook County to accurately portray our needs and form meaningful plans for our future. Highlights include the large number of respondents of persons in recovery (PIR) and affected others as well as overall individuals connected to opioid misuse. This is noted in the graphs below.

### Population of Participants in Community Survey




*Source: AMHC Community Survey, 2020*

### Have You or Someone Close to You Ever Misused Opioids?


*Percentages based on the number of total responsents.*
*Source: AMHC Community Survey, 2020*

The data will be used throughout the needs assessment. A copy of the community survey is included in this document's addendum.

### Table of Qualitative Data Methodologies

**Qualitative Data Collection Chart**

| *Population Identification* | Key Informant Interviews | Focus Group | Community Readiness Tool | Survey Representation |
|---|---|---|---|---|
| SUD Service Providers | X | X | | X |
| Healthcare Workers | X | | X | X |
| MAT Providers | X | | X | X |
| Law Enforcement | X | | X | X |
| Residential Treatment Clients | | X | | X |
| Seniors | X | | | X |
| Homeless | X | | | X |
| Incarcerated Individuals | | | | X |
| People in Recovery | X | X | X | X |
| Currently Using Individuals | X | | X | X |
| Local Native American Tribes | X | | | X |
| Domestic Violence Advocates | X | | | X |
| Sexual Assault Service Providers | X | | | |
| Local Municipality Representatives | X | | | |
| Veteran Representatives | X | | | X |
| Students/University Representatives | X | X | | X |
| Recovery Service Providers | X | X | X | X |
| EMS/First Responders | | | | X |
| Family Member/Affected Other | X | | | X |
| Community Member | X | X | | X |

## Secondary Data Strategies

### Local Services

The most important data comes from local sources. These are the "boots on the ground" groups and offer area-specific information and numbers. ACORP made connections with local hospitals (Northern Light A.R. Gould, Cary Medical Center, Northern Maine Medical Center, and Houlton Regional Hospital) to help gain valuable insight into morbidity and mortality rates within our local regions. The Aroostook County Sheriff's Department provided data on local arrest rates and individuals' identified charges. The Sheriff's Department also oversees the Aroostook County Jail—the only jail in the county. ACORP was fortunate to receive an "all-access" type approach by Sheriff Shawn Gillen, a consortium member.

Aroostook County has a well-connected Emergency Medical Services (EMS) program. It gave ACORP current regional data on overdose responses, transports to hospitals after an overdose, and naloxone administration. Aroostook Mental Health Services, Inc. (AMHC), Aroostook's largest SUD service provider, released current regional information on local intakes for various local SUD prevention, treatment, and recovery services across the county. Maine Access

Point (MAP) is a local partner that provides harm reduction services, including training around naloxone. They are required to collect data that is localized and distribute that data to the CDC, their contractor. This quantitative data fills in the gaps for the services that aren't in hospitals, EMS, or law enforcement efforts. The quantitative data will be reflected throughout the needs assessment.

## County-Wide Data Sets

Obtaining regional (northern, central, and southern) data was challenging (apart from the local data sources noted in the previous section). Predictably, county-wide data was more readily available. Maine has a SEOW (State Epidemiological Outcome Workgroup) that provides several state-wide data sets. SEOW also provides region-wide information based on population. Due to its large territory, SEOW collects data specific to Aroostook County, allowing us to compare Aroostook to the State of Maine. Due to funding, SEOW stopped doing local data reports in 2017. However, Aroostook County Action Program (ACAP) completed and released a 2020 community health needs assessment that provides helpful information for this assessment. Their quantitative data will be used as a current and accurate representation of county-wide health needs. The assessment provides solid information on the overall well-being of our citizens.

## Geographic Data Sets

The "go-to" data set for geographical, population, community income, and diversity is the U.S. Census Bureau. The Census is a well-known and cited source of quantitative data used nationwide. At the time of this assessment, the 2020 Census information had not been released. However, the Census Bureau uses algorithms to do estimations on local numbers. ACORP will use the 2019 estimates to better reflect a realistic and current assessment of Aroostook County. ACORP found this approach more effective given that the last full census report was released in 2016. With the opioid epidemic changing quickly from year to year, it was important to have current data.

## Statewide Sources

The State of Maine has a state agency under the Department of Health and Human Services (DHHS), known as the Maine Office of Behavioral Health (OBH). As it relates to SUD, OBH provides most of the state numbers. OBH is the lead contractor for SUD services and funnels federal funds to local and state organizations to complete the mission of the contracts issued. OBH provides data sets for a number of SUD/OUD services and makes the information easily accessible to the public. Although OBH data is generally one year old by the time it is issued, it nevertheless provides valuable information. OBH also has a marketing campaign that provides statistics that reflects the State of Maine as a whole. Some statistics include drug-affected infant data, prescription monitoring data, and Web Infrastructure for Treatment Services (WITS) information. Maine Center for Disease Control (CDC) offers Statewide data related to harm reduction services. CDC has a reliable data collecting system that reflects the services it oversees in Maine. This information will be reflected in the needs assessment.

### Table of Qualitative Data Methodologies

**Quantitative Data Collection Chart**

| *Organization* | SUD/OUD Service Data | Community Health Data | Overdose / Naloxone / Harm Reduction Data | All Other Informational Data |
|---|---|---|---|---|
| Local SUD Service Agencies (AMHC) | X | | | X |
| Aroostook County Hospitals (A.R. Gould, NMMC, Cary, HRH) | X | X | X | |
| Maine Access Points (MAP) | X | | X | |
| Aroostook County Sheriff Dept. | X | | X | X |
| Local State Agency (Maine OBH) | X | X | X | X |
| State Epidemiological Outcome Workgroup (SEOW) | | X | X | X |
| Local Emergency Medical Services (EMS) | | | X | X |
| Maine Center for Disease Control (MCDC) | | X | X | X |
| U.S. Census Bureau | | X | | X |

# OVERVIEW OF FINDINGS

## Existing Services

There are 13 substance use treatment facilities in Aroostook – a rate of 1.8 sites per 10,000 in population. However, in a sparsely populated area where transportation can prove a near-insurmountable barrier, access to treatment can be difficult. Notably, AMHC is the only agency in Aroostook County currently providing MAT Clinics in an outpatient setting with formal peer recovery services for adults with substance use and severe and persistent mental health disorders.

## Prevention

Services are limited and primarily focus on youth. Programs are dependent on funding which varies the consistency of efforts. Programs include AMHC's Aroostook Teen Leadership Camp, which reaches approximately 100 Aroostook teens per year with a primary focus on mitigating substance use, in addition to promoting leadership. In 2020, AMHC was awarded a contract with Maine Youth Access Network to build young people's leadership on issues of social justice, restorative practices, and public health, including addressing prevention efforts around substance use. Aroostook County Action Program's Drug-Free Communities works with coalition members to address factors that increase substance use and promote factors that minimize youth risk. The Aroostook Substance Abuse Prevention Coalition promotes youth activities to enhance education concerning substance use and its impact on their overall health. This program also serves adults, primarily incarcerated individuals. Cary Medical Center has a program called Power of Prevention (POP). The program primarily focuses on community education and prevention around the dangers of smoking, vaping, alcohol, and marijuana use. POP recently received additional funding to help with prevention efforts of more controlled substances such as opioids. Limited to northern Aroostook, the Community Health Needs Collaborative at Northern Maine Medical Center seeks to promote youth engagement by offering community activities to support education and awareness of the long-term effects of substance use, including tobacco use, obesity, and chronic health conditions. Finally, the Boys and Girls Club of Border Towns includes substance use prevention efforts targeted to Native American youth located in central Aroostook.

### Harm Reduction

Aroostook has a volunteer naloxone distribution group that trains and provides naloxone to anyone wanting the reversal drug. These distributors are local advocates who work together with agencies, schools, individuals who use drugs, people in recovery, and family members. Overdose prevention in Aroostook County has taken significant steps forward, including naloxone distribution at the Aroostook County Jail. Maine Access Points (MAPS) and AMHC have partnered to ensure that everyone who wants naloxone has access to it. Local data shows that from 11/1/2019 to 11/30/2020, 1,775 kits or 3,550 doses were distributed in Aroostook County[14].

Syringe Service Programs (SSP) are not available in Aroostook County. However, COVID-19 has resulted in an Executive Order by Maine's Governor Mills, which allows for the mailing of safe use supplies[15]. Since the order took effect, MAPS enrolled 89 unique individuals in Aroostook County, an unexpectedly high number given our population size[16].

The chart below reflects the harm reduction efforts here in Aroostook County.

### Aroostook Mental Health Center & Maine Access Points—Health Promotion Strategy/Harm Reduction Data (11/01/2019-11/30/2020)

| | |
|---|---|
| Number of unique participants in Mail Delivery SSP (syringe service program) in Aroostook | 89 |
| Number of Trained Community Naloxone Distributers / Trainers | 12 |
| # of unique individuals in the OEND (Opioid Overdose Education and Naloxone Distribution) Program<br>*OEND programs train laypersons to respond during overdose events and provide access to naloxone and directions for drug delivery* | 213 |
| Total # of naloxone kits distributed by AMHC SUD peer centers staff | 484 kits or 968 doses |
| Total # of naloxone kits distributed in Aroostook County | 1775 kits or 3550 doses |

*Source: Maine Access Point, 2020*

14 *https://www.maineaccesspoints.org*
15 *2020, https://www.ama-assn.org/*
16 *2020, https://www.maineaccesspoints.org*

### HIV/HCV Testing

Maine has had a 314% increase in acute HCV cases since 2013, and 80% of those are cases are among individuals who use drugs.[17] In Aroostook, the Maine CDC funds HCV testing for people at increased risk, i.e., persons who inject drugs (PWID), however clinic hours are very limited at the Maine Family Planning sites in Aroostook where the tests are available. Mostly, an individual who wants to be tested for HCV must have a primary care doctor and insurance coverage. This applies to treatment as well. An HCV treatment provider said: "Currently, HCV treatment is a minimum of $80,000 and is administered at only a few primary care facilities in Aroostook." In other words, PCP's who are capable of providing treatment usually refer the individuals to specialists instead of doing treatment themselves. As a result, even if you can get tested, you may not get treatment quickly. Aroostook shows one of the largest increases of acute HCV cases in Maine and HCV (chronic) diagnosis increases in general[18]. This would reflect the need for more testing and treatment.

Given that nearly 60% of new infections are due to injection drug use[19], (IDU) demonstrates a strong case for implementing a syringe service program (SSP) which is proven to lower rates of disease in people who use drugs (PWUD). While data shows that HIV in Aroostook is on the decrease, it may be due to under-reporting of IDU. The following chart reflects the steady increase in HCV cases in Aroostook County compared to the State of Maine.

| | Aroostook 2008-2012 | Aroostook 2013-2017 | Maine 2013-2017 |
|---|---|---|---|
| Hepatitis C (acute) new cases per 100,000 population | 18.4 | 30.3 | 44.0 |
| Hepatitis C (chronic) new cases per 100,000 population | 24.8 | 73.0 | 92.8 |

*Note: Not all Maine counties kept data in 2008-2013 making state data unmeasurable.*
*Source: SEOW, 2018*

17 2018, https://www.maine.gov/dhhs/mecdc/infectious-disease/epi/hepatitis/index.shtml
18 2018, www.maineseow.com
19 2018, https://www.maine.gov/dhhs/mecdc/infectious-disease/epi/hepatitis/index.shtml

## Treatment

Each of the three districts (northern, central, and southern) in Aroostook County provides outpatient substance use services (as previously noted, there are 13 in total). AMHC, the largest behavioral health services provider in Aroostook, offers a continuum of care for treatment services, including assessment, brief intervention, intensive individual and group treatment, and family treatment. There are smaller providers throughout the county who offer individual outpatient, MAT, and non-intensive group services.

As the largest provider of substance use services in Aroostook, AMHC has five MAT (Medication Assisted Treatment) Clinics, DEEP (Driver Education and Evaluation Program), Detox Management Services, and a 28-day Residential Treatment Facility. As part of its holistic care model AMHC advanced its MAT service to offer Opioid Health Home (OHH), a value-based payment and care coordination model promoted and supported by MaineCare (the State of Maine's Medicaid program) and includes nurses and peer recovery services. AMHC partners with the Aroostook County Jail by offering Breaking Free Groups, Relapse Prevention Groups, individual treatment, MAT services, and peer recovery services on site. AMHC partners with Pines Health Services, a federally qualified health center, to provide the only Women's and Children's MAT Clinic in Aroostook (Caribou). AMHC also offers "Pain on the Brain" Treatment intervention for MAT clients who are challenged by managing chronic pain through a cognitive-behavioral approach versus a sole medication management approach (this integrative health care model was developed by an AMHC behavioral health provider who works on-site at an FQHC. The model was then adopted throughout the State with the assistance of a Maine Quality Counts educational series.)

### AMHC Intake & Screening Data

| | CY2018 | | CY2019 | | CY2020 (1/1-6/30) | |
|---|---|---|---|---|---|---|
| Total Number Screened for SUD: | 321 | | 351 | | 212 | |
| Total Diagnosis of OUD: | 59 | | 70 | | 29 | |
| Location at intake | Total SUD | Total OUD | Total SUD | Total OUD | Total SUD | Total OUD |
| Northern Aroostook (Fort Kent, Madawaska) | 65 | 12 | 68 | 20 | 52 | 5 |
| Central Aroostook (Caribou Presque Isle) | 189 | 42 | 186 | 41 | 119 | 22 |
| Southern Aroostook (Houlton, Hodgdon) | 67 | 5 | 97 | 9 | 41 | 2 |

*Source: AMHC, 2020*

AMHC provides the behavioral health services, including MAT Induction services, for the HRSA-funded Rural Recovery Network grant led by Cary Medical Center working with four other rural hospital emergency departments (Northern Maine Medical Center and Houlton Regional Hospital in Aroostook County; Millinocket Regional Hospital in Penobscot County and Mount Desert Island Hospital in Hancock County). This grant educates Emergency Department (ED) providers, law enforcement, and ambulance staff about what to do when they encounter an individual in crisis and in need of MAT services to manage their OUD. The training includes how to initiate the process of medically stabilizing an individual so they can then begin to receive treatment and substance use peer recovery services. This project provides education and immediate medical care only. AMHC has complimented the work by offering behavioral health crisis services to support community linkages to treatment services and referrals to substance use peer recovery coaches.

A key initiative by Governor Mills of Maine is to offer incarcerated individuals who suffer from opioid use disorder (OUD) the ability to access MAT services in the jail[20]. AMHC partners with the Aroostook County Jail (ACJ) to provide behavioral health services and, as of July 2020, an on-site MAT clinic that includes medication, substance use treatment, and support with referrals to behavioral health services for case management that helps link individuals to treatment, naloxone, social and peer recovery resources. Since the clinic started, 30 inmates have enrolled or continued their MAT treatment while incarcerated.

In 2020, Wabanaki Public Health received an HRSA RCORP Implementation Grant. Wabanaki Public Health includes the two tribal communities in Aroostook County, the Houlton Band of Maliseet Indians in Houlton, Maine, and the Aroostook Band of Micmac Indians in Presque Isle, Maine. Their implementation grant is focused on efforts to place a recovery center in northern Penobscot County (Millinocket, Maine). This town was selected due to its central location for the five tribes in Aroostook, Washington, and Penobscot counties. The tribal populations have tremendous influence and impact on the overall community and economy of Aroostook County.

## Recovery

AMHC offers substance use peer recovery community centers (RCCs): Aroostook Recovery Center of Hope (ARCH) in Houlton and Roads to Recovery Community Center (R2RCC) in Caribou. Center staff partner with local grassroots efforts and community members, namely Link for Hope in Houlton and Recovery Aroostook in Caribou, who volunteer their time to support various activities, including individual and group support.

R2RCC in Caribou gets an average of fifteen visits per day, and ARCH in Houlton receives an average of five visits per day, numbers that demonstrate that they are well known and utilized recovery connection outlets. The centers are staffed by individuals with lived experience in SUD. Northern Aroostook does not have a recovery center.

Recovery coaching programs have developed and serve as a continuum of care for individuals who identify as in recovery or are still actively using. AMHC's peer recovery coaches play a key part in the community outreach for individuals who participate in the Opioid Health Home (OHH) service. Coaches engage individuals by encouraging follow-through and follow-up on their recovery goals. Coaches primarily operate out of the recovery centers and provide a voice for people who still use drugs. Aroostook has 18 trained recovery coaches based on the (Connecticut Community for Addiction Recovery) CCAR model, but only six coaches are active[21].

Coaches help navigate some of the toughest challenges for a person at their bottom, including assistance with signing up for Mainecare, making referrals to services, peer support, housing opportunities, and links for employment. In the State of Maine, recovery coaches are not a reimbursable service and function as volunteers. As a result, and even though demand is high, it is challenging to retain coaches. Until Maine has a certification process, recovery coaches will remain as volunteers. Recovery coaches in Aroostook County are active in ACJ, Hospital ER's, and locally throughout the community.

Throughout Aroostook, numerous Narcotics Anonymous, Alcoholics Anonymous, and similar groups occur in places of worship, local hospitals, and other facilities.

Central Aroostook County is home to Caribou Recovery House (CRH), the only recovery residency (sober house) in the county. This Maine Association of Recovery Residency (MARR) certified home is for men only and supports individuals enrolled in a MAT program. CRH houses seven, including the house manager. Opened in Spring 2020, it

20 2019, *https://www.maine.gov/future/sites/maine.gov.future/files/inline-files/MaineOpioidResponse.StrategicActionPlan.FINAL_.12.11.19.pdf*
21 2020, *www.AMHC.org*

has been at nearly 100% full capacity since that time. There is no women's recovery residency at the time of this assessment; plans are in the works to open the first one in 2021.

The Aroostook County Action Program (ACAP) also facilitates a new and innovative federal-funded program called the Connecting with Opportunities Initiative. Peer connectors help participants overcome barriers to employment; each participant also benefits from a workforce development specialist with expertise in career planning. This program is specific to displaced workers affected by OUD.

## Summary

Aroostook County has demonstrated a willingness to improve and support new evidence-based practices around prevention, treatment, and recovery of individuals with SUD. Aroostook has improved with the addition of new treatment modalities; however, northern and southern Aroostook still lacks many services located in the central region. With MAT services expanding, youth education continuing, recovery options available, and harm reduction services starting, where do we go from here?

# GAPS & NEEDS

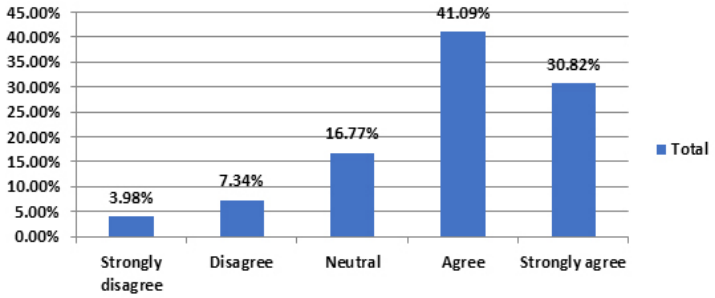
Although treatment and recovery options have improved since 2018, service gaps remain a challenge. Access and services vary widely in northern, central, and southern Aroostook; most prevention, treatment, and recovery services are closer to the larger towns and two cities. Maine's public health infrastructure has been stripped of much of its funding over the past decade – tobacco-litigation-related revenues once earmarked for prevention have plugged holes in the State of Maine's General Fund. Substance use and mental health-oriented programming is no exception. Most federal government (SAMHSA) funding to Maine is distributed through DHHS's Office of Behavioral Health through contracts with agencies and organizations. Rural areas like Aroostook County are typically underfunded as the contracts are written for the population rather than service size. This leaves large gaps in services for small rural communities outside the "brick and mortar" base sites.

The 2019 Community Health Needs Assessment (CHNA) cited several gaps in substance use services for Aroostook County. Prevention needs include, increased funding for strategies for age birth and up and more prevention in schools. Treatment needs include, more transition housing, structure, and reimbursement for treatment services, increased inpatient availability and outpatient follow-up and accountability, local residential care and methadone. Recovery needs include, greater access to sober houses, jobs, advocacy, and an increase in recovery coaches.

A significant barrier to treatment is transportation. Aroostook has no public transportation system outside the larger towns. Individuals with SUD rely on a Medicaid transportation system called Logisticare. Logisticare has posed challenges due to the unpredictability and inconsistent reliability of drivers. A person in recovery who receives MAT services explained it this way: "They are good at getting me here, but I could wait four hours for a ride home. How am I supposed to get a job if I am here all day?"

Peer recovery services are not billable services in Maine. Therefore, Logisticare cannot offer rides to and from recovery centers, group meetings, or recovery coach appointments for individuals on Medicaid. Our community survey results reflect the transportation barriers in accessing treatment and recovery services. The chart below reflects responses to the transportation barrier in ACORP's service area.

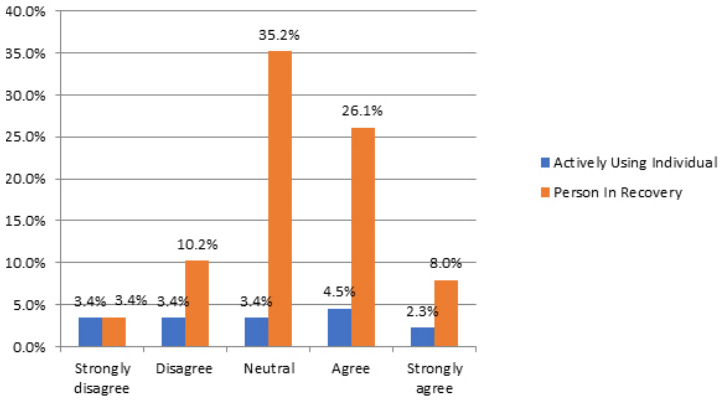
### Transportation is a Barrier to Accessing SUD Services




*Source: AMHC Community Survey, 2020*

An unexpected benefit of COVID-19 is the expansion of telehealth services. At AMHC, there has been a decrease in no-shows and cancellations and higher attendance rates to group therapies. Telehealth has brought opportunities for individuals to maintain a connection to services. One drawback to telehealth is the induction process of MAT Clinic services, which requires face-to-face interaction. However, once treatment has started, services are accessible by telehealth. Our community survey shows that nearly 1/3 of respondents agree that telehealth is a viable option to continue treatment and reduce transportation barriers, while more than 1/4 disagrees. Ideally, Aroostook County will offer what works best for the individual, be it in-person, by telehealth, or a combination of multiple platforms. Based on the ACORP community survey, 41% of PIR agree that telehealth in Aroostook County is a reliable option to continue treatment.

### PIR & Active Individual Using Telehealth




*Source: AMHC Community Needs Survey, 2020*

## Prevention

Prevention in Aroostook County is where most gaps are identified. This section will look at two gaps: youth and parent education and harm reduction strategies.

### Youth, Young Adult, & Parent Education

The vast majority of prevention work in Aroostook County is focused on youth drinking, smoking tobacco, and vaping for youth ages 18 and under. Initiatives are under development by local partners to increase awareness of opioid misuse in teens. However, our community survey showed that 91% of respondents agree with expanding new evidence-based prevention programs for adolescents and teens. Additionally, AMHC has identified a lack of screening for youth at risk of SUD/OUD. More education and training are needed for the youth workforce (educators, case managers, etc.) to prevent the development of SUD/OUD. As for young adults ages 18+, the community survey showed that a number of parents or affected others do not have access to programs or groups that help parents understand OUD in their adult children. One parent said: "I feel helpless not knowing what to say, do or relate to what they are going through or even if I should. I almost feel like I am watching my child die in front of me. I am completely powerless." There is a need for opportunities to educate parents and adult children on having a conversation about opioid use. Parents are essential to creating empathy which helps reduce stigma. One service provider stated, "They have 5k runs and events to support cancer, eating well, even for holidays, but no events on fighting substance use." Peer recovery centers are focused on serving individuals seeking recovery, not affected others. However, Kayty Jalbert, Peer Support Specialist at Roads to Recovery Community Center shared, "70% of our calls to the center are parents wanting help for their kids (adult children), and we can't offer them much outside of Al-anon."

### Harm Reduction & Health Promotion Strategy

ACORP took an active approach to further developing our knowledge around Harm Reduction and Health Promotion. As previously stated, Aroostook County has many services; however, outside of naloxone distribution, other health promotion strategies are nearly nonexistent. For example, Aroostook shows one of the largest increases of acute HCV cases in Maine, and HCV (chronic) diagnosis increases in general. This would reflect the need for more testing and treatment, Syringe Service Programs (SSP), and education on Good Samaritan Laws (GSL).

### CDC Community Readiness Tool Results

ACORP targeted populations based on consortium representation: law enforcement, current/past using individuals, and healthcare workers. The number of representatives completing the tool is noted along with the results.

- Law enforcement: n=3
- Healthcare workers: n=7
- Current/past using individuals: n=10
- Total completed: n=20

The results show a consensus to expand all three strategies. Interestingly, it also reveals that ACORP members do not believe the local community will support them, further demonstrating a need to focus on education. Surprisingly, local healthcare workers are in support of SSPs. With these results from our community leaders, we look toward data to support these strategies and community feedback.

***Strategy #1: Naloxone Access/Distribution***

| *Population* | *Personal awareness* | *Community awareness* | *Services Exist Here* | *Need to Expand* | *Level of Buy in within community* |
|---|---|---|---|---|---|
| Law enforcement | 4.75 | 2.25 | 4.25 | 4.0 | 2.0 |
| Healthcare workers | 4.16 | 3.14 | 3.8 | 4.5 | 2.85 |
| Current/past using individuals | 4.78 | 2.56 | 4.45 | 4.38 | 2.38 |
| Total | 4.56 | 2.65 | 4.16 | 4.3 | 2.41 |

Results are based on average of all responses per population. 1=not at all 5=absolutely

***Strategy #6: Good Samaritan Laws (GSL)***

| *Population* | *Personal awareness* | *Community awareness* | *Services Exist Here* | *Need to Expand* | *Level of Buy in within community* |
|---|---|---|---|---|---|
| Law enforcement | 4.5 | 1.5 | 5 | 5 | 2 |
| Healthcare workers | 3.14 | 3.17 | 4.4 | 3.8 | 2.75 |
| Current/past using individuals | 4.3 | 1.75 | 3.67 | 4.25 | 2.5 |
| Total | 3.98 | 2.14 | 4.36 | 4.35 | 2.42 |

Results are based on average of all responses per population. 1=not at all 5=absolutely

***Strategy #10: Syringe Service Program (SSP)***

| *Population* | *Personal awareness* | *Community awareness* | *Services Exist Here* | *Need to Expand* | *Level of Buy in within community* |
|---|---|---|---|---|---|
| Law enforcement | 1.67 | .33 | .33 | 1.67 | .66 |
| Healthcare workers | 3.57 | 2 | 2.28 | 4.14 | 1.86 |
| Current/past using individuals | 4.44 | 1.56 | 2.44 | 4.44 | 1.22 |
| Total | 3.23 | 1.29 | 1.68 | 3.42 | 1.25 |

Results are based on average of all responses per population. 1=not at all 5=absolutely

Naloxone, the overdose reversal drug, has made a strong showing in Aroostook County in the last 12 months. However, Emergency Medical Services (EMS) numbers show a substantial increase in suspected opioid overdoses in Aroostook for the first six months of 2020 compared to all of 2019. Additionally, the University of Maine, which reports overdose data for the State of Maine, shows more fatal overdose deaths in Aroostook for the first two quarters than local EMS data. Either way, the data represents that fatal overdose deaths have doubled, many of which had the presence of more than one substance. With EMS and State data reflecting a potential doubling of opioid overdoses in Aroostook, the need for naloxone expansion is vital.

| **Non-Fatal Opioid Overdose responses by EMS for Aroostook County** | | |
|---|---|---|
| | CY2019 | CY 2020 (1/1-6/30) |
| Total Number of Responses: | 43 | 39 |
| Northern Aroostook (Fort Kent, Madawaska) | 2 | 5 |
| Central Aroostook (Caribou, Presque Isle) | 26 | 26 |
| Southern Aroostook (Houlton, Hodgdon) | 15 | 8 |

*Source: Aroostook EMS, 2020*

| **Calendar Year 2019** | **Aroostook** | **Maine** |
|---|---|---|
| Total PRC Count[i] | 11781 | 253309 |
| # of Suspected OD[ii] | 397 | 9894 |
| # of Opioid Involved[iii] | 43 | 1375 |
| # of Lethal Outcome[iv] | 11 | 217 |
| # Naloxone Administered[v] | 56 | 1286 |
| # Transported to ED[vi] | 350 | 7796 |
| ***2020 1/1/2020-6/30/2020** | **Aroostook** | **Maine** |
| Total PRC Count | 5252 | 111677 |
| # of Suspected OD | 212 | 4802 |
| # of Opioid Involved | 40 | 804 |
| # of Lethal Outcome | 9 | 145 |
| # Naloxone Administered | 30 | 637 |
| # Transported to ED | 174 | 3714 |

*Source: Aroostook EMS, 2020 (see Appendix for details)*

## Maine First Half Trends in Opioid Overdose & Drug Related Deaths

The table below provides totals for Maine counties, comparing 2019 with the first half of 2020, and projecting to the end of 2020. The reader is cautioned that, because the numbers for individual counties are relatively small, fluctuations between quarters or years may be due more to random chance than to actual changes in underlying epidemiological trends.

| ***Table 7. Total drug deaths by county for 2019, in the first half of 2020 (H1), and projected for 2020, compared to percent of Maine census population*** **County** | **2019 (Total=380)** | **2020 H1 (Total=258** | **2020 Projection (Jan-Jun totals times two) (258 x 2=516)** | **Percent of Maine Estimated Census Population 2019** |
|---|---|---|---|---|
| Androscoggin | 33 (9%) | 24 (9)% | 48 | 8% |
| Aroostook | 14 (4%) | 13 (5)% | 26 | 5% |
| Cumberland | 100 (26%) | 48 (19)% | 96 | 22% |
| Franklin | 5 (1%) | 6 (2)% | 12 | 2% |
| Hancock | 9 (2%) | 9 (3)% | 18 | 4% |
| Kennebec | 42 (11%) | 24 (9)% | 48 | 9% |
| Knox | 7 (2%) | 11 (4)% | 22 | 3% |
| Lincoln | 11 (3%) | 5 (2)% | 10 | 3% |
| Oxford | 9 (2%) | 5 (2)% | 10 | 4% |
| Penobscot | 53 (14%) | 44 (17)% | 88 | 11% |
| Piscataquis | 3 (1%) | 7 (3)% | 14 | 1% |
| Sagadahoc | 8 (2%) | 1 (0)% | 2 | 3% |
| Somerset | 16 (4%) | 8 (3)% | 16 | 4% |
| Waldo | 3 (1%) | 4 (2)% | 8 | 3% |
| Washington | 10 (3%) | 11 (4)% | 22 | 2% |
| York | 57 (15%) | 38 (15)% | 76 | 15% |

Manners of death:

- Of the 258 total overdoses, 236 (91%) were accidental, 16 (6%) were suicides, and 6 (2%) were in an undetermined manner.

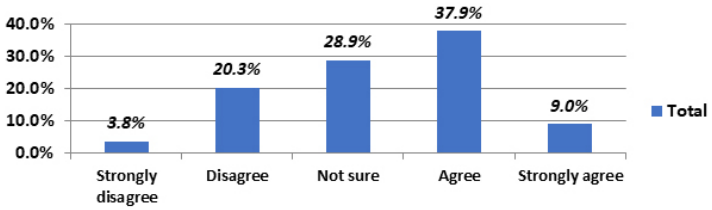
Overall patterns of note:

- Most (81%) drug deaths were caused by two or more drugs. The average cause of death involved three drugs.
- The vast majority of overdoses (82%) were caused by at least one opioid, including pharmaceutical and illicit (non-pharmaceutical) opioid drugs.
- Fentanyl (and or its analogs) caused 65% of deaths, usually in combination with other drugs, down slightly in proportion from 68% in 2019.
- Heroin/morphine caused 15% of deaths, usually combined with other drugs, down slightly in proportion from 16% in 2019
- Cocaine, crack, and methamphetamine caused 29% of deaths, usually in combination with other drugs, the same proportion as in 2019.
- Pharmaceutical opioid deaths caused 25% of deaths, almost all combined with other drugs, the same proportion as in 2019.

*SOURCE:*
*Marcella H. Sorg, PhD, Margaret Chase Smith Policy Center, University of Maine. This report, funded by the Maine Office of Attorney General, provides a summary of statistics regarding drug fatalities in Maine during January-June, 2020. Data for the report were collected at the Office of Chief Medical Examiner. A "drug death" is identified when one or more drugs are mentioned on the death certificate as a cause or significant contributing factor for the death.*

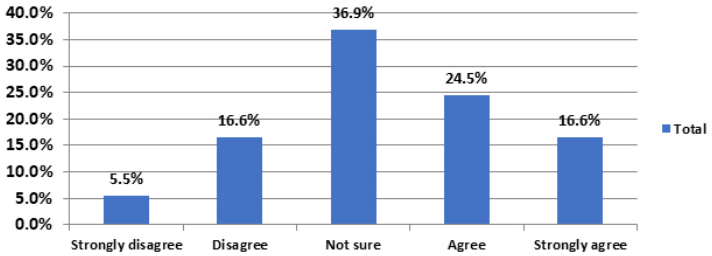
Naloxone distribution in Aroostook had a rough start but has continued to gain community buy-in. Naloxone administration training and distribution are held monthly training with daily distribution available to anyone seeking naloxone. Aroostook pharmacies distribute naloxone to anyone who asks for it; however, there is a cost. Community distribution is free. ACORP asked for community feedback on naloxone distribution in Aroostook on its community survey. The results are as followed based on 477 total respondents.

### My Community Supports Naloxone Distribution



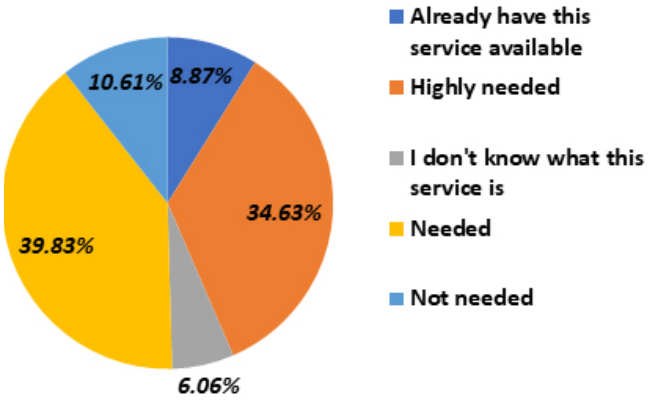

*Source: AMHC Community Survey, 2020*

### I Can Access Naloxone Easily




*Source: AMHC Community Survey, 2020*

### Naloxone Distribution Expansion Including in Jails & Treatment Centers



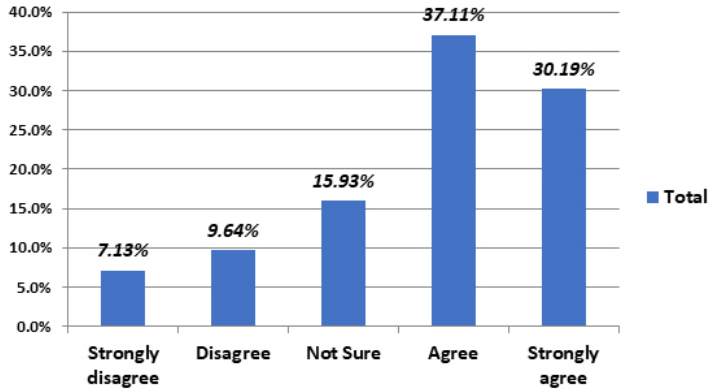

*Source: AMHC Community Survey, 2020*

Survey feedback shows strong support for naloxone distribution in our communities. Other findings include the amount of naloxone education still needed and the number of individuals in Aroostook who don't know where to find it. Community resource training is a gap that should be addressed to make Naloxone easily and knowingly accessible.

## Syringe Service Programs

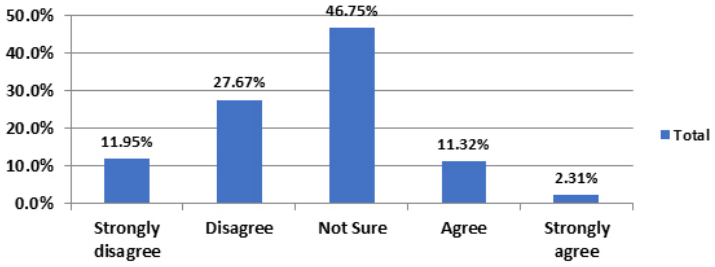
The State of Maine has a growing need for syringe service programs, and Aroostook is no exception. Currently, the CDC offers contracts to community coalitions or agencies willing to take on providing an SSP. SSP can be a controversial harm reduction program in rural communities. Due to misinformation or lack of education, many rural communities are not supporting SSP. The perceived opposition to SSPs in a rural community can provide a barrier. As shown previously in our Community Readiness Tool, ACORP believes the need to expand is high, but community buy-in is little. Our community survey also demonstrates that respondents think an SSP is needed but do not believe the general population is ready for such a program. This may be interpreted that our community is better prepared for SSP implementation than previously thought. Survey data noted below.

### I Am Supportive of SSPs in My Community



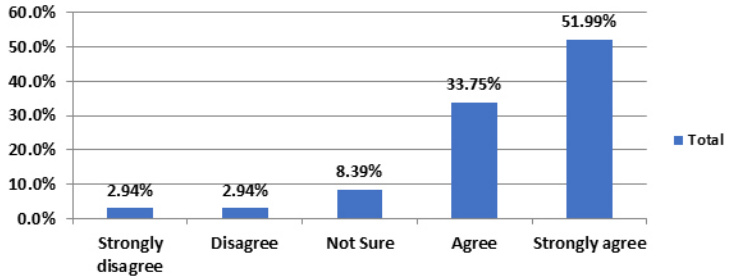

*Source: AMHC Community Survey, 2020*

### My Community if Supportive of SSPs



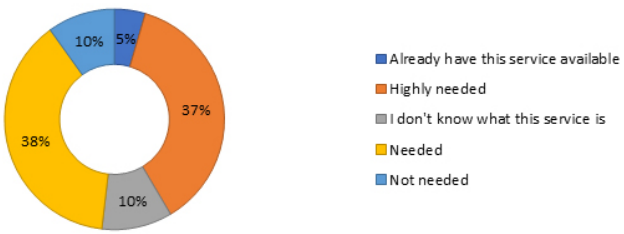

*Source: AMHC Community Survey, 2020*

### More Education on SSPs is Needed




*Source: AMHC Community Survey, 2020*

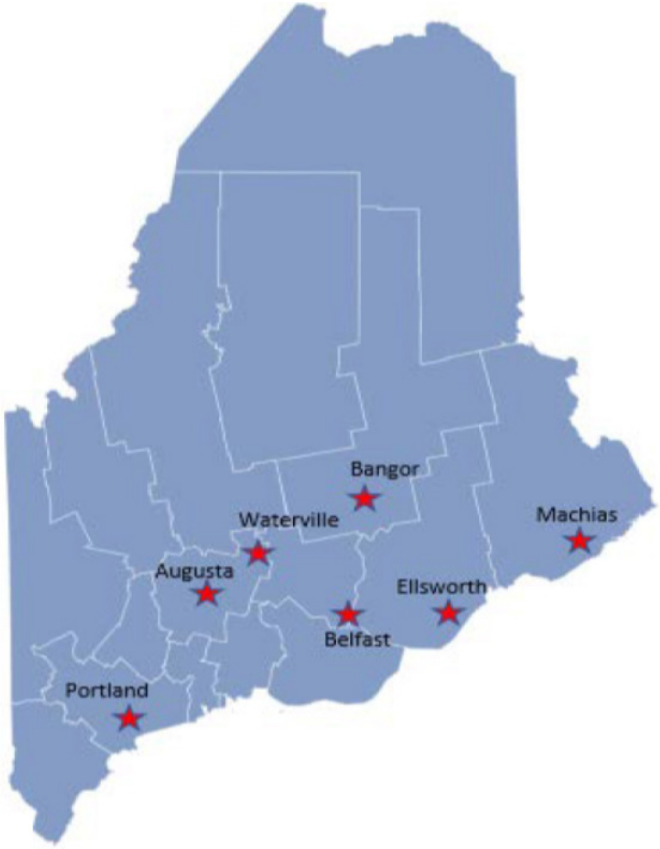
### SSP Expansion in Aroostook County




*Based on the total respondents. Source: AMHC Community Survey, 2020*

Aroostook County does not currently have any "brick and mortar" syringe service program. The closest program is in Bangor, Maine, 158 miles from Presque Isle, Aroostook's largest city. Maine has a developing SSP network, but rural counties like Aroostook are lagging due to their massive size and small populations. Additionally, Aroostook is unique beyond its size because its location makes it difficult to network with other SSPs in the state that could be leveraged as a resource. Maine does not currently have a mobile SSP network. The map below identifies where SSP programs are located in Maine and demonstrates a large gap in rural communities.

### Location of Syringe Service Program Sites in Maine

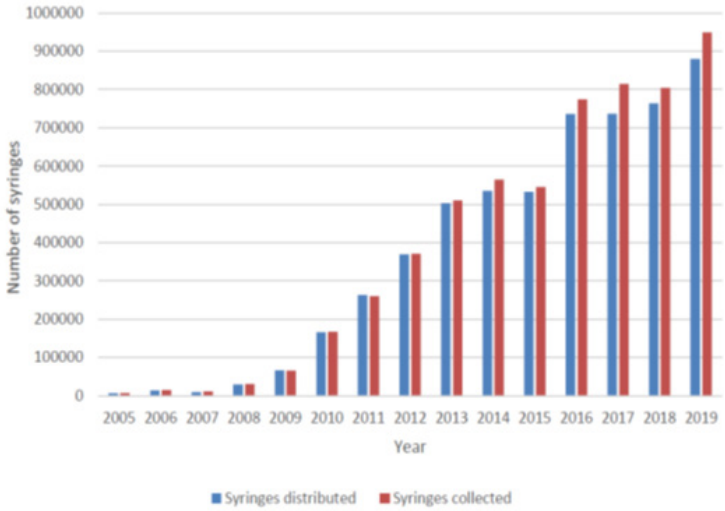



*Source: Maine CDC, 2019*

COVID-19 has provided Maine's Governor Janet Mills an avenue to institute an Executive Order that allows for syringe service programs to expand beyond traditional service means. With a state of emergency in effect, SSPs are allowed to mail safe use supplies to individuals that opt into their service. This has provided an opportunity for individuals seeking this service without leaving their homes. Maine Access Point has been able to help Aroostook County residents by offering them safe use supplies, including naloxone delivered to their door. Unfortunately, this service will end when the state of emergency ends, and Aroostook will be back to having no service at all. According to the Maine DHHS office and State of Maine CDC 2019 annual report, the effectiveness of syringe service programs (despite stigma around the program that it just puts more syringes on the street), SSPs collect more syringes than they give out.

### Total Number of Syringes Distributed & Collect at Syringe Service Programs (2005-2019)

Highlights the increase in both the number of syringes distributed and collected since 2005. In 2019, there were 948,904 syringes collected and 879,853 syringes distributed.



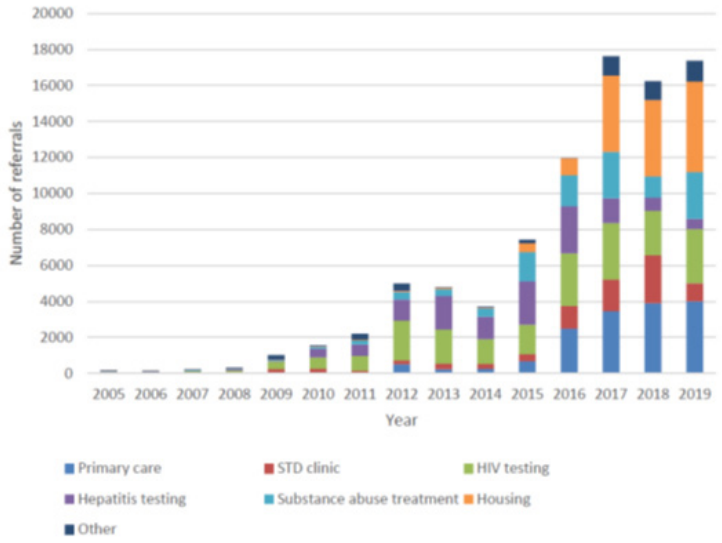

*Source: Maine CDC, 2019*

The growth of SSPs in Maine has also allowed for a connection to be created to the using population. SSPs provide referrals to many services outside of the SSP, including links to treatment for HIV/HCV, SUD/OUD treatment, MAT clinics, and many other treatments or health promotion modalities. It is worth noting, SSPs can also bridge people who use drugs (PWUD) to COVID-19 vaccination services. This is important because individuals with active OUD are ten times more likely to be hospitalized with COVID-19[22]. Maine's current SSPs log and keep track of these types of referrals and demonstrate the many other services that SSPs can connect individuals to.

22 *2020, Wang, Q.Q., Kaelber, D.C., Xu, R. et al., https://doi.org/10.1038/s41380-020-00880-7*

### Total Number of Referrals for Services at Syringe Service Programs from 2005-2019

This graph shows the importance of the Syringe Service Program in connecting People Who Inject Drugs to other services that may increase improved health outcomes for the population. These other services include referrals to primary care, STD clinics, HIV testing, viral hepatitis testing, substance use treatment, and housing services. In 2019, a total of 17,382 referrals were made.




*Source: Maine CDC, 2019*

Since Maine's first State of Emergency in April 2020, 89 individuals from Aroostook County have enrolled in mail-in SSP services[23]. It is imperative that these individuals be able to continue this service beyond the emergency order. The lack of SSP access in Aroostook is a large gap in not only lowering the morbidity and mortality of OUD, it is limiting the access we have in engaging individuals that consistently use substances.

## Good Samaritan Laws (GSL)

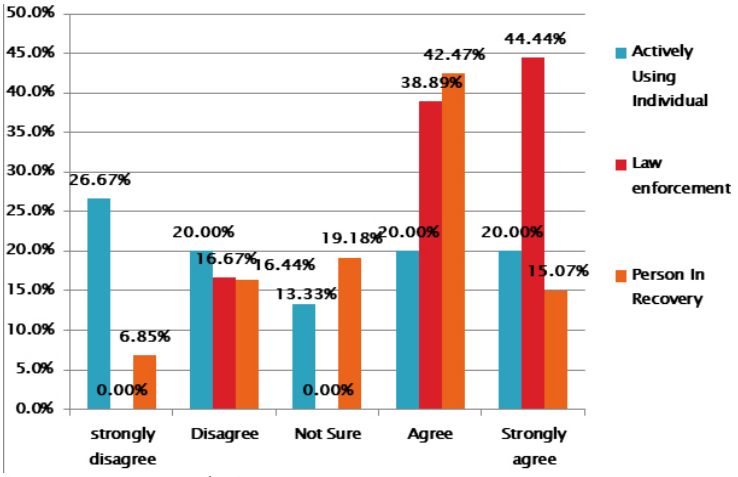
Good Samaritan Laws (GSL) in Maine is relatively new. According to the Maine.gov website, Law LD 329 was signed into effect on May 23, 2019[24]. Governor Mills stated, "As Maine continues to grapple with the opioid epidemic, arresting and prosecuting someone at their most desperate moment when their friend or family member is experiencing a medical emergency will not solve the problem. It discourages people from calling for help," said Governor Mills. "By signing this legislation, we take another step toward ensuring people seek help to survive an overdose and can pursue life-saving treatment for substance use disorder. I thank Representative Cardone for bringing forward this legislation and securing overwhelming bipartisan support in the Legislature for its passage."

When someone is experiencing a drug-related overdose, the most important action that person, or someone with that person, can take is calling for medical help. By signing this bill into law, Gov. Mills is eliminating the fear that comes with contacting authorities and protecting the lives of Mainers.

LD 329 prevents a person who, in good faith, seeks medical assistance for a person experiencing a drug-related overdose or who is themselves experiencing a drug-related overdose and requires medical assistance from being arrested or prosecuted for a violation of laws prohibiting the possession of scheduled drugs, acquiring drugs by deception, the possession of hypodermic apparatuses and the use of drug paraphernalia or violation of probation. (Maine.gov)

With the new LD 329, it was important for ACORP to assess community awareness of this law's existence. GSL was brought to light in interviews, surveys, and ACORP discussions to see who knows or understands the law. Based on interviews with still actively using individuals, ACORP found that very few know about the law or what it means. Data below from the actively using, person in recovery, and law enforcement populations shows that individuals actively using do not know about the law compared to those in recovery or those upholding it.

### I am Familiar with the Good Samaritan Law (GSL)




*Source: AMHC Community Survey, 2020*

This data set explains the need for more education and engagement for the population that most benefits from this law, the using population. Developing trust between law enforcement and the active using population can be bridged by educating both on the intent and use of LD 329. To further build trust, family members, affected others, emergency departments, service providers, and the community as a whole should be knowledgeable

23 2020, *www.maineaccesspoints.org*
24 2019, *https://www.maine.gov/governor/mills/news/governor-mills-signs-good-samaritan-bill-2019-05-23#*

about GSL. Survey results demonstrate overwhelming support for the expansion of education on GSL across Aroostook County.

## Treatment

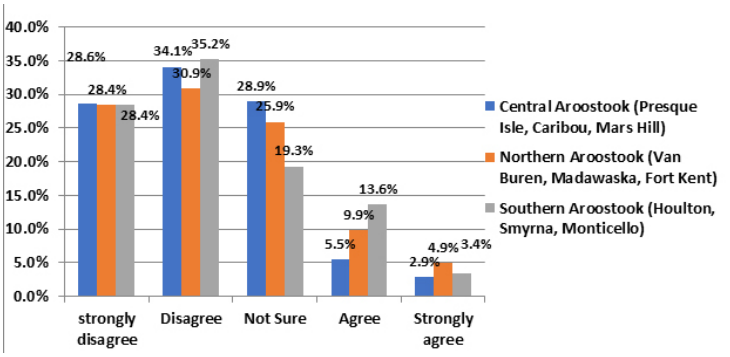
Treatment options for SUD/OUD in Aroostook County have expanded in the last five years. Medication-Assisted Treatment (MAT) expansion has provided many opportunities for those seeking options. It is now available in Aroostook's emergency departments, jail, and within one women's and children's provider in central Aroostook County. The progress that has been made is admirable; however, many gaps still exist.

An inpatient detox facility is a gap that was emphasized multiple times in ACORP's community survey. Detox facilities have been a staple in many individuals' recovery; however, the service is more of a medical facility than a SUD service. Detox facilities have low success rates and, similar to incarceration facilities, have a high rate of re-occurrence/relapse. Individuals often return and elect not to engage in services past the initial detox. Detox facilities are costly, short-term, and have little programming. For these reasons, as well as the danger of detoxing off opioids and returning to use where diminished tolerance now makes fatal overdose more likely, detox facilities are not recommended. Thanks to MAT Induction in our local ERs and Detox Management Services (DMS) through AMHC, ACORP will not be pursuing this service and addressing the gap with more evidence-based practices. The 2019 Community Health Needs Assessment (CHNA) identified the lack of Methadone treatment in Aroostook. No such service exists in this county. Some individuals in southern Aroostook report driving to Bangor daily to receive their dose and then return home, a 225-mile round trip. This service is not available for those in central or northern Aroostook. During COVID-19, Maine has allowed this service to become a prescription program, meaning individuals are allowed to get a prescription filled for Methadone to eliminate daily contact[25]. This state of emergency model is filling some needs for those that receive this service.

The 2019 CHNA also reports a gap in other treatment services. AMHC provides a 28-day, 12-bed, American Society of Addiction Medicine (ASAM) Level 3 Residential Treatment Facility (RTF) in Limestone, Maine. This is the only co-ed, state-funded, inpatient residential facility in Maine and the only inpatient facility in Aroostook. The facility has been in service for 45 years and is utilized by individuals across Maine. The gap for residential treatment in Aroostook County is adding to longer wait times for services. Currently, Mainecare only covers up to 30 days, and if an individual wants to stay longer, they would have to pay out of pocket. The RTF does provide a sliding scale fee for those identified as low income and will only allow a 35-day maximum stay. A focus group conducted by ACORP with clients from AMHC's RTF facility noted that 80% of individuals enrolled would stay longer if they were allowed to. 80% also noted that they wouldn't be able to without financial assistance. A program that would allow for an extended stay for someone self-identified as not ready, or identified by a professional as not ready for discharge, would be ideal. Twenty-eight days is often cited as not long enough; therefore, a transitional treatment center, or longer service term, is an identified gap.

Small Aroostook communities do not have the same treatment options as other communities. Often long distances away and not accessible without a full day of rescheduling, many find themselves forced to call EMS or continue to use. As noted in the introduction of this needs assessment, much of the services are brick and mortar services, and individuals seeking treatment must transport to these services sometimes on a weekly basis. ACORP community survey results reflect this statement.

### Smaller Towns Have the Same Access to MAT




*Source: AMHC Community Survey, 2020*

This also reflects the time, mileage, and scheduling conflicts that prohibit a healthy lifestyle. The demand for MAT clinics, probation, PCP appointments, and pharmacies does not allow individuals to participate in life's social constructs the same as other citizens. Many people using have no license, car, birth certificate, income, or even support system. These things are usually not developed until after treatment or recovery support programs begin. This creates a large barrier in our sparsely populated towns.

25 2020, *https://bangordailynews.com/2020/04/12/politics/maine-relaxes-needle-exchange-and-methadone-rules-during-coronavirus-pandemic*

ACORP's community survey asked if those in smaller communities had the same or equal treatment opportunities as Aroostook's larger communities, and it was an overwhelming response. 62% of respondents county-wide disagree, 26% are not sure, and only 11% agree, reflecting the need for an outreach program. A common recovery motto is "meet them where they are at." Unfortunately, many individuals are spread out across a large area with little opportunity to engage unless the service is localized. The gap here is making the services accessible to the smaller towns that are not near Aroostook's larger towns and two cities. A possible solution may be a mobile health unit to help provide MAT service, harm reduction services, peer support, and community outreach education.

## Recovery

Recovery services have taken a large leap forward in the last four years. The start of grassroots movements like Recovery Aroostook in Caribou and Link for Hope in Houlton have allowed the community to engage in support for those seeking recovery or maintaining a recovery lifestyle. AMHC has two state-contracted recovery centers or recovery community centers (RCCs). These two centers provide many services, including peer support, referrals, recovery coaching, peer groups, and 12-step meetings.

Gaps include state certification for recovery coaches. In addition, recovery coaching is not a billable service. With a certificate, coaches would be able to bill for service. At this time, recovery coaching is a volunteer program, and with that comes retention challenges. Many are willing to coach but realize that to continue to move forward in their personal recovery, they must secure stable employment.

Aroostook County has a long history of providing strong 12-step programming, including Alcoholics Anonymous, Narcotics Anonymous, Recovery Dharma, and Celebrate Recovery. Through COVID-19, many of these recovery groups expanded to provide group support over a digital meeting platform, and attendance more than doubled. However, northern Aroostook county doesn't have an RCC. The demonstrated success of central and southern Aroostook's RCCs highlights the need for northern Aroostook to also have a center.

As previously noted, transportation is a barrier, including for individuals wanting to access the centers. Peer centers do not have the same service level structure as clinical environments. As such, transportation services cannot bill for the rides since recovery centers are not recognized as a health or medical service.

Recovery residency or sober house is a safe home where individuals live together to try to maintain a connection with others in recovery. This transitional home provides a structured atmosphere for the individual but allows freedoms to help progress into healthier living. Recovery residencies are expanding across Maine. Aroostook County has only one facility for men in central Aroostook County. This seven-bed facility is open to anyone involved with MAT and is certified through the Maine Alliance for Recovery Residency (MARR). The need to expand recovery residencies or safe housing in all of Aroostook County is apparent. This is especially true for women. Currently, no women's recovery residency exists in Aroostook County, causing a large gap in service.

## Summary

ACORP has identified the following gaps in prevention, treatment, and recovery.

### Prevention

- Education for youth, young adults and affected others
- Harm reduction access-naloxone distribution, SSPs and GSL education
- Easily accessible HIV/HCV testing
- Engaging those that use substances

### Treatment

- Drug court
- Access to methadone treatment
- Transportation
- Long-term treatment center
- Insurance coverage
- Easy access to services for smaller rural communities.

### Recovery

- Paid recovery coaches
- Peer support recognized as a health service
- Expansion of recovery residences

ACORP concludes that despite the expansion of services in Aroostook County during the last five years, there is still a large need to expand or develop a structure that can provide education, easy access, and affordability to lower the morbidity and mortality of OUD.

# WORKFORCE GAPS

## Clinical Settings

There are 13 substance use treatment facilities in Aroostook—a rate of 1.8 sites per 10,000 in population. There is an ongoing challenge to recruit and retain SUD counselors for these facilities. One barrier is the State of Maine's certification process, which can be challenging to obtain compared to some other states. Aroostook County does not have enough SUD/OUD providers willing to continue providing services long-term. The burnout rate in counselors is high, and the workload is always increasing. This is a real concern during the COVID pandemic.

As more and more individuals seek recovery and services and counselors are on the decrease, waitlists continue to rise. In our community survey, waitlists were the number one reason people believe that individuals don't seek help. The same survey also identified a great need for SUD providers in all regions. As funding becomes available, ACORP recognizes the need for recruitment to increase the number of SUD providers. Service providers are in short supply and generally underpaid to provide life-saving work. Many new programs in local community colleges are providing an avenue to help with filling this gap. Eight-month SUD counselor trainings or programs are emerging to give individuals a chance to get their certification more quickly than traditional methods; however, this is a gap that needs to be addressed.

## MAT Providers

According to the Substance Abuse Mental Health Services Administration (SAMHSA), as of January 13, 2021, Aroostook County currently has 21 x-waivered providers[26]. However, only five provide MAT treatment services. Some x-waivered individuals do work in an Emergency Room setting in which they don't have time to commit to supportive treatment efforts. Primary care providers (PCPs), a majority of the individuals on the x-waivered list, could provide or collaborate with organizations to provide this treatment but elect not to.

This demonstrates a gap in service to individuals ready to move on from their local MAT clinic. Individuals in the maintenance stage of change have to stay in a clinic setting due to primary care providers not willing to prescribe this medication to their patients. This causes an overflow of clients at the clinics, reducing the clinics' ability to take on new referrals. One provider stated: "They don't see the reward in taking on what they believe to be a behavioral issue."

The stigma around MAT and SUD is an ongoing challenge. In its community survey, ACORP asked if primary care providers should provide MAT services. 66% of respondents said yes, with 15% saying no, and 18% were not sure. There is large community support for the expansion of MAT treatment in primary care settings. Furthermore, 61% of local healthcare workers agreed that PCPs should be providing MAT treatment to their patients, 20% disagreed, and 18% were unsure.

## Actively Using Individuals & People in Recovery Workforce

According to a report issued in early 2020, 75% of employers feel that their workplace has been impacted by opioid-related issues[27]. Employer concerns include difficulty finding qualified workers who can pass drug screens, rising health care costs, increased absenteeism, and reduced productivity. Aroostook County farmers, potato processors, logging businesses, wood manufacturers, contractors, and more depend on low-skilled labor to produce their products and services, but gaps in the workforce remain a significant challenge due to too many individuals unable to pass drug screens. A reliable and dependable workforce is on the decline in large part due to SUD/OUD.

People in recovery (PIR) want to fill that need. However, employers are faced with not knowing the difference between actively using and a person in recovery status. "People in recovery have trouble finding lasting reliable work, and when they do, they can't get hired due to background checks," said one career counselor. "I work to help people get their IDs, social security cards, birth certificates, everything they would need to get employment. Many times once they are ready, no one will take a chance on hiring a PIR due to past experiences with someone still using."

26 *2020, https://www.samhsa.gov/bupe/lookup-form*
27 *2019, https://www.cdc.gov/niosh/topics/opioids/data.html*

Another disadvantage can be a PIR's criminal record. Back fines that cannot be paid, loss of driver's licenses, and no public transportation are credited as working against the PIR in finding lasting employment. Stigmatization around criminal history happens in many workplaces as a policy issue. "Developing a group of 'recovery friendly businesses' may allow a whole new workforce to pick up some slack in our employment need," the counselor said. "Some PIR are far more qualified than other applicants, but the employer still doesn't take the chance on them." Education for employers, HR departments, and local businesses around SUD/OUD, PIR, and what they have to offer could help fill the gap.

## SPECIAL & VULNERABLE GROUPS

ACORP recognizes that different populations have different needs. ACORP evaluated the needs of special or vulnerable groups as it relates to SUD/OUD. Aroostook County's most susceptible populations lack immediate access to services, including financial resources to pay for services such as the transportation required to visit a facility that offers what they need.

The ongoing stigma associated with substance use prohibits many from asking for help, including the lack of recognition by our health care community that substance use is a chronic health condition that needs long-term support. Further, too few healthcare providers are reluctant to offer what is needed most, e.g., medication-assisted treatment. Our consortium's planning efforts will determine how to increase access to services to vulnerable populations.

The lack of data does not provide a complete picture of the epidemic we are experiencing for vulnerable populations in Aroostook County, including tribal community members, pregnant women, incarcerated individuals, seniors (nearly a quarter of our population), or individuals who are homeless.

### Tribal Community Members

Tribal communities are not immune to suffering from addiction or dying by overdose, but in fact, see disproportionate rates[28]. The unique challenge is that cultural factors prevent or discourage seeking services outside of the tribe. This includes MAT, harm reduction, and residential treatment. When individuals seek treatment outside the tribe, many services are not culturally responsive and potentially lack basic cultural competencies. Culturally responsive services available outside the tribe could increase engagement with our local tribal communities. This creates a bridge when seeking to access different levels of care that the tribes themselves may not be offering, such as MAT services, substance use and co-occurring treatment services and holistic care sensitive to cultural differences.

In one-on-one interviews, representatives of the tribal service sector noted the need for harm reduction services within the tribal communities. Although the Aroostook Band of Micmacs have their own drug task force and prevention services, 87% of tribal members that completed the community survey have either misused opioids or been affected by OUD. Identified gaps are harm reduction services, including naloxone distribution and SSP services, education, and culturally directed expansion such as a tribal recovery coach or White Bison.

ACORP was unable to obtain current tribal data for this needs assessment. Wabanaki Public Health is in the midst of a HRSA RCORP Implementation grant and had to step away from active involvement in ACORP's consortium. Wabanaki Public Health is focused on developing a holistic wellness center with culturally specific recovery services that will be a new opportunity in Maine. We are grateful that they were able to provide the following data, which was collected in 2010:

- 52% of Wabanaki Tribal members are current commercial tobacco smokers compared to 22.8% in Aroostook County and 20.2% statewide.
- 34.4% had a depressive disorder compared to 23.2% in Aroostook County and 23.4% statewide.
- 32.3% had an anxiety disorder compared to 21.5% in Aroostook County and 18.8% statewide.
- 8.2% considered suicide in the past 12 months, compared to 21.5% in Aroostook County and 18.8% statewide.
- 24% of males age 18-34 and 16.5% of Females age 18-34 have used prescription painkillers, i.e., nonmedical use of prescription drugs (NMPD) in the past year, as compared to adult use of NMPD of 1.8% in Aroostook County, and 1.1% statewide.
- 61.3% of Males age 18-34 and 37.2% of Females age 18-34 have used marijuana in the past year compared to adult use of marijuana 6.8% in Aroostook County, and 8.2% statewide.

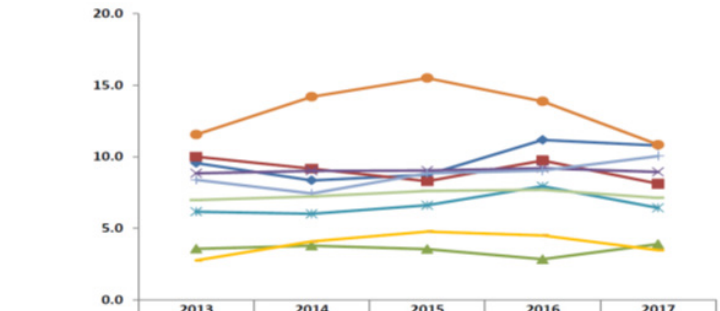
28 2019, https://www.ihs.gov/opioids/data/

» 65.2% of underage youth ages 18-20 say it would be very easy to get alcohol compared to 26.5% of youth in Aroostook County and 26% statewide.

## Pregnant & Parenting Women

According to State Epidemiological Outcomes Workgroup's (SEOW) 2019 report, about 4% of Maine women reported taking prescription pain medication. SEOW measures data by the eight districts in Maine, noted in the table below. In 2017, nearly 80% of substance use treatment admissions for pregnant women in Maine were related to opioids/opiates. Unfortunately, this data does not distinguish between Suboxone, methadone, heroin, fentanyl, or synthetic pharmaceutical opioids. The rate of substance-exposed newborns (SEN) in Aroostook remained relatively unchanged from 2016 (11.2 per 10,000 residents) to 2017 (10.8 per 10,000 residents). Aroostook is tied in last place for the highest rate among the districts. The proportion of live births with SEN's in Aroostook decreased slightly from 12 percent in 2016 to 11 percent in 2017; however, this is three percentage points higher than the State of Maine, which is 7.1% (according to SEOW 2019 report).

### The Number of Substance Exposed Newborns (SEN) 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: SEOW, 2019*

Currently, there is only one Women's and Children's MAT clinic in Aroostook. Located in Caribou, it is accessible for those pregnant mothers who live nearby, but not to others who would have to travel up to an hour or more for services or who do not want to change their OBGYN provider with whom they have a trusting relationship. Outside this service, in central Aroostook, there is little for those mothers and expecting mothers who have been affected by SUD/OUD. Expanding any service to help improve the health of mother and child should be a priority for ACORP.

ACORP requested data from the four local hospitals (all consortium members) to provide current data reflecting SUD/OUD related to births.

| **Incidence of Neonatal Abstinence Syndrome (NAS)/Neonatal Opioid Withdrawal (NOW)-related births – include all births regardless of specific opioid exposure in utero (heroin, synthetic opioids, MAT)** | CY2019 | CY2020 (1/1-6/30) |
|---|---|---|
| Cary Medical Center (Caribou) | 8 | 6 |
| Northern Light AR Gould (Presque Isle) | No data | 4 |
| Northern Maine Medical Center (Fort Kent) | 3 | 0 |
| Houlton Regional Hospital (Houlton) | No data | No data |

*Note: Due to COVID-19 demands, some data was unattainable.*
*Source: SEOW, 2019*

## Incarcerated Individuals

ACORP obtained current data from the Aroostook County Sheriff's Office, which oversees Aroostook County Jail (ACJ). This data shows just how many SUD screenings take place and the charges that reflect this. It is important to remember that ACJ is not a SUD provider, and much of the screening is based on self-reporting. The data below shows that in the first six months of 2020, 30% of all arrests were drug-related, which is consistent in prior year reports.

### Aroostook County Jail
### Booking & Arrest Information of County Residents

| | 2018 | 2019 | 2020 1/1 – 6/30 |
|---|---|---|---|
| Total Males | 323 | 374 | 204 |
| Total Females | 122 | 136 | 71 |
| Other | 0 | 0 | 0 |
| Male Multiple Returns | 220 | 266 | 129 |
| Female Multiple Returns | 81 | 102 | 51 |
| Adults 18-64 years of age | 442 | 505 | 270 |
| Elderly 65+ | 3 | 5 | 5 |
| White | 414 | 480 | 260 |
| Native American | 20 | 18 | 9 |
| Black | 8 | 9 | 3 |
| Latino | 1 | 1 | 1 |
| Unknown | 2 | 2 | 2 |
| Total Northern Aroostook | 52 | 47 | 30 |
| Total Central Aroostook | 233 | 297 | 143 |
| Total Southern Aroostook | 160 | 166 | 102 |
| Total Intake For Respective Years | 1814 | 1609 | 921 |
| **Total Inmates Affected by Substances** | 445 | 510 | 275 |
| **Percentage of Inmates Affected By (SUD) Alcohol/Drugs From The Total Intake** | 24.53% | 31.70% | 29.86% |

*Source: Aroostook County Sheriff's Office, 2020*

The Aroostook County Jail has made some significant programing changes and now offers a wide range of new services including Peer Support or Recovery Coaching for male and female populations, MAT Induction and services including Suboxone (as of July 2020), Breaking Free Groups, naloxone distribution (for MAT clients), and case management. Even so, recidivism rates remain high.

Incarcerated individuals are particularly at risk of re-occurrence and fatal overdose due to the lack of coordinated care to navigate inmates' resources upon release. In early 2020, focus groups were conducted by individuals representing MaineCare (Maine's Medicaid program) and AMHC, who partners with ACJ to provide services. This project was a part of the Maine Advanced Health Equity Project, which supports moving toward value-based payment models that encourage and support delivery reform to reduce disparities.

The focus groups were used to help determine how to better deliver services post-incarceration due to the high mortality rate of those with OUD. The information demonstrated that even with referrals to community resources, those who are released from jail need more direct hands-on support within the first one to two days upon release to avoid returning to the social, living, or family conflicts that do not support the recovery changes they may have gained while incarcerated. Findings revealed the need to address these social issues by attending to stigma, offering substance use peer recovery coaching immediately upon release, employment and training, sober living housing that supports MAT, naloxone access upon release, and substance use treatment. The state of one's physical health care also contributes to whether an individual returns to substance use, overdose, or other criminal activity.

There is a need to be able to produce an individualized discharge plan that is developed by the SUD counselor, recovery coach, and case manager. This would allow the person being released to connect with services or develop a structure that helps maintain a new way of living. Another gap is the lack of naloxone distribution to all released inmates that accept it. Inmates tend to be released with reduced tolerance and have the potential to overdose more easily once released. Incarcerated individuals, having been in jail for any length of time, need training and education on better understanding their limits, including why they shouldn't use alone if they choose to use.

## Seniors

Seniors make up nearly a quarter of Aroostook County's population. Aroostook Agency on Aging's Long Term Services and Support Director, Sharon Berz, MSW, LCSW, F-MGS, receives reports at least monthly about seniors who are selling their prescription medications to pay for food, rent, etc. In her one on one interview, Berz shares the vulnerabilities of seniors, "Many are taken advantage of and have the prescriptions stolen, sold, or misused. Aroostook isn't just getting old, they are getting poor too."

Berz also emphasized that many seniors are now raising their grandchildren or great-grandchildren due to parents challenged by SUD/OUD. This is a national crisis as more and more parents are using. Unfortunately, due to a lack of reunification programs for persons in recovery (PIR), grandparents raising grandchildren tends to be a permanent solution.

## Homeless

Since 1984, the Homeless Services of Aroostook has operated the only homeless shelter for the general public in Aroostook County, serving individuals and families with children. From June 2017 to June 2020, the Sister Mary O'Donnell Emergency Homeless Shelter, a high barrier program-based shelter, has provided services to 281 people. Nearly 7% of individuals self-identified as having had a substance use disorder in the past[29].

On July 1, 2019, the Homeless Services of Aroostook opened Aroostook Bridge, a low barrier shelter with a 20-bed capacity. No application or background checks are required for admission. Since its opening, Aroostook Bridge has provided shelter to 119 individuals. Upon admission, 15% of individuals self-identified as using substances, and due to the nature of self-reporting, this is likely an undercount[30]. Given that a large portion of our homeless population has self-identified as having SUD/OUD, building a referral program or coaching team would help this population. Naloxone distribution is currently taking place at the homeless shelter.

## Summary

ACORP has identified that the needs for Special and Vulnerable populations in Aroostook are similar to other populations. It is not easy to access SUD/OUD services for themselves or their loved ones. Unfortunately,

29 2019, Shirley Caron, Case Manager/Navigator, Homeless Services of Aroostook
30 2019, Shirley Caron, Case Manager/Navigator, Homeless Services of Aroostook

other barriers they face, e.g., lack of housing, previous incarceration, raising their children's children, creates additional complications to receive the support they need to be successful. As we look to new services, it will be important for ACORP to consider the unique challenges that our vulnerable populations face and work toward removing obstacles that impede access.

## STIGMA & BIASES

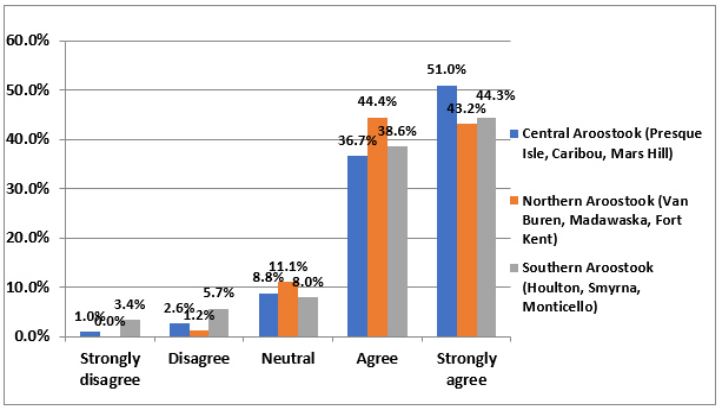
Stigma is a large barrier for individuals in Aroostook County. ACORP's community survey shows that it is the number two reason people believe that our using community doesn't seek help. The survey also indicates that there has been some progress in this area. One respondent shared the following in response to: "Has your opinion of SUD/OUD changed in the last five years?":

"I used to think that they were stupid for picking up that needle or snorting that pill until I knew addicts personally. Some just followed the crowd, but most have had some sort of trauma that they can't deal with."

The overall community perception has improved in the past five years. Aroostook County has started to be more accepting of evidence-based models. The addition of MAT clinics, MAT expansion in ER, MAT induction in jail, naloxone distribution, and opening of recovery residences is a demonstration of growth. The expansion of these programs, and the open-mindedness for more, shows a willingness to reduce stigma. However, there is still a great deal of work to do. In their one-on-one interviews, actively using individuals shared that they are not being treated well when in hospital settings, family medicine, or even by SUD services. One actively using individual stated: "I went to the ER and asked for help, they evaluated me and said I didn't meet the requirement, so they sent me home with no help. I will never ask them for help again." The community survey also highlighted how much stigma remains in our community. One healthcare worker stated,"I am not a supporter of naloxone outside of a hospital setting. I believe it to be a false safety net for users. Provides the illusion it's ok to continue their use because they can be saved."

A large outreach effort and stigma education platform are needed in Aroostook County. As the recovery community grows, so do the voices that will bring SUD/OUD out of hiding behind closed doors. As the recovery community uses its voice and demonstrates that it is possible to recover, they are more likely to be willing to be part of developing solutions to reduce stigma. Aroostook has been able to embrace its recovery community and allow it to have a voice in changing policies and providing training. This momentum needs to continue into our healthcare workplaces, law enforcement, SUD service providers, and within its own recovery community. ACORP community survey asked about community-wide stigma and the results are clear.

### Stigma is an Issue in My Community




*Source: AMHC Community Survey, 2020*

## LEVERAGING EXISTING RESOURCES

Leveraging funding and educational resources like Ryan White Part B, Health Resources Services Administration (HRSA), Federal Office of Rural Health, National Center for Disease Control (CDC) including Overdose Data to Action (OD2A), Maine CDC, Maine OBH, NEXT Distro, SAMHSA including State Opioid Response (SOR), and tapping into the infrastructure of Adverse Childhood Experiences (ACEs) will help ACORP achieve its vision. Morbidity and mortality rates are on the rise in Aroostook County. It will be critical to engage our local resources, including hospitals, law enforcement, the recovery community, SUD service agencies, and municipalities, in supporting ACORP's effort to change the SUD/OUD service landscape. Many of these local resources are already supporting this work on some level. ACORP plans to use data, community input, and key stakeholders to advance its work and demonstrate to federal, state, and local resources that our county is committed to lowering the morbidity and mortality rate in our service areas.

## MAINTAINING A CONSORTIUM

The largest challenge to maintaining consortium has been COVID-19. The pandemic has taken time away from our healthcare partners specifically, as they are understandably needed elsewhere. Due to COVID-19 and consortium members being located across Aroostook, meetings have been conducted using digital outlets. We are confident that Zoom meetings have increased the participation level for those who can attend.

ACORP was pleased to add a person in recovery (PIR) to the consortium, providing a critical perspective for the people we look to serve.

As the consortium moves forward, return on investment will be critical to the members' continued engagement. Initiatives will need to demonstrate a benefit to the members, e.g., reduced incarceration rates or fewer emergency room visits by those affected by SUD/OUD.

### Sustaining Services

Sustaining services in Aroostook County will be an ongoing challenge. Our low population and large geographic region can make it difficult to leverage the funding we need to support services, which can be viewed as not cost-effective due to our smaller participation levels. A "one-stop-shop" approach tends to have more sustainability in rural communities like Aroostook. This requires specific training to deliver a multitude of services.

Telehealth has been an invaluable tool in making sure that services remain sustainable. Local providers wasted no time at the beginning of the pandemic to adapt to a new way of keeping people engaged in their treatment.

Sustaining service in Aroostook County has always looked different than traditional outlets. Aroostook adapts to its local culture, need, and demand to offer the most effective services based on its unique situation.

## CONCLUSION

The needs assessment has provided ACORP with an opportunity to identify SUD/OUD gaps that affect each region of Aroostook County. As a whole, the county lacks access to medication assisted treatment (MAT) in smaller communities, Methadone options, recovery residencies, workforce recruitment and retention, pre-arrest diversion programs, Good Samaritan Laws (GLS) education, primary care for SUD/OUD treatment, and recovery coach compensation. Additionally, an increase in harm reduction services including access to Syringe Service Programs (SSP) and naloxone distribution is needed to support our most vulnerable populations.

This needs assessment has brought to light that Aroostook County residents are by and large ready to expand services or develop new services. Many myths about SUD/OUD have been and continue to be addressed to reduce stigma and encourage individuals to seek the help they need. ACORP is encouraged that Aroostook is ready for evidence-based strategies to address the morbidity and mortality of SUD/OUD. The community needs assessment and gap analysis has provided the guidance required to develop a comprehensive strategic plan and action plan.

*All information has been verified to the best of our abilities. This needs assessment will be reviewed annually and updated as appropriate to reflect current data, services and new information relevant to the work of the Aroostook Rural Communities Opioid Response Program (ACORP) Consortium. We encourage community feedback by reaching out to Erik Lamoreau by email at elamoreau@amhc.org or Debra Jacques by email at djacques@amhc.org.*

# APPENDIX

## EMS Data: The State of Maine & Aroostook County

| Calendar Year 2019 | Aroostook | Maine |
|---|---|---|
| Total PRC Count[i] | 11781 | 253309 |
| # of Suspected OD[ii] | 397 | 9894 |
| # of Opioid Involved[iii] | 43 | 1375 |
| # of Lethal Outcome[iv] | 11 | 217 |
| # Naloxone Administered[v] | 56 | 1286 |
| # Transported to ED[vi] | 350 | 7796 |
| *2020 1/1/2020-6/30/2020 | Aroostook | Maine |
| Total PRC Count | 5252 | 111677 |
| # of Suspected OD | 212 | 4802 |
| # of Opioid Involved | 40 | 804 |
| # of Lethal Outcome | 9 | 145 |
| # Naloxone Administered | 30 | 637 |
| # Transported to ED | 174 | 3714 |

i The total PCR Count based upon Incident Scene Location County and Incident Scene Location State and includes all EMS Activation types.

ii The number of Suspected OD is based on several indicators in the patient care report which may indicate an overdose. These indicators include:

- The administration of Naloxone
- The reported use of an overdose Maine EMS protocol
- A provider primary or secondary impression indicating an overdose or drug abuse
- Patient Drug Use indicators having Naloxone or drugs
- A complaint reported by dispatch of overdose
- A cardiac arrest etiology of a drug overdose

iii EMS Activations designated as Opioids involved are based on EMS clinician assessments and are not based on laboratory analysis or testing.

iv Patient outcome is limited to those patients who succumbed prior to EMS arrival, and an EMS Activation occurred where a patient care report was entered and when the patient expired while in the care of EMS prior to transfer of care to a receiving medical facility. Maine EMS does not receive outcome data from medical facilities to which patients are transported to. Therefore, patients who succumb after transfer of care of the patient by EMS to a medical facility are not included.

v This includes all instances where Naloxone is administered.

vi Patients Transported is a count of patients transported with a suspected overdose and not transports for all EMS activation types.

# CDC Community Readiness Tool

## Evidence-Based Strategies: What's Working in the U.S. (as per the CDC)

## CDC Strategy #1: Targeted Naloxone Distribution *1 = not at all; 5 = absolutely; n/i = no idea, couldn't guess

| Explanation | Strategy Works Best When: |
|---|---|
| Naloxone is an opioid antagonist that can quickly and safely reverse the potentially fatal effects of an opioid overdose. Targeted distribution programs seek to train and equip individuals who are most likely to encounter or witness an overdose—especially people who use drugs and first responders— with naloxone kits, which they can use in an emergency to save a life. There are many different approaches to distributing naloxone to people at high risk of experiencing or witnessing an overdose. Effective approaches include community distribution programs, co-prescription of naloxone, and equipping first responders. | • Naloxone is provided to people at high risk of experiencing or witnessing overdose.<br>• Outreach workers, harm reduction staff, and trusted clinicians are properly educated and comfortable distributing naloxone to those using illicit opioids or receiving a high-risk opioid prescription.<br>• People who use drugs and first responders are well informed as to the potential effects and actions of naloxone. Comfort with carrying |

| | *Level of Awareness/Understanding of the Intervention | | |
|---|---|---|---|
| CDC Strategy #1 | Myself | Within my Organization | In the Broader Community |
| Targeted Naloxone Distribution | 1 2 3 4 5 n/i | 1 2 3 4 5 n/i | 1 2 3 4 5 n/i |
| | *Awareness/Evaluation of Current Service Landscape | | |
| CDC Strategy #1 | These Services Exist Here | There are Gaps or Need to Expand | Barriers Exist to Meeting Need |
| Targeted Naloxone Distribution | 1 2 3 4 5 n/i | 1 2 3 4 5 n/i | 1 2 3 4 5 n/i |
| | *Level of Buy-in or Support for this Intervention | | |
| CDC Strategy #1 | For Myself | Within my Organization | In the Broader Community |
| Targeted Naloxone Distribution) | 1 2 3 4 5 n/i | 1 2 3 4 5 n/i | 1 2 3 4 5 n/i |

*1 = not at all; 5 = absolutely; n/i = no idea, couldn't guess

## CDC Strategy #2: Medication-Assisted Treatment (MAT)

| Explanation | Strategy Works Best When: |
|---|---|
| MAT is a proven pharmacological treatment for opioid use disorder. The backbone of this treatment is FDA approved medications. Agonist drugs, methadone and buprenorphine, activate opioid receptors in the brain, preventing painful opioid withdrawal symptoms without causing euphoria; naltrexone blocks the effects of opioids. MAT is effective at reducing use and helping people to lead normal lives. | • It is combined with ancillary treatment strategies like counseling and social support with fixed, safe, and predictable doses of medications.<br>• Public awareness of MAT as an effective medical intervention is promoted by local leadership. This helps to reduce stigma against MAT that discourages people from seeking this form of care.<br>• Entry into treatment is voluntary. Compulsory treatment programs through legal and social welfare systems are less effective than voluntary treatment.<br>• Patients have access to a variety of medication options. All patients are different, and treatment is best when individualized. Some people fare significantly better on buprenorphine than on methadone, and vice versa. Some may need to try several treatment options before discovering what works best, and some may not have access to all MAT medications.<br>• The challenges of receiving MAT are understood and mitigated. Many individuals face hurdles in receiving approval for MAT from their health insurance provider. Many methadone clinics require patients to attend daily to receive treatment. This can mean long, burdensome commutes at odd hours, which can conflict with professional, familial, or care-giving responsibilities. Those who live in rural areas, for example, may have to drive hours to receive care. Treatment is more successful when these obstacles are not placed in the way. |

| | *Level of Awareness/Understanding of the Intervention | | |
|---|---|---|---|
| CDC Strategy #2 | Myself | Within my Organization | In the Broader Community |
| Medication-Assisted Treatment (MAT) | 1 2 3 4 5 n/i | 1 2 3 4 5 n/i | 1 2 3 4 5 n/i |
| | *Awareness/Evaluation of Current Service Landscape | | |
| CDC Strategy #2 | These Services Exist Here | There are Gaps or Need to Expand | Barriers Exist to Meeting Need |
| Medication-Assisted Treatment (MAT) | 1 2 3 4 5 n/i | 1 2 3 4 5 n/i | 1 2 3 4 5 n/i |
| | *Level of Buy-in or Support for this Intervention | | |
| CDC Strategy #2 | For Myself | Within my Organization | In the Broader Community |
| Medication-Assisted Treatment (MAT) | 1 2 3 4 5 n/i | 1 2 3 4 5 n/i | 1 2 3 4 5 n/i |

*1 = not at all; 5 = absolutely; n/i = no idea, couldn't guess\

## CDC Strategy #3: Academic Detailing

| Explanation | Strategy Works Best When: |
|---|---|
| "Detailing" is a structured educational strategy developed by commercial manufacturers of medical and pharmaceutical technologies to market these products to prescribers and pharmacists. "Academic detailing" consists of structured visits to healthcare providers by trained professionals who can provide tailored training and technical assistance, helping healthcare providers use best practices. | • Dedicated and trained detailing teams are deployed for all academic detailing activities, as this strengthens the detailing approach and fosters consistency within the project.<br>• The individuals who receive academic detailing possess the means and resources to put their newly gained knowledge to use. For instance, physicians who treat patients receiving opioid medications often benefit from additional staff support, as evidence based opioid prescribing requires additional patient follow-up activities and administrative tasks. |

| | *Level of Awareness/Understanding of the Intervention | | |
|---|---|---|---|
| CDC Strategy #3 | Myself | Within my Organization | In the Broader Community |
| Academic Detailing | 1 2 3 4 5 n/i | 1 2 3 4 5 n/i | 1 2 3 4 5 n/i |
| | *Awareness/Evaluation of Current Service Landscape | | |
| CDC Strategy #3 | These Services Exist Here | There are Gaps or Need to Expand | Barriers Exist to Meeting Need |
| Academic Detailing | 1 2 3 4 5 n/i | 1 2 3 4 5 n/i | 1 2 3 4 5 n/i |
| | *Level of Buy-in or Support for this Intervention | | |
| CDC Strategy #3 | For Myself | Within my Organization | In the Broader Community |
| Academic Detailing | 1 2 3 4 5 n/i | 1 2 3 4 5 n/i | 1 2 3 4 5 n/i |

1 = not at all; 5 = absolutely; n/i = no idea, couldn't guess

## CDC Strategy #4: Eliminating Prior-Authorization Requirements for Medications for OUD

| Explanation | Strategy Works Best When: |
|---|---|
| In this scenario, health insurance providers cover the cost of MAT as a standard benefit and all requirements that a physician contact the insurance provider for approval prior to writing the prescription (a process called "prior authorization") are removed. Without these prior authorization requirements, prescriptions for MAT medications to treat opioid use disorder can be written and filled as soon as a physician deems this treatment necessary, free from artificial delays. | Policy makers and healthcare providers work collaboratively with health insurance companies and state Medicaid programs to design and implement these policy changes. |

| | *Level of Awareness/Understanding of the Intervention | | |
|---|---|---|---|
| CDC Strategy #4 | Myself | Within my Organization | In the Broader Community |
| Eliminating Prior-Authorization Requirements for Medications for Opioid Use Disorder | 1 2 3 4 5 n/i | 1 2 3 4 5 n/i | 1 2 3 4 5 n/i |
| | *Awareness/Evaluation of Current Service Landscape | | |
| CDC Strategy #4 | These Services Exist Here | There are Gaps or Need to Expand | Barriers Exist to Meeting Need |
| Eliminating Prior-Authorization Requirements for Medications for Opioid Use Disorder | 1 2 3 4 5 n/i | 1 2 3 4 5 n/i | 1 2 3 4 5 n/i |
| | *Level of Buy-in or Support for this Intervention | | |
| CDC Strategy #4 | For Myself | Within my Organization | In the Broader Community |
| Eliminating Prior-Authorization Requirements for Medications for Opioid Use Disorder | 1 2 3 4 5 n/i | 1 2 3 4 5 n/i | 1 2 3 4 5 n/i |

*1 = not at all; 5 = absolutely; n/i = no idea, couldn't guess

## CDC Strategy #5: Screening for Fentanyl in Routine Clinical Toxicology Testing

| Explanation | Strategy Works Best When: |
|---|---|
| The standard panel of substances included in routine clinical drug screens (carried out in hospitals, clinics, treatment centers, etc.) should include screening for fentanyl exposure, particularly in jurisdictions where fentanyl is known to be prevalent in the local illicit drug market. | • Adjustments are made to funding streams, standard lab procedures, and electronic medical records systems to accommodate and standardize this change in practice.<br>• Trends in the results of fentanyl screens are shared effectively across public institutions with the capacity to intervene amongst those who intentionally or unintentionally consume fentanyl and reduce the risk of overdose. |

| | *Level of Awareness/Understanding of the Intervention | | |
|---|---|---|---|
| CDC Strategy #5 | Myself | Within my Organization | In the Broader Community |
| Screening for Fentanyl in Routine Clinical Toxicology Testing | 1 2 3 4 5 n/i | 1 2 3 4 5 n/i | 1 2 3 4 5 n/i |
| | *Awareness/Evaluation of Current Service Landscape | | |
| CDC Strategy #5 | These Services Exist Here | There are Gaps or Need to Expand | Barriers Exist to Meeting Need |
| Screening for Fentanyl in Routine Clinical Toxicology Testing | 1 2 3 4 5 n/i | 1 2 3 4 5 n/i | 1 2 3 4 5 n/i |
| | *Level of Buy-in or Support for this Intervention | | |
| CDC Strategy #5 | For Myself | Within my Organization | In the Broader Community |
| Screening for Fentanyl in Routine Clinical Toxicology Testing | 1 2 3 4 5 n/i | 1 2 3 4 5 n/i | 1 2 3 4 5 n/i |

*1 = not at all; 5 = absolutely; n/i = no idea, couldn't guess

# CDC Strategy #6: 911 Good Samaritan Laws

| Explanation | Strategy Works Best When: |
|---|---|
| The standard panel of substances included in routine clinical drug screens (carried out in hospitals, clinics, treatment centers, etc.) should include screening for fentanyl exposure, particularly in jurisdictions where fentanyl is known to be prevalent in the local illicit drug market. | • Immunity is extended to all bystanders on the scene, not only to the individual in crisis and the individual who called 911.<br>• Bystanders are protected from parole violations and warrant searches in addition to receiving immunity from criminal charges. Any perceived risk to the freedom or safety of the bystander reduces the probability that 911 will be called.<br>• Police officers and other first responders are well informed as to their liabilities and responsibilities when responding to an overdose as outlined in their state's 911 Good Samaritan Law and other state and local regulations.<br>• People who use drugs are well informed about the 911 Good Samaritan law and have reason to trust that those protections will be consistently afforded to them when they call 911.<br>• The hospital experiences of people who use drugs are strengthened and improved. Individuals in crisis will not call for emergency care if they don't want to be transported to the hospital due to previous maltreatment. |

| | *Level of Awareness/Understanding of the Intervention | | |
|---|---|---|---|
| CDC Strategy #6 | Myself | Within my Organization | In the Broader Community |
| 911 Good Samaritan Laws | 1 2 3 4 5 n/i | 1 2 3 4 5 n/i | 1 2 3 4 5 n/i |
| | *Awareness/Evaluation of Current Service Landscape | | |
| CDC Strategy #6 | These Services Exist Here | There are Gaps or Need to Expand | Barriers Exist to Meeting Need |
| 911 Good Samaritan Laws | 1 2 3 4 5 n/i | 1 2 3 4 5 n/i | 1 2 3 4 5 n/i |
| | *Level of Buy-in or Support for this Intervention | | |
| CDC Strategy #6 | For Myself | Within my Organization | In the Broader Community |
| 911 Good Samaritan Laws | 1 2 3 4 5 n/i | 1 2 3 4 5 n/i | 1 2 3 4 5 n/i |

*1 = not at all; 5 = absolutely; n/i = no idea, couldn't guess

# CDC Strategy #7: Naloxone Distribution in Treatment Centers and Criminal Justice Settings

| Explanation | Strategy Works Best When: |
|---|---|
| Naloxone distribution programs in criminal justice and treatment facilities (both inpatient and outpatient) target individuals who are about to be released from supervision and/or cease treatment to receive overdose response training and naloxone kits prior to their exit from the program or facility. | • Coverage of these distribution programs is universal, providing all individuals leaving criminal justice settings or treatment with the opportunity to be trained and receive a naloxone kit. This is preferable to opt-in programs that require inmates to request special services to receive naloxone.<br>• Training is provided in a way that refrains from making negative judgments about drug use and focuses instead on the importance of every person's safety and wellbeing even in the context of drug use.<br>• Close contacts of the individual (family, partners, and children) are also trained in naloxone administration and overdose response.<br>• Naloxone distribution in treatment centers and criminal justice settings works best when there is certainty in the supply chain and in funding. In treatment settings, an individual's insurance can cover the cost of naloxone. |

| | *Level of Awareness/Understanding of the Intervention | | |
|---|---|---|---|
| CDC Strategy #7 | Myself | Within my Organization | In the Broader Community |
| Naloxone Distribution in Treatment Centers and Criminal Justice Settings | 1 2 3 4 5 n/i | 1 2 3 4 5 n/i | 1 2 3 4 5 n/i |
| | *Awareness/Evaluation of Current Service Landscape | | |
| CDC Strategy #7 | These Services Exist Here | There are Gaps or Need to Expand | Barriers Exist to Meeting Need |
| Naloxone Distribution in Treatment Centers and Criminal Justice Settings | 1 2 3 4 5 n/i | 1 2 3 4 5 n/i | 1 2 3 4 5 n/i |
| | *Level of Buy-in or Support for this Intervention | | |
| CDC Strategy #7 | For Myself | Within my Organization | In the Broader Community |
| Naloxone Distribution in Treatment Centers and Criminal Justice Settings | 1 2 3 4 5 n/i | 1 2 3 4 5 n/i | 1 2 3 4 5 n/i |

1 = not at all; 5 = absolutely; n/i = no idea, couldn't guess

## CDC Strategy #8: MAT in Criminal Justice Settings and Upon Release

| Explanation | Strategy Works Best When: |
|---|---|
| In this intervention, MAT should be made available as a standard of care for incarcerated individuals with opioid use disorder. Those receiving MAT when they enter a criminal justice setting may continue receiving this treatment, and those who are not on treatment may initiate and continue this form of care while incarcerated and then be linked with appropriate care providers to continue MAT upon release.* | • MAT is uninterrupted for those who were receiving care prior to incarceration.<br>• MAT can be initiated in criminal justice settings.<br>• Individuals have access to all available forms of MAT medication. This choice is essential, as some individuals fare much better (or worse) on one of these drugs than on the other.<br>• An effective system for referral and linkage to care is in place so that individuals on MAT can receive a "warm handoff" to providers who are able to continue their care upon release. Otherwise, recently released individuals are forced to choose between enduring painful opioid withdrawal and quickly finding another source of opioids. The quickest and easiest sources of opioids are illicit ones. |

* Medicare and Medicaid generally do not pay for services rendered to individuals in custodial settings. Applicable statutory and/or regulatory exclusions will apply.

| | *Level of Awareness/Understanding of the Intervention | | |
|---|---|---|---|
| CDC Strategy #8 | Myself | Within my Organization | In the Broader Community |
| MAT in Criminal Justice Settings and Upon Release | 1 2 3 4 5 n/i | 1 2 3 4 5 n/i | 1 2 3 4 5 n/i |
| | *Awareness/Evaluation of Current Service Landscape | | |
| CDC Strategy #8 | These Services Exist Here | There are Gaps or Need to Expand | Barriers Exist to Meeting Need |
| MAT in Criminal Justice Settings and Upon Release | 1 2 3 4 5 n/i | 1 2 3 4 5 n/i | 1 2 3 4 5 n/i |
| | *Level of Buy-in or Support for this Intervention | | |
| CDC Strategy #8 | For Myself | Within my Organization | In the Broader Community |
| MAT in Criminal Justice Settings and Upon Release | 1 2 3 4 5 n/i | 1 2 3 4 5 n/i | 1 2 3 4 5 n/i |

*1 = not at all; 5 = absolutely; n/i = no idea, couldn't guess

## CDC Strategy #9: Initiating Buprenorphine-based MAT in Emergency Departments

| Explanation | Strategy Works Best When: |
|---|---|
| Patients receiving care in emergency departments who have untreated opioid use disorder are referred to a provider for long-term buprenorphine-based MAT. This referral is accompanied by initial doses of buprenorphine or a short-term prescription that can be filled right away. The patient can begin treatment immediately, instead of waiting several days for their appointment with a new provider. | There is no broadly accepted "best practice" for initiating patients onto buprenorphine-based MAT in an emergency department. This intervention is very new, and researchers are still studying how best to serve patients' needs and assist them in engaging with care. Patients who are initiated in the emergency department are very likely there because they have experienced an overdose crisis. It can be expected that such an experience may change the meaning of treatment for these patients, and the value of treatment may change in an inconsistent or counter-intuitive way over time.<br><br>What we do know, however, is that each instance of engagement in MAT, even if the patient eventually drops out of care, predicts higher success the next time treatment is sought. Furthermore, providing "bridging" doses of MAT medications to individuals seeking treatment greatly improves patient engagement in MAT care during treatment initiation—a key moment for those with opioid use disorder, when maintaining trust and stability is of utmost importance. |

| | *Level of Awareness/Understanding of the Intervention | | |
|---|---|---|---|
| CDC Strategy #9 | Myself | Within Organization I represent | In the Broader Community |
| Initiating Buprenorphine-based MAT in Emergency Departments | 1 2 3 4 5 n/i | 1 2 3 4 5 n/i | 1 2 3 4 5 n/i |
| | *Awareness/Evaluation of Current Service Landscape | | |
| CDC Strategy #9 | These Services Exist Here | There are Gaps or Need to Expand | Barriers Exist to Meeting Need |
| Initiating Buprenorphine-based MAT in Emergency Departments | 1 2 3 4 5 n/i | 1 2 3 4 5 n/i | 1 2 3 4 5 n/i |
| | *Level of Buy-in or Support for this Intervention | | |
| CDC Strategy #9 | For Myself | Within Organization I represent | In the Broader Community |
| Initiating Buprenorphine-based MAT in Emergency Departments | 1 2 3 4 5 n/i | 1 2 3 4 5 n/i | 1 2 3 4 5 n/i |

*1 = not at all; 5 = absolutely; n/i = no idea, couldn't guess

## CDC Strategy #10: Syringe Services Programs

| Explanation | Strategy Works Best When: |
|---|---|
| Sometimes called "needle exchange" or "syringe exchange," syringe services programs provide access to clean and sterile equipment used for the preparation and consumption of drugs as well as tools for the prevention and reversal of opioid overdose, such as naloxone training and distribution, fentanyl testing strips, and more. Comprehensive syringe services programs also provide additional social and medical services such as: safe disposal of syringes and needles; testing for HIV and hepatitis C infection and linkage to treatment; education about overdose and safer injection practices; referral and access to drug treatment programs, including MAT; tools to prevent HIV and other infectious disease, such as condoms, counseling, or vaccinations; and linkage to medical, mental health, and social services. | • They provide an adequate supply of sterile syringes. Limiting the number of syringes an individual may receive reduces the effectiveness of the intervention. Programs with one-for-one exchange policies, for example, allow participants only as many syringes as the number of used syringes they return, thus undercutting the program's own effectiveness. When no limits are set on the number of syringes distributed, participants are more likely to have clean syringes on hand when they need them, and they can provide syringes to many more people than can't attend the program themselves, thus multiplying the program's effectiveness. This also increases participants' incentive to visit the program and interact with staff and counselors.<br>• The needs and concerns specific to the local drug using community are addressed and accommodated by the program.<br>• Program participants who are seeking treatment for opioid use disorder or for other physical or mental health concerns are offered assistance in accessing appropriate care. |

| | *Level of Awareness/Understanding of the Intervention | | |
|---|---|---|---|
| CDC Strategy #10 | Myself | Within Organization I represent | In the Broader Community |
| Syringe Services Programs | 1 2 3 4 5 n/i | 1 2 3 4 5 n/i | 1 2 3 4 5 n/i |
| | *Awareness/Evaluation of Current Service Landscape | | |
| CDC Strategy #10 | These Services Exist Here | There are Gaps or Need to Expand | Barriers Exist to Meeting Need |
| Syringe Services Programs | 1 2 3 4 5 n/i | 1 2 3 4 5 n/i | 1 2 3 4 5 n/i |
| | *Level of Buy-in or Support for this Intervention | | |
| CDC Strategy #10 | For Myself | Within Organization I represent | In the Broader Community |
| Syringe Services Programs | 1 2 3 4 5 n/i | 1 2 3 4 5 n/i | 1 2 3 4 5 n/i |

# AMHC/ACORP Community Needs Survey


## Substance Use Disorder/Opioid Use Disorder Community Needs Assessment Survey

Please help us evaluate SUD/OUD services in Aroostook County.
This survey should take about 10 minutes.
Name and contact information is optional!
Individuals that identify a name and contact number will be eligible for a drawing for one of four $50 gift cards.

* Required

### HRSA-Rural Community Opioid Response Program - Community Survey

Please complete this survey. Your voice will make a difference!

3. Please select the population you are representing in this survey. Pick only one. *

- ◯ Person In Recovery
- ◯ Incarcerated Individual
- ◯ Health Care Worker
- ◯ SUD Service Provider
- ◯ Tribal Member
- ◯ Affected Other/Family member
- ◯ Actively Using Individual
- ◯ Current Student
- ◯ Law enforcement
- ◯ First Responder
- ◯ Community Member
- ◯ Other

4. What age group do you belong too? *

- ◯ 10-17
- ◯ 18-24
- ◯ 25-34
- ◯ 35-44
- ◯ 45-54
- ◯ 55 or older

5. Gender *

- ◯ Woman
- ◯ Man
- ◯ Non-binary
- ◯ Prefer not to say

6. Ethnicity *

- ◯ White
- ◯ Native American
- ◯ Hispanic
- ◯ African American
- ◯ Asian
- ◯ Pacific Islander
- ◯ More than 1

7. Which part of Aroostook County do you currently reside in? *

- ◯ Northern Aroostook (Van Buren, Madawaska, Fort Kent)
- ◯ Central Aroostook (Presque Isle, Caribou, Mars Hill)
- ◯ Southern Aroostook (Houlton, Smyrna, Monticello)

8. Where did you stay last night? *

- ◯ My own home / apartment
- ◯ Someone else's home / apartment
- ◯ Outside / Car
- ◯ Shelter
- ◯ Recovery Residence/Sober Living
- ◯ Treatment Center
- ◯ Other

9. Have you or someone close to you ever misused opioids causing negative life impacts or irresponsibility? *

- ◯ I have
- ◯ Someone close to me has
- ◯ I have not /do not have anyone close to me that has

10. Rate the Level: Opioid Use Disorder is a serious issue in my community? *

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|

No issue at all — Very serious issue

11. Please rate the following statements. *

| | Strongly disagree | Disagree | Neutral | Agree | Strongly agree |
|---|---|---|---|---|---|
| I understand SUD/OUD and it complexities | ◯ | ◯ | ◯ | ◯ | ◯ |
| I am familiar with my local SUD/OUD services | ◯ | ◯ | ◯ | ◯ | ◯ |
| Transportation is barrier to receive services or maintain services | ◯ | ◯ | ◯ | ◯ | ◯ |
| Stigma is an issue in my community | ◯ | ◯ | ◯ | ◯ | ◯ |
| Individuals with SUD/OUD need safe housing options | ◯ | ◯ | ◯ | ◯ | ◯ |
| The War on Drugs is working | ◯ | ◯ | ◯ | ◯ | ◯ |
| Telehealth is a reliable option to treat SUD/OUD and provide recovery services | ◯ | ◯ | ◯ | ◯ | ◯ |
| If I needed/wanted help with my SUD/OUD, I can easily access services. | ◯ | ◯ | ◯ | ◯ | ◯ |
| SUD/OUD only affects the person using | ◯ | ◯ | ◯ | ◯ | ◯ |
| My community/town tends to understand people with SUD/OUD | ◯ | ◯ | ◯ | ◯ | ◯ |
| SUD/OUD is a chronic disease | ◯ | ◯ | ◯ | ◯ | ◯ |

12. NALOXONE/NARCAN: The CDC says naloxone access is one evidence based model to help with the morbidity and mortality of OUD. Please rate your opinion on the following statements. *

| | Strongly disagree | Disagree | Agree | Strongly agree | Not sure |
|---|---|---|---|---|---|
| My community supports Naloxone distribution | ◯ | ◯ | ◯ | ◯ | ◯ |
| My organization/ friends or co-workers supports Naloxone distribution | ◯ | ◯ | ◯ | ◯ | ◯ |
| Naloxone should be given to inmates upon release from jail | ◯ | ◯ | ◯ | ◯ | ◯ |
| Naloxone should be given to all clients at discharge of any SUD treatment | ◯ | ◯ | ◯ | ◯ | ◯ |
| Naloxone should be available in High schools | ◯ | ◯ | ◯ | ◯ | ◯ |
| If I need naloxone I can get it easily | ◯ | ◯ | ◯ | ◯ | ◯ |

13. Medication-Assisted Treatment (MAT): MAT is a proven pharmacological treatment for opioid use disorder supported by CDC and FDA. Rate your opinion on the following statements. *

| | strongly disagree | Disagree | Agree | Strongly agree | Not Sure |
|---|---|---|---|---|---|
| I support MAT as a viable treatment option | ◯ | ◯ | ◯ | ◯ | ◯ |
| My organization/friends or coworkers supports MAT as a viable treatment option | ◯ | ◯ | ◯ | ◯ | ◯ |
| My community supports MAT as a viable treatment option | ◯ | ◯ | ◯ | ◯ | ◯ |
| Primary Care Doctors should treat people with MAT | ◯ | ◯ | ◯ | ◯ | ◯ |
| If I needed MAT treatment I can easily access it. | ◯ | ◯ | ◯ | ◯ | ◯ |
| Small towns have the same access to MAT services as large towns | ◯ | ◯ | ◯ | ◯ | ◯ |
| Our Jails/ER's/Hospitals support MAT treatment | ◯ | ◯ | ◯ | ◯ | ◯ |

14. Good Samaritan Laws (GSL): Maine has a 911 Good Samaritan Law in effect, meaning that individuals who respond to overdose situations have immunity from prosecution. Please rate your opinion on the following statements. *

| | strongly disagree | Disagree | Agree | Strongly agree | Not Sure |
|---|---|---|---|---|---|
| I am familiar with the Good Samaritan Law (GSL) | ◯ | ◯ | ◯ | ◯ | ◯ |
| My community is familiar with the GSL | ◯ | ◯ | ◯ | ◯ | ◯ |
| My local law officials are familiar with GSL | ◯ | ◯ | ◯ | ◯ | ◯ |
| I feel safe calling 911 in an overdose situation | ◯ | ◯ | ◯ | ◯ | ◯ |
| My community needs more education on GSL | ◯ | ◯ | ◯ | ◯ | ◯ |

15. Syringe Service Programs (SSP): Also known as "Syringe Exchange" the CDC research has shown this strategy to be essential to prevention of morbidity and mortality of OUD. Please rate your opinion on the following statements. *

| | Strongly disagree | Disagree | Agree | Strongly agree | Not Sure |
|---|---|---|---|---|---|
| I am supportive of SSP's in my community | ◯ | ◯ | ◯ | ◯ | ◯ |
| My organization/friends or co-workers are supportive of SSP's in our communities | ◯ | ◯ | ◯ | ◯ | ◯ |
| My community is supportive of SSP's | ◯ | ◯ | ◯ | ◯ | ◯ |
| More education on SSP's is needed | ◯ | ◯ | ◯ | ◯ | ◯ |
| SSP's reduce the rate of Hepatitis C, and HIV | ◯ | ◯ | ◯ | ◯ | ◯ |
| SSP's improve safe disposal of used syringes | ◯ | ◯ | ◯ | ◯ | ◯ |
| SSP's can provide referrals to OUD treatment | ◯ | ◯ | ◯ | ◯ | ◯ |
| SSP's encourages individuals to continue to use substances | ◯ | ◯ | ◯ | ◯ | ◯ |
| SSP's are available in my community | ◯ | ◯ | ◯ | ◯ | ◯ |

16. What do you think is the primary reason people with SUD/OUD in Aroostook County don't get seek help? *

- ◯ Lack of transportation
- ◯ Lack of detox beds
- ◯ Waitlists for treatment (residential, MAT, or outpatient)
- ◯ Not enough providers/workforce need
- ◯ Stigma
- ◯ No insurance
- ◯ They don't want the help
- ◯ Other

17. Assess the need for the following identified gaps around prevention, treatment, and recovery for SUD/OUD in Aroostook County.

| | Not needed | Needed | Highly needed | Already have this service available | I don't know what this service is |
|---|---|---|---|---|---|
| Easier/affordable access to HCV/HIV treatment | ◯ | ◯ | ◯ | ◯ | ◯ |
| Peer Recovery Center, recovery coach services, meetings, peer run groups | ◯ | ◯ | ◯ | ◯ | ◯ |
| Long-term residential (60 days or longer) | ◯ | ◯ | ◯ | ◯ | ◯ |
| Women and Children's services/housing/MAT for expecting mothers, residential treatment options | ◯ | ◯ | ◯ | ◯ | ◯ |
| Crisis detox options | ◯ | ◯ | ◯ | ◯ | ◯ |
| Syringe Service Programs-SSP's (stationary or mobile) | ◯ | ◯ | ◯ | ◯ | ◯ |
| Stigma education for all populations | ◯ | ◯ | ◯ | ◯ | ◯ |
| Recovery residences/Sober living/Safe housing | ◯ | ◯ | ◯ | ◯ | ◯ |
| Law Enforcement Assisted Diversion (LEAD) programs/ community engagement teams | ◯ | ◯ | ◯ | ◯ | ◯ |
| More SUD/OUD workforce | ◯ | ◯ | ◯ | ◯ | ◯ |
| Naloxone distribution including in Jails/Treatment | ◯ | ◯ | ◯ | ◯ | ◯ |
| Primary care providers-providing MAT services | ◯ | ◯ | ◯ | ◯ | ◯ |
| Adolescent prevention programs in schools | ◯ | ◯ | ◯ | ◯ | ◯ |
| Mobile Recovery Unit/Bridge programs | ◯ | ◯ | ◯ | ◯ | ◯ |

18. Has your personal view around SUD/OUD changed in the last 5 years? Please explain.

Enter your answer

19. In your opinion, where do SUD/OUD services need to expand in your community?

Enter your answer

20. If there is one thing Aroostook County can do to reduce the morbidity and mortality of opioid use what would that be?

Enter your answer

21. Open Form:  Please add any additional information on OUD that you think is important for us to know.

Enter your answer

## Participants of the ACORP One-on-One Interviews

| Participant Name | Organization | Population Represented |
|---|---|---|
| Corey Tilley and Amber Tierney | Boys and Girls Clubs of Border Towns | Youth |
| Dr. Samuela Manages | Pines Health Services | MAT providers |
| Katia Sirois, LADC, CCS | Aroostook Mental Health Center | SUD counselor |
| Kayty Jalbert | Peer Support Specialist/ AMHC | Person in Recovery (PIR) |
| Pete McCorison, CCS | Maine Vet Center | Veterans |
| Ray Demko | AmeriCorp recovery coach/AMHC | Residents of Jail institutions |
| Ryan Pelletier | Aroostook County Administrator | Aroostook County Municipalities |
| Sharon Berz | Aroostook Agency on Aging | Seniors |
| Shawn Graham, CADC | University of Maine Fort Kent | Students / Administrators |
| Stacie Holton | Recovery center Manager/AMHC | PIR |
| Stephen Tibbert | Hope and Justice Project | Domestic Violence Victims |
| Trey Stewart | State Senate District 2 | Local government |
| Trudy Raidon | Link for Hope | Affected others |
| Wendy Page | Sexual Assault Services Manager/AMHC | Sexual Assault Victims |
| Michelle Barrows | Houlton Band of Maliseet Indians | Tribal communities |
| Tammy Goetsh | Adopt-a-Block of Aroostook | Underserved populations |
| Megan O'Berry | Aroostook County Action Program | SUD Workforce |
| Homeless individual with SUD | None | Homeless Population |
| People in Recovery x5 | None | People in Recovery |
| Actively using individual x4 | None | People who use substances |

# ACORP Focus Group Questions

Population of the Group:
Number in Attendance:

### General Questions

1. What, in your opinion, constitutes inappropriate use of opioids?

2. What are some factors specific to this community that lead people to misuse opioids? Heroin?

3. What are some of the barriers people with SUD/OUD don't seek help?

4. Do you know anyone who identifies openly about being a person in recovery?

### Community Norms

5. How do most people in community view individuals that use substances?

### Law Enforcement

6. What role does law enforcement play in terms of opioid misuse? In overdose situations?

7. What roles would you like them to play?

8. What are someone's chances of getting caught while using opioids/heroin?

9. Do you think law enforcement is doing enough or something better? Is what we're doing helping?

### Perceived Risk of Harm

10. What are the dangers associated with opioids/heroin use?

11. If applicable, what has your doctor or pharmacist discussed with you about opioids if anything at all?

### Retail & Social Access

12. How easily are opioids obtained? What does that process look like?

### Additional Questions for Using or Recovery Population

13. How or under what circumstances did you begin using substances?

14. What do providers need to do better? Community members?

15. What did/would it take for you to seek treatment? What does low barrier look like for you to seek treatment? What can we do to help engage individuals into seeking treatment?

16. What can our community do to make the biggest impact on reducing the morbidity and mortality of opioid use now? Stigma?

## Sample One-on-One Interview Questions

1. How does SUD/OUD related to the individuals you serve?
2. Is this a topic you see clients, recoverees, patients, co-workers talking about?
3. Do you see stigmatizing language being used?
4. In what ways does SUD/OUD affect the people you serve?
5. What is working in our communities to help combat SUD/OUD?
6. What do you believe our communities need to improve on to help battle SUD/OUD?
7. What specifically would help lower rates of morbidity and mortality right now?
8. What challenges professionally are you faced with when addressing SUD/OUD?
9. What patterns are you seeing that make treatment difficult?
10. If you could do one thing right now to help what would that be and why?