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"Never doubt that a small group of thoughtful, committed citizens can change the world. Indeed, it is the only thing that ever has."
--Margaret Mead.

Mr. Chairman, and Members of the Committee, I am Nancy Green, a certified nurse midwife in Calais, Maine. I have a Bachelor of Science in Nursing from Duquesne University and a Master of Science in Nursing from Case Western Reserve University, and I am certified as a nurse midwife from Frontier School of Midwifery and Family Nursing. I am board certified through the American College of Nurse Midwives. I am also one of the founders and now president of Neighbors Against Drug Abuse (N.A.D.A.), a "grass roots" group of citizens who have come together because of our concern with our current and still evolving substance abuse epidemic and crisis in Washington County, Maine.

The Problem

Washington County, population 35,352, is entirely rural, with a natural resource and service based economy. Its 47 towns, ranging in population from 10 to 4000, are widely dispersed in a heavily wooded region encompassing 2569 square miles, which corresponds to 14 persons per square mile in an area roughly twice the size of Rhode Island. Severe winters, poor road conditions and lack of public transportation contribute to the geographic isolation of the county.

The extreme poverty, poor economic environment, and low education achievement in the rural and isolated Washington County contribute to a social climate characterized by high stress, broken families, and poor preventative health care. These conditions contribute as risk factors to high rates of substance abuse starting with school age children and eventually leading to the high rates of prescription opiate abuse, which are poorly addressed by the limited resources for treatment and preventative interventions.

The geographic isolation, combined with a lack of transportation, contribute to a substantial barrier for substance abuse patients to access medical and mental health care or social services. In addition to difficulties for patients to travel, these factors pose a major challenge for health programs to deliver services and coordinate patient care in a

timely and cost effective manner. Moreover, the stigma of drug abuse and the lack of anonymity in small towns are well known barriers for clients seeking services in a rural area.

Emergence of the Current Epidemic

In 1999, the Office of the U.S. Attorney for the District of Maine noticed that law enforcement seizures and arrests for illegal possession of OxyContin and other abused synthetic narcotic prescription drugs had jumped nine fold. Arrests for illegal possession have quadrupled in four years. In Washington County, adult arrests for possession of synthetic narcotics were 2.5 times that for the state. The rate of possession of opiates or cocaine was twice the state average, and reports of arrests for breaking and entering were elevated 67 percent over the state (source: Maine Department of Public Safety).

In October 1999, U.S. Attorney Jay McCloskey traveled to Washington County to meet with concerned citizens. "The prescription pain medication abuse is the most serious criminal problem facing Maine and may be the most pressing social problem," he said at the meeting. I attended the meeting because of a phone call from Carrie MacDonald, a friend and patient of mine, who works for the Calais school system as the prevention coordinator under the Safe Schools and Healthy Students Initiative. She felt that this would be an important meeting for me, as a health care provider, in particular caring for women and newborns, to attend. And, she was right.

I still remember how I felt that October day last year. What a coincidence that this same day, I was approached by one of my patients, a 19 year old expecting her second baby, who was in her second trimester of pregnancy, asking for help. "Please get help for me," she said, "I was arrested for selling opiates outside the Calais Junior High School. I have been addicted to opiates for four-five years. I need to get 'clean'."

I made several phone calls to the emergency room at the Calais hospital and to Calais mental health counselors. They told me that there was NO help for her in this part of the state. I made phone calls to Mercy Hospital in Portland, Maine, a four hour drive away. They accepted her as a patient, but only because of her advanced stage of pregnancy. Otherwise, waiting lists for patients to get into "detox" were and still are four to six months long.

One week later, I received a phone call from this patient from Portland, in tears, asking me to take her back as a patient. "I miss home. I know you and trust you. I want you to deliver my baby." I explained to her that she could NOT come home, since there was nothing for her here in the way of substance abuse treatment, support or counseling. Also, she could not come back to the same environment she left from, same "circle of friends," "same life." I told her, "it's not safe for you to come home." What a coincidence that this took place about one hour before our meeting with U.S. Attorney McCloskey. I was able to share my very recent encounter with him and the group in attendance.

By January 2001, I was caring for six pregnant women, at all stages of pregnancy, with addiction to "legal" prescription medications. By now, I was becoming an "expert in addiction." One of my patients, who had transferred her care to me from another provider in January, delivered her baby four weeks prematurely. I could not understand why she was having such an unusual labor pattern, and why so early. She finally admitted to me in the birthing room, while laboring, that she was an opiate addict. Things became very clear to me - she had "snorted" four days before, but not since then. What I was seeing was actual withdrawal, not just hers but that of her soon to be born baby. She told me she "snorted oxys." I told her she was now going to have an addicted baby, and she said to me:

> **"My friends told me it was safer for me to snort OxyContin, because it was a legal prescription, written by doctors, and that nothing would happen to the baby."**

She ended up having the baby who went through withdrawal in the nursery (e.g., high pitched crying, difficult to console, exaggerated movements, tremors). Our pediatricians provided excellent care to this baby. The baby's grandmother adopted the baby in order to avoid the Department of Human Services "placing the baby with a stranger." My patient, I'm glad to say, has done extremely well with detox and rehab, through my support and the support of the few substance abuse counselors we have in the community.

"The drug problem is contributing to the break- up of families," according to Circuit Court Judge John Romei, who estimates that half of the child custody cases he handles involve family abuse of prescription drugs. "If there is a bigger problem in regard to the criminal justice system in this county, I don't know what it is....I've taken children away from numerous young moms because of prescriptive narcotic abuse."

An attorney in the area stated that she has served as court appointed attorney for approximately 40 young women in child protective cases involving prescription drugs. "I had my first child protective case involving opiates three or four years ago. Now it's just routine," she said.

Two more of my patients delivered this past week. With again, support from me, the one substance abuse counselor in town, education and determination, these women have been drug free for the past four to five months. Their babies were born weighing approximately five pounds at term. Luckily, and so far, this was the only consequence of their mothers' addiction earlier in their pregnancies. Several of my other addicted patients have suffered pregnancy losses, again at differing stages of their pregnancies.

A very dangerous consequence of substance abuse, and a serious public health issue, is the recent rise of Hepatitis C. According to Maine Center for Disease Control reports, a 47 percent elevation over state levels of Hepatitis C was identified within the county in 2000. This correlates with the epicenter of the recent epidemic of synthetic narcotics. Only 10

percent of opiate addicts have been tested for Hepatitis C and, of those tested, at least 30 to 40 percent have tested positive. That percentage may actually be higher since there is at least a six month time lag from exposure to Hepatitis C and any resulting infection to testing positive. If we assume a similar rate of infection among untested addicts, it means that 90 percent of Hepatitis C cases among the addict population have yet to be identified.

When speaking to our addicted patients who are still in recovery, they explain to us how they "crush the tablets" and then snort them with straws or use the bottom parts of pens, and/or they dissolve the tablets with water and inject them. Crushing or dissolving the tablet disarms the timed-release action of the medication causing a quick, powerful high similar to that of heroin. Hepatitis C is transmitted through blood to blood contact. When snorting, the mucous membranes in the nose become weakened and bleed. Addicts share their "snorting utensils" and, therefore, share Hepatitis C. HIV takes much longer to "show up" in a person. Hepatitis C shows up within a short period of time.

Listening to people affected with addiction is the most heart wrenching experience. One young man described how he moved along the progression of addiction from marijuana and alcohol to Percocets and Dilaudid (i.e., other forms of opiates). But when introduced to OxyContin, "bam what an experience!" "Nothing else compares to it." "An immediate sense of euphoria and energy that can't be described." The feeling with OxyContin is so magnificent that all other drugs of abuse pale by comparison. "I didn't want anything else." "I knew I was 'hooked' within two days of trying 'oxys'." "I needed and wanted more." "I couldn't wait to get up in the morning to snort another one." "It is cheaper for me to buy oxys in Canada because it is much cheaper than in Maine. I can buy a 40 (40 mg. Tablet) for $20.00 U.S. instead of $40.00 here at home."

Parents and grandparents describe how their families have been afflicted by this crisis. One family had their bible, which had been in the family for over 100 years, stolen by their child in order to get money to sustain her habit. Her own family called the police and had her arrested "because we just couldn't deal anymore with this problem."

Some quotes from the extensive press coverage of the OxyContin epidemic in Washington County highlight the large impact. For example, from a March 23, 2001, *Boston Globe* article, "Painkiller Tears Through Maine":

> **"OxyContin, a remarkably effective painkiller, is shredding the social fabric of parts of Maine, creating a Wild West-like anarchy in many communities. Pharmacies are being held up, the gunmen demanding only pills. Neighbors are robbing, even assaulting, one another. One couple tried to smuggle the drug from Canada, where it is cheaper, in the underpants of their handicapped child."**

Why rural Maine has been subject to this rapid growth in prescription narcotic abuse appears attributable to several factors, including the following:

- **The ready availability of the drug from the diversion of prescriptions or fraudulent prescriptions allowed abuse to develop among a larger population of users than typically have ready access to heroin.**

- **A Maine legislative rule in 1999 contributed to the problem by requesting doctors to treat pain more aggressively.**

- **The great profits to be made by its illegal sale are an additional reason why OxyContin abuse has grown so quickly. A 40 milligram pill costs approximately four dollars by prescription, yet it may sell for $35 to $40 on the street. Thus, a 100 tablet bottle purchased for $400 or subsidized through Medicaid, can sell for as much as $4,000 on the black market. In areas already beset by high unemployment and poverty rates, such high profits can tempt even "average" citizens to sell some or all of their or a family member's legitimate prescription. From this level of diversion, progressively more criminal steps predictably follow for addicts who need to sustain their habit and/or dealers seeking profits. These include "doctor shopping" with fake back injuries, forging or altering prescriptions, theft from incapacitated relatives with chronic diseases, robberies of homes and pharmacies and, ultimately, armed robberies with assaults on those with legitimate prescriptions.**

Neighbors Against Drug Abuse (N.A.D.A.)

N.A.D.A. was formed after hearing reports from the Maine U.S. Attorney and the Maine Office of Substance Abuse, and professional contact with substance abuse in our practices. It has five members: a prevention specialist with the Calais school system, a nurse practitioner, parents of an addicted son, and a certified nurse midwife.

N.A.D.A. is a group of citizens who have come together because of our concern over the very high and increasing problem of substance abuse in Washington County, in particular the abuse of opiates. We act as a fact finding and steering committee. Our group is further subdivided, focusing on prevention/education, treatment, law enforcement and funding (i.e., local, state, federal, private). We organized in December 2000. We work out of our kitchens, cars, anywhere we find space, and we have functioned without a budget! However, we have been able to bring awareness to the community, having launched an enormous public campaign through public meetings and media interviews. We applied for a $100,000.00 per year for five years grant from the federal Office of Juvenile Justice and Delinquency Prevention (OJJDP) to fund prevention efforts in northeastern Washington County. We have had no response. As a result of a workshop we organized in March 2001, the Washington County Planning Commission on Opiate Addiction Treatment was formed.

The Plan

I. The Planning Commission has determined there are a number of treatment services that are considered critical to effectively treat opiate addicts in the county. These are:

a) Intensive outpatient program
b) Replacement therapies
c) Outpatient counseling
d) Medical care
e) Nutrition counseling
f) Support services (intensive supports for recovering person including case management, help to reconstitute the family, employment, housing, financial assistance, recreation, transportation, drug testing and others)
g) Family counseling
h) Education

Unlike other affected communities, we have an addicted population that is isolated geographically, with no access to treatment facilities, transportation, counseling, support or education.

II.- A federal Substance Abuse and Mental Health Administration/Center for Substance Abuse Treatment (SAMHSA/CSAT) Grant for treatment services of $500,000 per year for three years was submitted on September 7, 2001. If awarded, this grant would not become available until the summer of 2002.

III.- A smaller proposal for support to continue the work of the Commission over the next year, on detailed implementation and planning for the treatment services, has been submitted.

IV.- $100,000.00 per year for five years to fund prevention efforts (Office of Juvenile Justice and Delinquency Prevention) for N.A.D.A.

V.- Continued support from the Maine Office of Substance Abuse (OSA). We hope to obtain direct funding next year from OSA for partial support.

VI.- Help from the county delegation to build support in the state legislature for replacing this $500,000.00 per year federal grant within three years, assuming we get the grant.

VII. The Washington County Sheriff's Office has reported that there are now over 1000 known opiate addicts in the county. The plan is to be able to offer intensive outpatient services to 30 percent of this population within the second year of operation.

Recommendations

1. Make awards of grants now. Money is needed now, not in July 2002. This crisis is present and worsening. Addiction experts have calculated that for every one dollar spent on rehabilitation of addicts approximately seven dollars are saved in the criminal justice

system.

2.- Nine months to "read and decide" over a grant application is too long. Particularly since it takes time to recruit professionals and set up licensed treatment facilities.

3.- $500,000 per year is a beginning but barely scratches the surface of what we need in order to provide comprehensive care. One cannot deal with a problem of this magnitude with $500,000 per year.

4.- We recommend that awards of $500,000 per year be given to help addicted adults and an additional $500,000 per year to help addicted adolescents initially over a period of three years. Ongoing assistance will definitely be needed.

5.- We are asking that Purdue-Pharma establish foundations and make donations to help affected communities deal with opiate addiction. We feel that this is the moral thing to do especially because the fabric of our community is being destroyed mainly by addiction to OxyContin, a Purdue-Pharma product that the company heavily promoted.

Concluding Thoughts

While we don't know where the story of opiate addiction begins for the addicts of Washington County, we can predict that their current prospects, and the prospects of the towns in which they live, are bleak unless access to a comprehensive treatment program becomes available immediately. The energy behind this planning effort comes from the stark realization that the future of this isolated rural county is hanging in the balance.