

**PEER RECOVERY CENTERS**

**Research and Needs Assessment**

AdCare Educational Institute of Maine, Inc.

The Co-Occurring Collaborative Serving Maine

Alliance for Addiction and Mental Health Services, Maine

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## **EXECUTIVE SUMMARY**

In 2016, the Maine State Legislature passed LD 1537, “An Act to Combat Drug Addiction through Enforcement, Prevention, Treatment and Recovery” (Public Law 378), which provides funding for the establishment and expansion of peer support recovery centers, among other initiatives. As a result of this legislation, the Maine Office of Substance Abuse and Mental Health Services (SAMHS) asked AdCare Educational Institute of Maine, Inc. (AdCare), the Co-Occurring Collaborative Serving Maine (CCSME), the Alliance for Addiction and Mental Health Services, Maine (AAMHS), and the Maine Alliance for Addiction Recovery (MAAR) to conduct a needs assessment of recovery services and supports in each of Maine’s nine public health districts. This report is the result of that needs assessment, which was conducted in the spring and summer of 2016.

To lay the groundwork for the needs assessment, AdCare and CCSME conducted a review of evidence-based aspects of recovery community organizations (RCOs) and peer recovery centers (PRCs), and research on national models and activities. The team then conducted an environmental scan of services currently provided by PRCs in Maine, focus groups with key stakeholders in each public health district (PHD), and focus groups with people in recovery and affected others in each PHD. The team combined the information from the environmental scan, the focus groups, and the results of the Maine Opiate Collaborative listening sessions to describe readiness for the establishment or expansion of a PRC in each district. The team referred to The Community Toolbox to identify aspects of readiness.<sup>1</sup>

Key findings of the report are:

**Social Support.** Research shows that four specific types of social support facilitate recovery. These types of support are important elements of programs that deliver peer-to-peer services: *emotional support* (demonstrating empathetic caring or concern); *informational support* (sharing knowledge or information, or providing life skills or vocational training); *instrumental support* (concrete help such as transportation, child care, or help with accessing services); and *affiliational support* (facilitating contact with other people that helps to establish a sense of belonging and community).

**Recovery-Oriented Systems of Care.** Peer-supported recovery services are an integral part of recovery-oriented systems of care (ROSCs), which incorporate community-based services, are person-centered, and build on the strengths and resilience of individuals, families, and communities to achieve wellness.

**Types of Peer Support Services.** The types of support services provided by peers includes mentoring/coaching, telephone support, linking people to services, support group facilitation, and building community.

**Community-Based Services.** Peer support services are provided in the context of many community-based services, including recovery residences, recovery schools, occupational support, in the criminal justice system, and in the health care setting.

**Recovery Community Organizations.** A recovery community organization (RCO) is a community, regional, statewide, or national entity that advocates for people in recovery, sets

policies that foster and enhance recovery, and provides support services for people in recovery. RCOs are independent, nonprofit organizations that are led and governed by people in recovery, family members, friends, and allies and that focus on public education, advocacy, and peer-based and other recovery support services.

**Peer Support Specialists.** Peer support can be provided informally, but there are trained peer support specialists (PSSs) as well. The Substance Abuse and Mental Health Services Administration (SAMHSA) has established 12 core competencies for PSSs: engage peers in collaborative and caring relationships; provide support; share lived experiences of recovery; personalize peer support; support recovery planning; link to resources, services and supports; promote information about skills related to health, wellness and recovery; help peers to manage crises; value communication; support collaboration and teamwork; promote leadership and advocacy; and promote growth and development.

**Peer Recovery Centers.** Peer support services may be delivered in many organizational contexts, such as faith-based organizations, treatment centers, correctional facilities, and other formal or informal settings. The most common organizational setting for peer support services is peer recovery centers (PRCs), which are typically supported by recovery community organizations (RCOs). Each PRC is slightly different; however at their core is the delivery of peer support services. Some examples include the Connecticut Community for Addiction Recovery (CCAR) and the Vermont Recovery Network.

PRCs may provide special services such as vocational training, or they may link people in recovery to services provided in the community. PRCs typically link with vocational

rehabilitation services, employment and jobs programs, recovery residences, health care providers, and law enforcement. Some PRCs also provide peer support within correctional facilities as well as after release, and some are linked with pre-booking programs, such as the Seattle, Washington Law Enforcement Assisted Diversion (LEAD) program.

PRCs may link with organizations serving special populations such as youth through, for example, recovery high schools, Young People in Recovery (YPR), and collegiate recovery programs (CRPs).

**Peer Support in Rural States.** Accessing peer support in rural states is particularly challenging due to transportation issues, lack of services including treatment, and overall health disparities. Research and development of technological solutions to delivering peer support in rural areas is underway.

**Peer Recovery Centers in Maine.** Maine has two fully developed PRCs: Portland Recovery Community Center (PRCC) and the Bangor Area Recovery Network (BARN). PRCC has full-time and part-time paid staff; BARN is run by volunteers only. Each center is a reflection of the community served and each offers different services and peer supports. For example, PRCC is working closely with some police departments to develop and support “angel” programs that allow people to turn in their drugs and paraphernalia and receive peer support and referrals to treatment. BARN is especially involved in linking people in recovery to employment resources, such as the Eastern Maine Development Corporation.

Key stakeholder focus group results indicate there are other recovery centers in Maine, though not peer-run and not as fully developed as PRCC and BARN. Midcoast PHD has three recovery centers (one is faith-based); Downeast PHD has a chemical-free community center in Ellsworth that hosts events and 12-step meetings; and Central PHD has a meeting place in Waterville for people in recovery. Planning activities of one sort or another are underway in each district to create and enhance peer services and supports, and in some districts that includes planning for a peer-run PRC and/or satellite locations (including in Cumberland District and Penquis District where PRCC and BARN are located, respectively).

**Common Themes across Maine’s Public Health Districts.** This report documents unique opportunities, challenges, barriers and current capacity to develop peer recovery services and PRCs in the nine public health districts. The research team identified several common themes.

One clear theme in each district is that communities all across Maine have become actively engaged in discussing the state’s substance use crisis, and particularly the widespread misuse of opioids. Many Maine communities have hosted listening sessions in conjunction with the work of the Maine Opiate Collaborative, which were well-attended and featured multiple community sectors already working to address the various consequences impacting individuals and communities. In some communities, conversations have centered on how to increase peer recovery services and recovery capacity, including establishing a PRC.

A second theme is the presence of a common ideal concept for a PRC. Focus group participants in all districts said their ideal scenario would be a PRC located in some “hub” within

the district, with satellite sites in other areas. A common idea expressed was that satellite sites could be open on a certain day of the week or month depending on the utilization of services and resources, or volunteers available for staffing.

A third theme is the challenge of transportation in every district. In a largely rural state, transportation is a major factor, and often a barrier, when it comes to accessing substance use services for treatment and recovery. Even in urban centers, transportation can be a barrier depending on the location of public transportation routes and bus schedules.

While community discussions and planning around substance use issues and recovery services have blossomed in communities across Maine, feedback from participants in the key stakeholder and peer focus groups makes it clear that stigma and shame are still significant factors and pose barriers that keep individuals from seeking services. In addition to keeping people from accessing a new PRC, stigma could also potentially create NIMBY issues (“not in my backyard”) when it comes to determining where to locate a PRC.

The last theme across the districts is the issue of current decentralized information for treatment and recovery services. In every district, the team heard from focus group participants that while it felt like there were pockets of great programs and services, there was no one centralized repository of information for these efforts; information on available services is too fractured and this creates inefficiencies in making referrals. The new PRCs would provide an excellent opportunity to centralize information on programs and services on a regional basis, creating the “one-stop-shop” hub Maine communities desperately need.

**Summary.** The common story that has emerged from the districts is the need for a centralized hub for peer recovery services and programs, but with flexibility and versatility to maximize access and reach. Finding creative ways to address transportation challenges, creating a centralized place where people in recovery can access information, and addressing stigma head-on through community education are also key. Most communities identified and had at the table multiple sectors and individuals ready to roll up their sleeves to offer and/or co-locate services, whether they be groups, career and education resources, or skill-building and enrichment activities. Given that there are differing levels of readiness and capacity in the districts, there may be benefit for initial and ongoing technical assistance with respect to start-up and implementation of the new PRCs in Maine, to maximize impact and fidelity to the national models. There may also be great benefit in creating networking opportunities for members and staff of the new PRCs to facilitate the sharing of lessons learned and other resources. The Peer Recovery Center request for proposal (RFP) will provide a golden opportunity at a crucial time where dire need has met with heightened awareness. It is clear that communities across Maine are poised for this opportunity.

## INTRODUCTION

This report is an overview of peer recovery centers (PRCs) as they currently operate both in the State of Maine and nationally. A PRC is defined as a program that provides services that are “designed and delivered by people who have experienced both substance use disorder and recovery.”<sup>2</sup> They are designed to help people achieve long-term recovery and to stay engaged in the recovery process and reduce the likelihood of relapse.

This report explores the structure and program design, history, and origins of peer support and then goes on to describe the actual implementation of those principles in select PRCs throughout the country. The report moves from the general to the particular in exploring how various centers use peer support principles in ways that are typical of all programs, and also in ways that are innovative and unique to specific environments and cultures. Finally, the report looks to the status of PRCs in Maine with an eye to exploring the ways that service innovation may address gaps in services and the specific needs of a rural state.

Throughout, the goal of this report is to highlight the basic principles of peer support and services as outlined by the Substance Abuse and Mental Health Services Administration (SAMHSA) and the research it has supported on evidence-based models that are effective in helping people achieve long-term recovery from substance use disorder (SUD).

The material in this report was obtained from SAMHSA, and from PRC websites around the country. Materials from various state programs were reviewed and several program directors, and members of Faces and Voices of Recovery and other major peer-led advocacy and policy

organizations were interviewed by phone. This report also reflects an extensive needs assessment that was conducted through focus groups throughout the state of Maine using standardized survey questions. The goal was to provide an overview of the peer recovery movement and its progress nationally as well as its current status in Maine.

## **PART ONE — PEER-SUPPORTED RECOVERY FOR SUBSTANCE USE DISORDER:**

### **WHAT IS IT?**

In his working paper on the history and future of peer-based support for recovery from substance use disorder (SUD), William White provides an extensive history of peer-based services.<sup>3</sup> He points out that substance use recovery and mutual aid societies have existed since the 18<sup>th</sup> century and have included Wellbriety and recovery circles originating in Native American culture, fraternal temperance societies, Alcoholics Anonymous (AA) and its counterparts in the 20<sup>th</sup> century, and multiple post-AA societies, including faith-based and nonprofit aid group approaches. He refers to these societies and groups as “mutual aid” rather than “self-help” groups to reflect the relational, interactive nature of the contact, and points out that they really are not “self-help” in nature because the healing aspect of them involves the relationship with others.<sup>4</sup> The history of these groups is rich and varied and has often included the use of people in recovery in paid service roles. What is unique at this point in time is that there is a growing evidence base for the effectiveness of peer support and a growing understanding of the importance of sustained recovery management.<sup>5</sup>

Research shows that recovery is facilitated by four specific types of social support: emotional, informational, instrumental, and affiliational.<sup>6</sup> *Emotional support* refers to demonstrating empathetic caring or concern. *Informational support* occurs when a peer shares knowledge or information, or provides life skills or vocational training. *Instrumental support* is concrete help — one might provide transportation, child care, or help with accessing services. Finally, *affiliational support* occurs when peers facilitate contacts with other people that help to

establish a sense of belonging and community. These four types of support are used by most programs to organize peer-to-peer services. Because these supports are designed and delivered by peers in recovery, they offer hope and experiential knowledge. They effectively extend the reach of formal treatment into the everyday environment throughout the recovery process.

### **Recovery-Oriented Systems of Care**

Peer-supported recovery services are an integral part of recovery-oriented systems of care (ROSCs). White defines such a system of care as “a coordinated network of community-based services and supports that is person-centered and builds on the strengths and resilience of individuals, families, and communities to achieve abstinence and improved health, wellness, and quality of life for those with or at risk of alcohol and drug problems.”<sup>7</sup> ROSCs are built on a set of values and principles that place the concept of “recovery” at the core and that make use of peer recovery support services (PRSS) as a major tool for recovery management. While addiction is understood as a chronic disease, most treatment that addresses it is embedded in an acute care model. An ROSC represents a chronic care approach that reflects the lifetime nature of recovery. Some of the values of an ROSC include being person-centered, strengths-based, and assuring the involvement of families, friends, caregivers and allies within the community. An ROSC works to educate and raise awareness, advocate, disseminate information, and to provide a continuum or menu of coordinated services, among other functions. Ideally, community and peer groups focused on treatment and recovery services, state offices responsible for behavioral health, law enforcement and criminal justice entities, educational services, and behavioral health agencies come together to collaborate and to decide on how such a system of care could be

consciously designed and sustained. Often the development of peer support services is a result of such collaborations.

### **Definitions of “Recovery,” “Peer,” and “Peer Recovery Support Services”**

For the purposes of this report, recovery from SUD is defined as a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. Four dimensions that support a life in recovery are defined as Health, Home, Purpose, and Community. The 10 guiding principles of recovery according to the Substance Abuse and Mental Health Services Administration (SAMHSA)<sup>8</sup> are:

- Recovery is person-driven
- Recovery emerges from hope
- Recovery occurs via many pathways
- Recovery is holistic
- Recovery is supported by peers and allies
- Recovery is supported through relationship and social networks
- Recovery is culturally based and influenced
- Recovery is supported by addressing trauma
- Recovery involves individual, family and community strengths and responsibility
- Recovery is based on respect

Recovery definitions were first developed by the Center for Substance Abuse Treatment (CSAT) in 2007<sup>9</sup> and it is important to note that since that time, concepts of recovery have

evolved to include patterns of both full and partial remission, and full and partial abstinence. Debate continues over whether a “harm reduction” approach that modifies substance use reflects a valid recovery process.<sup>10</sup> What is clear is that a recovery movement developed in part because of the perceived failure of treatment approaches to effectively address substance use problems. Advocates of recovery strongly differentiate between treatment and recovery. In their minds, treatment that is professionally directed may or may not be part of a recovery process — it is considered an adjunct to recovery. As White proposes, “The first avenue for problem resolution should be structures that are natural, local, non-hierarchical and non-commercialized.”<sup>11</sup> ROSCs utilize language that refers to a “recovery plan” rather than a “treatment plan” and are founded on several basic principles that include a commitment to PRSS. The following guiding principles of recovery are the basis for all peer services:<sup>12</sup>

- There are many pathways to recovery.
- Recovery is self-directed and empowering.
- Recovery involves a personal recognition of the need for change and transformation.
- Recovery is holistic.
- Recovery has cultural dimensions.
- Recovery exists on a continuum of improved health and wellness.
- Recovery is supported by peers and allies.
- Recovery emerges from hope and gratitude.
- Recovery involves a process of healing and self-redefinition.
- Recovery involves addressing discrimination and transcending shame and stigma.

- Recovery involves (re)joining and (re)building a life in the community.
- Recovery is a reality. It can, will, and does happen.

### **Definition of “Peer”**

The definition of “peer” can be highly politicized since there is controversy over who has the right to make the definition.<sup>13</sup> A peer is generally considered to be a person who has insider knowledge — one who is in recovery and has “lived experience” with SUD. This status may include a family member or other ally who shares some other significant quality of the recovering person, although communities vary in the acceptance of this wider definition of peer. Peers have “experiential knowledge” and expertise and it is this knowledge rather than professional training that qualifies them to help.

### **Peer Recovery Support Services**

Peer recovery support is defined as:

The process of giving and receiving non-clinical assistance to achieve long-term recovery from severe alcohol and/or other drug related problems. This support is provided by people who are experientially credentialed to assist others in initiating recovery, maintaining recovery and enhancing the quality of personal and family life in long-term recovery.<sup>14</sup>

Successful peer services are embedded in a system of social support provided by peers and peer leaders. They include the four major types of support mentioned earlier: emotional,

informational, instrumental, and affiliational.<sup>15</sup> These services may include peer mentoring or coaching, support groups led by peers, parenting classes, job readiness training, socialization opportunities, and many others. Services are meant to be adaptable to varying recovery stages and approaches, different organizational contexts, and different cultural and service settings.

However, all programs share an important set of values:<sup>16</sup>

- Keep recovery first
- Cultural diversity and inclusion
- Participatory process
- Authenticity of peers helping peers
- Leadership development among peers
- Adoption of a strengths perspective
- Self-direction, empowerment and choice

PRSS projects provide a number of different peer services. Based on the principles described above, these services are non-clinical and non-professional but provide essential recovery support. Thus, they support three critical aspects of recovery: sobriety (abstinence from alcohol and drugs), improvement in global health, and positive participation in community life.<sup>17</sup> Such services are typically provided in an organization called a peer recovery center (PRC). It is estimated that there are approximately 102 PRCs throughout the country, most supported by the SAMHSA Recovery Community Services Program (RCSP). Several of those programs will be described later in this paper.

While PRCs differ in their program structures and services provided, those services are always implemented by peers in recovery. The following are some of the more typical services one would find at a PRC.

### **Types of Support Services<sup>18</sup>**

*Peer mentoring or coaching* — developing a one-on-one relationship in which a peer leader with recovery experience provides encouragement, motivation and support. The coach helps the individual to make choices about which recovery pathway(s) will work. The coach is not a sponsor in the traditional 12-step role, but rather someone who supports and mentors, and also connects the person in recovery to health, employment, housing, educational, and other social service supports. Recovery coaching can be a contracted service provided through the PRC. In some states, the state behavioral health entity, a managed care organization, or even a state addiction association or organization that is part of an ROSC may contract for these services on a time-limited basis. The important point is that the services are provided by peer counselors who have specific credentials, the primary one being experience in recovery.

*Telephone recovery support* — peer mentoring can also be provided by phone. In this program, typically a volunteer peer or trained peer recovery coach makes a weekly call to the individual, who may be at any stage of recovery. The call is a “check-in” that allows the peer volunteer to provide support and to connect the individual to any community resources that may be needed. Evidence shows that such programs are effective in supporting recovery and preventing relapse. Internet-based recovery support is an increasingly popular form of access to

peer support in rural areas, or for people who prefer internet communication to other forms of contact.

*Peer recovery resource-connecting and programming* — a volunteer peer or recovery coach connects the person in recovery with professional and nonprofessional services and resources available in the community. These services may include case management, family support, life skills training, parent education and child development, vocational training, and career counseling. Other important connections include job search support, such as vocational guidance, training, health, wellness, and behavioral health services, and housing. In some states, many of these services or programs may be provided by the PRC itself. The availability of an array of programs depends on the PRC's resources and funding.

*Recovery support group facilitation* — peer coaches and other peer volunteers may lead specific educational and support groups within the PRC. These include many of the topics noted above. Often groups focus on basic life skills, such as financial literacy, parenting, family support, health topics, and basic recovery management strategies. In a tribal, Native American, or other indigenous community setting these services might include sweat lodges, healing circles, “sobering centers,” drumming, and other culturally specific supports that reflect the community values of the area or the population.

*Building community* — goals of peer recovery are to help the person in recovery make new friends and build healthy social networks through emotional, instrumental, informational, and affiliational types of peer support. This aspect of programming in the PRC might include the presence of mutual aid groups, such as AA, Al-Anon, Narcotics Anonymous (NA), Nar-Anon,

and SMART Recovery. Some groups may be faith-based and run through area churches or collaboratively with the PRC. This type of community-building is also supported through social clubs which are not to be confused with PRCs, although a combined type of program is tending to develop in many states. The social club is more or less a “drop-in center” that provides a social and recreational outlet for those in recovery. Here, a person in recovery can meet friends, sit, talk, take part in social outings, play games, and engage in other leisure activities.

Other community-based services that are increasingly connected to PRCs or that are developing in an effort to support recovery in communities include recovery residences, collegiate recovery programs (CRPs), recovery high schools, employment support programs, and programs developed in connection with local police departments.

*Recovery residences* — recovery-focused housing services that support recovery. They tend to be self-managed by peers and might have been referred to as halfway houses when they served as transitional housing for those leaving treatment. Currently, they are residences that are established for those who are abstinent from alcohol or drugs. They are usually self-managed and operate on different models depending on their location and purpose.

*Recovery schools* — provide support for students in recovery in the face of overwhelming anti-recovery attitudes within the larger environment. Such programs are found in both high schools and colleges.<sup>19</sup> These programs vary in design but generally emphasize academic excellence and combine access to treatment with special recovery services. They may offer special faculty guidance, recovery dorms, support meetings, drop-in centers, sober social activities, and peer mentoring. Peers may provide volunteer tutoring services and other supports.

*Occupational recovery supports* — increasingly, peer support services are focusing on the importance of employment in ongoing recovery. Employment support helps the person in recovery to return to regular employment within the community and to disengage from criminal behavior that might have been a prior source of income. Such services help the person in recovery to address discrimination that is often faced by those with past drug use or criminal behavior, or criminal records. Innovative programs, such as recovery work co-ops, will be discussed later in this paper.

*Recovery and criminal justice* — many jails and some prisons support addiction recovery programs, and mutual aid groups have traditionally been made available to incarcerated individuals thanks to AA or NA members' willingness to bring meetings to jails and prisons. A program may involve either treatment or recovery support of varying kinds. Often these programs occur during the transition in or out of incarceration. Those incarcerated typically also have access to internet-based programs. Peer centers often provide peer coaches or mentors, and peer services are frequently part of post-release care plans. One peer center in North Carolina offers a "Recovery through Correspondence" program to incarcerated people where peers write letters to inmates who qualify for the program. A more current movement among correctional officials has resulted in the development of programs that intervene, with people with SUD who engage in criminal behavior, before incarceration. These programs are varied but all have in common outreach to people with SUD to offer the opportunity to enter treatment rather than jail. Local police departments often partner with PRCs to provide volunteers who coach or offer support to people who voluntarily turn in all drugs and paraphernalia in their possession and

agree to go to treatment. Such programs typically partner and collaborate with many other community and national organizations.

*Recovery and health care* — health care providers, especially primary care providers (PCPs), support patients in recovery by providing medication-assisted treatment (MAT) and links to counseling, support groups, 12-step groups, peer support, and other services. Research shows that providing continuity of care (coordination across health care and other services) contributes to improved outcomes and helps individuals initiate and maintain recovery.<sup>20</sup> In areas where treatment and recovery support services are limited, PCPs may be the first contact a patient has where a discussion of treatment and recovery takes place, and may play an important role as part of the team that supports wellness and continuity of care. Peer support has been identified as a method to support patients in self-management of chronic conditions,<sup>21</sup> and health care providers may offer chronic disease self-management and peer support through their practices. Some hospitals are experimenting with trained peers in emergency departments to provide support and assistance to people in crisis as the result of a drug overdose. PRCs may provide referrals to health care, including primary care in health homes.

### **Recovery Community Organizations**

People in recovery have historically been a marginalized group, sometimes viewed as sick, sometimes as mad, and always viewed to some degree to be “less than” their sober, morally correct counterparts. The stigma directed at people with SUD is one of the primary barriers to seeking treatment. While the recovery movement has grown and changed dramatically since the early days of AA, so too have organizations grown to support and advocate for the millions of

people who seek and maintain wellness in recovery. In most instances, one of those organizations is the likely foundation for a PRC. A PRC is a community-based program that supports individuals in recovery with specific services offered daily or as frequently as possible.

A recovery community organization (RCO) is a community, regional, statewide, or national entity that advocates for people in recovery, sets policies that foster and enhance recovery, and provides support services for people in recovery. RCOs are independent, nonprofit organizations that are led and governed by people in recovery, family members, friends, and allies. While each organization has a mission that reflects the particular issues and concerns of its community, all focus on the following core purposes:<sup>22</sup>

- Public education — putting a face and a voice on recovery
- Advocacy
- Peer-based and other recovery support services

According to Valentine, et al., “The sole mission of an RCO is to mobilize resources within and outside the recovery community to increase the prevalence and quality of long-term recovery from alcohol and other drug addiction.”<sup>23</sup>

The national Association of Recovery Community Organizations (ARCO) is the primary organizer of RCOs and describes itself as follows: “The Association of Recovery Community Organizations (ARCO) unites and supports the growing network of local, regional and statewide recovery community organizations (RCOs). ARCO links RCOs and their leaders with local and national allies and provides training and technical assistance to groups. ARCO helps build the

unified voice of the organized recovery community and fulfill our commitment to supporting the development of new groups and strengthening existing ones.”<sup>24</sup>

ARCO’s parent organization, Faces and Voices of Recovery, works to build capacity in the recovery community, to set policy, and to make recovery more visible. It supports laws that enable recovery and access to quality health care, fosters civic engagement in issues of recovery, and influences perceptions of addiction and recovery. These organizations represent national RCOs and maintain as members multiple other state and regional entities that provide varying types of advocacy, policy work, and recovery support. Some other national RCOs, some of whom are ARCO members (over 100 currently), include:

- Faces and Voices of Recovery (national — see above)
- National Council on Alcoholism and Drug Dependence (NCADD)
- People Advocating Recovery (Kentucky — example of a statewide network of several chapters)
- Advocates for Recovery Through Medicine (national)
- White Bison (national — supports recovery for Native Americans)
- Association of Recovery Schools
- National Alliance for Recovery Residences
- Reach Out Recovery (Florida)

In Maine, our statewide RCO is the Maine Alliance for Addiction Recovery (MAAR). As MAAR describes itself: “The Maine Alliance for Addiction Recovery is the statewide coalition that organizes people in recovery from alcohol and drug addiction and recovery allies into a

unified recovery presence within Maine. We are a statewide recovery community organization that represents the many pathways of recovery.”<sup>25</sup> The Bangor Area Recovery Network (BARN) is the local RCO that provides “recovery support to local individuals while also standing with them as community allies to improve health, wellness, and quality of life” in the greater Bangor area.<sup>26</sup>

Most PRCs have been developed or funded by RCOs. The RCO is an important community link to the establishment and maintenance of recovery centers and cannot be overlooked as an important component of an ROSC.

### **Training and Credentials for Peer Support**

Because peer workers and support services have become increasingly critical to recovery for so many people with SUD, SAMHSA has established a set of core competencies, principles, and values that inform all training for peer volunteers who provide PRSS.<sup>27</sup> Competencies guide the delivery of services and support and can help to structure peer training programs. They assist in developing certification standards for programs and peer training. Those competencies for peer support specialists (PSSs) as described by SAMHSA are:

- Recovery-oriented
- Person-centered
- Voluntary
- Relationship-focused
- Trauma-informed

The corresponding standards and principles for these competencies are:

1. Engages peers in collaborative and caring relationships
2. Provides support
3. Shares lived experiences of recovery
4. Personalizes peer support
5. Supports recovery planning
6. Links to resources, services and supports
7. Promotes information about skills related to health, wellness and recovery
8. Helps peers to manage crises
9. Values communication
10. Supports collaboration and teamwork
11. Promotes leadership and advocacy
12. Promotes growth and development

Each of these standards is accompanied by a set of objectives and a description of the purpose of the standard. These competencies provide an overall suggested framework for PSS training. As of 2012, 36 states offered PSS training. Some have established “recovery academies,” some provide training through the state department that addresses behavioral health, and some training is provided through RCOs within states. Each state or program has different mandatory competencies, ethics, and requirements. Hours of training required typically range from 30 to 80, with a yearly expectation for continuing education hours.<sup>28</sup> Multiple organizations offer certifications for PSS training programs and for peer support services. Membership in these organizations is voluntary in most cases. Services provided by PSSs or recovery coaches who have acquired training, certification, and the title of Certified Peer Support Specialist may or may

not be eligible for Medicaid reimbursement. Certified Peer Support Specialists may be formally employed in paid positions or may volunteer their services. The function, availability, and employability of PSSs varies greatly by state and the overall recognition of the importance of having trained PSSs support people in recovery.

NAADAC, the Association for Addiction Professionals offers individuals a national certification for peer support called the Nationally Certified Peer Recovery Support Specialist (NCPRSS). It requires, among other qualifications, a certification or license from a state credentialing authority that testifies to at least 60 hours of education and training. It is unclear how useful this certification is in the current environment of peer services or how many people choose to become certified.

### **Certification for Peer Recovery Support Services**

The Council on Accreditation of Peer Recovery Support Services (CAPRSS) is a recently formed organization that is the only accrediting body in the United States for RCOs and other programs offering addiction PRSS for people in recovery from SUD. Accreditation of peer services and coaching practices is typically developed within established programs or is determined by individual states.

CAPRSS offers a recovery-oriented accreditation program that:

- Helps emerging and established RCOs and peer programs to build capacity;
- Improves the performance of organizations and programs providing peer services by setting and measuring the achievement of standards; and
- Increases accountability of peer services providers to funders, the public, and the field.

CAPRSS's belief is that a national accreditation system provides a comprehensive response to a range of peer issues, rather than piecemeal approaches that differ widely from state to state. The accreditation of programs that deliver PRSS will:

- Create infrastructure necessary for peer service delivery, including standards-driven continuous quality improvement;
- Facilitate and disseminate best — and, ultimately, evidence-based — practices; and
- Reinforce the recovery-based values and principles that underlie peer services and make them valuable in the continuum of care.

## **PART TWO — MODEL PEER RECOVERY CENTERS AND PROGRAMS**

### **SAMHSA and Recovery Support**

According to White, “Specialized addiction treatment grew out of the failure of the mainstream health and human service system to provide effective solutions for individuals and families experiencing alcohol and other drug [(AOD)] problems. Today, peer-based recovery support services are growing out of the failure of addiction treatment to provide a continuum of care that is accessible, affordable, and capable of helping people with the most severe and complex AOD problems move beyond brief episodes of recovery initiation to stable long-term recovery. P-BRSS (Peer-Based Recovery Support Services) are specifically designed to reach people earlier in their addiction careers, enhance recovery initiation and stabilization, improve linkage to recovery mutual-aid groups and other recovery support institutions, facilitate the transition to successful recovery maintenance, and enhance the quality of personal and family life in long-term recovery.”<sup>29</sup>

The Substance Abuse and Mental Health Service Administration (SAMHSA) provides programmatic and grant support for new approaches to alcohol and other drug problems with a shift from a pathology and medical intervention focus to a long-term recovery approach. This is similar to the chronic care management model emerging in health and behavioral health care. Focus has shifted in these arenas from acute care directed by an expert medical provider to self-directed, long-term, holistic care directed by the individual. A recovery model is based in an ethic of individual empowerment, healing, and responsibility. It is grounded in the concept of community inclusion and support. It assumes that peers are the biggest supports in the process of

change. Peer recovery support services (PRSS) are considered fundamental and central to a recovery-oriented system of care (ROSC). SAMHSA's commitment to the support and development of these peer-based programs has grown over time and currently includes several programs:

The Recovery Community Services Program (RCSP) is funded primarily by the Center for Substance Abuse Treatment (CSAT). This program provides funding for grantees to develop innovative, peer-based recovery support services in community settings.

Access to Recovery (ATR) is a competitive discretionary grant program funded by SAMHSA/CSAT to expand capacity and increase client choice by increasing the array of community providers available to provide support services. It is a voucher system that gives clients a choice of eligible treatment providers and recovery resources.

Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS) serves as a coordinated effort to facilitate the adoption and implementation of recovery concepts, policies, practices, and services. Through BRSS TACS, SAMHSA strives to bring recovery to scale through the adoption of recovery-oriented services and systems across the United States. BRSS TACS strives to build on the accomplishments of the mental health and addictions recovery movements and to involve people in recovery in every aspect of the project. Additionally, BRSS TACS is an important mechanism for carrying out the work of SAMHSA's Strategic Initiatives, most directly the Recovery Support Strategic Initiative (RSSI).

Partners for Recovery (PFR) seeks to improve services and systems of care and supports, and provides technical resources to those who deliver services to prevent and treat substance use and mental health conditions.

SAMHSA/CSAT supports PRCs primarily through the RCSP. SAMHSA believes that the services provided in a PRC can “extend the reach of treatment beyond the clinical setting into the everyday environment of those seeking to achieve or sustain recovery.”<sup>30</sup> Further, SAMHSA believes that “these services extend the continuum of care by facilitating entry into treatment, providing social support services during treatment, and providing a post-treatment safety net to those who are seeking to sustain treatment gains.”<sup>31</sup> SAMHSA notes improved outcomes when peer services are available in the context of chronic care self-management, and are part of a well-documented, evidence-based continuum of community support.

### **SAMHSA and Science: The Evidence Base for Peer Support**

SAMHSA promotes peer support approaches because research supports them. Peer support services are considered an evidence-based practice. Some of the outcomes demonstrated by the research include the following:

- Independent studies of some peer-based recovery support services have been linked to enhanced engagement, access, treatment completion, and improved long-term recovery.<sup>32</sup> Recovery check-ups and active linkage to recovery supports following treatment are important in maintaining recovery.<sup>33 34</sup>
- Providing comprehensive services assists recovery, and strong social supports improve recovery outcomes.<sup>35 36</sup>

- Reif, et al., in a paper in the journal *Psychiatric Services* provided an extensive review of published research, and studies found that peer recovery support produces reduced relapse rates, increased treatment retention, improved relationships with treatment providers and social supports, and increased satisfaction with the overall treatment experience.<sup>37</sup>
- Rowe et al., found that individuals with criminal justice involvement and co-occurring mental illness and alcohol use disorder who combined treatment with peer support had significantly lower use of alcohol than those in a control group with treatment alone.<sup>38</sup>
- O’Connell et al., found that a group that received skills training plus peer-led recovery support had 14.8 fewer drinking days than a standard care group.<sup>39</sup>

The SAMHSA white paper, *The role of recovery support services in recovery-oriented systems of care*, provides extensive support in the literature for the effectiveness of peer recovery services and the social supports they provide.<sup>40</sup> Recovery coaches, mutual aid, and families and other allies are also highly effective enhancers of recovery. In general, research finds that those who participate in both treatment and recovery support groups have better long-term recovery outcomes than those who use either service alone.<sup>41 42</sup>

### **Model State Peer Recovery Centers**

Peer support services may be delivered within a broad array of organizational contexts. They may occur in faith-based organizations, treatment centers, correctional facilities, clubs, and other formal or informal settings. The most common is the peer recovery support center or peer recovery center (PRC). Some PRCs provide recovery services and are also RCOs with an

education and advocacy role as well; some are PRCs only. Each of the programs described below has a different organizational format. Each is presented here because it supports a particularly significant or innovative set of practices, or because it stands out within its state or national community. Most provide compelling examples of the ways a peer center can be effective in supporting recovery. (Note that these are the conclusions of the researcher and not necessarily the status conveyed by any specific organization).

***Connecticut: The Connecticut Community for Addiction Recovery***

<http://ccar.us/>

*Services and Description:* The Connecticut Community for Addiction Recovery (CCAR) is a statewide recovery organization that has established four PRCs in areas throughout the state and is in the process of opening four more. CCAR was the outcome of Connecticut's participation in an ATR grant and participation with SAMHSA on numerous systems change processes. As a state, Connecticut has been among the first and most dedicated to developing an ROSC. CCAR has become a national model for PRSS programs. Its peer programs are replicated frequently and it is not unusual to speak with peer organizers in other states who describe their programs as having been modeled after CCAR. Its list of peer services is comprehensive.<sup>43</sup>

CCAR peer services include:

- Telephone recovery support
- Family/community education
- Family support groups
- All-recovery groups

- Volunteer training
- Recovery training
- Peer-operated transportation company
- Recovery coaching
- Referral to recovery housing
- Employment support
- Social activities supported by peer volunteers

*Innovations and Significance:* CCAR is a national model, Connecticut having been one of the first states to develop an ROSC. Telephone recovery support (TRS) is considered a particularly innovative part of CCAR’s programming. CCAR has established the Recovery Training Center and the nationally recognized Recovery Coach Academy. CCAR’s coaching and TRS programs have been replicated nationwide, and it has established training programs for peer recovery coaches called East Meets West Recovery Coach Training, which provide customized learning modules developed by peers that are delivered nationally.

***Vermont: Vermont Recovery Network***

<https://vtrecoverynetwork.org/>

*Services and Description:* The Vermont Recovery Network is a nonprofit organization that maintains PRCs throughout Vermont. Like Connecticut, its centers provide peer-supported recovery services. Currently there are 11 PRCs throughout the state.

Recovery support services provided by all centers include:

- Recovery coaching through a one-on-one relationship that encourages, motivates and supports another peer in his or her recovery.
- Making Recovery Easier, an evidence-based peer-led recovery support group.
- All-recovery meetings, a topic discussion model pioneered in Connecticut.
- Recovery is the Solution (RIS), which is under development. This peer-led six-session group model explains recovery and makes it an attractive goal. The group curriculum explains what recovery is, helps to create hope, and provides support for finding new peer groups.
- Seeking Safety practice groups, which address the needs of those who have experienced trauma. Seeking Safety is an evidence-based and well-known trauma treatment model developed by Lisa Najavits.
- Wellness Recovery Action Planning (WRAP), an evidence-based practice that is consistent with “recovery solutions training” and helps people in recovery to develop a recovery plan as well as a crisis plan. This model was developed by Mary Ellen Copeland.
- Wit’s End, a support group for parents of children with SUD.
- Families, Addiction and Recovery (FAR), a program where co-led peer groups are facilitated by a friend or family member of someone with active addiction, and a person in recovery from SUD.
- Nurturing Parents, a program that teaches age-specific parenting skills.
- Rocking Horse Circle of Support, an evidence-based practice and peer-led intervention group that promotes good parenting skills.

### *Youth Recovery Programs*

- Making Change brings together groups of youth for non-confrontational peer support.
- Get Your Stuff Together (GYST) is a mentoring style support group for youth, ages 17–26. Both male and female versions are offered.
- CHANGES is a support group for youth exploring recovery.

### *Other Practices*

- Building Body Mind and Spirit: Life Skills
- Mindfulness, Communication Groups
- Writing Groups
- Planned Group Recovery Activities
- Medication-Assisted Recovery (MAR) Groups
- Co-Occurring Support Groups
- Vet-to-Vet

*Innovations and Significance:* The Vermont Recovery Network provides a wide range of services that are evidence-based and unique to PRCs. Note that there is a particular focus on co-occurring support, groups for veterans, and specific programming for youth.

### ***Virginia: The McShin Foundation***

<http://mcshin.org/mcwp/about-the-mcshin-foundation/>

*Services and Description:* The McShin Foundation is an RCO that runs a PRC that employs people in recovery from SUD to educate and mentor individuals new to recovery. It is also

heavily supported by peer volunteers. Since its inception, the McShin Foundation has evolved in many directions. It boasts a 15,000-square-foot recovery center and several recovery houses.

Recovery support services provided include:

- Intervention and recovery services
- Recovery housing services
- Ongoing recovery support
- Community resource collaborative services
- Recovery education
- Recovery advocacy
- Speaker bureau services

The McShin Foundation branches out to local businesses and institutions that are willing to provide services such as: women's therapy (individual and group), employment opportunities, faith-based studies, and many resources to assist people in recovery with integrating successfully into society. The McShin Foundation believes strongly in the importance of prevention, and reaches out to youth and educators in order to broaden communication everywhere about the prevention and treatment of SUD. The McShin Foundation is growing, and continues to pioneer the idea of authentic peer coaching, training, and recovery.

The McShin Foundation's extensive programming includes a particular focus on families, and on peer leadership training. In 2015, the center provided 100,000 hours of assistance to incarcerated individuals with SUD. Its focus is community-based, and outreach along with

community events are a central part of the programming. One of its major programs is recovery housing. The McShin Foundation has 75 recovery beds in five houses. Its program is highly structured with very specific requirements for abstinence and other recovery-oriented commitments.

*Innovations and Significance:* The McShin Foundation exemplifies the combined capacity of a PRC and a PRO. It is one of the few centers that provides employment training by actually employing peers in certain roles. Its strong focus is outreach, particularly to youth.

### ***New York: The Turning Point***

<http://friendsofrecoverydo.org/overview/>

*Services and Description:* The Turning Point program runs two PRCs, in Oneonta and Delhi, New York. The programs are run by Friends of Recovery of Delaware and Otsego Counties (FOR-DO), the larger RCO for the area. Support services are broken down into the four general areas outlined by SAMHSA for organizing peer support: emotional, informational, instrumental, and affiliational. Their program description provides a useful breakdown of how those conceptual areas translate into actual service.

#### *Emotional Support Services*

- Peer-led support groups — recovery support for the whole family
- Peer-led recovery coaching (mentoring) projects that offer one-on-one guidance and direction, and help with identifying and accessing community resources that match self-identified needs and interests
- Telephone recovery support services

*Informational Support Services:* Peer-led resource connector programs that provide linkages to and assistance with:

- Housing, employment, public assistance, emergency relief
- Benefits and entitlements
- Legal services, citizen restoration
- Educational applications and financial aid
- Vocational rehabilitation and training
- Life skills classes and workshops, and how to access these resources
- Health and wellness classes and workshops
- Education and career-planning classes and workshops
- Access to resources, including Access to Recovery (ATR), a federal voucher program that provides funds to eligible individuals to receive services that might otherwise be unattainable
- Child care
- Transportation
- Clothing services
- Food banks
- Emergency services

*Affiliation Support Services:* Affiliation Support Services provides free social and recreational activities for people in recovery to substitute addiction-oriented social networks with pro-recovery networks, and communities of affiliation.

Affiliation Support Services include:

- Family-centered events
- Leisure interest development
- Speaker events, educational forums, community and cultural involvement
- Sports team events, health and information fairs
- Recovery Month events and conferences

*Innovations and Significance:* The Turning Point is a rural program that has partnered with the state to access federal vouchers to help cover the costs of services that would otherwise not be available to those eligible. Since rural areas are typically impacted significantly by poverty, this voucher program is essential in providing access and in supporting those in recovery in their attempts to find jobs, housing, and other essentials. Services are peer-led and include many of the common programs associated with other peer resource centers. The more innovative approaches include providing access to federal vouchers through the ATR or NY SOARS programs. These vouchers help to provide child care, transportation, clothing services, food banks, and emergency services. The centers also help with educational applications and financial aid, and vocational rehabilitation and training. The Turning Point also hosts the CCAR Recovery Coach Academy, as well as Recovery Oriented Employment Services (ROES).

***Michigan: Detroit Recovery Project***

<http://www.recovery4detroit.com/>

*Description and Services:* The Detroit Recovery Project (DRP) is a nonprofit corporation whose development was initiated by parents in recovery who wanted to prevent their children from

becoming addicted to substances. It provides innovative peer-to-peer support services that are integrated and culturally competent for those leaving treatment, those in long-term recovery, and families and significant others. The center is now supported by the Detroit Recovery Project Coalition, a partnership of state, local, and community-level agencies and individuals who are committed to keeping Detroit youth drug-free.

Along with the more standard recovery management services, DRP also provides treatment services that include a special program for women. The Women in Recovery Enhancement Development Program (WIRED) program provides a 12-week recovery support group, and it welcomes pregnant women and those with children. Services in the crisis-oriented recovery services (CORS) treatment programs are provided by licensed clinicians, with peers acting as recovery coaches. DRP has initiated a new recovery coaching approach called Recovery Is Yours to “facilitate the prevention, treatment, sustenance and ongoing recovery of DRP (Detroit Recovery Project) clients.” The program provides multiple services.

The center provides a Co-Occurring Peer Empowerment Program, based on SAMHSA’s GAINS Center APIC model,<sup>44</sup> that works with inmates of the local detention center and jail who have co-occurring mental health and substance use disorders to facilitate their transitions back into the community. These former inmates are then offered appropriate services at the center. Many of these individuals transition into the Trent Recovery Home for Men, a DRP recovery home that provides recovery resources, including peer recovery coaching.

DRP prizes health education and wellness promotion and they provide training and health education as well as vaccinations, Hepatitis vaccines, and HIV outreach to ex-offenders and other at-risk individuals. They provide prevention outreach services and case management.

*Innovations and Significance:* DRP is an inner-city, culturally competent program that has a unique focus on women and on men in the correctional system.

***Texas, Dallas: Association of Persons Affected by Addiction***

<http://apaarecovery.org/>

*Services and Description:* The Association of Persons Affected by Addiction (APAA) is a “nationally renowned, award-winning, grassroots, peer-driven and peer-led recovery community organization in Dallas, Texas.” APAA is another RCO that supports a PRC. The APAA PRC provides recovery support and services for hospitals, jails, treatment centers, other PRCs, and federal, state, and community agencies. APAA served over 25,000 peers and family members in 2015 and was awarded the Faces and Voices of Recovery 2010 Joel Hernandez America Honors Recovery Award.

APAA is an independent nonprofit agency that was one of the first in the nation to be awarded a Recovering Community Services Project grant by SAMHSA. That grant was renewed for three years in 2005. “APAA is not a treatment center, but provides recovery support services and social service referrals for people seeking to recover from drug and alcohol addiction. APAA also serves those with dual diagnoses of mental illness and drug addiction.”<sup>45</sup>

APAA plays a major role with job searching and job preparation, and assists in locating housing and advocating with housing providers to extend housing to high-risk individuals. It provides multiple peer recovery support services, assisting with all efforts to connect with the community and obtain benefits, legal entitlements, and medical services. It is a leader and innovator of peer recovery coaching.

*Innovations and Significance:* APAA has special expertise in advocating with housing providers to extend housing to high-risk individuals, in assisting with job searching and preparation, and in obtaining basic benefits for those in need. After Hurricane Katrina, APAA worked with those displaced from their homes and helped them to obtain housing, employment, and mental health and substance use counseling. As a result of this work, APAA was awarded several grants and was appointed by the City of Dallas to form a team of recovery professionals that has helped to support over 5,000 of the displaced in developing plans for meeting their basic needs.

***Texas, Houston: Center for Recovery and Wellness Resources***

<http://wellnessandrecovery.org/use-of-evidence-based-practice.html>

The Center for Recovery and Wellness Resources (CRWR) offers sober housing, employment support, “fun” groups, education, help with transportation, and multiple other peer-delivered services. It provides peer coaching training. CRWR was established with the help of multiple other RCOs in Dallas, Austin, and El Paso, and the Houston Department of Health and Human Services. CRWR opened in 2012 and was Houston’s first peer-led PRC. They are particularly focused on their work being evidence-based.

*Innovations and Significance:* CRWR has a transitional living program for women, and provides services to match people in recovery with employers.

***Pennsylvania: PRO-ACT and the Council of Southeast Pennsylvania***

<https://www.councilsepa.org/programs/pro-act>

*Services and Description:* From the PRO-ACT/Council website: “The Council of Southeast Pennsylvania, Inc. (The Council) is a private nonprofit prevention, education, advocacy, assessment, intervention, and recovery support organization, serving the counties of Bucks, Chester, Delaware, Montgomery & Philadelphia. The Council provides a wide range of services to reduce the impact of addiction and improve related health issues for the entire community including families, schools, businesses, individuals and the community, regardless of ability to pay, ethnicity, race, gender, age or sexual orientation. The Council, founded in 1975, is a member of a nationwide affiliate network of The National Council on Alcoholism and Drug Dependence.”

Pennsylvania Recovery Organization - Achieving Community Together (PRO-ACT) is a grassroots advocacy and recovery support initiative of The Council covering Southeastern Pennsylvania. One-to-one recovery support services and trainings occur primarily in three PRCs.

PRO-ACT supports all pathways to recovery and embraces the ROSC. In central Bucks County, PRO-ACT provides a women’s PRC offering multiple pathways of support to meet the unique needs of women. PRO-ACT works to reduce the stigma of addiction, ensure the availability of adequate treatment and recovery support services, and to influence public opinion and policy regarding the value of recovery. PRO-ACT is developing, educating and mobilizing a

constituency of Ambassadors for Recovery — those in recovery, their family members and friends, professionals working in the field, and others with a special interest in and knowledge of recovery. Over 400 volunteers serve in the five-county area.

*Innovations and Significance:* PRO-ACT delivers a wide range of peer-driven services in three recovery centers, including a specialized center for women. Each center provides services unique to the area in which it operates. Each center is a hub for all recovery-related services as well as treatment. This is a very comprehensive set of programs with an extensive base of community support. In a recent “Thriving in Recovery” walk and celebration, 25,000 people participated. PRO-ACT has a wide base of support among those in recovery in southeast Pennsylvania, and its advocacy work makes it highly visible.

***New Mexico: Totah Behavioral Health Authority Treatment Center***

<http://www.pmsnm.org/services/behavioral-health>

*Services and Description:* A program of Presbyterian Medical Services, Totah Behavioral Health Authority is a treatment facility in Farmington, New Mexico, that specializes in substance use services.

While it is not a recovery center, it is mentioned here because of the unique nature of its focus on culturally sensitive services. The center serves primarily natives of the Navaho community who make up about 96% of its service population. The center has staff who speak Navaho on every shift and each program engages peer supports. Some of the approaches used in the center include weekly sweat lodges, drumming and talking circles, and the presence of traditional native healers. Treatment is embedded in a clanship model, a concept that is

extremely important culturally. It is also trauma-informed. An innovative program currently in operation is a “sobering center” — a place for intoxicated individuals to stay for up to 11 hours. They meet with a mental health counselor before they leave. The center will be adding a dormitory for 45 people in the near future. Those who are homeless can receive case management and support for any law enforcement issues that need to be addressed. While there is no specific vocational programming, those who receive case management may focus on employment and on skills training.

*Innovations and Significance:* Totah Behavioral Health Authority provides Native American programming that is specifically designed in a culturally appropriate way.

### ***Arizona: WholeLife Recovery Community***

<http://recoverinaz.com/index.html>

*Services and Description:* WholeLife Recovery Community (WRC) is a nonprofit organization “dedicated to the principles of harm reduction and the acceptance of multiple pathways of recovery.” WRC is a community center that is peer-operated and managed, “based on an integrated model of sustainability.” It offers a wide range of activities, including classes, special events, education, life and vocational skills training, and entertainment. Based in a holistic perspective, it provides an intensive outpatient program (IOP), a peer recovery program, and groups for developing one’s passions. It invites the community in by providing musical and other entertainment. Some of its activities include WholeLife Music, the WholeLife Business Incubator, WholeLife Radio, and a music recording studio.

*Innovations and Significance:* This program is based in a belief in the importance of the creative process to enhancing recovery. While it provides structured treatment as well as peer recovery services, it also provides support for “passions” that include music as well as opportunities to explore business interests. It is the first substance use PRC in Arizona.

***Rhode Island: Anchor Recovery Community Center***

<http://www.anchorrecovery.org/>

*Services and Description:* Located in Pawtucket and Warwick, Rhode Island, these centers focus on community building, and restoring family relationships and bonds disrupted by addiction. The centers provide recovery coaching and telephone support. Most significantly, they provide a full-time employment counselor. The employment counselor helps provide training in job interviewing skills, computer skills, and interpersonal relationships skills.

*Innovations and Significance:* On-staff employment counselor.

***Massachusetts: Stairway to Recovery Center***

<http://caprss.org/content/stairway-recovery>

*Services and Description:* A program of the Gandara Mental Health Center in Brockton, Massachusetts, the Stairway to Recovery Center provides services to individuals in all phases of recovery from alcohol and/or drug abuse, including those who have not yet engaged in recovery, individuals who have relapsed, individuals in methadone programs, and individuals in recovery. The center also includes activities that engage family members. The Stairway to Recovery Center serves the larger communities from which the members come, including the Latino,

African American, Haitian, Cape Verdean, Portuguese, and Brazilian communities. The center also serves ex-offenders, women, immigrants, and elders through activities that meet the unique needs of these populations. The parent organization, Gandara Mental Health Center, provides residential, mental health, SUD, and preventive services for children, adults, and families across the Pioneer Valley of Massachusetts. Founded in the Hispanic community, the center values cultural diversity and strives to provide culturally competent, innovative services to a diverse community.

*Innovations and Significance:* The center provides culturally sensitive peer support to multiple diverse groups. It is supported by a behavioral health center.

### **Special Services Related to Employment, Corrections, Housing, Youth**

#### ***Employment: CCAR: Recovery Oriented Employment Services***

As perhaps the most recognized model of PRC in the country, CCAR developed a much imitated program called Recovery Oriented Employment Services (ROES). This seven-week program that infuses recovery principles into vocational training is based on a curriculum called Recovery Works — nine modules that focus on time management, employment risks in early recovery, writing a cover letter/resume that stands out, the internet job search, work challenges, interviewing skills, and integrating recovery thinking into workplace ethics. CCAR collaborates on this program with Alcohol and Drug Recovery Centers (ADRC), a treatment program that determines who is appropriate for the program, connects those in recovery with other vocational

resources, provides case management related to finding a job, and makes other important referrals.

ADRC works with the Department of Labor to provide referrals to job announcements and trainings such as felony/ex offender workshops, and works with ex-offenders to address past criminal issues and obtain bonding services. They work with the Department of Labor to find jobs throughout the state. CCAR offers job training, recovery plans, volunteer orientation, training, and opportunities to volunteer as a preparation for employment. The program offers many different life skills training opportunities.

Several PRCs in different states have developed ROES programs based on the CCAR model. See, for instance, New York's The Turning Point.

#### ***Vermont Division of Vocational Rehabilitation***

[http://www.vermontbusinessregistry.com/bidAttachments/15306/RFP\\_Recovery\\_Center\\_Pilot\\_RFQ236.pdf](http://www.vermontbusinessregistry.com/bidAttachments/15306/RFP_Recovery_Center_Pilot_RFQ236.pdf)

The Vermont Division of Vocational Rehabilitation (DVR) is currently soliciting proposals from the Vermont Recovery Center system to pilot the embedding of an employment consultant within one or more Recovery Centers. The goal is to provide seamless delivery of DVR services to Vermont Recovery Center participants.

#### ***Vancouver: Community Voices Are Born***

<http://www.cvabonline.com/>

Besides providing an online community, this organization incorporates both the REACH Center as well as the Val Ogden Center, whose focus is on education and employment. In this

program peers come together to achieve recovery goals through vocational development and specific work details. Work at the center is organized into three teams: Member, Culinary, and Facilities. The work is meaningful and engaging, and is essential to running the center. Here peers work to adjust to a regular work schedule, and to search and apply for jobs that fit their interests, skills, and abilities. Peers learn to develop effective resumes and cover letters, and coordinate and prepare for interviews. Assistance in locating community resources to aid in employment is provided, as is ongoing support to keep a job and develop a career. The program provides an actual work program as well as the support services to maintain it, helps reestablish work habits for peers and teaches skills, helps with finding employment, and supports ongoing career development.

***New Mexico: Albuquerque Center for Hope and Recovery***

<http://www.achnm.org/home.html>

The Albuquerque Center for Hope and Recovery (ACHR) is a peer-founded center that provides services for those with mental health and co-occurring disorders. It began as a center for those with mental health concerns. It is listed here because of its unique focus on job and employment services. ACHR participates in the Social Security Ticket to Work Program. ACHR has been an Employment Network with the Social Security Administration since 2010. As an Employment Network, ACHR provides job development to Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI) clients in order to assist them in finding gainful employment, and eventually stepping off of Social Security cash benefits. The program provides a job developer who teaches job skills, and job application and interviewing skills.

## *Corrections*

As noted, PRCs often partner with the criminal justice system (see Detroit Recovery Project and The McShin Foundation, above) to provide programming within correctional facilities, as well as ongoing services after release. More recently, in view of the growing epidemic of opioid misuse in many states, law enforcement has begun to offer programs to offenders that provide treatment options in collaboration with local programs in lieu of incarceration. Some examples of these programs are:

*Rolling Meadows, Illinois: Second Chance Heroin Amnesty Program*

<http://www.ci.rolling-meadows.il.us/612/Second-Chance-Heroin-Amnesty-Program>

Any resident of Rolling Meadows who enters the police station and requests help with an addiction to heroin will be immediately screened. Therapeutic Intervention Staff complete all intake paperwork with the client. The client is referred to the Salvation Army Rehab Center, which offers dorm-style communal living for up to a year. During that year the client receives treatment and case management, attends mutual aid groups, works for the Salvation Army, and is trained in life skills, career building, coping with stress, and financial literacy, among other topics. Services are also provided to youth who meet specific requirements and may have been referred through a “peer jury program.”

*Massachusetts: Police-Assisted Addiction and Recovery Initiative and Gloucester ANGEL Program*

<http://paariususa.org/>

The Police-Assisted Addiction and Recovery Initiative (PAARI) was developed to support local police departments as they work with people with opioid use disorder. It provides an alternative to arrest by offering treatment and support.

Its goals are to:

- Encourage opioid drug users to commit to recovery
- Help distribute life-saving opioid-blocking drugs to prevent and treat overdose
- Connect people with treatment programs and facilities
- Provide resources to other police departments and communities who are motivated to fight opioid addiction

In conjunction with PARRI Gloucester, Massachusetts, initiated its ANGEL program, which supports and assists any person interested in treatment and recovery to access that treatment. An ANGEL is a volunteer who is assigned to each person to guide and support them through the process of accessing treatment and maintaining recovery.

Many towns in Massachusetts are following the lead established by PAARI and are partnering with them and with other community resources to respond proactively to the opioid epidemic. PAARI is spreading nationwide and promises to become the national model for

diversion of people with opioid use disorder away from the correctional system. It depends on peer volunteers to accomplish its goals.

*Seattle, Washington: Law Enforcement Assisted Diversion*

<http://leadkingcounty.org/>

Law Enforcement Assisted Diversion (LEAD) diverts low-level drug offenders into community-based treatment and support services instead of processing them through the traditional criminal justice system. It represents a unique coalition of law enforcement agencies, public service agencies, and community groups. It is a pre-booking diversion program that sets up eligible offenders with case managers who provide help with housing, health care, job training, treatment, and mental health support. The program also provides peer outreach and counseling. The goal of the program is to reduce harm — both to the offender and the surrounding community.

*Pennsylvania: PRO-ACT Mentor+ Program*

<http://councilsepa.org/programs/pro-act/mentor-plus-program/>

PRO-ACT's Mentor+ Program was created by the recovering community of Bucks County, Pennsylvania, to serve inmates in early recovery at the Bucks County Correctional Facility (BCCF). Its purpose is to offer hope, advice, counsel, and friendship to inmates who are incarcerated directly or indirectly for substance use-related crimes. Working in pairs, the Mentors (trusted advisors) meet with the "Mentees" to assist them in making healthy decisions in the areas of housing, employment, transportation, parental issues, identification, health, substance use, and other support programs and social activities.

Mentor pairs meet with each Mentee weekly, while incarcerated, to assist the Mentee in formulating a plan for the relevant areas of their lives so that upon release, usually in about three months, the Mentee may increase the likelihood of success in Bucks County and minimize the risk of re-incarceration. Upon release from BCCF, the Mentor pair continues to work, usually weekly, with their Mentee, continuing to provide support and assistance while the Mentee begins to put his or her plan into action. Concurrently, all Mentors meet together as a group monthly. Mentors may ask for more information to assist their particular Mentee, and receive training in various related topics such as legal assistance in order to improve their utility to guiding the Mentees.

*Ohio: Circle for Reentry*

<http://www.umadaopfc.com/>

The Circle for Reentry Ohio (CFRO) is not a PRC, but it provides a model for peer services for offenders reentering the community.

The CFRO consists of three phases (note that Phase Three provides peer mentoring and recovery services):

- Phase One focuses on risk and needs assessments, intake, and case planning that builds a pathway as unique as each individual, supporting the ex-offender's desire to reintegrate into society and become a restored citizen.
- Phase Two emphasizes culturally relevant services and programming, including education, job readiness and placement assistance, social learning/pro-social skills,

ATOD [(alcohol, tobacco, and other drugs)], and intervention services. CFRO also provides wrap-around and family-based services.

- Phase Three provides aftercare, alumni, and mentoring services aimed at relapse prevention as well as recovery services. CFRO Mentors are ex-offenders who have successfully travelled down their own paths to freedom and are willing to share their experiences and strengths.

### *Youth*

Many peer centers provide programs specifically for youth. Nationally, various organizations support youth recovery, primarily by accrediting sober high school programs or college programs for those in recovery. While not accredited as such, these organizations operate like RCOs and/or PRCs in that they support recovery programs at various locations and in various forms, and some provide advocacy and policy development.

These organizations include:

- Association of Recovery Schools: <https://recoveryschools.org/>

The Association of Recovery Schools accredits high school programs specifically for students in recovery. These programs are separate from regular high school programs and provide daily mentoring or meetings with SUD counselors.

- Transforming Youth Recovery (TYR): <http://www.transformingyouthrecovery.org/>

TYR is an advocacy and capacity-building organization that operates within primary, secondary, and college educational settings, as well as peer and family networks, to add key resources from the private sector to the efforts of government and the educational

system with the goal of accelerating the rate of change in dealing with recovery. TYR mobilizes localized community assets into relevant recovery practices and coalitions. To help remove barriers to local action, they advocate for reforms in public policy, work to erase the social stigma associated with addiction, and fund studies aimed at uncovering and promoting best practices within the recovery field.

- Young People in Recovery (YPR): <http://youngpeopleinrecovery.org/>  
YPR is a subchapter of the national organization, Facing Addiction, Inc. Facing Addiction is a national nonprofit organization dedicated to finding solutions to the addiction crisis by unifying the voices of the over 45 million Americans and their families directly impacted by addiction. YPR is overseen by a national leadership team that creates and cultivates local community-led chapters through grassroots organizing and training. Chapters support young people in or seeking recovery by empowering them to obtain stable employment, secure suitable housing, and explore continuing education. Chapters also advocate on the local and state levels for better accessibility of these services and other effective recovery resources. Four major programs, EPIC, PHOENIX, CATALYST, and LYNX, provide a training curriculum for youth and families, reentry training and support for those in or at risk of entering the criminal justice system, peer recovery support training, and education/advocacy in the larger community.
- Association of Recovery in Higher Education (ARHE): <http://collegiaterecovery.org/>  
ARHE represents collegiate recovery programs (CRPs) and communities. It supports and helps to develop CRPs. The University of Southern Maine (USM) has become a member of this organization, though is not yet listed as such on the website.

## *Housing*

Once again, many peer centers (Vermont Division of Vocational Rehabilitation, PRO-ACT) provide housing resources as part of their programs and maintain their own housing units. Some house men, some only women, and some house those in transition from correctional centers. Recovery housing typically requires abstinence or a sustained period of recovery before one can be admitted. Each program has its own requirements.

Recovery housing is a model that uses substance use-specific services, peer support, and physical design features to support individuals and families on a particular path to recovery from addiction, typically emphasizing abstinence. Read the Recovery Housing Policy Brief:

<https://www.hudexchange.info/resource/4852/recovery-housing-policy-brief/>

*National Alliance for Recovery Residences*

<http://narronline.org/>

The National Alliance for Recovery Residences (NARR) is a nonprofit RCO that currently serves 25 regional affiliate organizations. These affiliate organizations collectively support over 25,000 persons in addiction recovery who are living in over 2,500 certified recovery residences throughout the United States. Their mission is to support persons in recovery from addiction by improving their access to quality recovery residences through standards, support services, placement, education, research, and advocacy.

## *Sober Housing*

Intervention America provides a listing and referral service for those seeking housing with others in recovery: [http://soberliving.interventionamerica.org/listing.cfm?Drug\\_Rehab\\_ID=5399](http://soberliving.interventionamerica.org/listing.cfm?Drug_Rehab_ID=5399)

## PART TWO SUMMARY AND COMMENTS

Part Two has reviewed peer recovery centers (PRCs) in some detail, focusing on those that stand out in various states and those whose programs represent new, innovative, and successful efforts to provide peer recovery services to the community of those affected by addiction. It outlines other forms of recovery programming in the areas of housing, youth, corrections, and employment. It has also provided some background material on research supporting recovery services as a best practice. Finally, it outlines certification standards for PRCs and discusses issues related to the training of peer recovery support workers. There are some notable and instructive points to be made from the material in this section:

- PRCs may be supported, developed, and sustained by multiple different organizations and funding sources.
- The most common support for a PRC is a recovery community organization (RCO) that is founded by peers themselves. RCOs are critical to the development and sustainability of the PRC because they provide advocacy, and often financial support, that keeps the center visible and often viable.
- PRCs are a reflection of the communities in which they are based.
- Most centers provide their own peer coaching training, but increasingly the Connecticut Community for Addiction Recovery (CCAR) model is the basis for that training. There is currently no uniform or standardized training, or national certification for peer coaching.
- Employment is generally a focus in most centers, but there is wide variability in what and how it is addressed.

## **PART THREE — PEER SUPPORT SERVICES IN MAINE**

### **Peer Support in a Rural State**

The Substance Abuse and Mental Health Services Administration (SAMHSA) Treatment Episode Data Set (TEDS)<sup>46</sup> data point out the notable differences between rural and urban substance use. Based on admissions to treatment, they find that:

- a. Rural admissions are younger, and less racially and ethnically diverse;
- b. Rural admissions report more primary use of alcohol or non-heroin opiates, urban admissions more abuse of cocaine and heroin/other opiates; and
- c. Rural admissions are more likely to be referred by the criminal justice system.

While these are national data that don't always reflect the exact nature of the urban versus rural populations in Maine, they do comment on the health disparities in urban versus rural populations in general, and certainly Maine could almost be characterized as two different states from south to north, or east to west, when it comes to regional differences based on rural versus urban communities. The National Rural Health Association<sup>47</sup> also reports that rural communities are at higher risk for substance use disorder (SUD) among youth, motor vehicle fatalities, hypertension, cigarette smoking, suicide, and death from serious injuries. Thus, addiction consequences differ and are often coupled with economic disadvantage, poor education, and greater social and economic obstacles to health and suitable living environments. There tend to be great differences in access to treatment, barriers to treatment such as lack of transportation, and disparities in federal grant funding, along with poor access to health

insurance. See Reduction of Health Disparities in Rural Settings:

[http://www.attcnetwork.org/explore/priorityareas/wfd/lead/AdvancedLI/documents/ReductionofHealthDisparities\\_RuralSettings.pdf](http://www.attcnetwork.org/explore/priorityareas/wfd/lead/AdvancedLI/documents/ReductionofHealthDisparities_RuralSettings.pdf)

The Rural Health Association proposes enhancement of peer support or drop-in centers as one of the solutions to these disparities and as an alternative method for providing education and counseling to those seeking recovery. It suggests increased access to Alcoholics Anonymous (AA) and other mutual aid, and the involvement of schools, churches, and community organizations in recovery campaigns. It recommends making use of the Access to Recovery (ATR) model and emphasizes the importance of establishing a recovery-oriented system of care (ROSC).

One major recommendation of the Rural Health Association is wider use of internet technology services, particularly telehealth and the use of electronic handheld devices to provide e-messages offering support, encouragement, connection, live chats, and access to employment support programs. Ernest Kurtz and William White first wrote about the use of telephone and Internet Peer Support services.<sup>48</sup> They found a substantial demand for telephone and internet-based services, and studies of effectiveness indicated that they had “promise in promoting long-term recovery outcomes.” Online services have been available and in use since as early as 1983. Currently, there is an evolving literature and substantial research support for the efficacy of technology-assisted care.<sup>49 50</sup> The resource hub, <http://sudtech.org/>, is a blend of resource development between SAMHSA and the National Institute for Drug Abuse (NIDA) that provides

access to the latest research and programming information related to technology use in behavioral health, SUD treatment, and recovery.

In a 2014 article, Wendy Hausotter points out that technology-assisted care has applications in many settings and can be viewed in many ways “as part of brief intervention in a primary care setting for instance...” She points out that “technology based behavioral health interventions have been shown to be well accepted, efficacious, and cost effective.”<sup>51</sup> Lisa Marsch describes a recovery-based support tool called Addiction Comprehensive Health Enhancement Support System (ACHESS), which is a smartphone-based recovery support program.<sup>52</sup> The tool is built on evidence-based principles of recovery support, and offers several types of personalized monitoring and support to individuals in recovery. Early research shows that it may be a valuable relapse prevention aid. In 2011, Kimberly Johnson et al. wrote a review of potential roles for communication technologies in addiction treatment.<sup>53</sup> She focuses on the opportunity such tools offer clinicians to work with patients to manage chronic conditions. Cunningham et al. describe the emerging technologies, including screening apps, websites for cognitive behavioral treatment or support, text messaging with sponsors or recovery coaches, and telephone support.<sup>54</sup> Luo and Campbell describe an intervention called Therapeutic Education System (TES), which consists of 62 interactive multimedia modules, whose goal is to increase positive reinforcement for non-drug-using activities.<sup>55</sup> Studies show that TES, an internet-delivered intervention, dramatically reduced drug use to the point of abstinence among those using drugs at the beginning of the study.

Technology promotes the availability of online meetings of mutual aid groups, such as AA, Women for Sobriety, SMART Recovery and others. Women in particular tend to be high users of internet support since there tend to be far fewer all-female support groups and since women, as caretakers, are often homebound.

“Online recovery support occurs in many formats. Individual email exchanges, in the form of alternating bulletin-board postings, came first and in their more developed form remain a lively and rich means of support. These relationships often involve sponsorship. They also remain private between those who send them or those to whom they may be forwarded. Although rarer, immediate communication is also available via Instant Messaging...Finally, web-based groups more easily reach special populations.”<sup>56</sup> Computer contact reduces barriers of time, distance, and social status, allowing persons with physical disabilities, homebound caregivers, status-conscious professionals, and individuals in remote locations the opportunity to participate actively and on an equal basis with the more advantaged.<sup>57</sup> Internet services can provide helpful responses when traditional means of counseling or help are unavailable or when those in recovery are simply too shy or fearful to meet with groups.

The Addiction Technology Transfer Center (ATTC) Network, at [www.nfarattc.org](http://www.nfarattc.org), has a National Frontier and Rural training section devoted to awareness and implementation of telehealth technologies to deliver treatment and recovery services in rural areas. Some specific technologies with which they train include: telephones, cell phones and smartphones, Interactive Voice Response, web-based programs, blogs, social network sites, and texting. These services all play a role in reducing barriers for recovery support, and the ATTC has found that they extend

the reach of recovery, increase participation, and decrease the rate of relapse. Training those in peer centers to make use of this technology would greatly extend the reach and effectiveness of peer support services in a state as large and diverse as Maine.

### **Maine Recovery Centers**

Maine currently has two peer recovery centers (PRCs) that could be classified as urban versus rural. Their programs and organization are completely different, reflecting the unique qualities of their environments.

#### ***Portland, Maine: Portland Recovery Community Center***

<http://www.portlandrecovery.org/>

The Portland Recovery Community Center (PRCC) was developed about five years ago. The Maine Association of Substance Abuse Providers (MASAP) proposed it to the Department of Health and Human Services (DHHS) and the Maine Office of Substance Abuse and Mental Health and Services (SAMHS), and the proposal was accepted and funded through the Federal Substance Abuse Block Grant. The developers visited programs in Connecticut, Vermont, and Rhode Island, and based the initial programming primarily on the Connecticut Community for Addiction Recovery (CCAR) and Vermont models. Initially the center was open five days per week from 9:00 a.m. to 5:00 p.m. Currently it is open seven days per week for close to 12 hours per day. In its first year it had 10,000 visits. Today visits number about 40,000 annually. It has become a mainstay of recovery in the greater Portland area, and it partners with many community organizations, including multiple law enforcement departments, Portland Health

Center, and increasingly with Maine Medical Center (MMC). Some of PRCC's outreach and collaborative efforts include the work it does with local police departments to implement Operation HOPE. PRCC provides “angels” or peers who help those going through withdrawal, particularly from opioids, and who want to access treatment. This program is a collaboration with police departments in Scarborough, Kittery, Eliot, South Portland, Boothbay Harbor, and York, and the York County Sheriff’s Department. PRCC is working increasingly with the local medical community to integrate peer supports. PRCC has a co-located peer support coordinator at the Greater Portland Health Center who works on-site as a member of the Substance Use Disorder Treatment Team. There is also a peer support coordinator working on referral with long-term patients at MMC.

When asked about PRCC’s programming its director, Steve Cotreau, described it as “anything that will support recovery,” meaning that the center strives to be responsive to the needs and strongly felt wishes of its peer members. For instance, a recovering mother with a very young child commented that it was too bad there wasn’t a group for recovering moms. With support from the staff, she was able to organize a group that will start within the month. The center is not aligned with any one model of recovery so that it supports all paths to recovery, including mutual aid groups like SMART Recovery and multiple 12-step groups. It provides telephone recovery support. Life in Balance is a community support program that teaches life skills that include education, employment, and wellness.

Employment support is provided in a number of ways. PRCC maintains connections with temporary employment agencies and employers who are recovery-friendly and who are able to

employ people in recovery who may have criminal backgrounds. Maine Works is an employment agency owned by a person in recovery who has a special interest in helping those in recovery. One employer in the area employs 100 people, 90 of whom are recovering. Youth are a significant part of the center's activities — 60% percent of the peers at the center are under the age of 25. One of these youth became so passionate about the recovery movement, he went on to start a chapter of Young People in Recovery (YPR) that has grown throughout the state.

Steve Cotreau believes that the success of a peer center has to do with how welcoming it is. He strives to keep the center upbeat, inviting, and vital to both its members and the community. PRCC is the only comprehensive community peer center in the area and its function goes beyond meeting the needs of individuals in recovery — it meets the recovery needs of an entire community. What he notes is a need for more residential rehab facilities in the state — as peers work with Operation HOPE, they find themselves without resources to which to refer people. His volunteers spend countless hours on the phone calling other states and asking for scholarship beds in their facilities.

### ***Bangor Area Recovery Network***

<http://www.bangorrecovery.org/>

The Bangor Area Recovery Network (BARN) is a recovery center completely run by volunteers. It was started in 2008 by a newly established coalition of people in recovery called the Bangor Area Recovering Community Coalition (BARCC). BARCC provided technical assistance to a group who wanted to establish a recovery center along with a sobriety club. Today, BARCC and BARN are merged, the 24-hour club has shut down, and BARN is housed in

an 8,000-square-foot facility that is completely debt-free. Foundation grants have been the main support for the evolution of BARN along with sound fiscal management by the volunteer board of directors.

BARN currently supports 110 different types of meetings — primarily 12-step mutual aid groups. It has a highly informative website providing links to many recovery and treatment resources. It also features a Medication-Assisted Persons group. BARN is unable to provide the more typical PRC services because it has no funding to hire staff. Its only operational funds come from a small store on-site that sells T-shirts and other small items, and rent money from the groups that meet there. It is completely staffed by volunteers, who provide 600–900 hours of service weekly. However, this leaves the center with no formal staff structure. In spite of this drawback, BARN provides a vital recovery presence in this more northern area of the state.

*Employment:* An innovative aspect of BARN is a focus on helping its members to find work. Job listings in the center are posted over the coffee pot, and relationships have been built with local contractors who hire center members for landscaping and other construction jobs. The Eastern Maine Development Corporation maintains a connection with the board and has an interest in establishing work programs, particularly for those involved with the Maine Pretrial program. BARN has resources that would be ideal for work and job development programs. It has on-site capacity for a 25-seat café, along with an industrial kitchen, and has raised garden beds on-site. However, it lacks the funding to develop these resources, hence a formal jobs program is at a standstill.

*Housing:* BARN has purchased and established a nine-bed sober housing unit for women, Holyoke House, based on the Oxford Houses model. This house was developed with grant money and is fully debt-free. Its website also refers those in recovery to multiple housing options.

### **Youth Recovery Programs in Maine**

As noted earlier, Maine has a chapter of YPR, and collegiate recovery programs (CRPs) are currently being established at both the University of Southern Maine (USM) and the University of Maine, Orono at the Student Wellness Resource Center. The USM CRP received a BRSS TACS grant that has accelerated program development. The program has the full support of USM's president and is part of their University Health and Counseling Services. Staff positions include the Coordinator of Clinical Substance Use Services and a Program Coordinator. Beginning in the 2016–17 academic year, the USM CRP will include a recovery center, support groups, and programming for any student in recovery.

### **Corrections**

Programs supported by the PRCC:

- Police-Assisted Addiction and Recovery Initiative (PAARI)/Community Access to Recovery: About to establish programs in Eliot, York, Kittery, and York Hospital
- Operation HOPE

*Employment: There are no specific employment programs in collaboration with either recovery center. Both centers have informal relationships with some employers and with the Division of Vocational Rehabilitation.*

## **Housing**

Maine has a large inventory of recovery housing of various types. Much of it is located in the southern part of the state. For instance, Oxford Houses — self-directed homes that support up to 15 people each — are located primarily in the Portland area, with one house in Brewer and two in Bangor.

### **PART THREE SUMMARY AND COMMENTS**

This section has reviewed the peer services available in Maine. Clearly, student and youth services are newly under development. It appears there are no recovery high schools in the state and those at the universities are just recently being developed. Sober and recovery housing seems more available than peer services in general. Correctional programs have begun to develop in the face of the opioid crisis, primarily at the initiative of police departments. There is no formal programming with the Division of Vocational Rehabilitation to connect peers with jobs or job training.

The two recovery centers in the state reflect the north/south, urban/rural divide. The urban Portland Recovery Community Center (PRCC) hosts multiple programs and community connections, and was started and is supported by the one state recovery community organization (RCO) — Maine Alliance for Addiction Recovery (MAAR) — with help from the Maine Office of Substance Abuse and Mental Health Services (SAMHS). It is able to hire staff and develop programmatically because of the wealth of community resources to be accessed. The Bangor Area Recovery Network (BARN), on the other hand, is a completely volunteer-run organization, with no state or other support, which primarily hosts mutual aid meetings of various types. While it has the strong support of its peer founders — the Bangor Area Recovering Community Coalition (BARCC) — it is unable to develop programs because of lack of funding. These two centers might ideally serve as anchors for peer support services in their respective regions, but they operate on unequal footing.

## **PART FOUR — PUBLIC HEALTH DISTRICTS**

### **Methods and Data Utilized to Assess Readiness**

AdCare Educational Institute of Maine, Inc. (AdCare) with its partners — the Co-Occurring Collaborative Serving Maine (CCSME) and the Alliance for Addiction and Mental Health Services, Maine (AAMHS) — (hereinafter referred to as “the team”) relied on several sources of information to conduct the needs assessment and describe readiness in each public health district (PHD).

#### ***Research on national models***

The team conducted research on recovery community organizations (RCOs) as part of a recovery-oriented system of care (ROSC). The purpose of this research was to highlight the basic principles of peer support and services of peer recovery centers (PRCs) as outlined by the Substance Abuse and Mental Health Services Administration (SAMHSA), and to describe the research on evidence-based models that are effective in helping people achieve long-term recovery from substance use disorder (SUD). The team also highlighted a sample of RCOs across the United States, and the services they provide, based on information available online and from telephone interviews with RCO staff.

### *Environmental scan*

The team conducted an environmental scan of the recovery services that Maine's two RCOs — Bangor Area Recovery Network (BARN) and Portland Recovery Community Center (PRCC) — provide. The environmental scan was conducted by contacting the RCOs.

### *Key stakeholder focus groups*

The team conducted focus groups with key stakeholders in each PHD. The team identified key stakeholders from the following sectors: peer leaders, civic/elected leaders, law enforcement/corrections, treatment providers, career resources, employers, academic institutions/colleges, medical providers, hospitals, prevention, housing, and clergy. The team then worked with the public health liaison in each district to identify people in each sector, to set a time and place for each focus group, and to invite key stakeholders to participate in the groups. To the extent possible, the team conducting the focus groups included a facilitator and note taker. A total of 158 individuals participated in the focus groups. CCSME collected the notes from each key stakeholder focus group, collated the information, and provided it to focus group participants for vetting. The team identified themes from the key stakeholder focus groups.

### *Peer focus groups*

The team conducted focus groups with people in recovery from each PHD. Trained facilitators who were also in recovery led the focus groups and took notes. All focus group results were confidential, and responses were de-identified. A total of 73 individuals in recovery

and three people with family members in recovery participated in the focus groups. The team identified themes from the peer focus groups.

### ***Maine Opiate Collaborative listening sessions***

The team reviewed the collated notes from the Maine Opiate Collaborative listening sessions in each PHD and identified themes from the sessions.

The team combined the information from the environmental scan, the focus groups, and the results of the Maine Opiate Collaborative listening sessions to describe readiness for the establishment or expansion of an RCO in each PHD. The team utilized the Community Toolbox, a resource provided by the University of Kansas Institute for Life Span Studies, to identify aspects of community readiness for change.<sup>58</sup>

### **Common Themes Across Districts**

From the outset, the team expected to discover unique opportunities, challenges, and barriers when it came to peer recovery services and capacity across the nine PHDs. Indeed, the team fully expected to see differences within the districts, as will be unveiled in the district summaries that follow. At the same time, the team expected there would be some overarching themes that would be present in most, if not all districts. This was indeed the case, with several commonalities emerging as the team synthesized and assembled the collected data.

One clear theme in each district was that communities all across Maine have become actively engaged in discussing the state's addiction crisis. Even before the team had set up the

key stakeholder and peer focus groups, many Maine communities had hosted listening sessions in conjunction with the work of the Maine Opiate Collaborative. Many of the sessions were very well-attended and featured multiple community sectors already working on the ground to address the various consequences impacting individuals and communities. In some communities, conversations have gravitated around how to increase peer recovery services and recovery capacity, up to and including exploring setting up a PRC. This bodes well for the request for proposal (RFP) process in terms of mobilizing many potential bidders to put in applications to set up a center in their district or community.

There were two other themes that emerged, which primarily relate to each other. One theme that was present in roughly every district was a common ideal concept for a PRC. Participants expressed that their ideal scenario would be one where they could identify a key hub within their district to locate the PRC, but that there would be options, or flexibility of resources, to allow for satellite facilities in other key hubs within the district. A common idea expressed was that satellite sites could be open on a certain day of the week or month depending on the utilization of services and resources, or volunteers available for staffing. One of the team's questions within the key stakeholder focus groups was how a PRC would be set up to best serve the entire district — the central recovery center and satellite site model was the most common response.

This dovetails into the other prominent theme across the districts, which is the theme of transportation. In a largely rural state, it came as little surprise to hear from participants in the key stakeholder and peer focus groups that transportation is a major factor, and often barrier,

when it comes to accessing SUD services, whether treatment or recovery. Even in urban centers transportation can be a barrier, depending on where one lives relative to public transportation routes or when one needs transportation relative to the operating schedules of buses. It is within this context that most districts mentioned satellite sites to increase access, and it underscores that transportation resources will need to be a considerable factor in developing a plan for a PRC, no matter where it may be located in Maine.

Previously in this section it was noted that discussion, conversation, and planning around SUD and recovery services has blossomed in communities across Maine. At the same time, feedback from participants in the key stakeholder and peer focus groups makes it clear that stigma and shame are still significant factors and pose barriers that keep individuals from seeking services. Stigma, then, factors into PRC efforts in two ways: one is that, as already mentioned, stigma could keep individuals from accessing a new PRC. The other is that stigma could potentially create issues of NIMBY (“not in my backyard”) when it comes to determining where to locate a PRC. It would then follow that any implementation plans for a PRC would need to consider how to address any stigma that may exist within a community, build buy-in, and maximize sustainability and utilization.

One last theme to discuss, which provides a key opportunity for new PRCs, is the issue of decentralized information for SUD services. In most, if not all of the districts, the team heard from focus group participants that while it felt like there were great pockets of programs and services, there was no one centralized repository of information for these efforts. This in particular has posed challenges for the law enforcement-driven programs like Operation HOPE

and the various “angel” programs. There was a common sense in many of the districts that information on available services was too fractured, and created inefficiencies in making referrals. The new PRCs would provide an excellent opportunity to centralize information on programs and services on a regional basis, creating the “one-stop-shop” hub Maine communities desperately need.

The common story that has emerged from the districts is the need for a centralized hub for peer recovery services and programs, but with flexibility and versatility to maximize access and reach. Most communities identified and had at the table multiple sectors ready to come to the table to offer and/or co-locate services, whether they be groups, career and education resources, or skill-building and enrichment activities. Given that there are some differing levels of readiness and capacity between districts, there may be benefit for initial and ongoing technical assistance with respect to start-up and implementation of the new PRCs in Maine, to maximize impact and fidelity to the national models. There may also be great benefit in networking the new PRCs to facilitate the sharing of lessons learned and other resources. The Peer Recovery Center RFP will provide a golden opportunity at a crucial time when dire need has met with heightened awareness. It is clear that communities across Maine are poised and ready for this opportunity.

## District Readiness

### *York — District 1*

#### *Overview*

York Public Health District has a population of 200,710 people...it [is] the second most urban Public Health District (PHD) in Maine...In York, approximately 18 percent of the population was 65 years old or older in 2014. Approximately 96 percent of York's population is Caucasian, followed by Hispanic (1.7%), Asian (1.3%), and African American (0.7%) With a median income of \$57,348 (second-highest in the state),...about ten percent of the population in this district lives below the poverty level (the lowest in the state). In sum, York tends to be richer and more urban compared to the rest of the state.

Source: Substance Abuse Trends in Maine Epidemiological Profile 2015 York District

[http://www.maine.gov/dhhs/samhs/osa/data/cesn/Files/York\\_EPI\\_2015\\_FINAL.pdf](http://www.maine.gov/dhhs/samhs/osa/data/cesn/Files/York_EPI_2015_FINAL.pdf)

#### *Readiness for Peer Recovery Center: Needs and Opportunities*

There is a high level of engagement and collaboration around SUD in York County. Listening sessions for the Maine Opiate Collaborative attracted over 300 citizens from across the region. Multiple sectors are engaged in conversations and efforts around addressing SUD on a community level, including the integration of peers and peer services. Sectors at the table include prevention, treatment, Young People in Recovery (YPR), law enforcement, business, civic

groups, colleges and universities, medical, and others. The region features three active prevention coalitions, some with federal Drug-Free Communities (DFC) funding. The district also has two newly formed chapters of YPR, in Biddeford and Sanford. York County is building leadership among the recovery community as more community organizations within York County are creating seats on their boards for people in recovery. Recovery coach training programs have been held in York County to build peer recovery capacity. There is an attitude, among those citizens engaged, of readiness to do anything to help in the region. Focus groups highlighted many organizations and programs, including career and education resources, which could potentially be linked with a recovery center.

One area of opportunity is to continue to increase community dialogue around SUD and the importance of addressing it. Focus group participants remarked that the general public is aware of those efforts that are covered in the media, but may not be as well-informed on all the other initiatives. Another challenge is that the district covers a lot of territory, and transportation is an issue for many and would provide barriers to access for some. Some discussions of this barrier included exploring the possibility of satellite sites to broaden access to recovery services.

Participants in the peer focus groups echoed many of the strengths illuminated in the key stakeholder focus groups. Participants in this district's peer focus group did comment that while counseling services are available in York County, recovery supports are lacking. However, community leaders have been very supportive in starting a YPR chapter in Sanford. One challenge brought up in the peer focus groups is that stigma could influence people outside of the recovery community, as far as buy-in to welcoming a recovery center in the area. Participants in

the Maine Opiate Collaborative listening sessions also echoed many of the strengths and challenges posed by the key stakeholder and peer focus groups. Listening session participants noted that it will be important to engage in efforts to reduce stigma. Additionally, they commented that additional resources are needed for long-term recovery services and support to help with transportation, housing, and employment — all services that could be housed or linked with a recovery center.

## *Cumberland — District 2*

### *Overview*

Cumberland Public Health District consists of Cumberland County which has a population of 287,797 people...[It is] the most densely populated county in Maine...In Cumberland, 16.4 percent of the population was 65 years old or older in 2014. Approximately 93 percent of Cumberland's population is Caucasian, followed by African American (2.9%), Asian (2.2%), and American Indian and Hispanic (1.9%). With a median income of \$57,461 (the highest in the state), 11.4 percent of the population lives below the poverty level (the second-lowest in the state). In sum, Cumberland tends to be slightly younger, more affluent and more urban compared to the rest of the state.

Source: Substance Abuse Trends in Maine Epidemiological Profile 2015 Cumberland District

[http://www.maine.gov/dhhs/samhs/osa/data/cesn/Files/Cumberland\\_EPI\\_2015\\_FINAL.pdf](http://www.maine.gov/dhhs/samhs/osa/data/cesn/Files/Cumberland_EPI_2015_FINAL.pdf)

### *Readiness for Peer Recovery Center: Needs and Opportunities*

Community members generally feel that in the last two years they have seen a dramatic shift in the attitude toward SUD and recovery. Police departments are going out to the community to talk, and people are paying attention in a different way. YPR is providing personal faces to recovery. Grants are now including peers in their initiatives, e.g., the Greater Portland Health Center is offering medication-assisted treatment (MAT) to 30 individuals and hiring a peer coordinator in collaboration with PRCC, the University of New England (UNE) is doing a

peer recovery coaching training with their school of pharmacy, and Maine Medical Center (MMC) utilizes peers in their emergency room. Peer empowerment is being recognized and sought after, though there is still quite a bit of stigma in the larger community.

There are many services available in the city of Portland, but not across the rest of the county. PRCC is the only state-funded recovery center in Maine. It is a hub for people in recovery to meet, socialize, and support each other, and has expanded its reach into the community. The University of Southern Maine (USM) started the collegiate recovery program (CRP) on campus and was awarded a grant for a recovery center, which will open in September. It will provide peer-to-peer support recovery. In addition, there are many coalitions such as Healthy Maine Partnerships (HMPs) and drug-free coalitions working on SUD prevention and treatment, some of which are developing and connecting peer recovery. However, across the district there is no one place to access information about the various initiatives, and there is some duplication of efforts.

Portland is known for its strong recovery community, and sober housing has proliferated. Sober housing in the Portland area is becoming more affordable. However, there continues to be limited sober housing for those on MAT and for women. There is also no oversight as to the quality of the housing. There have been many efforts to support people in recovery gaining employment and employment skills. Maine Works and Goodwill Work Force Solutions are a big resource. PRCC has a jobs board. Maine Works does provide transportation to jobs. Goodwill is also helping in the Bridgton area and does in-reach at the Cumberland County jail.

Many felt that PRCC is a good model as a freestanding recovery center not attached to any treatment center. It has been able to create itself as the community needed it. Key stakeholders felt each center should be different depending on what the community itself wants, needs, and develops. There were some very specific ideas offered from various key stakeholders regarding the creation of additional recovery centers.

The peer focus group felt that with all the press coverage the general public knows there is a problem, but many think it's a drug problem — not an addiction problem. There is still stigma, but it is slowly breaking down. Losing the Mercy Recovery Center left a huge hole in recovery supports and community efforts outside of Portland. Transportation came up as an issue with this group. Ideas offered regarding the best location were in Windham, the Westbrook Community Center, creating a hub-and-spoke model, or a mobile recovery center.

The Maine Opiate Collaborative listening sessions indicated a need for more residential care, sober housing, and PRCs in rural areas. Funding is a critical need to support the programs, additional personnel, and facilities needed to support the treatment and recovery of affected persons. They also indicated a need for more education and community collaboration to reduce stigma/bias/shame surrounding substance use. In addition, more community partnerships and information-sharing needs to take place among law enforcement, schools, and families.

## *Western — District 3*

### *Overview*

Western Public Health District (PHD) has a population of 194,974... This is split between Androscoggin County (107,440), Franklin County (30,296) and Oxford County (57,238), the three counties that make up the district. In Western PHD, approximately 18 percent of the population was 65 years old or older in 2014. Approximately 96 percent of Western PHD's population is Caucasian, followed by African American (1.6%), Hispanic (1.4%), and Asian (0.7%). At 3.8 percent, Androscoggin County has the highest proportion of African Americans of any county in the state. The median household income in 2014 differed little within the district. The median household income in 2014 differed little within the district...In Western PHD 15.4 percent of the population was living below the poverty level. In sum, compared to the rest of the state, parts of Western PHD are more diverse while others are more rural.

Source: Substance Abuse Trends in Maine Epidemiological Profile 2015 Western District  
[http://www.maine.gov/dhhs/samhs/osa/data/cesn/Files/Western%20EPI%202015\\_FINAL.pdf](http://www.maine.gov/dhhs/samhs/osa/data/cesn/Files/Western%20EPI%202015_FINAL.pdf)

### *Readiness for Peer Recovery Center: Needs and Opportunities*

There is a growing awareness of how SUD is impacting the community, and it is one of the top health issues for all three counties in the district. However, even though an annual Alcohol and Addiction Conference has been held, with over 1,100 people attending over the

years, discussions and treatment continue to be hindered by the general perceptions of stigma associated with SUD. The Western Maine Addiction Task Force, with support from the Oxford County Wellness Collaborative (OCWC), has as its focus getting people to rethink attitudes and beliefs around addiction. OCWC also provided training for law enforcement around trauma and crisis, as well as addiction as a disease.

Many sectors are engaged in the dialogue about how to address SUD and integrate peer supports, including prevention coalitions, treatment providers, schools, law enforcement, clergy, civic groups, the business sector, legislators, the district attorney (DA), and consumers. The hospitals provide many needed services, and the Behavioral Emergency Department of St. Mary's Health System has become somewhat of the safety net for the region around SUD. There are several active prevention coalitions, including two with federal DFC funding. There is also a great presence on social media, with lots of posts around recovery and other SUD information.

Long-standing challenges revolve around transportation, due to the rural nature of the district, and lack of access to treatment. Family members often bring in someone to detox, but then find there is no residential or intensive outpatient program (IOP), or medication management for them after detox.

There are some new challenges surfacing around immigrant populations and prescription confusion and sharing. Healthy Androscoggin is developing new tools to help explain medication usage and rules with this community. Their Neighbor 2 Neighbor programs work with the New Mainer community for education around alcohol, tobacco, and SUD.

Law enforcement is very engaged on this issue across the district. Alcohol enforcement teams and police departments are working together on prevention efforts. There is a strong restorative justice program established, and the DA is highly engaged. Law enforcement is very supportive of getting people treatment instead of incarceration. There is a large presence at task force meetings.

Many are talking about PRCs, and peer recovery coaches are being trained in Oxford. There is no specific development yet for a PRC, but brainstorming and discussions have begun. It would be impossible to serve the entire district in one location. Multiple locations would be ideal, preferably in the most densely populated areas.

Maine Opiate Collaborative listening session participants noted that general funding is needed to educate, and to implement new programs for long-term support, as insurance coverage is lacking for individuals with SUD. Respondents stated that a PRC/club would be best with services such as walk-in resources — with counselors available, safe peer-to-peer engagement, regular outreach calls to those utilizing services, and education on how to use/navigate existing resources. Feedback also indicated that more residential care facilities and sober houses are needed. Focus group participants agreed that more services are sorely needed, including peer support and links to services such as employment and education. Given the size of the substance use problems in the Lewiston–Auburn area, they thought either Lewiston or Auburn would be the best location for a peer recovery center.

## *Midcoast — District 4*

### *Overview*

Midcoast Public Health District is made up of four counties: Knox, Lincoln, Sagadahoc and Waldo. All together [sic], the district has a population of 147,942 people...In Midcoast Public Health District, approximately 22 percent of the population was 65 years old or older in 2014. Knox and Lincoln Counties have a greater proportion of residents over 65 years old...compared to Sagadahoc...and Waldo County..., which are closer to the statewide average. Approximately 96 percent of Midcoast PHD's population is Caucasian, followed by Hispanic (1.2%) and both African American and Asian at 0.6%. The median income in 2014 ranged from \$42,221 in Waldo to \$56,733 in Sagadahoc; 12.5 percent of the population in this PHD lives below the poverty level. In sum, Midcoast is older, more Caucasian and generally middle-income.

Source: Substance Abuse Trends in Maine Epidemiological Profile 2015 Midcoast District  
[http://www.maine.gov/dhhs/samhs/osa/data/cesn/Files/Midcoast\\_EPI\\_2015\\_FINAL.pdf](http://www.maine.gov/dhhs/samhs/osa/data/cesn/Files/Midcoast_EPI_2015_FINAL.pdf)

### *Readiness for Peer Recovery Center: Needs and Opportunities*

There is a growing awareness of how SUD is affecting the community as it continues to impact individuals and families, and there have been several community-wide discussions throughout the district that focused on the opioid problem. Community members generally understand that there is a lack of resources to address the problem, including a lack of peer

activities. Four coalitions in the district are working in different ways to raise awareness, increase access to treatment, foster support for family members and friends of people with SUD, provide recovery support for people leaving county jails, coordinate with law enforcement, and link people to resources. There are three organizations that function as recovery centers (in Brunswick, Wiscasset, and Dresden), and the Knox County Recovery Coalition (KCRC) is actively seeking support for a recovery center. Cultural differences and geographic distance across the district are a challenge, and there is a need for some type of clearinghouse that coordinates services and resources throughout the district.

The peer focus group participants felt that there is a lack of peer support and recovery resources, as well as lack of awareness in the community of the extent of the problem and the nature of SUD and recovery. Stigma is a significant problem. The peer group also viewed transportation as a significant barrier to accessing services.

The Maine Opiate Collaborative listening sessions echoed the need for raising awareness of existing services and a more a coordinated approach to service delivery, as well as providing treatment and support for incarcerated individuals, and increasing resources for new and existing programs to support all paths to recovery.

## *Central — District 5*

### *Overview*

Central Public Health District has a population of 172,275 people...split between Kennebec County (121,112) and Somerset County (51,163)...Kennebec County is home to Maine's capitol [sic] city, Augusta...In Central Public Health District, approximately 18 percent of the population was 65 years old or older in 2014. Approximately 97 percent of Central's population is Caucasian, followed by Hispanic (1.3%), Asian (0.8%), and Black/African American (0.6%)...Sixteen percent of the Central Public Health District is below the poverty level. Somerset has the fourth lowest income in the state, yet Kennebec has the seventh highest income among counties in Maine. In sum, Central makes up a very cross-representational demographic view of the State [sic].

Source: Substance Abuse Trends in Maine Epidemiological Profile 2015 Central District

[http://www.maine.gov/dhhs/samhs/osa/data/cesn/Files/Central\\_EPI\\_2015\\_FINAL.pdf](http://www.maine.gov/dhhs/samhs/osa/data/cesn/Files/Central_EPI_2015_FINAL.pdf)

### *Readiness for Peer Recovery Center: Needs and Opportunities*

Awareness of the issue is high, and the Central PHD was the first to identify SUD and mental health as a priority through a PHD needs assessment. They have had an active mental health and SUD workgroup since 2011, and advocated to the State Coordinating Committee that SUD needed to be addressed at the state level through the state public health plan. Over 600 people have participated in forums in Augusta and Gardiner in six separate events around SUD/opioids.

Stigma was felt to be present, even within the recovery community, and was even a barrier to building a recovery coalition in Waterville. There is also stigma and bias even within health care, with several providers concerned that serving Suboxone patients may impact other patients. More and more people, though, are recognizing that they are linked to or impacted by the opioid/addiction crisis, which leads to less “othering” of people with addiction.

The district houses both the Department of Veterans Affairs facility at Togus and the state’s Riverview Psychiatric Hospital, as well as several hospitals and active community coalitions. Two clubhouses are active in Kennebec County, run by Kennebec Behavioral Health (KBH) for co-occurring disorders. There are several programs within law enforcement, and some trained peer recovery coaches in southern Kennebec, but it was felt that there are the “bones” for peer support with no funding.

The issue of transportation was a high priority for Central PHD, as it is a huge district with little public transportation. There is no transportation connection between Somerset and Kennebec Counties. Three out of five town clusters are trying to address some of the transportation needs through volunteer transportation. It remains hard to locate services in an area that benefits everyone in the district. Due to the rural nature of the district, there was a lot of talk about examples in other New England states for PRCs in rural areas. It is important that considerations for different geographies of different districts are involved in the RFP. It was mentioned that you could create a centralized anchor with separate programs at satellite sites (with central coordination).

The peer focus group participants felt that there was a lack of understanding in the community about how addiction works and how the community could help. There is stigma attached to being addicted, and poverty and addiction go hand-in-hand in the PHD. It was noted that there was not much in the way of recovery support services beyond a few 12-step programs. The Kennebec Club in Waterville has dwindled in participation and lacks leadership.

In the Maine Opiate Collaborative listening sessions it was made clear that more local treatment options with counseling were needed in Somerset County, especially for those using MAT. The survey indicated a need to fund additional resources to support programs dealing with SUD to support those still struggling and those in recovery. There is a need for more funding for safe houses and sober living options, but no specific PRC was mentioned. There was a strong focus on needing more funding and resources to support current and expanded programs and services, and to educate teachers, law enforcement, and community organizations about the problem and ask for their support and help to resolve it.

## *Penquis — District 6*

### *Overview*

Penquis Public Health District (PHD) is comprised of the Penobscot and Piscataquis Counties and is home to 170,440 people. It...is the third-least densely populated district in the state (primarily due to the low population in Piscataquis County)... In Penquis PHD, 20.1 percent of the population was 65 years old or older [in 2014].

Approximately 96 percent of Penquis PHD's population is Caucasian, followed by Hispanic (1.4%), Asian (1.0%), and American Indian/Alaska Native (0.9%)... The poverty rate is approximately 18 percent in the PHD. In sum, parts of Penquis PHD are somewhat older and more rural compared to the rest of the state, while other areas are on par with the statewide rates.

Source: Substance Abuse Trends in Maine Epidemiological Profile 2015 Penquis District

[http://www.maine.gov/dhhs/samhs/osa/data/cesn/Files/Penquis\\_EPI\\_2015\\_FINAL.pdf](http://www.maine.gov/dhhs/samhs/osa/data/cesn/Files/Penquis_EPI_2015_FINAL.pdf)

### *Readiness for Peer Recovery Center: Needs and Opportunities*

The community in Penquis PHD is increasingly aware of SUD issues and has come together in several ways to address the problem. Coordinated efforts include the Community Health Leadership Board, the Public Health Advisory Board, community conversations about the opioid problem, and activities sponsored by the BARN, such as the annual summit on recovery, training for peer recovery coaches, and programming at the BARN building in Brewer. Law

enforcement and civic leaders in the greater Bangor area are involved in different capacities to address the problem as well, including working toward a Law Enforcement Assisted Diversion (LEAD) program similar to the LEAD program in Seattle. BARN is considering ways to address the challenge of the district's large geographic area, such as technology for interactive television-type meetings throughout the district.

The peer focus group highlighted the work of BARN as well as other service providers, such as Penquis Community Action Program, Wellspring, Higher Ground, and Penobscot Community Health Center. Resources are not interconnected, though, and some type of coordination is needed; people in early recovery do not know how to access resources. Stigma is a problem.

The Maine Opiate Collaborative listening session in Penquis PHD reflected the need for additional resources for existing and new services, such as recovery residences and a centralized hub where services can be located and where coordination with other services can occur.

## *Downeast — District 7*

### *Overview*

Downeast Public Health District is comprised of two counties, Hancock and Washington, and has a population of 87,035 people...Downeast PHD is relatively rural...Washington is the third most rural county in Maine...In Downeast PHD, 18.5% of the population is 65 years or older. The majority of the population...is Caucasian (95.2%). In 2010, 2.1 percent of the population...identified themselves as American Indian. Economically, the two counties within Downeast PHD differ greatly. During the period of 2008-12, the median family income in Washington was \$36,486 (lowest in the state), whereas the median income in Hancock was \$48,635 (the fifth-highest statewide). Just over 15 percent of the population in Downeast PHD lives below the poverty level. Overall, Downeast PHD tends to be older and more rural compared to the rest of the state and varies greatly in terms of socioeconomic factors.

Source: Substance Abuse Trends in Maine Epidemiological Profile 2015 Downeast District

[http://www.maine.gov/dhhs/samhs/osa/data/cesn/Files/Downeast\\_EPI\\_2015\\_FINAL.pdf](http://www.maine.gov/dhhs/samhs/osa/data/cesn/Files/Downeast_EPI_2015_FINAL.pdf)

### *Readiness for Peer Recovery Center: Needs and Opportunities*

Downeast PHD has more SUD per capita than any other district in the state. Hancock County reports that data is showing a spike in high school senior prescription drug misuse, while heroin use is 12% higher than the state overall (6%). There are many challenges in accessing treatment. The district overall is poor in peer recovery supports and treatment, but efforts to

utilize more services, improve access, and expand peer supports are underway. Travel and connections across the PHD are challenging due to the district's rural nature and geographic spread.

Hancock County has been meeting to create a hub-and-spoke model for MAT to mobilize the prescribing community, as has Washington County. Hancock County historically has a strong recovery community, and a training for recovery coaching is being planned along with a recovery messaging campaign. Your Place Inc., based on a 12-step model, has been in place for 20 years in Hancock County, and there is a new faith-based, residential, 12-bed, six-month program that recently began in Washington County. The Maine Opiate Collaborative listening sessions have been well-attended in both Washington and Hancock Counties, contributing to ongoing community discussions. Washington County is working on getting a local detox facility, and the Arise Program is hoping to open a 10-bed women's facility in Calais by September. Joint planning across the counties, though, has not occurred. However, in each county there are pockets of activities and connections developing with law enforcement, career development, employment, sober housing, emergency rooms, hospitals, Federally Qualified Health Centers (FQHCs), and educational programming within their respective communities. Washington County and Hancock County both have the Adult Drug Treatment Court programs, and in Hancock County the Ellsworth Police Chief is coordinating with Healthy Acadia for a Project Hope effort.

There have been discussions about a PRC. In Hancock County, Your Place, Inc., could be a hub for a PRC, but one center will not be able to serve the two counties. There are ideas about

utilizing the FQHCs across the district to create satellite sites, and/or having virtual connections. It was emphasized that a PRC must meet the needs of the local communities but also be effective in meeting the needs of multiple communities at the same time.

Feedback from the peer focus group substantiated that there is stigma, and a need for community-wide education about substance use. In the provider arena, peers felt that hospital staff have a very low awareness of how addiction works, and overall the community is not prepared for the level of care that is needed to address the issue. They emphasized the need for PRCs in both Washington and Hancock Counties.

## *Aroostook — District 8*

### *Overview*

Aroostook Public Health District has a population of 69,447 people, representing approximately 5.2 percent of Maine’s total population in 2014. There are 10.8 people per square mile, making it the most rural public health district in Maine...In Aroostook Public Health District, 21.3 percent of the population was 65 years old or older in 2013. Approximately 95 percent of Aroostook’s population is Caucasian, followed by American Indian and Alaska Native (1.9%), Hispanic (1.1%), and Black or African American (0.8%). With a median income of \$37,855 (lowest public health district in the state), approximately 16 percent of the population lives below the poverty level. In sum, Aroostook tends to be older, poorer, and more rural compared to the rest of the state.

Source: Substance Abuse Trends in Maine Epidemiological Profile 2015, Aroostook District

[http://www.maine.gov/dhhs/samhs/osa/data/cesn/Files/Aroostook\\_EPI\\_2015\\_FINAL.pdf](http://www.maine.gov/dhhs/samhs/osa/data/cesn/Files/Aroostook_EPI_2015_FINAL.pdf)

### *Readiness for Peer Recovery Center: Needs and Opportunities*

There is increasing recognition of SUD throughout the district and, in particular, a growing methamphetamine problem. However, the culture has been that people do not speak out and advocate until it affects them or their significant others. Peer advocacy historically has been more mental health than SUD-related, and on a one-to-one basis but not organized. There is growing recognition and momentum for peer support and addressing the challenges of SUD. A

community coalition, Link for Hope, has brought together people in business, health care, law enforcement, and in recovery, in the Houlton area. This group is actively pursuing the establishment of a PRC and is an example of the growing empowerment in the region to address their needs. The feedback from the group is that the momentum, people, and energy are there and that the big missing piece is the resources to start the recovery center.

The challenge of a large geographic area is maximizing access to a PRC throughout the district. Feedback from the district is that ideally there would be flexibility for a main PRC with capacity for satellite sites in the other major district hubs (Presque Isle/Caribou and the St. John Valley). These satellite sites might have services available on a periodic basis (once per week, once per month, etc.). Additionally, parts of Aroostook County are still underserved in terms of telecommunications infrastructure, namely high-speed internet access. This could impact accessibility to tele-recovery services.

The peer focus group reflected similar themes — that there is a need, that recovery supports historically have been limited to personal efforts, and that the coalition, Link for Hope, has brought various sectors together. Similarly, the Maine Opiate Collaborative listening sessions echoed the need to support community engagement to address the problem and the drivers of SUD, such as prescribing practices, unemployment, and the need for treatment and educational resources. Those sessions identified the possibility of more clubhouses and storefronts that could serve as meeting places and resource hubs.

## *Tribal Public Health District*

### *Overview*

Collectively, the four Native tribes of Maine, the Passamaquoddy, Penobscot, Maliseet and Micmac tribes are known as Wabanaki, “People of the Dawn.” Each of these four federally recognized tribes, consisting of five tribal communities, maintain their own governments, cultural centers and schools, and manage their respective land and resources. Passamaquoddy, Penobscot, and Maliseets have their own Health Centers, and Micmacs having a service unit through Indian Health Services. Although most of the Native population of Maine belongs to one of these four tribes, and reside on tribal lands, there are still many who live in towns and cities across the state.

Source: Maine Government, Division of Public Health Systems

<http://www.maine.gov/dhhs/mecdc/public-health-systems/tribal/>

The Wabanaki PHD was created in statute in 2011 and serves all five tribal communities in Maine: Aroostook Band of Micmacs, Houlton Band of Maliseets, Penobscot Nation, Passamaquoddy Tribe at Indian Township, and Passamaquoddy Tribe at Pleasant Point. Unique to this district is that it is based upon tribal communities, and crosses geographically the other PHDs. Therefore, it has the widest geographic spread of any of the PHDs in the rural areas of the state.

The Wabanaki PHD is culturally rich and recognizes native and tribal identities. Recovery and empowerment initiatives must reflect culture and help people reconnect with

traditional ceremonies and heritage. Moreover, intergenerational historical trauma, oppression, and social justice issues significantly impact the quality of treatment and health disparities.

Source: The Penobscot Nation Health Needs Assessment Summary Report

<http://www.maine.gov/dhhs/mecdc/health-equity/documents/Final%20Penobscot%20Community%20Profile2.pdf>

*Readiness for Peer Recovery Center: Needs and Opportunities*

The tribal leadership are well aware of the effects of drugs and alcohol on individuals and their communities as a whole, and they are aware of the growing problems associated with methamphetamines and opioids. However, within the communities in each tribal area, there is a varied understanding of the problem and a varying reaction to it. It is felt that while many people have awareness, and many families are touched by the problem of addiction, some respond by hiding it, for fear of legal or social ramifications. Others feel that it is still a much “normalized” experience in the community, with people assuming that you cannot change it. Tribal leadership has identified community education and outreach around addiction as a top priority to help reduce the stigma associated with it.

The PHD is unique as it represents five different tribal communities, each with a richly distinct culture and heritage. Additionally, it has the widest geographic spread of any of the other PHDs and is not geographically contiguous. Transportation will be an even bigger challenge than in many of the other districts, and many mentioned the possibility of some type of mobile peer recovery outreach.

The public health directors of the five tribal health facilities meet regularly, as do the chiefs, providing an already existing structure to plan and develop a PRC. They have had successes with the Tribal Wellness court and with culturally responsive models for recovery (e.g., Wellbriety). Many mentioned that ceremonies are important in their culture for empowerment — any PRC would need to be sensitive to this fact. Currently, they have the Wabanaki Health and Wellness Agency, with its community room and pee-to-peer programming, which could be built upon.

The key stakeholder focus groups identified that a PRC would need to recognize native and tribal identities and be culturally responsive. Although there are different thoughts about where a PRC might be placed and how it would interconnect across the tribes, it was identified that a PRC would provide an opportunity for empowerment within the community. An asset they identified is that each tribal group has community spaces that could be utilized.

The Maine Opiate Collaborative listening session underscored the need for resources to support recovery, and the need to address underlying trauma. It reinforced that in order for treatment to be effective it needs to help reconnect people with traditional ceremonies and heritages. The results from the peer focus group conducted at Wabanaki Health and Wellness echo the need to address stigma, to educate the broader tribal community about recovery, and to recognize the different tribal identities and cultures.

## APPENDICES

## **Appendix A: Key Stakeholder Focus Group Questions**

## Peer Support Recovery Centers

### Key Stakeholder Focus Group Questions for Needs Survey June–August 2016

Welcome, introductions, and description of project

Begin by asking key stakeholders to describe their district and highlight any general assets and challenges, e.g., culture, rural geography, health disparities, employment, etc.

Continue with specific questions.

1. We'd like to understand how knowledgeable your community is about recovery from substance use disorder, and what community efforts and activities have taken place to address substance use issues in your district. Please try to be as specific as possible.
  - a. To what extent do you think community members know or understand how substance use is affecting the community?
    - i. Probe: Has data been identified to substantiate the needs? If so what are those data sources? What does the data show?
  - b. What community efforts have taken place to address substance use in your district?
    - i. Probe: How many meetings have been held? When did they start? Who organized them? Is program development being discussed? Have programs been developed? What types of peer empowerment have taken place? Have there been efforts to develop a peer center? If so what is or has been done?
  - c. How knowledgeable are community members about those efforts or programs?
    - i. Probe: Are there minutes (and where are they posted)? Organizational structure for these meetings? Visions, goals, objectives? Subcommittees? MOUs? How is it connected to community leadership and peers? Are the efforts accessible to all segments of the community and how?
    - ii. Probe: What kinds of representation do you have at these meetings? Does it include peers and peer leaders? Law enforcement/corrections? Vocational/career resources? Local businesses? Civic leaders? Educators? Housing resources? Are the appointed leaders and influential community members supportive and/or involved?
  - d. What is the prevailing attitude of the community toward the issue and efforts?
    - i. Probe: What type of attitude is there toward peer recovery and empowerment?
  - e. Describe the resources and linkages to leverage existing initiatives/activities/businesses/volunteers that are available in your community—people, time, money, potential space, etc.

- i. Probe: Is there an identified a potential space or location If so, please describe.
2. What activities are occurring to support recovery occurring in your district?
  - a. What is the level of peer engagement (leaders, participants, linkages)?
  - b. What are linkages to: law enforcement/corrections? Career development/resources? Businesses for employment? Housing resources? Educational programs/institutions?
3. Is there a Peer Recovery Center for people with substance use disorder in your district?

If yes:

  - a. What is its structure? 501(c)(3)? Advisory board? Peer-led? Members? Staffing? Operating policies?
  - b. What services does it offer?
  - c. How is it connected to the community? What are the connections and to whom—Law enforcement/corrections, career centers/resources, businesses, self-help groups, treatment, housing? What types of agreements have been defined?
  - d. Is there peer training? Peer development for leadership?

If no:

  - a. Where might a peer center be located? And why? How might it serve your entire district and respond to rural challenges?
  - b. What resources could it link with?
  - c. What would you envision it offering? And why?
  - d. What would be the challenges to developing a peer center?
  - e. How might your address those challenges?

## Recovery Supports Needs Assessment: Peer Focus Group Script

### Welcome, introductions, and description of project

Welcome, and thanks for agreeing to participate in this focus group. We appreciate your willingness to be a part of this research and needs assessment of recovery supports in Maine.

My name is, and.... [add a little about yourself, your recovery, and why you are interested in this topic. Both facilitator and note taker introduce themselves.]

We're working with the AdCare Educational Institute of Maine to conduct focus groups in Maine's nine public health districts. The purpose of this focus group is to find out about recovery supports in your community. We need your input and want you to share your honest and open thoughts with us.

*Show the map and identify the public*

The results of these focus groups will be used to help determine where peer-run Peer Recovery Centers are needed in the public health districts and which communities are ready to run a center. If you'd like to see the results of the research, we'll be happy to send them to you if you leave your email on the sign-up sheet."

Does anyone have any questions about the purpose of the focus group?

### Send around the sign-up sheet

While the sign-up sheet is going around, let's go around the room and have everyone introduce themselves. Just say your name, the town where you live, and anything about your recovery journey you'd like the group to know.

*Point out that we only want first names, and the reason we need*

### Set the ground rules

OK, let's set the ground rules for the discussion this evening:

- We want you to do the talking. We'd like everyone to participate, so we'll go around the room and give everyone a chance to answer each question. The facilitator may call on you if we haven't heard from you in a while.
- There aren't any right or wrong answers. Everyone's experiences and opinions are important, and you should speak up, whether you agree or disagree. We want to hear all opinions.
- If someone has already answered a question the way you would, it's ok to say "I agree with what he said," or it's OK to answer the question again.
- All discussions are confidential. What is said in this room stays in this room.
- If sensitive issues come up, and you don't feel comfortable answering a question, it's ok to just say, "pass."

- We'll be taking notes because we want to capture everything you have to say. We won't identify anyone by name in the report; your anonymity will be protected.

Does anyone have any questions about how we're going to conduct the focus group?

## Questions

We'd like to understand how much you think your community knows about recovery from substance use disorder, and what community efforts and activities have taken place to address substance use issues in your district. Please try to be as specific as possible.

1. How much do you think community members know or understand how substance use is affecting the community? Please give examples!
2. What community efforts have taken place to support substance use recovery, and how much do community members know about those efforts or programs? Please be as detailed as possible!
3. How much peer support is in your community, and what is the community's attitude toward peer recovery support? Please give examples!
4. How are people in recovery linked to resources like career development, employment, resources and education? Please give examples!
5. Is there a Peer Recovery Center for people with substance use disorder in your community?  
If yes, we'd like to know all about it:
  - e. How is it governed and staffed?
  - f. What services does it offer?
  - g. How is it connected to the community?
  - h. Is there peer training? Peer development for leadership?
  - i. What geographic area does it serve? How might it serve your entire district and respond to rural challenges?

If no:

  - g. Where might a peer center be located? And why? How might it serve your entire district and respond to rural challenges?
  - h. What resources could it link with?
  - i. What services would you envision it offering? And why?
  - j. What would be the challenges to developing a peer center?
  - k. How might you address those challenges?
6. Is there anything you'd like to add about having a Peer Recovery Center for people with substance use disorder in your community?

### **Thank you and wrap-up**

Thank you very much for helping us understand recovery supports for people in your community. Now the note taker will summarize your responses, to be sure we have recorded what you said accurately.

[Note taker summarizes discussion for each question.]

Thanks again for your help. [Facilitator hands out gift cards.] Feel free to stay and chat after the group.

## **Appendix B: Metrics for Analysis**

<b>District #: Name</b>	
<b>Knowledge of the Issue:</b>	
<i>Causes</i>	•
<i>Consequences</i>	•
<i>Impact on community</i>	•
<i>General Comments about readiness in this domain</i>	
<b>Efforts:</b>	
<i>Programs, services, activities</i>	•
<i>Policies</i>	•
<i>General Comments about readiness in this domain</i>	
<b>Knowledge of Efforts:</b>	
<i>Know about efforts, programs, services, activities</i>	•
<i>General Comments about readiness in this domain</i>	
<b>Leadership:</b>	
<i>Leaders supportive</i>	•
<i>Influential members supportive</i>	•
<i>General Comments about readiness in this domain</i>	
<b>Community Climate:</b>	
<i>Helplessness</i>	•
<i>Responsibility</i>	•
<i>Empowerment</i>	•

<i>General Comments about readiness in this domain</i>	
<b>Resources:</b>	
<i>People</i>	•
<i>Time</i>	•
<i>Money</i>	•
<i>Space</i>	•
<i>General Comments about readiness in this domain</i>	
<b>Is there a Recovery Center and/or suggested locations for Peer Recovery Center</b>	
<i>General Comments about readiness in this domain</i>	
<b>Overall comments about the district's readiness</b>	

## **Appendix C: Analysis of Key Stakeholder Focus Groups**

<i>District 1 — York</i>	
<b>Knowledge of the Issue:</b>	
<i>Causes</i>	<ul style="list-style-type: none"> <li>• Interstate drug trafficking</li> <li>• Although there is a wealth of resources in the district, it lacks treatment capacity, and people have to travel long distances</li> <li>• More people are speaking out</li> </ul>
<i>Consequences</i>	<ul style="list-style-type: none"> <li>• Deaths are being identified as overdoses in obituaries</li> <li>• Hospitals and the community are reviewing health outcomes which include SUD and making implementation plans</li> <li>• YPR have recently founded a chapter in the district</li> <li>• Local citizens have been creating affected others support groups</li> <li>• Opioid use has gotten a large amount of attention, but other SUDs are not recognized by the general community</li> <li>• See efforts below</li> </ul>
<i>Impact on community</i>	<ul style="list-style-type: none"> <li>• Concerned community members attended the listening sessions</li> <li>• The community has voiced the desire to act</li> </ul>
<i>General Comments about readiness in this domain</i>	The community and provider organizations have knowledge of the problem and have come out en masse to the Maine Opiate Collaborative listening sessions.
<b>Efforts:</b>	
<i>Programs, services, activities</i>	<ul style="list-style-type: none"> <li>• Many initiatives are underway, some of which include the police, to support access to treatment</li> <li>• YPR started a chapter in York County</li> <li>• A methadone clinic that was opened has closed, but another is opening its doors</li> <li>• Recovery coaching training was delivered and peer coaching is being organized</li> <li>• York hospital is planning to provide MAT in its PCP sites</li> <li>• A program is being planned to divert people from the Alfred jail into treatment</li> <li>• Substance use and mental health services are offered at LongCreek along with diversion programming</li> <li>• York County has a drug court</li> <li>• There are DFC grants</li> <li>• University of New England (UNE) has a large grant to do interdisciplinary training on recovery issues and MAT across their health programs</li> </ul>
<i>Policies</i>	<ul style="list-style-type: none"> <li>• Sanford and Biddeford–Saco have DFC grants</li> </ul>

	<ul style="list-style-type: none"> <li>• UNE grant to do interdisciplinary training will be changing the curriculum</li> </ul>
<i>General Comments about readiness in this domain</i>	There are various initiatives and grants that are underway or being sought by different communities and key stakeholders. The district has active mobilized group meetings and planning.
<b>Knowledge of Efforts:</b>	
<i>Know about efforts, programs, services, activities</i>	<ul style="list-style-type: none"> <li>• Newspaper articles have been published — however, circulation has decreased</li> <li>• Deaths are being identified as overdoses in obituaries</li> <li>• There is no central hub or vehicle for communication across the district</li> <li>• The Sanford School Superintendent posts notices on their website</li> </ul>
<i>General Comments about readiness in this domain</i>	A general theme was that there is no central place to know what is happening across the district, or an efficient way to create a district-wide plan. The public has awareness of the issues, but not necessarily of the initiatives taking place in the district.
<b>Leadership:</b>	
<i>Leaders supportive</i>	<ul style="list-style-type: none"> <li>• Behavioral health providers</li> <li>• Physicians, and primary care organizations and hospital systems</li> <li>• District liaisons are involved in meetings</li> <li>• Congressional participation is occurring</li> <li>• Police chiefs and sheriffs have gotten involved</li> <li>• YPR is at the table</li> <li>• Agencies have peers on their boards, and are hiring peers</li> <li>• Vocational leaders</li> <li>• Academic leaders</li> </ul>
<i>Influential members supportive</i>	<ul style="list-style-type: none"> <li>• A number of Rotary clubs (Biddeford, Kennebunk, York) are creating divisions to address SUD</li> </ul>
<i>General Comments about readiness in this domain</i>	Involved leadership has expanded over the district, drawing from different sectors. It has increasing peer presence.
<b>Community Climate:</b>	
<i>Helplessness</i>	<ul style="list-style-type: none"> <li>• The community wants to help</li> </ul>
<i>Responsibility</i>	<ul style="list-style-type: none"> <li>• Rotary clubs are taking on the issue to effect change</li> <li>• Sheriffs' departments are working to create diversion and release programs</li> </ul>
<i>Empowerment</i>	<ul style="list-style-type: none"> <li>• YPR chapter has started</li> <li>• Organizations have hired peers, and they are being included in grants</li> </ul>

	<ul style="list-style-type: none"> <li>• Some organizations’ boards have recruited peers historically</li> </ul>
<i>General Comments about readiness in this domain</i>	Peers are at the various tables and are being hired to represent the recovery perspective in organizations and grant initiatives. However, that empowerment is in the beginning stages for the majority of the organizations.
<b>Resources:</b>	
<i>People</i>	<ul style="list-style-type: none"> <li>• Peer recovery leaders, Rotary clubs, schools, PCP organizations, hospitals, behavioral health providers, law enforcement and corrections, district liaison, congressional representative</li> </ul>
<i>Time</i>	<ul style="list-style-type: none"> <li>• People are meeting</li> </ul>
<i>Money</i>	<ul style="list-style-type: none"> <li>• Grants are being sought, received and applied for; UNE interdisciplinary grant was funded</li> </ul>
<i>Space</i>	<ul style="list-style-type: none"> <li>• Meeting space is being offered by the FQHC and at a community college. Jail spaces are being offered for treatment services.</li> </ul>
<i>General Comments about readiness in this domain</i>	The resources are being leveraged and there are grant-funded projects, but additional funds are needed for new and expanded programming and staffing.
<b>Is there a Recovery Center and/or suggested locations for Peer Recovery Center</b>	<ul style="list-style-type: none"> <li>• Location is a challenge because of the expanse of the district</li> <li>• Community members have visited Safe Harbor in Portsmouth, NH, and PRCC</li> <li>• The topic of a PRC has come up in various planning discussions</li> <li>• Satellite offices discussed</li> </ul>
<i>General Comments about readiness in this domain</i>	Various groups have been discussing having a PRC and exploring the possibilities. They are in action, having visited other PRCs, and are exploring what they would like for themselves.
<b>Overall comments about the district's readiness</b>	The community is mobilized and aware. Key stakeholder have begun meeting in response to the opioid crisis, and the peer voice is increasingly being sought and recognized. Various initiatives have been funded and/or are in planning or grant submission phases. Discussions about a PRC have begun, and visits to other PRCs in Maine and New Hampshire have been made in preparation to determine what services it could offer. There are challenges in that there is no single mechanism for communication across the district, and that there are multiple community hubs in the district.

<i>District 2 — Cumberland</i>	
<b>Knowledge of the Issue:</b>	
<i>Causes</i>	<ul style="list-style-type: none"> <li>• Data has been analyzed — eight community assessments</li> <li>• The Opportunity Alliance (TOA) has done a comparison of SUD rates in the district compared to the state — higher marijuana and higher overdoses, but lower alcohol, tobacco, and prescription drug use in the district</li> <li>• SCHNAPP data shows adult binge drinking is high, with increased admission rates</li> <li>• A large treatment provider, Mercy Recovery Center, closed its doors as it was unable to maintain financial viability</li> <li>• Local detox services are overstretched</li> </ul>
<i>Consequences</i>	<ul style="list-style-type: none"> <li>• Four Maine Opiate Collaborative listening sessions, of which two were organized by local efforts in Westbrook and Windham</li> <li>• DFC grants are being applied for or have been funded</li> <li>• Newspapers regularly run stories</li> <li>• Overdose rates are high</li> <li>• The multi-lingual and multi-cultural groups have been affected</li> <li>• See efforts below</li> </ul>
<i>Impact on community</i>	<ul style="list-style-type: none"> <li>• The provider resources are stretched</li> <li>• The community is concerned</li> </ul>
<i>General Comments about readiness in this domain</i>	The community is knowledgeable and aware of the consequences and impact of SUD. That knowledge is being shared at community/provider meetings, within local school educational programming, and through news media, on a regular basis.
<b>Efforts:</b>	
<i>Programs, services, activities</i>	<ul style="list-style-type: none"> <li>• Coalitions have formed, and have or are developing plans — Portland Mayor’s Task Force, Greater Portland Addiction Collaborative, LEAAP, Operation HOPE, CASH (has been meeting for over a year), drug-free coalitions (Casco Bay, South Portland, Westbrook)</li> <li>• The City of Westbrook is developing a grant proposal with the Gorham, Windham, and Buxton Police Departments and the Cumberland County Sheriff’s Department to create a regional plan</li> <li>• MAT is being expanded through local programs and systems — MMC, Maine Medical Partners, and Maine Behavioral Health Care are implementing the Integrated Medication-Assisted Therapy (IMAT) project; Greater Portland Health is expanding</li> </ul>

	<p>SBIRT and MAT through a federal grant; North Bridgton Family Practice collaborates with Crooked River Counseling</p> <ul style="list-style-type: none"> <li>• USM is developing a peer recovery program through a federal BRSS TACS grant</li> <li>• USM nursing program has community services experiences with the HOME Team</li> <li>• PRCC offers support resources and is increasingly doing outreach in the community programs</li> <li>• Needle exchange</li> <li>• YPR chapter organized</li> <li>• SIRPs being offered</li> <li>• UNE has SBIRT grant to expand training in their health professional programs</li> <li>• Project Reentry at the Cumberland County Jail</li> <li>• Sober housing is expanding, however the quality is variable. Housing for women and for those on MAT is limited. Community Housing of Maine (CHOM) is developing 48 beds for sober living. There are residential programs through Mercy Hospital (McCauley House) and TOA (Morrison Place).</li> <li>• Local PCP and SUD programs have paired to offer MAT with counseling in the Bridgton area</li> <li>• ARC’s program in Brunswick offers MAT, which is in demand</li> <li>• ARC’s Healthy Generations program for pregnant and parenting women</li> <li>• Goodwill Work Force Solutions</li> <li>• Federal SWITCH program</li> <li>• Drug court</li> <li>• Restorative justice initiatives in schools</li> </ul>
<i>Policies</i>	<ul style="list-style-type: none"> <li>• Policies are being developed for MAT</li> <li>• DFC working on developing community strategies</li> <li>• Program policies developing — SBIRT and others</li> </ul>
<i>General Comments about readiness in this domain</i>	<p>There is a lot of recognition and energy to mobilize, develop and expand services. Portland, as the largest urban area in the state, draws people to its resources, which are being taxed. PRCC has expanded outreach to programs in the area to offer peer support services, and its services are being sought after. Rural areas of Cumberland County are organizing themselves, and have taken a leadership role of offering MAT in partnership between a PCP and a counseling organization. Linkages and relationships with the police and the jail have been established and programs have been developed (Reentry, Operation Hope, LEAAP, CASH). Fundraising has taken place. Grant proposals are being developed.</p>

<b>Knowledge of Efforts:</b>	
<i>Know about efforts, programs, services, activities</i>	<ul style="list-style-type: none"> <li>• The news coverage has highlighted activities that are taking place in the community</li> <li>• The community has been involved in the listening sessions</li> <li>• Coalitions are large, and communicate with their memberships</li> <li>• TOA provides a clearing house, but there is some duplication around communication</li> <li>• There is no central clearing house to connect all the initiatives</li> <li>• The DCC was offered as option to fill this role. They meet every other month and do share information among the groups.</li> </ul>
<i>General Comments about readiness in this domain</i>	There is general knowledge about the activities and efforts, however there is no one place to go to get up-to-date information on all the initiatives.
<b>Leadership:</b>	
<i>Leaders supportive</i>	<ul style="list-style-type: none"> <li>• SUD providers, hospital administrators, large health care systems, peer leaders, leaders of employment services, elected officials, university leaders, and law enforcement are participating and voicing their support</li> </ul>
<i>Influential members supportive</i>	<ul style="list-style-type: none"> <li>• Key leaders are involved, and individuals have stepped up to be leaders in their community, professions, and/or as peers</li> </ul>
<i>General Comments about readiness in this domain</i>	Strong and comprehensive leadership in Cumberland County has been mobilized.
<b>Community Climate:</b>	
<i>Helplessness</i>	<ul style="list-style-type: none"> <li>• YPR is adding personal faces to recovery</li> </ul>
<i>Responsibility</i>	<ul style="list-style-type: none"> <li>• Communities are mobilized</li> </ul>
<i>Empowerment</i>	<ul style="list-style-type: none"> <li>• PRCC offers services and supports by peers, for peers, and have expanded their outreach to the community</li> <li>• Speakers bureaus through TOA and the Cumberland County Jail</li> <li>• Community Partnership for Protecting Children (CPPC) is in the process of organizing training for speakers</li> </ul>
<i>General Comments about readiness in this domain</i>	The last two years have seen a dramatic shift in the attitude toward SUD and recovery. Stigma, however, is still an ongoing issue, but more people are outspoken. Peers are being hired in programs to offer peer services.
<b>Resources:</b>	
<i>People</i>	<ul style="list-style-type: none"> <li>• Leadership from various sectors — treatment, law enforcement, vocational/workforce development, employers, housing, universities, peers</li> </ul>

<i>Time</i>	<ul style="list-style-type: none"> <li>• People are meeting</li> </ul>
<i>Money</i>	<ul style="list-style-type: none"> <li>• Funding is needed. There are current grants and grants that have been applied for.</li> </ul>
<i>Space</i>	<ul style="list-style-type: none"> <li>• There is a PRC in Portland which offers space for support groups; meeting space is being found</li> <li>• Detoxification has become more limited due to demand and Mercy Recovery Center closing</li> </ul>
<i>General Comments about readiness in this domain</i>	Cumberland is resource-rich, but as an urban area it draws people from across the state to its resources and services, which become overtaxed and limited. The demand for detoxification cannot be met. Similarly, funding and services for those who do not have a payer source are limited. Peers are a growing resource in the community and are being recognized and sought after.
<b>Is there a Recovery Center and/or suggested locations for Peer Recovery Center</b>	<ul style="list-style-type: none"> <li>• Portland has PRCC, which is highly utilized. It has expanded its services out into the community, linking with schools, providers, primary care, and law enforcement. It offers a variety of support groups, pro-social activities, shame and stigma reduction efforts, telephone support for its members, etc.</li> <li>• The Bridgton area is talking about developing a PRC</li> <li>• Westbrook identifies a need for a PRC or a satellite office to connect with another PRC</li> <li>• Telehealth services were identified as a possibility for those who do not have transportation, or who live a great distance from a center</li> </ul>
<i>General Comments about readiness in this domain</i>	The Cumberland District has an established PRC. The need for more PRCs in the district and possible locations have been identified. The options of having satellite sites, mobile recovery centers, and/or telecommunications to those who are isolated geographically are being discussed.
<b>Overall comments about the district's readiness</b>	The Cumberland District has an established PRC whose services and connections are being sought after by many programs and is highly utilized by people in recovery. A need to reach beyond the walls of a center and connect with people who are geographically isolated in the district, through telecommunications, satellite sites, mobile centers, or additional centers, has been discussed. There are two communities who have discussed the need for a PRC in their community — Westbrook and Bridgton. This focus group identified that centers should reflect the needs of a community, be independent from treatment agencies, and have funding to support expansion and development over time.

*District 3 — Western*

<b>Knowledge of the Issue:</b>	
<i>Causes</i>	<ul style="list-style-type: none"> <li>• SUD is one of the top issues for all three counties on a district level</li> <li>• Data underscores need: arrests, ODs, County Health Rankings</li> <li>• MIYHS data is available, WITS treatment data is more difficult to get</li> <li>• The hospitals completed community health needs assessments</li> <li>• Lack of MAT providers</li> <li>• Lack of or limited IOPs, residential, and detox levels of care</li> <li>• 12-step groups hard to start due to transportation issues</li> <li>• Androscoggin Jail has increasing number of inmates going through withdrawal</li> <li>• Prescription abuse/safety (dropboxes and take-backs in place to address)</li> <li>• Transportation issues are huge across the district, which impacts access to services and recovery</li> <li>• Lack of employment/job opportunities</li> <li>• Poverty</li> <li>• Lack of insurance</li> <li>• Lack of residential programs that are available after detox</li> <li>• Influx of khat</li> <li>• SUD is identified in the top five risk factors for child protection cases within Franklin County</li> </ul>
<i>Consequences</i>	<ul style="list-style-type: none"> <li>• Forums on SUD held in Rumford, South Paris, Farmington, Lewiston–Auburn; one planned for West Paris</li> <li>• Annual Alcohol and Addiction Conference, with over 1000 people attending over the years</li> <li>• Presentations at Bates, education programs at schools</li> <li>• Recovery event planned for September</li> <li>• See efforts below</li> </ul>
<i>Impact on community</i>	<ul style="list-style-type: none"> <li>• CN Brown identifies how it’s impacting business and the employer sector</li> <li>• Regular media coverage and posts on social media</li> </ul>
<i>General Comments about readiness in this domain</i>	<p>The community is well abreast of the issue of SUD. The HMPs have worked effectively through the DCC for a while, and communication has been established. Data has been evaluated to identify needs.</p>

<b>Efforts:</b>	
<i>Programs, services, activities</i>	<ul style="list-style-type: none"> <li>• Forums in Rumford, South Paris, Farmington, Lewiston–Auburn and Fryeburg; one is planned for West Paris</li> <li>• Three forums have been held in Franklin County</li> <li>• Longstanding Substance Abuse Prevention Coalition meeting held in Franklin County</li> <li>• An Operation HOPE program in the Franklin area</li> <li>• A collaborative program between Healthy Community Coalition and Maine Area Health Education Center out of UNE to host a Prevention Advocacy Training Health Careers event this fall at Franklin Memorial Hospital</li> <li>• SAVE ME, a Rumford PD program which involved Rumford Hospital</li> <li>• Dropboxes in all three counties and take-back prescription programs in place — in April over 700 people participated in a take-back program, education for elderly population on medication safety</li> <li>• Two successful fundraisers</li> <li>• SUD community education by HMPs, robust SUD prevention work planned</li> <li>• Neighbor-to-neighbor with New Mainers provided education around alcohol, tobacco and SUD</li> <li>• Project Unit task force organized</li> <li>• SIRP in Auburn</li> <li>• Marijuana education in every school</li> <li>• Restorative Justice program in Oxford Comprehensive School, SAD 17 restorative justice-trained faculty</li> <li>• Piloting prevention program in schools in Oxford in six homerooms</li> <li>• River Valley DFC coalition, Healthy Androscoggin DFC</li> <li>• Western Maine Task Force</li> <li>• Oxford County Wellness Collaborative (providing background support for the Western Maine Task Force)</li> <li>• Oxford County Mental Health does ride-alongs with PDs</li> <li>• Insight Vision — being created with strategy maps with measures</li> <li>• Meetings with Senator Angus King</li> <li>• A mom started a Nar-Anon meeting</li> <li>• NA meeting only in Norway, active AA in Lewiston–Auburn</li> <li>• St. Francis residential care</li> <li>• A recovery event is being planned for September</li> <li>• Oxford County Mental Health has a drop-in center in Rumford — Beacon House (co-occurring focus)</li> </ul>

	<ul style="list-style-type: none"> <li>• CN Brown employer efforts — interns will be learning their protocols, they will disseminate learnings to other businesses to grow efforts</li> <li>• Peer recovery coaches have been trained</li> <li>• St. Mary’s outpatient, detox, and counseling</li> <li>• Great social media presence, with posts about recovery information and other SUD issues</li> </ul>
<i>Policies</i>	<ul style="list-style-type: none"> <li>• See above</li> </ul>
<i>General Comments about readiness in this domain</i>	<p>Community groups have been meeting. The Substance Abuse Prevention Coalition has been meeting since 2006, while the Western Maine Task Force began meeting in 2015. There are active DFC coalitions and PD initiatives and involvement. Restorative justice initiatives are in place. Communities have hosted successful fundraising events, and a recovery event is being planned. However, in general the need is higher than the amount of services in place.</p>
<b>Knowledge of Efforts:</b>	
<i>Know about efforts, programs, services, activities</i>	<ul style="list-style-type: none"> <li>• Knowledge of the Oxford initiatives is widespread, with diverse key stakeholders</li> <li>• There is a great presence on social media for Oxford</li> <li>• Employers are involved in Oxford and are being included in the efforts</li> <li>• There is a lack of understanding between abstinence programs and harm reduction</li> <li>• There is a lack of understanding of the recovery process</li> <li>• Those involved are knowledgeable, but not the general public</li> </ul>
<i>General Comments about readiness in this domain</i>	<p>There is widespread knowledge and inclusion in the efforts going on in the district. The public is less aware about the efforts.</p>
<b>Leadership:</b>	
<i>Leaders supportive</i>	<ul style="list-style-type: none"> <li>• Western Maine Addiction Task Force in Oxford has diverse key stakeholders: education, social services, media, health, clergy, consumers, DA, lawyers, restorative justice, local legislators, state representatives, congressional representatives, pharmacy, public health, students, renters associations, transportation, housing, employers</li> <li>• The Substance Abuse Prevention Coalition has a diverse key stakeholder group which meets regularly</li> <li>• Hospitals are supportive</li> <li>• Law enforcement supportive</li> </ul>

	<ul style="list-style-type: none"> <li>• Interns will be learning from CN Brown protocols and will disseminate learnings to other businesses</li> </ul>
<i>Influential members supportive</i>	<ul style="list-style-type: none"> <li>• CN Brown has been involved in the Western Maine Addiction Task force from the beginning and has talked about how it's impacting business and the employer sector</li> <li>• Law enforcement officer is public about family impact</li> </ul>
<i>General Comments about readiness in this domain</i>	Leadership has been engaged in the work across the district on more of a county basis. The key stakeholders are community-dependent, but in general have diverse representation. Not all groups have peer involvement.
<b>Community Climate:</b>	
<i>Helplessness</i>	<ul style="list-style-type: none"> <li>• Culturally, marijuana and alcohol use are accepted</li> <li>• Peers want a PRC, a safe space to socialize and network in Oxford</li> <li>• A co-occurring clubhouse is closing in Lewiston and others are not coming forward to apply to the RFP</li> </ul>
<i>Responsibility</i>	<ul style="list-style-type: none"> <li>• Stigma is still a huge issue</li> </ul>
<i>Empowerment</i>	<ul style="list-style-type: none"> <li>• Peer leaders are involved on the Western Maine Addiction Task Force and the Wellness Collaborative</li> <li>• CN Brown wanted to step up and help</li> <li>• There has been discussion about using natural resources, land trusts, etc., as opportunities for people in recovery to “give back” with possible internships/positions, etc. A bike-sharing program that was mentioned might also be an opportunity.</li> <li>• Peer coaches have been trained in Oxford</li> <li>• No clear involvement of peers in Franklin, and not active involvement in Androscoggin</li> </ul>
<i>General Comments about readiness in this domain</i>	Stigma was identified as a significant barrier across the district. They do have some key leadership outside of social services who are involved (employer and law enforcement) and who are public in their efforts. Peers are involved and ways to “give back” and utilize their resources are being discussed in some of the communities.
<b>Resources:</b>	
<i>People</i>	<ul style="list-style-type: none"> <li>• Peers and key leaders across sectors in Oxford County</li> <li>• Two large hospitals in Lewiston</li> <li>• New Mainers</li> </ul>
<i>Time</i>	<ul style="list-style-type: none"> <li>• Meetings are held; identifying possible ways for people in recovery to “give back”</li> </ul>
<i>Money</i>	<ul style="list-style-type: none"> <li>• Successful fundraising has taken place</li> <li>• Funding would be needed for a PRC</li> </ul>

<i>Space</i>	<ul style="list-style-type: none"> <li>• Hard to start 12-step meetings due to transportation issues</li> <li>• 100 Pine Street was a clubhouse for mental health and is/was closed. It might be a location for a PRC.</li> </ul>
<i>General Comments about readiness in this domain</i>	Limitations in treatment resources and peer supports were identified; however there is diverse sector involvement.
<b>Is there a Recovery Center and/or suggested locations for Peer Recovery Center</b>	Although there are a lot of people talking about PRCs, and peer recovery coaches have been trained, to date there is no specific development for a PRC. They stated that if an RFP came out, they felt like they would easily find a fiscal nonprofit sponsor. No specific location has been named, and NIMBY might be a challenge but not a big one. There also is some concern about building a brick and mortar place without first building the engagement with peers. Stigma may prohibit engagement. A PRC should be developed developmentally.
<i>General Comments about readiness in this domain</i>	A PRC is desired and the needs have been identified. They would mobilize to respond to an RFP and have had peers involved in their work to date.
<b>Overall comments about the district's readiness</b>	In Oxford County initiatives are in place, and they have been addressing linkages between systems to support leveraging the resources they do have. A well-respected and outspoken employer has been at the table. The need for a PRC was identified in each key stakeholder forum in this district and there has been discussion. Oxford has had peers trained in peer coaching. The peer engagement is not as clear across the district as a whole, but there is a clear, articulated need.

<i>District 4 — Midcoast</i>	
<b>Knowledge of the Issue:</b>	
<i>Causes</i>	<ul style="list-style-type: none"> <li>• Absence of an organized effort for treatment in Knox County</li> <li>• Higher rates of youth misusing prescription drugs</li> <li>• Services are not able to meet the demand</li> </ul>
<i>Consequences</i>	<ul style="list-style-type: none"> <li>• Documented in obituaries</li> <li>• Media coverage of the problem</li> <li>• Jails are full</li> <li>• Shelters are full</li> <li>• Drain on their resources</li> <li>• Hospitals are treating more overdoses and SUDs</li> <li>• Increase in substance-exposed infants</li> <li>• Health care system is strained</li> <li>• Forums have had standing room-only attendance</li> <li>• Since 2012, Knox county arrest rate for trafficking in controlled substances has gone up about 29%</li> <li>• During 2008–2011 there was more diversion of prescription drugs, no more heroin</li> <li>• There are four coalitions in the district</li> </ul>
<i>Impact on community</i>	<ul style="list-style-type: none"> <li>• The community is realizing the need for resources, but at the same time there is the NIMBY issue</li> </ul>
<i>General Comments about readiness in this domain</i>	Communities are aware of the issue, and those working in community services recognized the strained resources because of the SUDs.
<b>Efforts:</b>	
<i>Programs, services, activities</i>	<ul style="list-style-type: none"> <li>• There are four coalitions in the county — Knox County Recovery, Knox County Community Health Coalition, Lincoln County Recovery Collaborative and another related to the Knox Free Clinic.</li> <li>• A new treatment center, Recover Together, has just arrived in the area.</li> <li>• In 2004, a Waldo county community task force was developed and made recommendations about service delivery, prevention, law enforcement, treatment, and drug courts. This was received positively, but the Task Force disbanded after eight months.</li> <li>• Formation of We Care (Waldo Encourages Community Assisted Recovery Efforts) in 2014; has had a decline in participation but is currently being reinvigorated.</li> <li>• Well-attended Maine Opiate Collaborative listening session</li> </ul>

	<ul style="list-style-type: none"> <li>• Mid Coast Hospital ARC, Maine Behavioral Healthcare and PenBay Hospital are working on a hub-and-spoke model for MAT</li> <li>• Knox County Recovery Coalition (KCRC) formed five different weekly work groups who are meeting</li> <li>• KCRC are starting a Friends and Family group</li> <li>• Lincoln County Recovery Collaborative</li> <li>• Sagadahoc County has a substance abuse prevention coalition and an ACEs initiative led by local pediatricians, Mid Coast Hospital, and United Way of Midcoast Maine</li> <li>• Waldo is forming Children and Recovering Mothers (CHARM) with Seaport Community Health Center/Waldo County Hospital to support pregnant women/young mothers in recovery</li> <li>• Boothbay is doing something similar to CHARM and is also working on a holistic approach to housing, employment, etc.</li> <li>• The Ecumenical Council out of Damariscotta provides assistance in linking people to Tedford Housing and other daily needs, offers the Open Door Café, and hosts a volunteer driving service</li> <li>• Rockland homeless shelter offers a resource room and case management</li> <li>• Rockland Superintendent and Rockland PD have created a task force</li> <li>• Lincoln Academy works with restorative justice</li> <li>• Career center</li> <li>• Formation of a new coalition between New Ventures and the career center to develop one-on-one coaching</li> <li>• Restorative justice initiatives</li> <li>• Waldoboro Baptist Church and Freedom Church (Wiscasset)</li> <li>• Celebrate Recovery groups held</li> <li>• Freedom Center in Dresden offers housing and peer support</li> <li>• Lincoln County has their version of Operation HOPE</li> <li>• Living in Freedom Everyday offers Teen Challenge</li> </ul>
<i>Policies</i>	
<i>General Comments about readiness in this domain</i>	There are initiatives underway and there have been some historical efforts toward community mobilization, but those have had to be reinvigorated.
<b>Knowledge of Efforts:</b>	
<i>Know about efforts, programs, services, activities</i>	<ul style="list-style-type: none"> <li>• There is knowledge for those involved, and those in the focus group could identify where services and initiatives are taking place. However, across the district as a whole, there is not an overall communication strategy.</li> </ul>

<i>General Comments about readiness in this domain</i>	There is knowledge about the activities, but no overall communication plan across the district. Although there are similarities in the communities, there is a lot of diversity, and the peninsulas make communication, transportation, and centralization difficult.
<b>Leadership:</b>	
<i>Leaders supportive</i>	<ul style="list-style-type: none"> <li>• Behavioral health providers, hospitals, primary care organizations, coalitions, police departments/chiefs, a couple of church groups, schools, senators, YMCA, United Way, employers, peers, YPR, and social services</li> </ul>
<i>Influential members supportive</i>	<ul style="list-style-type: none"> <li>• Chiefs of Police, senators, administrators of schools, behavioral health services, hospital, church leaders, social services, CAP agencies, peer leaders</li> </ul>
<i>General Comments about readiness in this domain</i>	Key stakeholders are involved, but generally with a community-specific focus.
<b>Community Climate:</b>	
<i>Helplessness</i>	<ul style="list-style-type: none"> <li>• Stigma is present, and attitudes are all over the board</li> <li>• Lack of understanding about MAT</li> </ul>
<i>Responsibility</i>	<ul style="list-style-type: none"> <li>• Yearning for something to be done</li> <li>• People want to get involved</li> </ul>
<i>Empowerment</i>	<ul style="list-style-type: none"> <li>• There is increased understanding and knowledge of the issue</li> <li>• The community is talking about peer activities</li> <li>• Shift to managing SUD as a health condition, not as a crime or as a moral issue</li> </ul>
<i>General Comments about readiness in this domain</i>	The community climate is changing, but stigma is still a significant issue. People in the communities are getting involved, and there are peer leaders who are being recognized and supported.
<b>Resources:</b>	
<i>People</i>	<ul style="list-style-type: none"> <li>• Key leaders are emerging in the communities. Agencies' leadership are engaged.</li> </ul>
<i>Time</i>	
<i>Money</i>	<ul style="list-style-type: none"> <li>• Knox County is looking for grants</li> </ul>
<i>Space</i>	<ul style="list-style-type: none"> <li>• There is a possible donation of land in Rockland for a PRC</li> </ul>
<i>General Comments about readiness in this domain</i>	There are leaders in the Midcoast area. Resources are stretched but churches, CAP agencies, and coalitions are supporting activities.

<p><b>Is there a Recovery Center and/or suggested locations for Peer Recovery Center</b></p>	<p>There have been discussions in different groups about a PRC. The challenge is the geographic configuration of the district, with peninsulas and different community centers, and four counties which are isolated from each other. At the time of the focus group there was a possible land donation for a PRC in Rockland, but there are also other sites which function like PRC, including the Freedom Center in Dresden and Celebrate Recovery in Wiscasset, which could be augmented and enhanced.</p>
<p><i>General Comments about readiness in this domain</i></p>	<p>Discussion of and solutions for creating a PRC are occurring in various communities within the district. Ideas about what services would be included in a PRC have started to be expressed.</p>
<p><b>Overall comments about the district's readiness</b></p>	<p>The district identifies challenges due to the diversity and geographic separation of the communities, with the district's multiple peninsulas. The Midcoast district is significantly impacted by SUD, and there are various initiatives that are being resurrected and new ones underway. The peer voice is in the discussion and there is some planning underway for a PRC. The need, however, will be how to adapt a model to meet the geographic and community separation challenges. The group felt it was important to identify specific funds to be available to address transportation.</p>

<i>District 5 — Central</i>	
<b>Knowledge of the Issue:</b>	
<i>Causes</i>	<ul style="list-style-type: none"> <li>• First district to identify SUD and mental health as priorities through PHD needs assessment</li> <li>• Over 600 people participated in the forums in Augusta and Gardiner, in six separate events on the topic of SUD/opioids</li> <li>• Data has been collected on MeHAF grant, MIYHS, and BRFSS summaries</li> <li>• SUD is in the top six public health issues for the District Public Health Improvement Plans (DPHIP)</li> <li>• MaineGeneral community needs assessment identifies SUD prevention and treatment as a major priority for the system</li> </ul>
<i>Consequences</i>	<ul style="list-style-type: none"> <li>• State Coordinating Council mental health and SUD workgroup since 2011</li> <li>• Identified as a key issue affecting family welfare</li> <li>• Food insecurity tied to recovery issues</li> <li>• Child abuse and neglect</li> <li>• Poverty</li> <li>• Barriers to employment</li> </ul>
<i>Impact on community</i>	<ul style="list-style-type: none"> <li>• The effects of SUD on the community that were cited are above.</li> </ul>
<i>General Comments about readiness in this domain</i>	The community is knowledgeable on the social disparities of SUD. Data has been analyzed, and this community states it was the first to prioritize this issue across the state in health needs assessments.
<b>Efforts:</b>	
<i>Programs, services, activities</i>	<ul style="list-style-type: none"> <li>• An alternative SUD program came out of the Somerset SUD task force and has been operating since 2010</li> <li>• MaineGeneral has been hosting waiver training since 2014, and continues to offer training to build community capacity</li> <li>• Attempts to build a community coalition in Waterville and involve people in recovery</li> <li>• A dozen people trained in peer recovery coaching</li> <li>• Augusta PD is using peer recovery coaches, and there is a partnership amongst the Augusta PD, MaineGeneral Outpatient, Crisis and Counseling, and MAAR to link people to services</li> <li>• Criminogenic Addiction &amp; Recovery Academy (CARA) program at Kennebec Jail</li> <li>• CARA-like program in Somerset</li> <li>• Department of Labor/Augusta Career Center is connected to CARA</li> </ul>

	<ul style="list-style-type: none"> <li>• University of Maine at Augusta (UMA) is preparing students for Certified Alcohol and Drug Counselor (CADC) licensing exam</li> <li>• New Nar-Anon meeting in Skowhegan for affected others</li> <li>• MaineGeneral is meeting and looking at increasing their capacity</li> <li>• Career centers are located in both Augusta and Skowhegan</li> <li>• Two clubhouses in Kennebec County for individuals with co-occurring conditions</li> <li>• SMART Recovery group meeting started in Augusta within the past six weeks</li> </ul>
<i>Policies</i>	
<i>General Comments about readiness in this domain</i>	Some efforts to start coalitions have not been successful. Specific programs have been developed, and there is training happening and being offered.
<b>Knowledge of Efforts:</b>	
<i>Know about efforts, programs, services, activities</i>	<ul style="list-style-type: none"> <li>• At the Somerset forums people wanted more knowledge and information</li> </ul>
<i>General Comments about readiness in this domain</i>	The group identified the geographic spread and isolation across the district. It is unclear if this translated to lack of knowledge of the efforts underway. Leadership and coalitions are aware of the efforts across the district.
<b>Leadership:</b>	
<i>Leaders supportive</i>	<ul style="list-style-type: none"> <li>• Director of Transportation at Kennebec Valley CAP is working on the transportation issues</li> <li>• Augusta PD, Kennebec County Sheriff</li> <li>• MaineGeneral, educators, family violence project, peers, Southern Kennebec Child Development Center, drug-free coalitions, UMA, Augusta Mayor, clergy, etc</li> <li>• At least 20 active leaders looking for additional funding to reduce stigma and increase connection to the community</li> </ul>
<i>Influential members supportive</i>	<ul style="list-style-type: none"> <li>• The career center director has collegiate recovery community background</li> <li>• Law enforcement leaders</li> <li>• Mayor of Augusta, city counselors</li> <li>• CEOs of organizations</li> <li>• Physicians</li> <li>• Peer leaders</li> </ul>
<i>General Comments about readiness in this domain</i>	The community has key leaders involved and supportive. Peer leadership is not as clear or strong.

<b>Community Climate:</b>	
<i>Helplessness</i>	<ul style="list-style-type: none"> <li>• Stigma is present and was a barrier to building a recovery coalition in Waterville</li> <li>• Fear of hiring people in recovery</li> <li>• Negativity surrounding people in recovery from within the health care systems</li> <li>• Providers are judged for prescribing narcotics</li> <li>• Some of the news coverage is raising fear</li> <li>• Fear of mixing Suboxone clients with other clients, with the belief that it will cause other clients to become more criminal in their thinking/actions</li> </ul>
<i>Responsibility</i>	<ul style="list-style-type: none"> <li>• Long history of working together in the district to address public health issues</li> <li>• At the last Central DCC mental health and SUD meeting, recovery was the priority for moving forward</li> <li>• MeHAF-funded group has priorities of reducing stigma and increasing connectedness to the community</li> <li>• As more people are linked with or impacted by opioid problems, it leads to less “othering”</li> </ul>
<i>Empowerment</i>	<ul style="list-style-type: none"> <li>• Support is seen from banks, foundations, and radio stations to develop public service announcements, and there was a series developed that featured patients from Discovery House</li> <li>• SMART Recovery group has just formed</li> <li>• Kennebec Journal focused on recovery presentation in the opiate forums</li> <li>• The Augusta Church of the Nazarene is working to expand peer recovery programming</li> </ul>
<i>General Comments about readiness in this domain</i>	There is a lot of fear and stigma around SUD, but change has been seen over the past two years. The community is talking differently about the issue — “it’s their children, it’s their future.”
<b>Resources:</b>	
<i>People</i>	<ul style="list-style-type: none"> <li>• Key leaders are involved in the community, but they are underdeveloped in the level of peer engagement</li> <li>• Need more peer leaders</li> </ul>
<i>Time</i>	<ul style="list-style-type: none"> <li>• Need funding to pay recovery coaches to resolve the issue of needing to maintain employment and getting involved in peer recovery</li> <li>• It is difficult for people who are in recovery and are maintaining jobs to find the time be involved in leadership and advocacy</li> </ul>
<i>Money</i>	<ul style="list-style-type: none"> <li>• Funding has been limited</li> </ul>

	<ul style="list-style-type: none"> <li>• Some MeHAF funding</li> <li>• DCC has implementation funds and they are hiring a staff person to move things forward at the DCC level</li> <li>• The career center has grants available for workforce development</li> <li>• Need resources to maintain and sustain recovery long-term, not just short-term between treatment and early recovery</li> </ul>
<i>Space</i>	<ul style="list-style-type: none"> <li>• No public transportation between Somerset and Kennebec Counties</li> <li>• Volunteer transportation in three out of five town clusters</li> <li>• Two clubhouses run by KBH focused on co-occurring</li> <li>• Sober house for women is opening in Hallowell</li> <li>• Augusta and Gardiner City Councils are open to discussing drug-free neighborhoods and zoning to make it easier to develop sober housing</li> </ul>
<i>General Comments about readiness in this domain</i>	The community has resources, but funding was identified as a need to begin to focus on a PRC and to be able to pay peer leaders for their efforts and their time.
<b>Is there a Recovery Center and/or suggested locations for Peer Recovery Center</b>	It was identified that one PRC would not be able to serve the community without outreach to the community either through satellite offices or virtual support. Transportation needs would require planning and an expansion of the transportation system. A PRC would need to link to employment support and scholarship opportunities. Peers would need to be part of the leadership in a PRC.
<i>General Comments about readiness in this domain</i>	The community has not done any specific planning because there is no current funding. They have ideas of what is needed and how to address the challenges of the geographic separation and transportation issues in the district.
<b>Overall comments about the district's readiness</b>	The district has leadership involved, and efforts have been made and programs are in place. Stigma and the lack of funding have been significant issues. The attitude in the community is changing, but efforts to address stigma have been priorities in the community. Peer leadership needs to be supported and identified as a needed area in the development of a PRC.

*District 6 — Penquis*

<i>District 6 — Penquis</i>	
<b>Knowledge of the Issue:</b>	
<i>Causes</i>	<ul style="list-style-type: none"> <li>• The SUD issues are substantiated by many surveys and data sources, e.g., SHNAPP, BARN utilization data, emergency rooms, AG data on overdose deaths by county, SAMHS data</li> <li>• Bangor Daily News raising awareness through coverage</li> <li>• Limited capacity for treatment in the community</li> <li>• Penquis is resource for all of northern Maine, which can be challenging and overwhelming</li> <li>• #healthyregion blog with Bangor Daily News</li> <li>• Manna, a faith-based extended shelter and care facility, is closing its program</li> </ul>
<i>Consequences</i>	<ul style="list-style-type: none"> <li>• Deaths</li> <li>• Struggles of older population from injuries due to medications and SUDs</li> </ul>
<i>Impact on community</i>	
<i>General Comments about readiness in this domain</i>	SUDs are substantiated in the district and stories are run in the Bangor Daily News highlighting the challenges and celebrating the recovery that happens.
<b>Efforts:</b>	
<i>Programs, services, activities</i>	<ul style="list-style-type: none"> <li>• LEAD planning grant in Bangor from the Open Society, held by Health Equity Alliance</li> <li>• Community Health Leadership Board focusing on SUD</li> <li>• Public forums — Director of National Drug Control Policy, Michael Botticelli, has been to Bangor twice</li> <li>• The establishment of BARN in 2010</li> <li>• Have had a summit that initially started with BARCC, now merged with BARN</li> <li>• BARN has done awareness activities, held candlelight vigils with hundreds attending</li> <li>• Northeastern Workforce Development Board (NWDB), which covers Aroostook, Washington, Penobscot, Piscataquis, and Hancock counties, is working with the Chamber of Commerce to help educate our business partners about recovery resources</li> <li>• Peer recovery coach training done and peers are going into the Penobscot county jail and connecting with BARN</li> <li>• HMP — DFC grant</li> <li>• Linking Partnership — group of 30 organizations coming together to support families identified with SUD</li> </ul>

	<ul style="list-style-type: none"> <li>• From that, wrote a federal grant to do work more intensively — Linking Project — Eastern Maine Medical Center Neonatal involved, supports from public health nursing when babies are discharged — Collaborative Home Alternative Medication Program (CHAMP) clinics</li> <li>• Eastern Maine Development Collaborative — work readiness trainings: resume writing, interviewing tips, etc. Work done through cohorts. Can access training dollars for support up to an Associate’s Degree. Assistance w/certificate programs.</li> <li>• Housing: women’s sober house at BARN, Oxford House (men), Penobscot Community Health Care (PCHC) put together transitional housing — need more</li> <li>• Educators — connected to Adult Ed, community colleges, high schools, etc. Working on growing relationships with Adult Ed (with BARN)</li> </ul>
<i>Policies</i>	
<i>General Comments about readiness in this domain</i>	There are active planning task forces and coalitions across the community. BARN is almost entirely a volunteer organization that works to provide recovery supports and put a face on recovery to address stigma.
<b>Knowledge of Efforts:</b>	
<i>Know about efforts, programs, services, activities</i>	
<i>General Comments about readiness in this domain</i>	The efforts are integrated across Bangor into their public health department, and with CEOs from organizations in the region. Celebrations of recovery are organized and well-published.
<b>Leadership:</b>	
<i>Leaders supportive</i>	<ul style="list-style-type: none"> <li>• Civic leaders indirectly involved, woven into different boards</li> <li>• PHD provides structure to planning efforts</li> <li>• Forum with elected officials</li> </ul>
<i>Influential members supportive</i>	<ul style="list-style-type: none"> <li>• Peer leadership through BARN</li> <li>• Eastern Maine Development leadership</li> <li>• Northeastern Workforce Development Board</li> <li>• Bangor Public Health</li> </ul>
<i>General Comments about readiness in this domain</i>	Leadership is involved.

<b>Community Climate:</b>	
<i>Helplessness</i>	<ul style="list-style-type: none"> <li>• Stigma is intense in Bangor because of the high portion of methadone clinics — but not true for BARN activities</li> <li>• People still have a “self-inflicted disease” attitude but it seems to be changing</li> <li>• People are viewing BARN as helping people they know</li> <li>• BARN is seen favorably because of celebration of recovery</li> </ul>
<i>Responsibility</i>	<ul style="list-style-type: none"> <li>• We have switched from “we don't want these people” to be more accepting of “this is a disease and we need to help”</li> <li>• BARN was awarded the Agency of Distinction Award WLBZ 2, United Way 2015. Other awards/recognition: grassroots award, women leadership in recovery award, recovery advocacy, key to the city from Brewer</li> </ul>
<i>Empowerment</i>	<ul style="list-style-type: none"> <li>• BARN is accepted and cherished in the community — 1,500 visits per week, has received the Agency of Distinction Award WLBZ 2, United Way 2015, grassroots award, women leadership in recovery award, recovery advocacy, key to the city from Brewer</li> <li>• YPR feeling empowered to be part of the conversation</li> <li>• No NIMBY attitudes in the region</li> <li>• Other counties want to learn from BARN’s development</li> <li>• Recovery coaches</li> </ul>
<i>General Comments about readiness in this domain</i>	BARN anchors the recovery climate that has emerged in Bangor and the surrounding areas. Stigma is still present but it is changing.
<b>Resources:</b>	
<i>People</i>	<ul style="list-style-type: none"> <li>• Growing, but all volunteer, and outgrowing capacity at BARN</li> <li>• PHD infrastructure</li> <li>• BARN has 600–900 volunteer hours per month</li> </ul>
<i>Time</i>	<ul style="list-style-type: none"> <li>• BARN has 600–900 volunteer hours per month</li> </ul>
<i>Money</i>	<ul style="list-style-type: none"> <li>• Resources are needed. BARN cannot expand without structured support in terms of staffing.</li> </ul>
<i>Space</i>	<ul style="list-style-type: none"> <li>• BARN is a cherished placed in the community, named an Agency of Distinction. “Pride of the Community.”</li> <li>• BARN is a nonprofit corporation, 501(c)(3), with 50% of the board in recovery</li> <li>• Housing: women’s sober house at BARN, Oxford House (men), PCHC put together transitional housing — need more</li> <li>• BARN offers space for 12-step programs, periodic parenting classes, educational workshops, community education, sober social activities, etc.</li> </ul>

<i>General Comments about readiness in this domain</i>	The district has resources to leverage, but funding is needed.
<b>Is there a Recovery Center and/or suggested locations for Peer Recovery Center</b>	BARN is located in Brewer and serves as a volunteer regional hub, but could expand on its services, its connections with other organizations, and resources, and offer robust recovery coaching if funding was available. Through technology it could connect with other areas. Staffing and infrastructure is needed — not another new PRC. BARN was awarded the Agency of Distinction Award WLBZ 2 and United Way 2015. Other awards/recognition: grassroots award, women leadership in recovery award, recovery advocacy, key to the city from Brewer.
<i>General Comments about readiness in this domain</i>	BARN was identified repeatedly as a center that could be used to expand to reach the larger district if it had the resources. It already has made a significant impact on the community’s recognition that recovery is possible, and is offering services to many people.
<b>Overall comments about the district's readiness</b>	Coordinated efforts are taking place in Bangor through the Community Health Leadership Board and BARN, a PRC. Like other urban centers, the Bangor area draws others to its area and their services. However, because of that demand services are taxed. BARN is an existing, primarily volunteer-run PRC, and is involved in many initiatives in Bangor and offers support services to many in the community. It is a 501(c)(3) with a board of whom 50% identify as “in recovery.” However, like most districts in Maine, the geographic spread of the district would need to be addressed creatively to meet peer needs across the district. BARN is in a position to utilize funding to expand its services and link across the district.

<i>District 7 — Downeast</i>	
<b>Knowledge of the Issue:</b>	
<i>Causes</i>	<ul style="list-style-type: none"> <li>• Highest unemployment rate in the state</li> <li>• Perception of harm from marijuana has decreased, with tripling of use since 2013</li> <li>• Prescription misuse and heroin use higher than the state’s as a whole</li> <li>• 40% of high school students use marijuana and tobacco</li> <li>• Peer support has historically been poor</li> <li>• Treatment services lacking</li> </ul>
<i>Consequences</i>	<ul style="list-style-type: none"> <li>• Maine Opiate Collaborative listening sessions were well-attended</li> <li>• The community is “coming out in droves” for forums around SUD</li> </ul>
<i>Impact on community</i>	<ul style="list-style-type: none"> <li>• Community has been active in fundraising</li> </ul>
<i>General Comments about readiness in this domain</i>	The community is knowledgeable and “coming out in droves” to the Maine Opiate Collaborative listening sessions and other community gatherings.
<b>Efforts:</b>	
<i>Programs, services, activities</i>	<ul style="list-style-type: none"> <li>• Planning for hub-and-spoke MAT services in Hancock County</li> <li>• Faith-based programs have been established (Arise — 12-bed male residential program) and planning is occurring for a 10-bed facility in Calais by September — working with the ED, local housing, businesses</li> <li>• Developing a proposal for MeHAF to create a road map in six areas</li> <li>• Family services have been developed in Eastport</li> <li>• School program in place (Keeping it Real)</li> <li>• Drug courts in Washington County and Hancock</li> <li>• Regional Medical Center Lubec has a program that connects to Pleasant Point, also has a relationship with the recovery community and has an MOU</li> <li>• Ellsworth is developing Operation HOPE</li> <li>• Prime for Life is offered in Machias High Schools and at Princeton Elementary School</li> <li>• Your Place, Inc. in Hancock county has been in existence for 20 years — has a sober, free community center and hosts weekly 12-step meetings; 2700–3000 visits per year</li> </ul>
<i>Policies</i>	

<i>General Comments about readiness in this domain</i>	The planning and expansion of connections across the community continues. A new faith-based program has been implemented. A hub-and-spoke model is in the planning process. There are DFC grants and drug courts in the district.
<b>Knowledge of Efforts:</b>	
<i>Know about efforts, programs, services, activities</i>	<ul style="list-style-type: none"> <li>• Those involved are knowledgeable, but not across the district.</li> </ul>
<i>General Comments about readiness in this domain</i>	There are around four planning initiatives underway, but they are not connected.
<b>Leadership:</b>	
<i>Leaders supportive</i>	<ul style="list-style-type: none"> <li>• Law enforcement</li> <li>• Healthy Acadia</li> <li>• Bangor Saving has expressed a willingness to do financial literacy training</li> <li>• Peers are involved</li> <li>• Treatment providers involved</li> <li>• Hospitals at the table</li> <li>• Faith-based community</li> <li>• FQHCs</li> </ul>
<i>Influential members supportive</i>	
<i>General Comments about readiness in this domain</i>	A variety of leaders are involved in the initiatives. In the district, there is a faith-based program which has begun to offer services and connect with the greater community resources.
<b>Community Climate:</b>	
<i>Helplessness</i>	<ul style="list-style-type: none"> <li>• More people are willing to share their stories</li> </ul>
<i>Responsibility</i>	<ul style="list-style-type: none"> <li>• Peer have had peer recovery coaching</li> </ul>
<i>Empowerment</i>	<ul style="list-style-type: none"> <li>• Fundraising done</li> <li>• Family support meetings established</li> </ul>
<i>General Comments about readiness in this domain</i>	Individually, people are engaged in various initiatives and projects. Community members have become more vocal about their struggles and their recovery.
<b>Resources:</b>	
<i>People</i>	<ul style="list-style-type: none"> <li>• Elected officials are getting involved</li> <li>• Peers have identified themselves</li> </ul>

<i>Time</i>	
<i>Money</i>	<ul style="list-style-type: none"> <li>• Fundraising</li> </ul>
<i>Space</i>	<ul style="list-style-type: none"> <li>• Your Place, Inc. is an established sober community center</li> <li>• FQHC</li> </ul>
<i>General Comments about readiness in this domain</i>	Generally the resources are scarce, but developing peer involvement is helping to reach across systems.
<b>Is there a Recovery Center and/or suggested locations for Peer Recovery Center</b>	There is a sober community resource center in Hancock which has been there for 20 years. It was identified as a possible location for a PRC. It was mentioned that FQHCs might be used as satellite sites, along with the possibility of virtual communities.
<i>General Comments about readiness in this domain</i>	There is a current center which could be expanded, but there is a need to address the geographic spread of the district. There are a number of different options are that are being discussed.
<b>Overall comments about the district's readiness</b>	Although the district generally has high needs and lacks treatment resources, the peer recovery community is becoming more organized. Efforts across the district are community- or program-based and there is no organized effort across the district. There is a sober community center in Hancock, which has historically supported 12-step meetings and sober gatherings, which was identified as a possible location to expand for a PRC. Others identified the need for PRCs across the district, or multiple centers. The idea of satellite centers was identified, coordinating with FQHCs or through telecommunications.

<i>District 8 — Aroostook</i>	
<b>Knowledge of the Issue:</b>	
<i>Causes</i>	<ul style="list-style-type: none"> <li>• Geographic isolation in certain parts of the district</li> <li>• Poverty and unemployment occurs with the closure of mills and shrinking natural resource-based jobs in forestry</li> <li>• Farming does not employ as many people as in the past</li> <li>• Drugs entering through the international border</li> <li>• Meth is a growing issue in southern and central Aroostook areas, bigger than the opioid issue; the recognition is not as strong for alcohol</li> <li>• Meth manufacturing is making money to fuel use, but also it pays the bills</li> <li>• People underreport about drug use</li> </ul>
<i>Consequences</i>	<ul style="list-style-type: none"> <li>• Needles being discarded in the environment</li> <li>• People showed up for the viewing of Anonymous People and the Maine Opiate Collaborative listening sessions, parent forums are attended</li> <li>• Pharmacists have taken Sudafed off the shelves in Van Buren</li> </ul>
<i>Impact on community</i>	<ul style="list-style-type: none"> <li>• A lot of people don't believe it's as bad as it is</li> <li>• CADET has a long history, but it needs a new life</li> <li>• Youth are becoming involved with Youth Voices coalition in the Valley</li> <li>• Link for Hope has been there and grows in their efforts</li> <li>• See efforts below</li> </ul>
<i>General Comments about readiness in this domain</i>	There is a growing recognition of the problem, but for many it is not viewed as a community issue — rather a person's issue until it affect themselves or their significant others.
<b>Efforts:</b>	
<i>Programs, services, activities</i>	<ul style="list-style-type: none"> <li>• Link for Hope coalition is engaging their community</li> <li>• Maine Opiate Collaborative listening sessions held</li> <li>• Youth Voices in the Valley</li> <li>• Prescription drug take-backs in every PD in Aroostook</li> <li>• NA mostly in central Aroostook, and ebbs and flows</li> <li>• AA is working to strengthen a residential program in Limestone</li> <li>• UMFK is discussing models for education and prevention through the student affairs branch</li> <li>• Celebrate Recovery Group, Wesleyan Church</li> <li>• Military St. Church offers recovery groups</li> <li>• Annual parent forums are held</li> </ul>

	<ul style="list-style-type: none"> <li>• ER doctors in Houlton Regional Hospital are changing their prescription practices and attitudes</li> <li>• Marijuana work groups are meeting</li> <li>• SIRP and Prime for Life implemented</li> <li>• Aroostook Teen Leadership Camp developed by AMHC for 6th, 7th, and 8<sup>th</sup> grades, and high school weekend program</li> <li>• MAT being implemented through Pines Health and AMHC through the efforts of CADET</li> <li>• Diversion Alert is being implemented</li> <li>• UMFK has advisory council, which serves as a communication vehicle — they are developing substance use academic concentration program</li> <li>• IOP in the Houlton area has a Matrix model with a peer recovery group</li> <li>• Reentry work with the Aroostook County Jail which includes the career center</li> </ul>
<i>Policies</i>	<ul style="list-style-type: none"> <li>• DCC has substance misuse as one of the top three priorities on the policy level — meets quarterly</li> <li>• Twin Rivers employment assistance program (EAP) has developed policies and procedures</li> </ul>
<i>General Comments about readiness in this domain</i>	There is a variety of new programming that has grown with the recognition of the needs, which include treatment, as well as prevention activities which include youth, parents, schools, academic programs, and treatment providers (PCPs and behavioral health).
<b>Knowledge of Efforts:</b>	
<i>Know about efforts, programs, services, activities</i>	<ul style="list-style-type: none"> <li>• Peer leaders are involved in coalitions, but don't necessarily use this terminology</li> <li>• Awareness of efforts is low, despite media coverage</li> <li>• People do show up when invited</li> </ul>
<i>General Comments about readiness in this domain</i>	General community awareness of the efforts is low, but people come when they are invited. People are becoming more involved.
<b>Leadership:</b>	
<i>Leaders supportive</i>	<ul style="list-style-type: none"> <li>• Peer leaders</li> <li>• DCC with wide sector representation</li> <li>• UMFK</li> <li>• Behavioral health treatment providers</li> <li>• FQHCs</li> <li>• Employers, but do not publically announce</li> </ul>

	<ul style="list-style-type: none"> <li>• Religious community is involved</li> </ul>
<i>Influential members supportive</i>	<ul style="list-style-type: none"> <li>• Leaders were identified, but there is also a sense that leaders hold back expressing their support publically</li> </ul>
<i>General Comments about readiness in this domain</i>	The coalitions are widening their representation, but generally people are not outspoken but are supportive.
<b>Community Climate:</b>	
<i>Helplessness</i>	<ul style="list-style-type: none"> <li>• People are frustrated, and tired of meth and opioids</li> <li>• More peer support around mental health than SUD</li> <li>• There is stigma around attending groups because of the tight-knit nature of the community, but the tight-knit nature is also a support for social connections</li> </ul>
<i>Responsibility</i>	<ul style="list-style-type: none"> <li>• People are uncomfortable seeing needles in their environment</li> </ul>
<i>Empowerment</i>	<ul style="list-style-type: none"> <li>• There is a level of readiness to decrease stigma</li> <li>• No organized peer support, but lots of individualized peer support</li> <li>• Level of readiness to engage in peer recovery work</li> <li>• CADET has been in Caribou for a long time</li> <li>• Youth Voices coalition in the Valley has formed</li> <li>• Link for Hope in Houlton has been engaging their community and has wide representation, including peers</li> <li>• Maine Opiate Collaborative listening sessions were well-attended</li> </ul>
<i>General Comments about readiness in this domain</i>	The community is frustrated, and there is a growing empowerment to want change and to support engagement.
<b>Resources:</b>	
<i>People</i>	<ul style="list-style-type: none"> <li>• Leaders of organizations involved</li> </ul>
<i>Time</i>	
<i>Money</i>	<ul style="list-style-type: none"> <li>• Funding is needed</li> </ul>
<i>Space</i>	<ul style="list-style-type: none"> <li>• There are people working to develop sober housing</li> <li>• One shelter, but it is a dry shelter</li> <li>• Housing is a need and challenge — need transitional housing</li> </ul>
<i>General Comments about readiness in this domain</i>	
<b>Is there a Recovery Center and/or suggested locations for Peer Recovery Center</b>	<ul style="list-style-type: none"> <li>• Link for Hope, a community coalition, is working on developing a PRC in Houlton</li> <li>• Need more than one, need a minimum of three</li> </ul>

	<ul style="list-style-type: none"> <li>• Possible satellite sites (maybe once per month/week point of engagement in other parts of the county)</li> <li>• Presque Isle/Caribou</li> <li>• Fort Kent/Madawaska</li> <li>• A list of services were identified that a PRC could provide, including MAR/MAT, career services, education, co-operative extension, SNAP, tobacco cessation, ACAP/workforce development/employment coaches; testing for HIV/Hepatitis C/tuberculosis, 12-step and other meetings, educational information, peer support (with telephone services and outreach services), social activities</li> <li>• Challenges identified: long-term funding and sustainability, community support across the county, how to get people certified if peer recovery becomes billable, further connections with sheriff and jail for peer support, need for community education on the role of peer recovery, getting businesses to support financially</li> </ul>
<i>General Comments about readiness in this domain</i>	There are discussion underway about a PRC, but how it would reach the rest of the county is unclear — but there are ideas. Funding is needed.
<b>Overall comments about the district's readiness</b>	The culture has historically been one in which people do not speak out and advocate unless it affects them or their significant others, but that is culture is changing. There is a community coalition, Link for Hope, in the Houlton area which is an example of the growing peer empowerment movement. This group is actively working on the development of a PRC and is seeking resources. The challenge will be how to connect peer supports linked to a PRC across the large geographic district, and how to leverage the peer empowerment that is emerging in the Houlton area in the rest of the district.

<i><b>Tribal Public Health District</b></i>	
<b>Knowledge of the Issue:</b>	
<i>Causes</i>	<ul style="list-style-type: none"> <li>• Historical trauma</li> <li>• Poverty</li> <li>• Clandestine meth laboratories</li> <li>• The Community Readiness Assessment helped to identify substance use, but the assessment could have been expanded</li> </ul>
<i>Consequences</i>	<ul style="list-style-type: none"> <li>• Dangers of needs and “shake and bake” — bottle on the roadside</li> <li>• Everyone knows at least one person struggling in their family or neighborhood</li> <li>• Youth Council has identified it as the top concern and focus</li> <li>• The administrative office and health departments are sending out flyers and quarterly and monthly paper newsletters, and are using Facebook</li> <li>• Some feel that the personal touch is being lost with reliance on flyers and electronic communication</li> <li>• Prevention and planning is happening</li> </ul>
<i>Impact on community</i>	<ul style="list-style-type: none"> <li>• Community cleanup activities with youth stopped</li> <li>• People don’t have time or know what to do</li> <li>• Many know it is a problem</li> <li>• Those struggling don’t see how it impacts those around them</li> </ul>
<i>General Comments about readiness in this domain</i>	SUD affects the Tribes and their members, and is recognized by the Tribal leaders and health directors. Data and surveys on substance use issues could be expanded upon what was done recently. Communication mechanisms are being utilized to reach out.
<b>Efforts:</b>	
<i>Programs, services, activities</i>	<ul style="list-style-type: none"> <li>• There are five Tribal Heal Health Facilities</li> <li>• Suboxone is offered at a couple of locations; Vivitrol at one location</li> <li>• Out-of-state tribal programs are available on a limited access basis</li> <li>• Tribal members use treatment outside of their tribes or Native American communities as well</li> <li>• Historically there have been Wellbriety meetings</li> <li>• Sweat lodge ceremonies</li> <li>• Prayer drum circles</li> <li>• AA has been meeting for 40–50 years</li> <li>• Healthy Wabanki partnership has programs aimed at reducing underage drinking, prescription drug misuse, and marijuana</li> </ul>

	<ul style="list-style-type: none"> <li>• Prime For Life has been offered in the past, and new individuals have been identified to become certified Prime For Life instructors and to have new offerings at Indian Township and Pleasant Point</li> <li>• Teen center on Indian Island, and after-school and community activities take place</li> <li>• Wabanaki Health and Wellness organization</li> <li>• Wellness Court</li> <li>• MeHAF grant supporting speakers</li> <li>• SUD science fair for youth held</li> <li>• Tribal Health is looking at a grant for a navigator to help connect people to resources</li> <li>• Mental health first aid (MHFA) training with youth</li> <li>• Meth and suicide prevention grants — have done a community engagement night and conducted an evidence-based curriculum</li> <li>• Active Youth Council</li> <li>• A lot of focus on youth and elders</li> <li>• Recently held a community forum and 25 people came</li> <li>• A lot of prevention activities are happening — youth group babysitting training, MHFA, mentorship programs</li> <li>• Planning is occurring through their Community Health Implementation Plan (CHIP)</li> <li>• A resource directory is being developed</li> <li>• A patient navigator position has been created</li> <li>• Held a large community gathering with a national tribal group called Eagles Wings — youth came to speak with each other, and the whole community came out to hear the stories</li> <li>• They are looking to do peer trainings for peer recovery coaches</li> <li>• Naloxone grant was received for all tribes in the district and training to administer it</li> </ul>
<i>Policies</i>	
<i>General Comments about readiness in this domain</i>	There are supports groups, and treatment and prevention activities in place. There are more activities and supports for youth and elderly than for the 18–50 age group. There is interest in expanding the culturally responsive programs and building a strong community to address the substance use issues.
<b>Knowledge of Efforts:</b>	
<i>Know about efforts, programs, services, activities</i>	<ul style="list-style-type: none"> <li>• Flyer disseminated to households monthly</li> <li>• Social media is utilized</li> <li>• Some felt the personal touch has been lost in communicating</li> </ul>

	<ul style="list-style-type: none"> <li>• The Community Readiness Assessment helped to identify substance use, but the assessment could have been expanded</li> </ul>
<i>General Comments about readiness in this domain</i>	There is knowledge of the efforts. It is not clear if there is knowledge across the PHD or if it is Tribe- or community-specific.
<b>Leadership:</b>	
<i>Leaders supportive</i>	<ul style="list-style-type: none"> <li>• Health directors meet regularly and identify the issues</li> <li>• Chiefs meet regularly</li> <li>• There are peer-to-peer activities occurring through the Wellness Court</li> <li>• The Youth Council has identified it as the top concern and focus</li> </ul>
<i>Influential members supportive</i>	<ul style="list-style-type: none"> <li>• Chiefs</li> <li>• Health Directors</li> </ul>
<i>General Comments about readiness in this domain</i>	The leaders meet regularly and have the structure to develop comprehensive plans. SUD is recognized as the biggest issue in the community (MBMI).
<b>Community Climate:</b>	
<i>Helplessness</i>	<ul style="list-style-type: none"> <li>• Historical trauma is present</li> <li>• People don't know what to do</li> <li>• Having an addiction can be embarrassing, and anonymity in seeking treatment is not always kept</li> <li>• Stigma is present</li> <li>• Families are struggling with SUD issues</li> <li>• Others normalize addiction and are desensitized to it, accept it as it is</li> </ul>
<i>Responsibility</i>	<ul style="list-style-type: none"> <li>• Culturally rich and has native and tribal identities</li> <li>• They have a MeHAF grant — had speakers come</li> <li>• Held an SUD science fair for youth that received press coverage — the youth were very involved and interested</li> <li>• The community wants to deal with the issues, and wants better access to treatment and recovery supports</li> </ul>
<i>Empowerment</i>	<ul style="list-style-type: none"> <li>• Traditional ceremonies and heritage help with empowerment</li> <li>• Ceremonies are important in their culture, but it is hard to get people who are actively using to attend and participate in sweat lodge ceremonies</li> <li>• Many don't realize it is an illness, but see it as a moral failing</li> <li>• Tribal Health is looking at a grant for a navigator</li> <li>• Looking to do peer training for peer recovery coaches</li> <li>• A resource guide is being developed</li> </ul>

<i>General Comments about readiness in this domain</i>	The heritage and culture provide a mechanism for empowerment that is recognized and supported. Peer supports are being developed and have been identified as a need and want.
<b>Resources:</b>	
<i>People</i>	<ul style="list-style-type: none"> <li>• Tribes, health directors, chiefs</li> <li>• There is a job bank, and tribal members can put their names in the job bank and they rotate the individuals who get assistance — includes job training</li> <li>• Vocation rehabilitation available</li> <li>• Patient navigator position</li> <li>• Have brought behavioral health into their own health center (Houlton Band of Maliseets) with a 40-hour MSW therapist, and are building support groups</li> </ul>
<i>Time</i>	
<i>Money</i>	<ul style="list-style-type: none"> <li>• MAT can be expensive</li> <li>• They have workforce investment monies</li> <li>• Received a \$66,000 grant for technical assistance to help planning around transportation issues</li> </ul>
<i>Space</i>	<ul style="list-style-type: none"> <li>• Teen Center</li> <li>• The Wabanaki Health and Wellness agency has a community room</li> <li>• There are many spaces that could be used for a PRC — elder center, gym, etc.</li> <li>• Their land is theirs, so they don't have to look for other places. They can adapt or build as wanted and needed.</li> </ul>
<i>General Comments about readiness in this domain</i>	The Wabanaki PHD has a rich tribal and native heritage which offer significant resources for efforts to address substance use issues. However, that heritage also brings to bear intergenerational historical trauma, oppression, and social justice issues.
<b>Is there a Recovery Center and/or suggested locations for Peer Recovery Center</b>	<ul style="list-style-type: none"> <li>• A PRC could be placed in any one of the communities, but there would be a need to address how the center could meet the needs of the district as a whole and be responsive to the cultural diversity and heritage. They have been talking about this for a couple of years.</li> <li>• The Wabanaki Health and Wellness agency in Bangor was identified as a possibility</li> <li>• Old Town area</li> <li>• The attributes were described as friendly, non-institutional, and reflecting natural settings</li> </ul>

	<ul style="list-style-type: none"> <li>• They have many spaces that could be used — elder center, gym, etc.</li> </ul>
<i>General Comments about readiness in this domain</i>	A PRC would need to be responsive to the cultural needs of the Tribes and the geographic challenges. A number of possibilities were identified. It was suggested that a PRC be linked to treatment and detoxification. The center would be a friendly environment that is more home-like, with natural attributes to sit in outdoor spaces.
<b>Overall comments about the district's readiness</b>	The Wabanaki PHD has the richness of all five federally recognized tribes with their cultural and native heritages. This culture provides an opportunity for empowerment. There are significant health disparities and substance use issues, which are in part related to the historical trauma. A PRC is an opportunity that the district welcomes, and there are many thoughts about how it could be responsive to addressing their needs. They have the resources of their own buildings and land, and have been thinking about this for a couple of years. There are multiple services and activities they envision linking with a PRC. Transportation is a challenge that would need to be addressed.

## **Appendix D: Analysis of Maine Opiate Collaborative Listening Sessions**

<i>District 1 — York</i>	
<b>Knowledge of the Issue:</b>	
<i>Causes</i>	<ul style="list-style-type: none"> <li>• Prescribing practices for opioids (change the culture of how we treat pain)</li> <li>• Oppose the legalization of marijuana which would increase access to marijuana and lead to more addiction</li> <li>• Health care personnel need to educate patients about the side effects of long term opiate usage</li> </ul>
<i>Consequences</i>	<ul style="list-style-type: none"> <li>• The prescribing of opioids and legalization of marijuana will increase addiction to drugs.</li> </ul>
<i>Impact on community</i>	
<i>General Comments about readiness in this domain</i>	The community is identifying current and future contributing factors to SUD.
<b>Efforts:</b>	
<i>Programs, services, activities</i>	<ul style="list-style-type: none"> <li>• Recover Together computer application: This could be embedded on partner websites and provided to 211</li> <li>• Out of the Shadows: In-person meetings in Eliot</li> <li>• Young People in Recovery: Biddeford chapter recently started</li> <li>• Kennebunkport: Information packets (signs/symptoms, skills, resources) being distributed to churches, libraries, and police</li> <li>• NAR-ANON: In-person meetings on Sundays at 7 p.m. at the York County Sheriff's office</li> <li>• SIRP (Student Intervention &amp; Reintegration Program)</li> <li>• Cottage Program at York Hospital</li> <li>• Medication Assisted Treatment (MAT): Recovery Together (Suboxone, group counseling), Key3West (Suboxone, psychiatry (mental health prescribers, SMHC (Vivitrol)</li> <li>• York County Shelter Programs: Key to success is the point-to-point support/transfer in real-time</li> <li>• Schools: Youth, adult education and college programs</li> <li>• Domestic violence agencies, DHHS, employers, hospitals, primary care/community health centers, pain management providers, OB/GYNs</li> <li>• Emergency Depts: South Maine Health Center, Biddeford, Sanford, Tele-Psychiatry, York, Portsmouth, Maine Medical Center, Mercy, Frisbie (Rochester, NH), Wentworth-Douglas (Dover, NH), Nasson Health Centers/Hospitals can provide long-term comfort packs</li> </ul>

	<ul style="list-style-type: none"> <li>• Partial Hospitalization: SMHE (includes co-occurring and has some free-care), McGeachey Hall at MMC (has some free care), Portsmouth Regional Hospital (probably has some free care)</li> <li>• Intensive Out-Patient: Maine Behavioral Health Care - Springvale; Central Maine Counseling - Key3West - Biddeford, SMHC, York Hospital, Addiction Recovery Center - Portsmouth, Portsmouth Hospital, Day One, Affordable prescriptions for uninsured and Logistic are (Non-Emergency Transportation) through MaineCare</li> <li>• Residential Rehab: Our Father's House, Day One, Milestone, York County Shelter Programs, Recovery Inc., Green Mountain Treatment Center (Effingham), Crossroads (women) Windham, Back Bay Cove</li> <li>• Aftercare and Preventative Care: York Hospital - Cottage Program, York County Shelter Programs, Maine Behavioral Health, Key3West, Ester House (women), Pre-trial Services, AA, NA, NAR-Anon, AL-Anon</li> <li>• Recovery Support: Young People in Recovery and AA and some NA</li> <li>• More Drug Take-Backs</li> </ul>
<i>Policies</i>	
<i>General Comments about readiness in this domain</i>	York County has many types of treatment and recovery programs available or developing in the County as well as programs available in neighboring Cumberland County and New Hampshire towns.
<b>Knowledge of Efforts:</b>	
<i>Know about efforts, programs, services, activities</i>	<ul style="list-style-type: none"> <li>• More funding is needed treatment for detox beds, residential care</li> <li>• More resources for the uninsured</li> <li>• More support from insurance companies (create a flyer for members who call)</li> <li>• More aggressive dissemination of information for individuals and families at points of entry</li> <li>• Expand comfort packs at urgent care sites to eliminate referrals that may be barriers for patients</li> <li>• Prescribe Suboxone induction via tele-psychiatry</li> <li>• More adolescent treatment, detox unit, half-way house for women, re-entry house, more beds overall, more county-wide coordination, more MAT</li> <li>• More Suboxone prescribers (including a strategic targeting plan with exact numbers and locations and higher patient cap for prescribers)</li> </ul>

	<ul style="list-style-type: none"> <li>• Support primary care providers with other treatment resources (Maine Health is starting to do)</li> <li>• Utilize empty beds in IOP</li> <li>• More funding for law enforcement skill building and efforts that support transitions to treatment programs</li> <li>• Operation HOPE</li> </ul>
<i>General Comments about readiness in this domain</i>	There is general knowledge about what is currently available and what is needed.
<b>Leadership:</b>	
<i>Leaders supportive</i>	<ul style="list-style-type: none"> <li>• Continued conversations with Public Health Council</li> <li>• Leaders reviewed recovery center grant for its design to fit York County needs</li> <li>• Strategic plan developed to target the need for more Suboxone prescribers - hospitals can take the lead</li> <li>• Community Care team - case review</li> </ul>
<i>Influential members supportive</i>	
<i>General Comments about readiness in this domain</i>	There has been support from community members but additional support from community influential members need to be cultivated, e.g. the Ribbon Committee of the Biddeford Rotary. There has been some work with the Public Health Council. Leaders have gotten together to review potential grants and develop strategic plans.
<b>Community Climate:</b>	
<i>Helplessness</i>	
<i>Responsibility</i>	<ul style="list-style-type: none"> <li>• More programs are needed for early intervention/prevention, early childhood education, and youth programs (Youth meetings, teen centers, student advocacy/sobriety groups, peer-to-peer support groups, forums just for young people)</li> <li>• Identify high-risk students</li> <li>• Train Educators on assessment</li> <li>• Train kids on signs of opiate usage among family members</li> <li>• More funding for DHHS staff and funding for kids in trauma</li> <li>• Later schools starts</li> <li>• Schools need to use evidence based curriculum for health and prevention</li> <li>• Pay attention to the precursors of opiates that our youth are using: prescription pills, marijuana and alcohol</li> <li>• Coordinate with hospitals to work with pregnant moms so they can get education and help around drug use</li> </ul>

	<ul style="list-style-type: none"> <li>• Integrate prescription monitoring across state lines</li> <li>• Education people about proper prescription disposal</li> <li>• Reduce bias/stigma - educate providers and their staff on the importance of using "person first" language</li> <li>• Engage the recovery community in humanizing the issue and stop vilifying people and providers</li> <li>• Training and skill building for health care and social service professionals re: ACEs</li> <li>• Accountability if caught doing drugs</li> <li>• Mandatory use of Prescription Monitoring Program (PMP) and improve functionality of PMP</li> </ul>
<i>Empowerment</i>	<ul style="list-style-type: none"> <li>• Deliver positive messages to kids, not scare tactics (e.g. "Above the Influence" program)</li> <li>• Talk to your kids; break the silence</li> <li>• Engage recovery community in programs to empower kids, help them cope and find hope</li> <li>• Establish programs that make kids feel good about themselves</li> </ul>
<i>General Comments about readiness in this domain</i>	<p>York County indicated more programs with education components are needed for early prevention and intervention for at-risk kids, teenagers in school and outside of school, pregnant females and families. Education to reduce bias/stigma of drug use is needed. The messaging to empower kids to feel good about themselves and seek help for themselves or a family member was identified. Parents need to talk to their kids and break the silence about drug and drug usage.</p>
<b>Resources:</b>	
<i>People</i>	<ul style="list-style-type: none"> <li>• Additional resources are needed to implement educational and treatment programs for early prevention and intervention for youth, parents, affected others, law enforcement personnel, healthcare professionals, and the person with SUD.</li> <li>• Additional resources will be needed for long-term recovery services and support to help with transportation, housing, employment</li> <li>• Community/parent education and support includes programs that include and understanding that drug change the brain</li> <li>• Partnerships need to be built with the community to show "we care"</li> </ul>
<i>Time</i>	<ul style="list-style-type: none"> <li>• Community/parents donate time and money</li> </ul>
<i>Money</i>	<ul style="list-style-type: none"> <li>• Additional funding will be needed for new and existing programs, resources and services (more Suboxone providers, more availability to Narcan (e.g. over the counter access)</li> </ul>

	<ul style="list-style-type: none"> <li>• If financial barriers are implemented for no/low cost treatment, money will be needed for this service/program</li> <li>• Funding for programs to get drugs out of prisons</li> <li>• Funding for more law enforcement personnel especially in the rural areas</li> <li>• Funding for more therapeutic programs while people are in jail and support for people getting out of jail and who are in recovery</li> <li>• Funding for law enforcement so they can follow up with people who overdosed</li> <li>• More drug courts</li> </ul>
<i>Space</i>	<ul style="list-style-type: none"> <li>• Use empty beds in IOP programs for people in need</li> </ul>
<i>General Comments about readiness in this domain</i>	York County has resources but more is needed. Additional community leadership can be a resource.
<b>Is there a Recovery Center and/or suggested locations for recovery community center</b>	
<i>General Comments about readiness in this domain</i>	The need for peer recovery centers was identified and an RFP was being reviewed if it could be used for this purpose.
<b>Overall comments about the district's readiness</b>	<p>The York district has clear knowledge of their drug crisis and some of the causes. They have access to inpatient and outpatient programs (including a drug court) but more treatments resources are needed. Recovery supports, Recovery Center and the need to address stigma were part of the conversation. They have begun planning and taken steps to reviews grants.</p> <p>York district's next steps are:</p> <ol style="list-style-type: none"> <li>1. To keep conversations going with the Public Health Council and to keep planning and building on SHNAPP assessment;</li> <li>2. Review the Recovery Center Grant and design it to fit York County needs; and</li> <li>3. Create a strategic plan with the focus on obtaining more prescribers for MAT - hospitals can take the lead; and</li> <li>4. Community Care Team - Case Review</li> </ol>

<i>District 2 — Cumberland</i>	
<b>Knowledge of the Issue:</b>	
<i>Causes</i>	<ul style="list-style-type: none"> <li>• Reduce access to opiates/change prescribing practices</li> <li>• Change our approach to chronic pain management/support patient education and involvement in their own health care decisions</li> <li>• Support for people who are feeling disconnected and/or hopeless</li> </ul>
<i>Consequences</i>	
<i>Impact on community</i>	<ul style="list-style-type: none"> <li>• Limit arrests following overdose reporting because more arrests mean less reporting will happen</li> </ul>
<i>General Comments about readiness in this domain</i>	Multifaceted reasons why people begin to use opioids was acknowledged
<b>Efforts:</b>	
<i>Programs, services, activities</i>	<ul style="list-style-type: none"> <li>• Diversion/LEAD model</li> <li>• Operation HOPE (like Scarborough) with local treatment options</li> <li>• Portland LEAAP model (mental health/substance use disorders professionals embedded in the police department)</li> <li>• Connect young people with people in recovery (e.g. Young People in Recovery model)</li> <li>• Engage youth, including video storytelling (Project Award model)</li> <li>• Greater Portland Addiction Collaborative model</li> <li>• Recover Together model (Group Therapy)Embed mental health personnel in the police department</li> <li>• Add more drug courts and defer adjudication</li> <li>• "Safe Sites" - supervised injection sites (Vancouver, Ithaca NY models)</li> <li>• South Portland tip line</li> </ul>
<i>Policies</i>	<ul style="list-style-type: none"> <li>• A marketing/branding of stories and blueprint for action and changes needs to be developed including more funding for prevention, treatment and recovery.</li> <li>• Expansion of MaineCare and lower insurance costs is needed.</li> <li>• We need to be strong advocates for federal, state, and local programs and funding.</li> </ul>
<i>General Comments about readiness in this domain</i>	There is a desire to expand the programs listed above. There is a strong belief more efforts need to be centered on education and outreach for youth (starting at a young age), parents, law enforcement personnel.

<b>Knowledge of Efforts:</b>	
<i>Know about efforts, programs, services, activities</i>	<ul style="list-style-type: none"> <li>• More funding is needed treatment of single men, women, parents; detox and residential care</li> <li>• More peer recovery centers (especially in rural areas)</li> <li>• More sober housing (bigger is better: more people = more support for anyone struggling)</li> <li>• More forums/meetings for discussion, sharing, education, connecting to resources</li> <li>• More funding is needed for prevention</li> <li>• More funding for law enforcement efforts that support transitions to treatment programs</li> <li>• More Residential care (especially for women and women and/or men with children)</li> </ul>
<i>Know about effectiveness of services, programs, activities</i>	
<i>Programs, services, activities are accessible</i>	<ul style="list-style-type: none"> <li>• There needs to be more collaborative efforts to expand access to treatment with existing resources.</li> <li>• More treatment options to which law enforcement can refer</li> <li>• Focus on retention - keep people in the system</li> <li>• Embed mental health personnel in the police department</li> <li>• Add more drug courts and defer adjudication</li> </ul>
<i>General Comments about readiness in this domain</i>	<ul style="list-style-type: none"> <li>• Community members are knowledgeable of the efforts but it needs to be expanded</li> <li>• Focus on retention - keep people in the system</li> </ul>
<b>Leadership:</b>	
<i>Leaders supportive</i>	<ul style="list-style-type: none"> <li>• Add more drug courts and defer adjudication</li> </ul>
<i>Influential members supportive</i>	<ul style="list-style-type: none"> <li>• More work around engaging state and local community and business leaders through shared and ongoing conversations/dialogue about the opioid usage.</li> </ul>
<i>General Comments about readiness in this domain</i>	Leadership needs to be expanded with the engagement of state, community and local business leaders
<b>Climate: Metrics for readiness:</b>	
<i>Helplessness</i>	<ul style="list-style-type: none"> <li>• Support for people who are feeling disconnected and/or helpless</li> </ul>
<i>Responsibility</i>	<ul style="list-style-type: none"> <li>• Through education of youth/students create school programs which reduce stigma/shame and provide support, teach kids they</li> </ul>

	<p>can help others and where they can get help and school forums tailored to young people with young people on the panel</p> <ul style="list-style-type: none"><li>• More forums/meeting need to be schedule with community and family members for discussions, information sharing, education and connecting to resources.</li><li>• Engage recovery community in supporting people with substance use disorder who are getting out of the hospital or jail</li><li>• Arrest more traffickers than users</li><li>• Provide option such as needle exchange, more public access to Narcan/Naloxone, train more people how to administer Narcan/Naloxone besides EMTs (e.g. police, first responders state troopers) and provide safe sites</li></ul>
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<i>District 3 — Western</i>	
<b>Knowledge of the Issue:</b>	
<i>Causes</i>	<ul style="list-style-type: none"> <li>• Confront poverty and social issues</li> <li>• Change prescribing culture</li> <li>• The perception of lower risk of marijuana could increase use/experimentation</li> <li>• Concerns about expanded use/scope of medical marijuana without adequate evidence (e.g. treating opiate addiction)</li> <li>• System inefficiencies are a burden and a barrier to someone with addiction</li> </ul>
<i>Consequences</i>	<ul style="list-style-type: none"> <li>• Not confronting poverty and social issues and changing the prescribing culture increases substance abuse. In addition the increasing perception around expanded use of marijuana for treating opiate addiction and other medical issues is a concern due to lack of evidence.</li> </ul>
<i>Impact on community</i>	
<i>General Comments about readiness in this domain</i>	The causes mentioned by the Western district are poverty and social issues, the prescribing culture and the increasing acceptance that marijuana should be used to treat opiate addiction and other medical issues.
<b>Efforts:</b>	
<i>Programs, services, activities</i>	
<i>Policies</i>	
<i>General Comments about readiness in this domain</i>	
<b>Knowledge of Efforts:</b>	
<i>Know about efforts, programs, services, activities</i>	<ul style="list-style-type: none"> <li>• Community and parent groups and community relationships</li> <li>• Comprehensive school and community programs like Project Unite in Lewiston</li> <li>• Women for Sobriety (<a href="http://www.womenforsobriety.org">www.womenforsobriety.org</a>)</li> <li>• Operation Hope (Gloucester, MA)</li> <li>• Project Save ME model (including local Fundraisers) for people who are actively using to get into treatment</li> <li>• NAR-Anon, Al-Anon and other groups</li> <li>• Learn2Cope Program</li> </ul>

	<ul style="list-style-type: none"> <li>• Head Start</li> <li>• More Medication Assisted Therapy (MAT) options locally</li> <li>• Expand DARE K-12</li> </ul>
<i>Know about effectiveness of services, programs, activities</i>	<ul style="list-style-type: none"> <li>• Resource Hub - Maine.gov needs to be easier</li> </ul>
<i>Programs, services, activities are accessible</i>	
<i>General Comments about readiness in this domain</i>	The community has knowledge about some programs Statewide, and very few in their communities. The effectiveness of the Maine.gov site needs to be improved so it is easier to obtain information. Generally, there was an indication that some of the programs offered in the State by other communities should be rolled out Statewide.
<b>Leadership:</b>	
<i>Leaders supportive</i>	
<i>Influential members supportive</i>	
<i>General Comments about readiness in this domain</i>	
<b>Climate:</b>	
<i>Helplessness</i>	
<i>Responsibility</i>	<ul style="list-style-type: none"> <li>• This problem needs a community response - we all need to sign up together to help</li> <li>• EMS, law enforcement and treatment providers should work as a team</li> <li>• Programs to reduce bias/stigma are needed</li> <li>• Educate the community including children, youth, parents on the risks associated with marijuana use and medical marijuana and limits on location/venting of medical marijuana production/sales</li> <li>• More programs are needed to educate children at a young age with many of the programs in the schools.</li> <li>• Meetings should be set up between people in recovery and law enforcement</li> <li>• Screen children regularly for trauma and mental health issues at school and pediatrician's office</li> </ul>

	<ul style="list-style-type: none"> <li>• Six-month maternity leave to reduce stress on parents and give babies a strong start</li> <li>• More detox options in Maine and regions and more counseling and treatment options</li> <li>• Additional treatment is needed such as more detox beds, residential rehab with longer stays, treatment option for people getting out of the hospital, more Suboxone providers, and longer treatment periods</li> <li>• Need treatment alternatives other than jail</li> </ul>
<i>Empowerment</i>	<ul style="list-style-type: none"> <li>• Parents need to be open-minded about what your kids might be doing (trust other parents) and need to do tell other parents what their kids are doing/going through</li> <li>• Faith-based support</li> <li>• Normalize hospitals as a point of entry - it shouldn't be law enforcement</li> <li>• Ways for the public to provide anonymous information to law enforcement</li> <li>• Make law enforcement part of the solution - be a friend</li> </ul>
<i>General Comments about readiness in this domain</i>	
<b>Resources:</b>	
<i>People</i>	<ul style="list-style-type: none"> <li>• Additional resources needed for new educational programs and infrastructure for educators, families, employers, law enforcement and other members of the community as well as the person with a substance abuse issue.</li> </ul>
<i>Time</i>	
<i>Money</i>	<ul style="list-style-type: none"> <li>• Need to accept federal funds and have a plan for when new resources become available</li> <li>• Need to do some analysis to figure out what successful states are doing to get federal funding</li> <li>• More funding for new educational programs for children, youth, families, teachers, community and law enforcement.</li> <li>• More funding needed to support infrastructure - state cuts are very problematic</li> <li>• Explore use of other accountability tools, including new technology/bio-monitoring</li> </ul>
<i>Space</i>	<ul style="list-style-type: none"> <li>• Recovery Community Center/Club with services such as walk-in resources - counselors available, safe, peer-to-peer engagement, regular outreach call to folks who go there, education how to use/navigate existing resources and on resources available</li> </ul>

<p><i>General Comments about readiness in this domain</i></p>	<p>Additional resources and infrastructure to educate families, educators, employers, law enforcement and other member of the community as well as the individual with a substance use disorder are needed. Analysis needs to be done to determine how other states get federal funding and Maine need to do the same. Infrastructure is needed to provide a safe place for people with substance use disorders and where they can get counseling and help with questions about detox to long-term recovery. Law enforcement need to understand substance abuse is a disease and not something easily fixed and more meetings between law enforcement and the person who has a substance use disorder and their families will help. In general funding is needed to educate and implement new programs for long-term support. Insurance coverage is needed for the individual with a substance use disorder.</p>
<p><b>Is there a Recovery Center and/or Suggested locations for recovery community center</b></p>	<ul style="list-style-type: none"> <li>• More Sober Housing</li> <li>• More Residential Rehab beds</li> <li>• Recovery Community Center/Club</li> </ul>
<p><i>General Comments about readiness in this domain</i></p>	<p>Feedback from the Western district indicate more residential care facilities, sober houses and a recovery community centers/club are needed.</p>
<p><b>Overall Comments about the District's Readiness</b></p>	<p>Western district indicated in their survey responses that there is a drug addiction crisis due to the current opiate prescribing culture, the lack of addressing the poverty and social issues and the push to legalize marijuana for medical and general population use. The surveys indicated a specific need for a Recovery Community Center/Club (not specific location) as well as a need for more Sober housing and Residential Rehab beds. The Center/Club would include walk-in resources, safe peer-to-peer engagement, regular outreach with volunteers, engaging landlords, businesses, and volunteers, education on how to use existing resources and education on resources availability to others.</p>

<i>District 4 — Midcoast</i>	
<b>Knowledge of the Issue:</b>	
<i>Causes</i>	<ul style="list-style-type: none"> <li>• Elimination of "chem-free" floors on campus, which condone substance/alcohol use by others</li> <li>• Marketing of prescription drugs</li> <li>• The marijuana ballot question is concerning</li> <li>• Mental health not identified as a major related/contributing factor to substance use disorder</li> </ul>
<i>Consequences</i>	<ul style="list-style-type: none"> <li>• Our jails are filled with people who've committed drug/alcohol related crimes and emergency rooms are being used by people who can't access treatment.</li> <li>• Substance use disorder and opiate/heroin problems extracts a high cost on families, local economies and the jail system</li> </ul>
<i>Impact on community</i>	<ul style="list-style-type: none"> <li>• High costs for families, local economies and the jail system</li> </ul>
<i>General Comments about readiness in this domain</i>	<p>With the elimination of "chem-free" floors on campus and limiting the marketing of prescription drugs substance use could be minimized. There is concern with the marijuana ballot question because easy access to marijuana would increase substance use. Substance problems fill our jails with people who are not harden criminals and extract high costs for families, local economies and the legal system.</p>
<b>Efforts:</b>	
<i>Programs, services, activities</i>	
<i>Policies</i>	
<i>General Comments about readiness in this domain</i>	
<b>Knowledge of Efforts:</b>	
<i>Know about efforts, programs, services, activities</i>	
<i>Know about effectiveness of services, programs, activities</i>	<ul style="list-style-type: none"> <li>• Waldo County's "We CARE" (Waldo Encourages Community Assisted Recovery Efforts) is very important but more must be done</li> <li>• Expand the types of providers who can treat (e.g. Nurse Practitioners, Physician Assistants) with MAYT</li> <li>• Physician medication management</li> </ul>

	<ul style="list-style-type: none"> <li>• Programs like Project HOPE that create resources for law enforcement to help people access treatment</li> <li>• More medication assisted treatment</li> <li>• Needle Exchange Program</li> </ul>
<i>Programs, services, activities are accessible</i>	
<i>General Comments about readiness in this domain</i>	The community has little knowledge about programs, services and activities in their district. Waldo has the We Care program but more funding is needed to expand the program. A program like Project HOPE would benefit the Midcoast area. In addition, more providers are need to treat the person with a substance use disorder. There should be drug regulation rather than drug prohibition.
<b>Leadership:</b>	
<i>Leaders supportive</i>	
<i>Influential members supportive</i>	
<i>General Comments about readiness in this domain</i>	
<b>Climate:</b>	
<i>Helplessness</i>	
<i>Responsibility</i>	<ul style="list-style-type: none"> <li>• We need to build relationships and restore connect with schools, families, neighbors, law enforcement and employers/employees.</li> <li>• We need ALL treatment options because the path to good health will be different for different people - we should not be pitting one approach against another approach.</li> <li>• Need to prevent legalization of marijuana</li> <li>• Law enforcement and treatment providers should work as a team</li> <li>• Programs to reduce bias/stigma and isolation - need to talk to the community more, put a face on the disease, use first person language need to educate neighbors - show we care</li> <li>• More coordination between clinics, hospitals insurance companies</li> <li>• More programs are needed to educate children at a young age with many of the programs in the schools (e.g. including kids aged 0-3 years, look at family court system and child protection system, and talk to kids to find out why they do drugs)</li> <li>• Have specialists go into schools regularly</li> </ul>

	<ul style="list-style-type: none"> <li>• Programs to educate teachers, parents and get them involved, health care providers, businesses so they can support their employees and to help everyone understand it's a brain disease</li> <li>• More police in schools as a deterrent</li> <li>• More Suboxone treatment providers</li> <li>• Extended probation times - probation is an important piece of the support system</li> <li>• More treatment in jails and support for those being released</li> <li>• Make Suboxone treatment the first step in the judicial system</li> <li>• Support for the spiritual aspects of treatment</li> <li>• Affordable health insurance</li> <li>• Drug court diversion programs</li> </ul>
<i>Empowerment</i>	<ul style="list-style-type: none"> <li>• Reduce bias among health care providers - create an easier path for accessing treatment</li> </ul>
<i>General Comments about readiness in this domain</i>	<p>Midcoast have many needs starting with education of young children, youth, school personnel, families, neighbors, law enforcement personnel and employers/employees. The programs need to reduce the bias/stigma and isolation and help them seek the treatment option that would be best for them. There also needs to be education about all types of treatment options (e.g. acupuncture). It is important to also promote communication and coordination among hospitals, clinics and insurance companies. Finally, programs and treatments need to be available in jails and once the individual is out and a longer probation time. Suboxone needs to be readily available for people with a substance abuse disorder.</p>
<b>Resources:</b>	
<i>People</i>	<ul style="list-style-type: none"> <li>• Additional resources needed for new educational and support programs and infrastructure for youth, young people, educators, families, employers/employees, law enforcement and other members of the community as well as the person with a substance abuse disorder.</li> <li>• More funding is needed to implementing more types of treatment options</li> <li>• More providers willing and able to treat disorder and addiction</li> </ul>
<i>Time</i>	
<i>Money</i>	<ul style="list-style-type: none"> <li>• Funding for law enforcement efforts and treatment program for individuals in jail</li> <li>• More funding for new educational programs for children, youth, families, teachers, community and law enforcement including volunteers</li> <li>• Funding for individuals in recovery (e.g. housing, employment assistance, community support)</li> </ul>

	<ul style="list-style-type: none"> <li>• Funding for needle exchange program</li> <li>• Funding for We Care program</li> </ul>
<i>Space</i>	<ul style="list-style-type: none"> <li>• Facilities needed for programs such as Project Hope</li> <li>• Increase availability of treatment options, including beds for people without health insurance</li> </ul>
<i>General Comments about readiness in this domain</i>	<p>Additional funding is needed for existing and new programs for to educate families, educators, employers, law enforcement and other member of the community as well as the individual with a substance abuse disorder. Programs and Infrastructure will provide a safe place for people with substance abuse disorders; and where they can get counseling and help with questions about detox to long-term recovery. In addition, funding and facilities are needed for people in long-term recovery for housing, employment assistance, etc. Finally, it is important to be open to treatment options and have as many available to individuals as possible. A treatment option for one person may not work for another.</p>
<b>Is there a Recovery Center and/or Suggested locations for recovery community center</b>	<ul style="list-style-type: none"> <li>• Housing for people in recovery</li> <li>• Need more places in the community for people in recovery to live and gather such as sober houses, coffee house, recovery centers and other substance-free group spaces</li> </ul>
<i>General Comments about readiness in this domain</i>	<p>Listening sessions from the Midcoast district indicate more housing is needed for people in recovery especially for those people without insurance. These options may include sober houses, coffee houses, recovery centers and other substance-free group spaces.</p>
<b>Overall Comments about the District's Readiness</b>	<p>Midcoast district indicated in their survey responses that there is a drug addiction crisis due to the current opiate marketing culture, mental health (major factor to drug use), the push to legalize marijuana for medical and general population use and "chem-free" floors on campus which condone substance/alcohol use. The surveys indicated a specific need for housing for people in recovery and more beds for people without insurance. The places for people to gather could be sober, coffee and recovery centers. Although the surveys indicated a need for recovery centers, there was no indicate where the Centers need be located.</p>

<i>District 5 — Central</i>	
<b>Knowledge of the Issue:</b>	
<i>Causes</i>	
<i>Consequences</i>	
<i>Impact on community</i>	
<i>General Comments about readiness in this domain</i>	Central district, survey from Skowhegan specifically, did not list any cause for the drug crisis in their community. Their survey responses indicate they know there is a crisis, but did not list causes or consequences.
<b>Efforts:</b>	
<i>Programs, services, activities</i>	
<i>Policies</i>	
<i>General Comments about readiness in this domain</i>	
<b>Knowledge of Efforts:</b>	
<i>Know about efforts, programs, services, activities</i>	<ul style="list-style-type: none"> <li>• Al-A-Teen - support for kids in families with addiction</li> <li>• ACEs - brain development</li> <li>• Resources for NAR-Anon and similar groups</li> <li>• Primary doctors should screen for ACEs (Adverse Childhood Experiences)</li> <li>• More local treatment options with counseling in Somerset County - especially Medication Assisted Therapy</li> </ul>
<i>Know about effectiveness of services, programs, activities</i>	
<i>Programs, services, activities are accessible</i>	
<i>General Comments about readiness in this domain</i>	The community in the Western district mentioned several programs in their survey but it as not stated whether or not these programs were available. The programs mentioned are those that are national and available throughout the country. It is clear that more local treatment options with counseling are needed in Somerset County especially those using Medication Assisted Therapy.

<b>Leadership:</b>	
<i>Leaders supportive</i>	
<i>Influential members supportive</i>	
<i>General Comments about readiness in this domain</i>	
<b>Climate:</b>	
<i>Helplessness</i>	<ul style="list-style-type: none"> <li>• No one group can solve this alone - the community must come together; we all need to sign up and get involved</li> </ul>
<i>Responsibility</i>	<ul style="list-style-type: none"> <li>• Break down information silos - create ways for teachers, law enforcement and providers to share information</li> <li>• There needs to be more education for the addiction - it's all about the brain!</li> <li>• Programs need to be available to reduce bias/stigma and denial (for example: bring stories of recovery forward, engage recovery community to lead discussions at schools, educate on value of caring, kindness and compassion.</li> <li>• Educate the addict that addiction is a brain disease, choice is lost with addiction, that treatment works and recovery happens</li> <li>• More open conversations in schools; mandated curriculum in junior high and high school, and get involved in other kids' lives.</li> <li>• Identify and put programs into other prevention setting for youth and young adults</li> <li>• Educate, communicate and engage the community, parents, employers and provide support through community meetings, online resources, match the right message for the audience, setting clear and healthy boundaries.</li> <li>• Make Narcan available from all first responders</li> <li>• Create more needle exchange programs</li> <li>• Educate law enforcement on how to be proactive</li> </ul>
<i>Empowerment</i>	<ul style="list-style-type: none"> <li>• Break down information silos - create ways for teachers, law enforcement and providers to share information</li> <li>• Break the "no talk" rule for kids - break the silence</li> <li>• Support for employers for appointment times</li> <li>• Make sure company insurance plans cover treatment</li> </ul>
<i>General Comments about readiness in this domain</i>	Central district indicated a strong need for more education to reduce bias/stigma and denial surrounding drug use as well as scientific education about the brain. The community needs to bring together schools, youths/students, parents, law enforcement and employees to openly discuss drug usage to break down the barriers. In addition

	<p>more community partnerships and information sharing needs to take place between law enforcement and the schools and families. Communities need to have a safe way to communicate to law enforcement about drug dealers. Finally to help reduce the feeling of helplessness, all groups need to "get involved" because no one group can solve the problem.</p>
<b>Resources:</b>	
<i>People</i>	<ul style="list-style-type: none"> <li>• Additional staff will be need to implement educational and treatment programs for youth, parents, law enforcement personnel, and the addict. It will take more personnel to support the affected person beginning with prevention, treatment and recovery. Treatment access should be real-time to help the affect person get help quickly. Additional resources for long-term in-state treatment programs</li> <li>• More resources are needed to support people in recovery. They need help with finding work, housing, access to programs such as NA, AA programs.</li> <li>• Engage the community in providing volunteer supports - rides to appointment and meetings, buying lunch, and building community relationships which will increase hope</li> </ul>
<i>Time</i>	
<i>Money</i>	<ul style="list-style-type: none"> <li>• Additional funding will be needed to increase staffing for new treatment (group and individual) and recovery programs.</li> <li>• If treatment is kept local, it will be less expensive - we need to shift resources to local solutions.</li> <li>• Local fundraising for scholarships (e.g. walks, 5K, etc.)</li> <li>• Expansion of MaineCare</li> <li>• Affordable insurance that cover treatment</li> <li>• Funding is need for treatment in jail through release including a warm handoff, Diversion programs, funding for a drug court and judge.</li> </ul>
<i>Space</i>	<ul style="list-style-type: none"> <li>• More safe houses and sober living options</li> <li>• More local treatment options</li> <li>• Skowhegan needs an intensive outpatient program</li> </ul>
<i>General Comments about readiness in this domain</i>	<p>Specifically stated in the Central district survey, there is a need to fund additional resources to support programs dealing with SUD to support for those still struggling and those in recovery. Educational programs are needed for the community, law enforcement, schools, youth, and parents. Skowhegan need an intensive outpatient program and there is a need to add a judge and create a drug court. All of this requires more funding and resources, but it was mentioned that some of the funding could be offset by fundraising.</p>

<b>Is there a Recovery Center and/or Suggested locations for recovery community center</b>	<ul style="list-style-type: none"> <li>• Safe Houses</li> <li>• Sober Living options</li> </ul>
<i>General Comments about readiness in this domain</i>	<p>Surveys from the Central district indicate more safe houses and sober living options are needed.</p>
<b>Overall Comments about the District's Readiness</b>	<p>Although Central district understands there is a drug crisis in their district, no causes were listed for the crisis. The survey indicated a need for more funding for safe houses and sober living options, but no specific peer recovery center was mentioned. There was a strong focus on needing more funding and resources to support current and expanded programs and services and to educate teachers, law enforcement and community organizations about the problem and ask for their support and help to resolve.</p>

***District 6 — Penquis***

<b><i>District 6 — Penquis</i></b>	
<b>Knowledge of the Issue:</b>	
<i>Causes</i>	<ul style="list-style-type: none"> <li>• The pharmaceutical industry drove the problem by marketing drugs to providers and consumers</li> <li>• Heroin is cheaper and becoming more available</li> <li>• In the process of addressing heroin/opioid addiction, we can't lose track of other drug/alcohol threats</li> <li>• Seeing more fetal alcohol syndrome</li> <li>• Mental health issues</li> <li>• Screen for ACEs (Adverse Childhood Experiences)</li> <li>• Need to get to the root cause (e.g. trauma, pain, brain changes)</li> <li>• Change our cultural response to pain (the "fifth" vital sign)</li> </ul>
<i>Consequences</i>	<ul style="list-style-type: none"> <li>• 80% of law enforcement/police time spent on drug-related issues</li> <li>• Emergency room data shows big increases over last year</li> </ul>
<i>Impact on community</i>	
<i>General Comments about readiness in this domain</i>	Penquis district indicated the opiate problem began with the pharmaceutical industry advertising and marketing drugs to the providers and consumers. Currently, heroin is cheaper and becoming more available to the public. Eighty percent of the arrests are drug related and there is an increase in the number of people using the emergency rooms over last year. Finally, although there is a heroin epidemic, there are also other SUDs that need to be addressed such as alcohol.
<b>Efforts:</b>	
<i>Programs, services, activities</i>	<ul style="list-style-type: none"> <li>• NA/AA meetings (Narcotics Anonymous/faith-based options)</li> <li>• Drug take-backs are working</li> <li>• Needle exchange program</li> </ul>
<i>Policies</i>	
<i>General Comments about readiness in this domain</i>	Penquis named a few community prevention and supports which are available including NA/AA meetings, drug take-backs and needle exchange. Specifically stated the drug take-back program is working.
<b>Knowledge of Efforts:</b>	
<i>Know about efforts, programs, services, activities</i>	<ul style="list-style-type: none"> <li>• Save a Life Coalition - 1st Thursday of every month from 12-1</li> <li>• NAR-Anon group</li> <li>• Local NAMI (National Alliance on Mental Illness) group</li> <li>• MAT</li> </ul>

<i>Know about effectiveness of services, programs, activities</i>	
<i>Programs, services, activities are accessible</i>	
<i>General Comments about readiness in this domain</i>	
<b>Leadership:</b>	
<i>Leaders supportive</i>	
<i>Influential members supportive</i>	
<i>General Comments about readiness in this domain</i>	
<b>Climate:</b>	
<i>Helplessness</i>	<ul style="list-style-type: none"> <li>• Youth and educational programs to build hope, reduce stigma</li> <li>• Poverty/hopelessness/insecurity</li> </ul>
<i>Responsibility</i>	<ul style="list-style-type: none"> <li>• Primary care must embrace addiction as a chronic disease.</li> <li>• Primary care doctors should screen for ACEs (Adverse Childhood Experiences)</li> <li>• Providers collaboration (example: Penobscot Community Health's Controlled Substances Committee)</li> <li>• Through education of youth/students create school programs which reduce stigma/shame and provide support</li> <li>• Peer-to-Peer communications to help reduce stigma (e.g. mentoring, shadowing to reduce stigma, fears about treating people with substance use disorder)</li> <li>• Address bias and stigma in community leaders, providers, communities, lawmakers, law enforcement (e.g. people in treatment who have babies feel shunned)</li> <li>• Educate the public this is a disease</li> <li>• Public education to reduce stigma of mental illness</li> <li>• Educate youth/students, communities/families and include faith-based support (e.g. ACEs, adults need to create a health environment, group therapy for families, mentoring programs)</li> <li>• Educate youth/student for Fatherhood Initiative, create a safe place to talk about feelings, normalize the conversation around</li> </ul>

	<p>trauma, teach the teachers about trauma and addiction, teach life/coping skills.</p> <ul style="list-style-type: none"> <li>• Educate communities/families regarding how to break the cycle of addiction, hold venues for support and story-sharing, engage recovery community in community educations and support for families with kids, stress reducing strategies</li> <li>• Educate youth regarding how drugs will affect their hopes and dreams</li> <li>• Invest in kids early with programs in early childhood education, home visits and public health nursing - add capacity and restore scope of services, population.</li> <li>• Education for community members, social service agencies (e.g. domestic violence hotline staffers), families: what is addiction like ad how can we support people</li> <li>• Should treat alternatives to chronic pain (e.g. acupuncture, CMS evaluation change, Tai Chi, Massage, Cognitive Behavioral Therapy (CBT), etc.</li> <li>• Break down information silos - create ways for teachers, law enforcement, and providers to share information</li> <li>• Require use of prescription monitoring program and engage pharmacists - proactive calls from pharmacists to providers</li> <li>• Program to educate consumers on effects of opiates</li> <li>• Give prescribers the option to fill a prescription with a smaller quantity - need legal and insurance changes to support this</li> <li>• Stop import of opiates</li> <li>• Pharmacies shouldn't be able to fill prescriptions written at out of state pain clinics</li> <li>• Insurance companies shouldn't be able to cover prescriptions written at out of state pain clinics</li> <li>• Mandate provider and pharmacist adherence to PMP (Prescription Monitoring Program) and Make PMP more user friendly</li> <li>• Educate primary providers on reducing number and dosage of prescriptions</li> <li>• Change the culture of prescribing (too often ad high doses)</li> <li>• Screening in primary care setting and screening for pharmacists</li> <li>• More access to naloxone Promote the statewide crisis line (1-888-568-1112) - this keeps people out of the emergency room.</li> <li>• Education: setting boundaries, how best to help people actively using, in treatment or recovery</li> <li>• Train teachers in what to do when they know there is a substance use disorder at home</li> </ul>
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	<ul style="list-style-type: none"> <li>• Reduce financial barriers through providing more insurance options (e.g. MaineCare) and/or changing the reimbursement for primary care to create incentive for physicians to be PC providers</li> <li>• More emphasis on mental health and combine mental health and substance abuse treatment at the same time, including out-patient (e.g. more local treatment to reduce wait time, treatment for methadone and expand physician cap)</li> <li>• Need to reassess our priorities for government spending</li> <li>• Create a system outside the primary care offices (burnout levels high) - clinics that provide MAT and counseling</li> <li>• Support for people in recovery needs to include housing, transportation to meetings (AA/NA, faith-based meetings) counseling support, employment and skill-building, help with long-term debt due to addiction)</li> <li>• Use technology to connect people in recovery (e.g. folks in jail and people without transportation)</li> <li>• Tip Line - Engage the community to report what's happening</li> <li>• Share drug arrest data (Diversion Alert model) and more collaboration among the police, DEA and sheriff</li> <li>• Change jail policies to ensure safer access to existing prescriptions</li> <li>• Update rules of evidence - how to collect and use</li> <li>• While in jail have more treatment options</li> </ul>
<i>Empowerment</i>	<ul style="list-style-type: none"> <li>• Federal funding can flow into HUD Zones (like Piscataquis County)</li> <li>• "It takes a village" - get involved - create community collaborative</li> <li>• Community ACEs training</li> <li>• More Suboxone providers (current wait list if over 75 people)</li> <li>• Promote success stories</li> </ul>
<i>General Comments about readiness in this domain</i>	<p>The Penquis district indicated a strong need for more education for youth, educators, pharmacists, medical personnel, recovery community and the individual struggle with addiction. All members of the community need to understand why individuals turn to drugs (e.g. root cause) and how to best help these people. New policies are needed to so prescription usage is connected to MAT. To empower the community and create new programs Federal funding need to flow into HUD zones. Create a program where recovering addicts can share their success stories</p>
<b>Resources:</b>	
<i>People</i>	<ul style="list-style-type: none"> <li>• Additional resources will be needed for the implementation of educational and treatment programs for youth, parents, law</li> </ul>

	<p>enforcement personnel, medical personnel, drug company personnel, pharmacists, social service agencies and the individual struggling with addiction. It will take more personnel to support the affected person beginning with understanding root cause of drug usage to prevention, treatment and long-term recovery.</p> <ul style="list-style-type: none"> <li>• Resources are needed for detox and social detox, especially out of hospital/ER with no delay and resources for emergency departments connect patients with someone in recovery</li> <li>• Resources needed for sober housing/early recovery and a resource center (e.g. center/hub, wrap-around services)</li> <li>• Resources needed to educate Suboxone providers to break down stigma of providing MAT and train all primary care providers, not just doctors</li> <li>• Resources to support law enforcement efforts (more law enforcement personnel)</li> <li>• Resources to support recovering addicts in jail and in recovery</li> </ul>
<i>Time</i>	
<i>Money</i>	<ul style="list-style-type: none"> <li>• Additional funding will be needed for the educational and treatment programs as well as recovery programs. In addition funding is needed for the uninsured for the cost of treatment and recovery house.</li> <li>• FQHCs can support each other in order to bring more funds and sites into the mix (4 FQHC's are getting new HRSA funds for screening and treatment)</li> <li>• Need sober housing and resource center (e.g. center/hub)</li> <li>• Funding for hospitals/providers (e.g. higher reimbursement rates, base reimbursement on actual costs and eliminator sequester)</li> <li>• More Federal and State funding to support programs</li> <li>• Funding to more support law enforcement personnel to root out drug dealers</li> <li>• Funding for jails - more treatment options while in jail</li> </ul>
<i>Space</i>	<ul style="list-style-type: none"> <li>• Build infrastructure including space for Suboxone providers to care for patients.</li> </ul>
<i>General Comments about readiness in this domain</i>	<p>The Penquis district has many needs for resources for existing and new programs and services. They indicated a need to expand existing programs and services and create new program and services especially facilities for detox and treatment and recovery as well as adding new programs for people in jail. Funding will be need to support these efforts and will need monies from the Federal and State support program.</p>

<p><b>Is there a Recovery Center and/or Suggested locations for recovery community center</b></p>	<ul style="list-style-type: none"> <li>• Sober Housing/early recovery</li> <li>• Resource Center/Hub</li> <li>• Create a facility that focuses on addiction</li> </ul>
<p><i>General Comments about readiness in this domain</i></p>	<p>Surveys from the Penquis district indicate more sober housing/early recovery, resource center/Hub and a facility that focuses on SUD are needed.</p>
<p><b>Overall Comments about the District's Readiness</b></p>	<p>The Penquis district clearly understands there is not only a drug crisis but alcohol crisis that needs to be addressed. The surveys responses indicate the pharmaceutical industry drive the problem by marketing drugs to providers and consumers and heroin is now cheaper and more available. In addition, there is an increase in fetal alcohol syndrome. Mental health issues need to be considered when treating an individual for SUDs. The district's surveys indicated a need for more sober housing, resource center/Hub and a facility that focuses on addiction, but there is no indication in their responses where these facilities should be located. There is also a need for additional services such as the need for more Suboxone providers with a higher cap for patients, more access to Naloxone, lower cost of insurance, and more Medication Assisted Treatment (MAT) and counseling in general as well as long term support for the individual recovering.</p>

<i>District 7 — Downeast</i>	
<b>Knowledge of the Issue:</b>	
<i>Causes</i>	<ul style="list-style-type: none"> <li>• Move away from "a pill for everything"</li> <li>• Change the culture of prescribing for both providers and patients</li> <li>• Reduce trauma and deep seated pain</li> <li>• Concern with legalizing marijuana</li> </ul>
<i>Consequences</i>	<ul style="list-style-type: none"> <li>• By moving away from "a pill for everything", fewer people would use drugs</li> <li>• By changing the culture of prescribing for both providers and patients, drug usage would decrease</li> </ul>
<i>Impact on community</i>	
<i>General Comments about readiness in this domain</i>	The culture needs to be changed to decrease prescribing "a pill for everything" both by the prescriber and patient. The drug usage is also attributed to trauma and deep seated pain. Again, providers and patients need to know and understand the effects of the drugs and trauma and consider other alternatives to treat pain and address trauma.
<b>Efforts:</b>	
<i>Programs, services, activities</i>	<ul style="list-style-type: none"> <li>• Acupuncture options, including NADA (National Acupuncture Detoxification Association): <a href="http://www.acudetox.com">www.acudetox.com</a> (Local contact: Jean Guyette, 565-3891)</li> <li>• More/universal use of Prescription Monitoring Program (PMP)</li> <li>• MAAR Community Asset Map</li> <li>• Washington County Addiction Resource Page</li> <li>• Maine.gov offers online resources</li> <li>• Residential rehab that offers Medication Assisted Therapy (MAT) - currently there is only one location in the county and it is abstinence-based</li> <li>• Currently only 3 Suboxone providers in county</li> <li>• Create a NAR-Anon group - can build on the AA system in place</li> <li>• Kids/parents programs (like "Primed for Life" program at Jonesport Beals High School)</li> <li>• Model: Courage to Speak Foundation</li> <li>• "Teen Challenge" programs</li> <li>• Support for people in recovery - "I Care Too" program it has to start in the community</li> </ul>
<i>Policies</i>	<ul style="list-style-type: none"> <li>• Change federal law regarding who can provide MAT and how many patients they can work with</li> </ul>

<i>General Comments about readiness in this domain</i>	There are several programs and services available in Aroostook County but they may not be used to the fullest extent. Currently there is not a NAR-Anon group available in the County.
<b>Knowledge of Efforts:</b>	
<i>Know about efforts, programs, services, activities</i>	<ul style="list-style-type: none"> <li>• Acupuncture options, including NADA (National Acupuncture Detoxification Association): <a href="http://www.acudetox.com">www.acudetox.com</a> (Local contact: Jean Guetta, 565-3891)</li> <li>• More/universal use of Prescription Monitoring Program (PMP)</li> <li>• MAAR Community Asset Map</li> <li>• Washington County Addiction Resource Page</li> <li>• Maine.gov offers online resources</li> <li>• Residential rehab that offers Medication Assisted Therapy (MAT) - currently there is only one location in the county and it is abstinence-based</li> <li>• Only 3 suboxone providers in the county</li> <li>• Can hospitals take on detox (currently hoping to do 3-day alcohol detox in hospital but not thinking about narcotics at this point)</li> <li>• Help with employment: Career Centers and Employers willing to hire - especially folks just getting out of jail</li> <li>• Kids/parents programs (like "Primed for Life" program at Jonesport Beals High School)</li> <li>• Model: Courage to Speak Foundation</li> <li>• "Teen Challenge" programs</li> </ul>
<i>Know about effectiveness of services, programs, activities</i>	
<i>Programs, services, activities are accessible</i>	
<i>General Comments about readiness in this domain</i>	Some of the programs or services are not readily accessible while others are local.
<b>Leadership:</b>	
<i>Leaders supportive</i>	<ul style="list-style-type: none"> <li>• Maine.gov offers online resources</li> </ul>
<i>Influential members supportive</i>	
<i>General Comments about readiness in this domain</i>	

<b>Climate:</b>	
<i>Helplessness</i>	<ul style="list-style-type: none"> <li>• Provide Hope</li> </ul>
<i>Responsibility</i>	<ul style="list-style-type: none"> <li>• More access to treatment services in real-time</li> <li>• A community strategic plan needs to be created (e.g. what's our vision? What's our collective story to raise funds?)</li> <li>• More collaboration among providers, including wraparound services</li> <li>• Educate and implement robust communications with schools, parents, the community, law enforcement, churches, and the medical profession (including pharmacies) about the disease. It is a chronic, recurring disease; and we need to educate and not be judgmental.</li> <li>• Give the parents the tools and information to make good choices</li> <li>• Adjust our language and vocabulary</li> <li>• More community collaboration and community engagement...We need to stop minding our own business; Get involved, pay attention, help call law enforcement, talk more, have compassion; Get involved to create a solid foundation for kids.</li> <li>• Create safe and supportive places for youth to gather in each town; create an inventory of options, what kids like to do and what they can control</li> <li>• Counter the growing perception problem that marijuana is a medicine</li> <li>• Jail the dealers but more support for people in jail who are users</li> <li>• Require that providers with a license to prescribe must do so</li> <li>• Engage employers to support volunteerism (e.g. Machias Savings, Bangor Savings)</li> <li>• Need a county or public health district resource hotline that is 24/7 - not just AA line</li> <li>• Support for family and friends in recovery, including how to best help people in recovery</li> <li>• Funding for life skills, housing and employment assistance.</li> <li>• More law enforcement resources for smaller towns</li> </ul>
<i>Empowerment</i>	<ul style="list-style-type: none"> <li>• Patients should get their PMP summary at the pharmacy when they pick up their prescriptions - this gives them information to discuss directly with the providers</li> <li>• More individuals should carry Narcan</li> <li>• Good Samaritan policy to incentivized 911 calls</li> <li>• Engage adults in supporting/volunteering/mentoring</li> <li>• Build a network for people looking for help, in crisis, or leaving jail - need structured programs available on demand</li> </ul>

	<ul style="list-style-type: none"> <li>• Recovery community could reach out to people who haven't reached their "bottom" - create opportunities to socialize and support them in moving into treatment and recover</li> <li>• Be careful of language - all drug (nicotine, alcohol, etc.) are different and affect all differently.</li> <li>• Peer-to-Peer Counseling</li> </ul>
<b>General Comments about readiness in this domain</b>	<p>There is a strong need to educate all community organizations about the disease of drug addiction. Everyone needs to have to right "tools" and "understanding" to help the addict. Through education and collaboration all organizations within the community will be able to support individuals through recovery. In addition, there is a growing perception that marijuana is a medicine, and this needs to be resolved quickly. All member of community organizations need to be empowered to carry Narcan and incentivized to call 911. Finally when dealing with the addict, we need to speak his/her language and not be judgmental.</p>
<b>Resources:</b>	
<i>People</i>	<ul style="list-style-type: none"> <li>• Build a network for people looking for help, in crisis, or leaving jail - need structured programs available on demand</li> <li>• Recovery community could reach out to people who haven't reached their "bottom" - create opportunities to socialize and support them in moving into treatment and recovery</li> <li>• Engage employers to support volunteerism (e.g. Machias Saving, Bangor Savings)</li> <li>• Educate providers on alternatives to treatment for chronic pain</li> </ul>
<i>Time</i>	
<i>Money</i>	<ul style="list-style-type: none"> <li>• To implement educational programs, treatment options and support the addict through treatment and recovery more funding will be needed.</li> <li>• In additional, there need to be more less expensive insurance options available, including MaineCare.</li> <li>• More funding may become available through support of bills in the legislature.</li> <li>• More funding through fund raising</li> <li>• Train Law enforcement to help people find treatment - before jail and in jail</li> <li>• Support law enforcement by reporting what you see/here</li> <li>• Need county or public healthier district resource hotline that is 24/7</li> </ul>

<i>Space</i>	<ul style="list-style-type: none"> <li>• More safe hospital-based detox that includes education about recovery and a direct transfer to a treatment center.</li> <li>• Diversion to treatment: jail is not the place for people with a sickness or illness</li> <li>• Build a "hub" treatment center</li> </ul>
<i>General Comments about readiness in this domain</i>	<p>The surveys from Ellsworth indicate there is very little available for an individual struggling with drug (opiate) issues. Throughout their surveys, they indicated a need for more programs to educate a variety of organizations in the community giving them the "tools" they need to support and individual struggling with drug addiction. In additional funding is needed to support individuals and families in treatment and recovery including building a "Hub" center more beds for detox and providing more safe hospital-based detox available. Funding is a critical need to support the programs to remove dealers off the streets to offering less expensive insurance, including MaineCare.</p>
<b>Is there a Recovery Center and/or Suggested locations for recovery community center</b>	<ul style="list-style-type: none"> <li>• Build a "hub" treatment center</li> <li>• Residential Rehab/recovery especially for women</li> </ul>
<i>General Comments about readiness in this domain</i>	<p>Surveys from the Downeast district indicate a "Hub" treatment center needs to be built.</p>
<b>Overall Comments about the District's Readiness</b>	<ul style="list-style-type: none"> <li>• The culture today is to prescribe "a pill for everything", and prescribers and patients need to consider alternative options to pain management. There is concern with the legalization of marijuana.</li> <li>• The survey from Ellsworth indicated there need to be education regarding no benefits before age 20 and using marijuana may increase psychoses and need to counter the growing perception surrounding the normalization that marijuana is medicine.</li> <li>• Responses from the Downeast surveys not only the need to build a "Hub" treatment center but also to add Residential rehab/recovery especially for women.</li> </ul>

<i>District 8 — Aroostook</i>	
<b>Knowledge of the Issue:</b>	
<i>Causes</i>	<ul style="list-style-type: none"> <li>• More employment opportunities are needed so drugs are not a lucrative business.</li> <li>• Stop prescription advertising</li> <li>• Do not legalize more drugs - don't add legal options for substance use</li> <li>• Work with Canada where there is more open access to prescription medication</li> <li>• There are alternatives to prescribing for pain - for example, Physical Therapy, Cognitive Behavioral Therapy and we need to make sure provider and consumers know these options are available.</li> <li>• We need to de-link patient satisfaction from pain management- this has created a disincentive to limited opiate prescribing.</li> </ul>
<i>Consequences</i>	<ul style="list-style-type: none"> <li>• Increase in drug sales because there low employment opportunities</li> <li>• Prescription drug advertising increase the use of prescription drugs</li> <li>• Legalizing more drugs adds to increase drug usage</li> </ul>
<i>Impact on community</i>	
<i>General Comments about readiness in this domain</i>	There are many reasons a person begins to use opiates - some had doctors prescribe opiates for pain and others begin because they need a source of income. There are a few reasons with more listed above. A few of the consequences around drug use are listed above and if some are implemented, drug usage in a community would decrease.
<b>Efforts:</b>	
<i>Efforts</i>	<ul style="list-style-type: none"> <li>• Train/connect law enforcement to treatment options (see Aroostook County Resource flyer)</li> </ul>
<i>Programs, services, activities</i>	<ul style="list-style-type: none"> <li>• Presque Isle has a Drug-Free Community grant. A meeting was held on March 31 from 9:30 am - 11:00 at the Aroostook County Action Program (ACAP)</li> <li>• Al-Anon underutilized</li> </ul>
<i>Policies</i>	
<i>General Comments about readiness in this domain</i>	In general, there are few programs available in Aroostook County. There is a strong belief more efforts need to be centered on education and outreach for youth (starting at a young ages through early 30s), parents, law enforcement personnel, medical personnel,

	faith based personnel, as well as a reduction of media advertisement by the drug companies. The youth need to be educated in the issues surrounding drug use especially opiates.
<b>Knowledge of Efforts:</b>	
<i>Know about efforts, programs, services, activities</i>	<ul style="list-style-type: none"> <li>• Presque Isle has a Drug-Free Community Grant</li> <li>• More providers are doing MAT/MAR (medication assisted treatment/recovery)</li> <li>• Bangor is doing more social detox which is approximately one week, then treatment plan (including medication assisted treatment option)</li> <li>• Link for Hope (Houlton model) - breaks down anonymity</li> <li>• Adopt-A-Block (Houlton adopted Los Angeles model) which reduces the stigma and increases compassion</li> </ul>
<i>Know about effectiveness of services, programs, activities</i>	<ul style="list-style-type: none"> <li>• The two programs adopted by Houlton reduce stigma and increase compassion for the addict.</li> </ul>
<i>Programs, services, activities are accessible</i>	<ul style="list-style-type: none"> <li>• Presque Isle has a Drug-Free Community Grant</li> <li>• More providers are doing MAT/MAR (medication assisted treatment/recovery)</li> <li>• Bangor is doing more social detox which is approximately one week, then treatment plan (including medication assisted treatment option)</li> <li>• Link for Hope (Houlton model) - breaks down anonymity; Adopt-A-Block (Houlton adopted Los Angeles mode) which reduces the stigma and increases compassion</li> </ul>
<i>General Comments about readiness in this domain</i>	There are some programs in Aroostook County which help to break down anonymity and decreases the stigma of drug use, and increases compassion for the person with SUDs. Some of the programs have been adopted from other states and some are using federal resources.
<b>Leadership:</b>	
<i>Leaders supportive</i>	<ul style="list-style-type: none"> <li>• Presque Isle has a Drug-Free Community Grant</li> </ul>
<i>Influential members supportive</i>	
<i>General Comments about readiness in this domain</i>	Presque Isle has a Drug-Free Community Grant and a meeting was held on March 31 at ACAP (Aroostook County Action Program).

<b>Climate:</b>	
<i>Helplessness</i>	<ul style="list-style-type: none"> <li>• Engage faith-based communities to confront the sense of hopelessness</li> </ul>
<i>Responsibility</i>	<ul style="list-style-type: none"> <li>• More education and speaking out/up to break down stigma and misplaced belief that "it doesn't happen here - not by people from here".</li> <li>• There needs to be more education for the addiction - it's all about the brain!</li> <li>• Law enforcement collects a lot of information that goes unused - we need more resources to make the linkages between what the law enforcement knows and what the schools know (e.g. truancy and family situations) in order to support children</li> <li>• More community partnerships and information sharing - no one entity can solve this alone.</li> <li>• More relationship building and support including appropriate messaging for families and communities</li> <li>• Increase access to take-home Naloxone and increase law enforcement access to Naloxone</li> <li>• Implement round the clock prescription take-back programs</li> </ul>
<i>Empowerment</i>	<ul style="list-style-type: none"> <li>• People need to hear, “this person with an addiction is your neighbor.” There needs to be more venues for people in recovery to tell their story. To break down the secrecy around addiction. While people are in recovery help families change behaviors and reorganize so they can help the person in recovery. Support needs to be available to help people and providers to people with addiction to wean off prescription drugs.</li> <li>• Expand authority and funding to go after the dealers.</li> <li>• Educate communities so they can assist with tips</li> </ul>
<i>General Comments about readiness in this domain</i>	<p>Aroostook County indicated a strong need for more education to reduce stigma surrounding drug use and scientific education about the brain. The community needs to openly discuss drug usage to break down the secrecy. In addition more community partnerships and information sharing needs to take place between law enforcement and the schools and families and communities need to have a safe way to communicate to law enforcement about drug dealers. Finally to help reduce the feeling of helplessness, organizations need to partner with faith-based communities.</p>
<b>Resources:</b>	
<i>People</i>	<ul style="list-style-type: none"> <li>• Additional will be needed to staff and implement educational programs for youth, parents, law enforcement personnel, medical personnel, drug company personnel, faith based personnel and the</li> </ul>

	addict. The needs with education, but continue for those affected through treatment and recovery.
<i>Time</i>	
<i>Money</i>	<ul style="list-style-type: none"> <li>• Additional funding will be needed for the educational and treatment programs as well as recovery programs. In addition funding is needed for the uninsured for the cost of treatment and recovery house.</li> </ul>
<i>Space</i>	<ul style="list-style-type: none"> <li>• Currently there are not enough bed for rehab. Space that could be used include churches, building with empty stores</li> </ul>
<i>General Comments about readiness in this domain</i>	The surveys from Presque Isle and Fort Kent indicate there is very little available for an individual struggling with drug (opiate) issues. Throughout their surveys, they indicated a need for more programs to educate a variety of groups in the community as well as youth and young adults. In addition funding is needed to support individuals and families in treatment and recovery including more beds for detox, real-time treatment, recovery houses as well as mental health personnel. Funding is a critical need to support the programs, additional personnel and facilities needed to support the treatment and recovery of addicts.
<b>Is there a Recovery Center and/or Suggested locations for recovery community center</b>	<ul style="list-style-type: none"> <li>• There are not enough rehab beds/facilities in Maine</li> <li>• More recovery houses - at least two (male and female separate) per region</li> <li>• Housing for people getting out of prison</li> <li>• More "clubhouses" - storefronts that serve as meeting places and resource hubs</li> </ul>
<i>General Comments about readiness in this domain</i>	Surveys from the Aroostook indicate more rehab beds/facilities are needed in Maine and at least 2 recovery houses (male and female separate) per region as well as more housing for people getting out of prison. In addition more "clubhouses" are needed to serve as meeting places and resource hubs.
<i>General Comments about readiness in this domain</i>	
<b>Overall Comments about the District's Readiness</b>	<ul style="list-style-type: none"> <li>• The Aroostook district surveys indicate the district struggles with high unemployment so individuals turn to selling and using drugs. To treat pain, prescribers commonly prescribe options, and both the prescriber and patient need to know there are other alternatives such as Physical Therapy and Cognitive Behavioral Therapy. Aroostook district indicated that to reduce opiate use, prescription advertising needs to stop. Finally surveys from Fort Kent and Presque Isle state marijuana use should not be legalized.</li> </ul>

	<ul style="list-style-type: none"><li>• The surveys indicate there is a need for more rehab beds/facilities in Maine and housing for individuals getting out of prison. "Clubhouses" such as storefronts are needed as meeting places and resource hubs.</li><li>• The surveys did indicate more recovery houses are needed in Maine at least two (2) in each region (e.g. at least two - male and female separate per region).</li></ul>
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<i><b>Tribal Public Health</b></i>	
<b>Knowledge of the Issue:</b>	Preventing and treating substance use disorder is the number one priority in the community and youth surveys.
<i>Causes</i>	<ul style="list-style-type: none"> <li>• Tribes have become illegal drug havens due to tribal policing and very few law enforcement resources</li> <li>• Reduce/eliminate over-prescribing (e.g. opioids)</li> <li>• Get deeper into the issues in families and the community that underlie substance use disorder</li> <li>• Train providers in using alternatives to chronic pain treatment (e.g. chronic pain collaborative)</li> </ul>
<i>Consequences</i>	<ul style="list-style-type: none"> <li>• Due to the lack of policing and few law enforcement resources and the over-prescribing of opioids, the illegal drug usage is at an epidemic state. With understanding of the issues in families and the community around substance abuse disorder, the families and community would understand the causes and effects which would help decrease usage. Finally, providers need to be trained in using alternatives to chronic pain treatment.</li> </ul>
<i>Impact on community</i>	
<i>General Comments about readiness in this domain</i>	With additional policing would help decrease in drug usage. In addition, there needs to be programs available to families and the community to help understand the underlying reasons for substance abuse disorder.
<b>Efforts:</b>	
<i>Programs, services, activities</i>	
<i>Policies</i>	
<i>General Comments about readiness in this domain</i>	
<b>Knowledge of Efforts:</b>	
<i>Know about efforts, programs, services, activities</i>	<ul style="list-style-type: none"> <li>• Maine Opiate Collaboration Task Force needs to include people in recovery Support "Caring for ME" initiative that give providers tools/resources</li> <li>• Model: Bangor Area Controlled Substances Workshop Medication Assisted Therapy (MAT)- use to resist peer pressure to sell/share</li> <li>• Bureau of Indian Affairs or Maine DEA (must have a player on the team to get help)</li> </ul>

<i>Know about effectiveness of services, programs, activities</i>	
<i>Programs, services, activities are accessible</i>	
<i>General Comments about readiness in this domain</i>	The Wabanaki community know about some programs that are available in the State, but did not list any specific program or services in their community. They indicated there is a need for a local treatment center that is culturally competent. To accomplish this, a new Wabanaki Rehabilitation, Treatment and After-Care Center needs to be created in their community. Although the community is aware of the Bureau of Indian Affairs and/or Maine DEA, they are not receiving any help from these organizations.
<b>Leadership:</b>	
<i>Leaders supportive</i>	
<i>Influential members supportive</i>	
<i>General Comments about readiness in this domain</i>	
<b>Climate:</b>	
<i>Helplessness</i>	
<i>Responsibility</i>	<ul style="list-style-type: none"> <li>• Community education to reduce bias/stigma/shame, communicate in a language that reduces stigma and disempowers</li> <li>• Raise community awareness about Suboxone programs and expand access to Suboxone - more providers doing MAT</li> <li>• There needs to be safer Suboxone dispensing through a reduction diversion, including "compassionate diversion", signing a contract, urine testing, pill counts, and required office visits</li> <li>• Third party access to Naloxone and train law enforcement on use of Naloxone</li> <li>• Create additional community support groups and train the public, people with a substance use disorder and family and friends in overdose prevention education</li> <li>• Train providers in using alternatives to chronic pain treatment (e.g. chronic pain collaborative)</li> <li>• Reconnect folks with traditional ceremonies and heritage, help people overcome emotional and help people with trauma to reconnect and heal the injury to their spirit</li> </ul>

	<ul style="list-style-type: none"> <li>• More beds for real-time treatment - eliminate wait times</li> <li>• More resources for clinics - both funding and staffing</li> <li>• Support for people in recovery such as wellness education, supports to avoid relapse, life skills, mentoring - short and long term, support from the community and engage the recovery community in a peer-to-peer wellness program - help connect people in recovery.</li> <li>• Law Enforcement needs to know about treatment options and not always select jail</li> </ul>
<i>Empowerment</i>	
<i>General Comments about readiness in this domain</i>	The Wabanaki community has many, many needs for the substance abuse situation. In general, their needs are the same as other communities in Maine with an emphasis on their culture, environment and spirit.
<b>Resources:</b>	
<i>People</i>	<ul style="list-style-type: none"> <li>• Resources are needed for new programs, new services and facilities. Currently, they do not have support from any State organization such as the Bureau of Indian Affairs so representatives will be needed from the appropriate State organizations.</li> </ul>
<i>Time</i>	
<i>Money</i>	<ul style="list-style-type: none"> <li>• Funding is needed for more staffing and facilities and new community and law enforcement programs</li> </ul>
<i>Space</i>	<ul style="list-style-type: none"> <li>• A facility is needed for people in treatment and recovery. Current there is no facility available.</li> </ul>
<i>General Comments about readiness in this domain</i>	The Wabanaki community has little funding and few resources to support the individual struggling with addiction. They need funding and resources to support a facility for individuals in treatment and recovery.
<b>Is there a Recovery Center and/or Suggested locations for recovery community center</b>	
<i>General Comments about readiness in this domain</i>	The Survey from the Tribal district indicate a Wabanaki Rehabilitation, Treatment and After-Care center is needed which is sensitive to the traditional culture of Wabanaki tribe and one that would help people with trauma to reconnect and heal the injury to their spirit.

<b>Overall Comments about the District's Readiness</b>	<ul style="list-style-type: none"><li>• The survey from the Tribal district indicate there exists illegal drug havens due to tribal policing and very few law enforcement resources, family and community issues as well as a culture of over-prescribing opiates.</li><li>• The survey from the Tribal district clearly laid out the need for a Wabanaki Rehabilitation, Treatment and After-Care center that is sensitive to the their culture and needs.</li></ul>
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## **Appendix E: Key Stakeholders Focus Group Reports**

*District 1 — York*

Peer Support Recovery Centers  
Key Stakeholder Focus Group  
July 25, 2016

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**Attendees:** Johanna Moody, Intern for Senator King, Barb Crider, YCCAC/Nasson HC, Bonita Pothier, for Senator King, Adam Hartwig, ME CDC, Sally Manninen, York Hospital, Matthew Braun, Young People in Recovery, Heidi McLeod, YCCAC, Amy Glass, Goodwill Workforce Solutions, Elizabeth Dailey, Sweetser, Bill Paterson, UNE/CHCC, Kate Meredith, MBH, Barbara Erksaul, MBH, Cherylan Camire, MBH/Crisis, Christine Grant, Day One, Doug Brag, York Police, Sara Bachelder, Milestone, Jayme Villanuva, Milestone, Dawn Self-Cooper, Labor, Erin Lovejoy, Sweetser, Jen Ouellette, YSSP

**Representation:** Peer leader, Civic/Elected Leader, Law Enforcement/Corrections, Treatment, Career Resources, School/Academic, Prevention

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**Describe your district and highlight any general assets and challenges: e.g., culture, rural geography, health disparities, employment etc.**

York District has many centralized community hubs. There is no overall one collective community that reflects York County. The district has been working on the topic of substance use for one and a half years and there have been many partners who have been included in those efforts. There are Drug-Free Communities Grants awarded in the district. There is a perception that York County has a wealth of resources but it actually lacks treatment resources. People have to travel long distances for services.

Many people in York County are transient from New Hampshire, Massachusetts and elsewhere which can make accessing resources difficult while drug use and drug trafficking knows no boundaries.

**To what extent do you think community members know or understand how substance use is affecting the community?**

The tragedies of opiate overdoses and use is well-publicized but the general public is not aware or have as much interest in other SUDs such as alcohol or marijuana. They don't know the scope of the problem of those issues. There are obituaries in the paper that note deaths from overdoses which demonstrates the willingness to acknowledge the issue.

The opiate listening sessions were well-attended by multiple sectors.

People in the community are asking how they can help, but there is no well-organized response to capitalize and coordinate the efforts across the community. Schools and coalitions review the survey information from the youth surveys and adult surveys; hospitals are reviewing the health outcomes. The district health assessment has brought together the community and hospitals to review the data. SUD is always high on the needs on health assessments. There is a lot of sharing about the health needs assessment, but the public generally is less aware of the specific data.

**To what extent do you think community members know or understand how substance use is affecting the community?**

There have been many community conversations that have brought together many people from many different sectors: four different meetings were held with 120, 50, 60 and 100 people respectively. The general public, law enforcement, physicians, and treatment organizations were represented. There are many different initiatives underway but not an overall plan for the district. Examples mentioned include:

- York County Shelter is working with the Sheriff to create recovery options in the jail.
- The county of York (County Government) is planning to open a detox and recovery center in Alfred, ME.
- *Chief of Police Douglas Bracy is working with NH Seacoast to access resources for people in need.*
- York hospital is looking to provide MAT in its PCP sites.
- YCSP is working with their psychiatrist in providing MAT (suboxone) to patients; YCSP is also adding an IOP to its level of care currently being offered
- A methadone clinic closed, but another clinic has opened.
- A chapter of YPR has been organized but is still recruiting members.
- A Peer Recovery Center, Safe Harbor Recovery Center in Portsmouth opened July 1<sup>st</sup> and will assist those in Maine, as well as those in New Hampshire. However, it is located in New Hampshire.
- A recovery coaching training was done in York. The YPR are talking with the Biddeford community about having recovery coaches and/or a 12-step recovery list to support those accessing treatment or after treatment.
- An initiative, the Community Access to Recovery program brought together the police chiefs and police departments in Kittery, York and Eliot together with local providers to offer transportation to the nearest hospital, detox facility or recovery program. Recovery coaches have been trained to work the individuals to help them navigate treatment options and support systems. A recovery coaching training (30 hour course) was provided to support this effort
- Southern Maine Health Care, Sanford location, is using Vivitrol in their partial program.
- Sanford and Saco/Biddeford have Drug-Free Community Grants.
- YPR; a second chapter in Maine was organized in Biddeford this year and another one is now in Sanford. There are efforts to get one started in York with outreach to Ogunquit.
- Treatment programs of Sweetser and Maine Behavioral Health (MBH) have hired peers (historically mental health peers but that is changing); Sweetser runs the statewide warm

line; MBH has two peer community centers (historically mental health-focused with one in Biddeford and one in Springvale); those Peer Recovery Centers do workshops on recovery from both mental health and SUD.

- York County Shelters has peers(s) on their board of directors; in their residential program they utilize a self-govern model.
- The York County Shelter works with Project Hope out of Scarborough. They have served 8 people through this program — none have received suboxone to date — that is an upcoming initiative through YCSP

### **How knowledgeable are the community members about these efforts?**

The general public generally doesn't know of the activities other than what they read in the paper but circulation for papers has decreased significantly. There is no central hub for communication and no overarching structure. YPR could serve as a vehicle for communication. There is a new developed District 1 Coordinator position which could serve this function for communication.

The Sanford Strong Coalition with its Drug-Free Community Coalition posts its notices on the superintendent's website.

### **What is the attitude toward SUD, toward empowerment and recovery?**

The people who are showing up at forums, they want to do something, anything. Someone put it this way "if you want me to hold someone up when they vomit I will do it."

Medication-Assisted Treatment (MAT) is not universally accepted in the community and this is true in the recovery community as well. There is an attitude that MAT is enabling continued use.

Primary Care Physicians are trying to get the word out to other physicians to step up and use MAT. UNE has a large grant to do interdisciplinary training on recovery in their health programs and have hired a peer to work with them. York Hospital is working with their PCPs to offer MAT.

A number of Rotary clubs (Biddeford, Kennebunk, York) are creating divisions to address SUD over the past 5–6 months. A Red Ribbon initiative formed in the Biddeford/Saco Rotary club is working to mobilize the community to encourage healthy and thriving behaviors without the influences of illegal drugs and other misused substances.

York and Kennebunk have Drug-Free Community Grants.

### **What are the resources and linkages in your community?:**

- Law enforcement/Corrections:
  - Day One has services at the LongCreek Youth Center and supports diversion and reentry for youth.

- York County Jail: Workforce Solutions and the Career Center work with the jail.
- There is program being planned to divert people from the Alfred jail and have them go into detox and a 6-month program.
- MBH has providers at the York County Jail and is the treatment provider for the York County Drug Court.
- Career development:
  - There could be a potential labor pool from people in recovery in light of the current labor shortages.
  - Goodwill Workforce Solutions program has historically worked with people in recovery and have identified employers who are open to hiring people in recovery and maintaining drug-free/supportive environments for them to work in.
  - MBH has case workers who work with vocational rehabilitation services
  - Goodwill has a program at LongCreek and has worked with Day One residential services.
  - Milestone has linked with the Maine Works program who hires people who are in recovery and ex-felons for day labor. However, transportation to job sites has been a challenge.
  - The Rotary has had this issue on their agenda.
  - York County Sheriff has discussed with Laudholm Trust the possibility of a work release program for those with drug offenses to do farm work.
  - YCSP is currently providing 12 vocational training slots to homeless, and formerly homeless, residents. These positions provide on the job training, support, evaluation, and minimum wage.
- Education programs/Institutions:
  - UNE has received a large SBIRT (screening, brief information, referral and treatment) grant which will be integrating SUD education into all health professions (3 year grant) and interdisciplinary education programs,
  - York County Community College hosted one of the opiate meetings and has had some internal meetings at the school for the school; they are a resource but are not generally represented in the community meetings.
  - Prevention Coalitions have done lots of work in the schools with youth trainings and speakers in recovery.

### **What activities to support recovery/peer engagement**

See above in the notes:

- Youth in Recovery chapters formed in the district
- Board of directors of agencies have seats designated for those in recovery
- Recovery coach trainings have taken place
- Peers are included in community meetings but not in large numbers
- UNE has hired a peer in their recent SBIRT grant award to train future health providers
- Residential programs utilize self-governance models
- Sweetser offers the warm line (peers supporting peers- historically out of mental health)
- Programs have intentional peer support specialists on staff (historically mental health)

- A program to have peers in the ED is in process

**Where might a peer center be located, resources could it link with, challenges, how would you address those challenges**

Location is a challenge due to the geographic expanse of the district. Transportation is an issue. The topic of a recovery center has come up in some recent community meetings and in Youth in Recovery meetings. The possibility of satellite sites was discussed at one of the meetings. People recently visited the newly formed Safe Harbor in Portsmouth, and others went to visit the Portland Recovery Community Center. The group commented on the large array of services done at the Portland center.

It was noted that the PRCC does not have recovery coaches training at their center. Other peer centers across the US do.

**Thoughts about the RFP?**

- Have some of funding cover the need for convening and networking across the community.
- The Public Health Councils should have required seats for people in recovery and for prevention.
- They should be flexible so they can meet and evolve to the changing needs.
- The Centers should welcome people in all phases of recovery and not exclude people who might be under the influence (although they may not be included in all the activities of the center)
- Should address the need for drug-free social and recreational programming, support linkage to treatment and services.
- Transportation needs to be addressed in responses and more funding for transportation be included in districts that have large geographic areas.

## *District 2 — Cumberland*

Peer Support Recovery Centers  
Key Stakeholder Focus Group  
July 28, 2016

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**Attendees:** Kristen Dow, Portland Public Health, Toho Soma, Portland Public Health, Zoe Miller, The Opportunity Alliance, Liz Blackwell-Moore, The Opportunity Alliance, Jiffy Kelley-Young, Catholic Charities Maine, Charlie Bernacchio, USM, Steve Cotreau, PRCC, Dan Kent, Recover Together, Jo Morrissy, MCDPH, Kelly Dell’Aquila, My Sister’s Keeper, Daniel Jones, Gorham PD, Michael Connors, Grace Street Services, Bob Fowler, Milestone, Diane Geyer, USM, Beth Blakeman-Pohl, Casco Bay CAN, Kaleigh Sloan, Casco Bay CAN, Peter Wohl, BHRM

**Representation:** Peer Leader, Civic/Elected Leader, Law Enforcement/Corrections, Treatment, Career Resources, Schools/Academic, Hospital, Prevention

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### **Describe your district and highlight any general assets and challenges: e.g., culture, rural geography, health disparities, employment, etc.**

Cumberland District is very diverse with many different communities — urban, rural, immigrants, and a varied socio-economic population. Portland is an urban hub for the county and state. There are many services available in the city of Portland, but not across the county. In addition there are many coalitions working on substance use disorders prevention and treatment in different communities, some of which are developing and connecting peer recovery. However, across the district there is no one place to access information about the various initiatives.

The Portland Recovery Community Center is located in Portland and is the only state-funded recovery center in Maine. It offers many recovery services and supports, including telephone support for its members. It has evolved over time connecting to various community initiatives, including law enforcement, primary care, and educational institutions.

The one freestanding detoxification program, Milestone, has seen an increase in demand due to the Mercy Hospital closure and is unable to accommodate the demand from Portland, the county and other communities. Many people are without insurance so upon discharge there is no follow up.

In Portland, with high rents and high occupancy, there is a lack of affordable housing. There are an abundance of sober housing and more recently, affordable sober housing has developed but the quality is variable. Most sober housing does not accept individuals on MAT and women sober housing, in particular, is limited.

**To what extent do you think community members know or understand how substance use is affecting the community?**

Over the past year there has been an increased awareness of the SUD due to media stories, the completion of eight community assessments, four opiate community listening sessions, of which two were organized by local efforts in Westbrook and Windham as well as local drug-free coalitions and others community initiatives that have formed.

Initiatives that have been formed include:

- Windham DFC coalition - Be The Influence
- Casco Bay CAN DFC Coalition
- South Portland DFC coalition - SoPo Unite (application pending)
- Westbrook DFC coalition - Communities That Care
- Westbrook CASH program — Community Approach to Stopping Heroin (and other substance use disorders)
- Bridgton community group- an active volunteer group that is pulling in community members from Oxford and New Hampshire.
- Portland Mayor’s Task Force on SUD
- Greater Portland Addiction Collaborative (GPAC); There is a Law Enforcement Addiction Advocacy Program (LEAAP) staff person in the Portland PD to answer calls for service with overdoses and help bridge to treatment.
- A multi-lingual and multi-cultural group in Portland applied for a DFC grant which is now pending.

Available data to substantiate the needs:

- Community assessment is available from Casco Bay CAN — a year 6 DFC grant.
- Opportunity Alliance has done a comparison with the rest of the state. There is higher marijuana use compared to the rest of Maine, but a reduction in alcohol, tobacco, and prescription drug use; however, overdose rates are higher.
- SCHNAPP process data: Adult binge drinking is high in the Cumberland district with an increase in treatment admissions rates.
- 21 Reasons/MCDPH has compiled data comparing Cumberland County to the state, with emphasis on multilingual/multicultural needs as well. It is part of the DFC application.

**What community efforts have taken place to address SUD in the district?**

See the above initiatives. In addition there are other initiatives and activities.

- City of Portland, in addition to the LEAAP, has a needle exchange program
- The District Coordinating Council will be looking at the SHNAPP data and formulating a District Public Health Improvement Plan (DPHIP) by December 31, 2016.
- The City of Westbrook is in process of creating a grant proposal and has reached out to Gorham, Windham and Buxton Police Departments to create a regional plan. Their CASH Coalition has been planning how to effectively address the opiate crisis locally for over a year and the initiative is composed of key stakeholders from all sectors, including

those community members in recovery. They have hired a coordinator and have three workgroups on prevention, intervention/treatment/recovery and awareness/stigma reduction that meet monthly.

- The Portland Recovery Community Center
- USM has just received a federal BRSS TACS grant and is developing a collegiate peer recovery program.
- YPR chapter was organized in Portland
- Operation Hope in Scarborough (access to treatment through the police)
- USM nursing students backpack program are working to do health assessments with the HOME team in Portland.
- MAT is being expanded through local programs and systems (MMC, Maine Medical Partners and Maine Behavioral Healthcare implementing the Integrated Medication-Assisted Therapy (IMAT) project, The Greater Portland Health is expanding MAT and has hired a peer to work full time to provide recovery support, North Bridgton Family Practice collaborates with Crooked River Counseling to offer MAT and counseling).
- Addiction Resource Center in Brunswick offer counseling and MAT and has a Healthy Generations program from pregnant and parenting women.
- Drug court has been restarted

### **How knowledgeable are the community members about these efforts?**

The community has been involved in listening sessions and initiatives and those efforts have received on going media coverage. Coalitions are doing the prevention work. Casco Bay CAN works to get information out through schools. The Opportunity Alliance provides a clearinghouse and connector to get information out. There is some duplication of efforts and some areas where the dissemination of information is not as good and there are no formalized groups that do the work to connect all of the initiatives. The District Coordinating Council, which meets every other month on the 3<sup>rd</sup> Friday does offer information among groups so they are in a position to do more collaboration. 211 is promoted to get the information about what is available for services.

### **What are the resources and linkages in your community?**

#### **Law enforcement /corrections:**

- Portland Police Chief Michael Sauschuck has been doing outreach and many police departments are working to help shape these efforts.
- Scarborough Operation Hope efforts are pulling people in from the greater Portland region.
- South Portland is following up on overdoses to help those individuals connect to resources.
- Gorham PD just received Narcan and training to dispense. It is being supplied it to police departments free of charge.

- Westbrook PD is taking the lead on a grant for SUD with the participation of Windham, Scarborough, Gorham, Cumberland Sheriff's Office and Buxton PD
- LEAAP in Portland is operational
- Project Re-Entry (BJA-funded for past 1.5 years) through the Cumberland County Sheriff's Office and Cumberland County government is a collaborative project with Maine Pretrial Services, Probation, Catholic Charities, Family Crisis Services, My Sister's Keeper, CCSME, and UNE to support successful reentry for individuals with co-occurring mental health and SUD
- Catholic Charities does clinical work with the drug court and federal SWITCH program. They also do work with a residential drug use inmate program in the federal prison.

### **Career Development:**

There have been many efforts supporting people in recovery gaining employment and employment skills. Maine Works and Goodwill Work Force Solutions are a big resource. PRCC has a jobs board. Maine Works does provide transportation to jobs. Goodwill is also helping in the Bridgton area and does in-reach at the Cumberland County jail.

Businesses are offering work to the recovery community:

- Maine Works — Construction, etc.
- Auto Europe
- Dunkin Donuts is providing work to lots of people coming out of the jail.
- DeMillo's Restaurant
- Otto Pizza
- Landscaping businesses

### **Housing Resources**

Portland is known nationally for its strong recovery community and sober housing has proliferated. Sober housing in the Portland area is becoming more affordable. However, there continues to be limited sober housing for those on MAT and for women. There is no oversight as to the quality of the housing. A new Oxford house is opening and Community Housing of Maine (CHOM) as part of GPAC is developing 48 beds for sober housing. McCauley House offers housing to women and children and Morrison Place is a residential program for individuals with co-occurring disorders.

### **Educational Programs/Institutions:**

USM started the ROCC on campus and was awarded a grant for a recovery center which will open in September. It will provide peer-to-peer support recovery. Services will be available to all students.

UNE has a SBIRT grant and providing education on recovery to all of its health professional programs. It has hired a person in recovery to assist.

Milestone HOME team has a partnership with USM. USM developed the nurses with backpack program which takes basic nursing and assessment into the field.

HMPs are doing school policy work with schools around substance use. The future funding for this effort is uncertain.

Student Integration and Reintegration Program (SIRP): Based on the Prime for Life curriculum, SIRP can be offered in the community as an alternative to suspension for at-risk youth, or it can be delivered in the school setting as part of a regular health class. When delivered in this manner, it is referred to as SIRP universal. AdCare is offering training in the delivery of both these modalities to prevention field across the state during the week of August 8<sup>th</sup>, with the intention that for every person trained, they offer at least one session and submit a sustainability plan to continue delivering this program in their communities. This is offered throughout Cumberland County, and schools and law enforcement are using it. FMI: AdCare.

### **What is the attitude toward SUD, toward empowerment and recovery?**

The last two years have seen a dramatic shift in the attitude toward SUD and recovery. Police departments are going out to the community to talk, and people are paying attention in a different way. YPR are providing personal faces to recovery. Grants now are including peers in their initiatives, e.g., the Greater Portland Health is offering MAT to 30 individuals and hiring a peer coordinator, UNE is doing a peer recovery coaching training with their school of pharmacy and MMC has a peer support program.

The Portland Recovery Community Center is a hub for people in recovery to meet, socialize and support each other. It has expanded their reach into the community and is connecting peers to other initiatives and is involved in outreach to local high schools and outpatient providers, homeless shelters, etc., and joined with YPR. There are groups at the recovery center for yoga, peer-led sober activities, and also for mental health recovery. . Peer empowerment is being recognized and sought after.

That being said, there is still quite a bit of stigma in the larger community. Drug use is often associated with people with mental health issues adding additional stigma. Family members continue to have a hard time discussing it and being public with their struggles.

Even though there is still stigma, shifts are happening. Schools are seeing diversion efforts with PDs and restorative justice initiatives are being offered rather than shaming, blaming and excluding them from school.

Language changes to substance use disorders (SUD) from substance abuse (SA) have helped. The increase in access to Naloxone shows a shift in attitude. Acceptance to MAT practices seems to be helping shift attitudes as well. SUD are being seen more as a medical diagnosis or a disease rather than a personal shortcoming.

## **What activities are there to support recovery/peer engagement?**

Dr. Craig Smith in Bridgton is advocating for more doctors to provide MAT. Dr. Andrew Leighton and Opportunity Alliance are coordinating a SUD community task force group in Bridgton area. There is a lot of readiness in Bridgton to do this work and they are pulling in people from the region around them.

PRCC is engaging peers in initiatives, empowering them to contribute what they can. The Opportunity Alliance and the Cumberland County Jail have Speaker's Bureaus. Also, the Communities Partnership for Protecting Children is developing a speaker's bureau to provide guidance and training of the speakers.

## **Peer Recovery Center Currently or in the Future**

Currently, the PRCC is a very successful recovery center in Portland with only positive references. It is a solid model for replicating elsewhere. It is a freestanding recovery center not attached to any treatment center and it has been able to create itself as the community needed it. An independent reference source for people in recovery to share and access mutual support and not be tied to a treatment center is important. Each center will be different depending on what the community itself wants, needs, and develops.

The Bridgton area is significantly distant to Portland. Transportation is a barrier. Crooked River Counseling has some peer services, but no center. The Bridgton task group would like to see one in their area. Tri-County Mental Health Services and hospital offer services in that area and they are all at the table and want to do something. They have a courthouse they share with Oxford County which is not in the district.

The CASH Coalition in Westbrook discusses with regularity the absolute need for more recovery resources. With the closing of Mercy Recovery Center, only a few support meetings have found new "homes" in Westbrook and the Portland Metro bus routes do not allow easy access to the PRCC. CASH has discussed the possibility of a small "hub" of another recovery center, an "arm" of the PRCC inside of the existing Westbrook Community Center or a "recovery bus" to access the PRCC more directly.

## **Portland Recovery Community Center Services:**

- Peer-to-peer support services
- 12-step and smart recovery
- Yoga, reiki
- Open mic, movie night
- Pro-social activities
- Outside activities in the community
- Shame and stigma reduction efforts
- Rally for Recovery

## **Thoughts about the RFP**

People responding to the RFP should be a part of the community and region they would be serving. This should be community-focused, not district-wide applications. It should not have any economic impact criteria points so it is more available for smaller organizations to apply. A 3–10 year RFP for establishing the center would be helpful; the start-up can take a while. They also would also like to see increased funding over time as capacity grows.

There should be a set funding amount in the RFP and not just go to the lowest bidder to ensure proficient capacity for delivery of services.

There might be a need for a satellite set-up or pop-ups, or multiple centers throughout rural areas. Maybe some type of telehealth piece for those in rural communities outside of community centers.

## **Who are in leadership not represented in this room that we can reach out to?**

- Chief Sauschuck and Chief Roberts in Westbrook. GPAC list: housing is part of GPAC. Mayors list. Bridgton list
- The Brunswick area hasn't been as involved in the Cumberland District as it identifies more with Midcoast.
- Locally elected officials that haven't been involved. Greater Portland Council of Governments has the ear of these officials but don't deal with the issue.
- Cumberland delegation
- Community Colleges
- EMS and medical providers
- Maine Youth Action Network
- The faith community needs to be more involved - Hope Gateway has been involved to date and My Sister's Keeper was developed out of the Cape Elizabeth United Methodist Church and connects to many other members of the faith community.
- Pharmacies

*District 3 — Western*

Peer Support Recovery Centers  
Key Stakeholder Focus Group  
Western — Oxford/Franklin/Androscoggin, District 3 — July 7, 2016  
Androscoggin County — August 9, 2016  
Franklin County — August 25, 2016

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**Attendees July 7:** Jim Douglas, Healthy Oxford Hills, Taylor Owens, Healthy Oxford Hills, Katrine Waite, CN Brown, Jennifer Small, Common Ground Counseling

**Representation:** Treatment, Employer, Prevention

**Attendees August 9:** Corrie Brown, Healthy Androscoggin, Erin Guay, Healthy Androscoggin, Elizabeth Keene, St. Mary's, Paul Rouleau, St. Mary's, Jillian Duplissis, St. Mary's, Chap. Eddie Greyfux Burgess, Carpe Diem, Emily Duley, Healthy Androscoggin

**Representation:** Peer leader, Law Enforcement/Corrections, Treatment, School/Academic, Hospital, Prevention

**Attendees August 25:** Lorri Brown, Healthy Community Coalition, Bridgette Gilbert, Farmington Police Dept., Darin Gilbert, Farmington Police Dept., Shane Cote, Farmington Police Dept., Marc Bowering, Farmington Police Dept., Richard Caton IV, Jay Police Dept., Brock Caton, UMaine/Campus Police, Brady Croteau, Health Community Coalition, Joan Dawson, Dept. of Corrections/State of Maine, Jenn Bell, Sexual Assault Prevention and Response Services, Stacie Bourassa, Franklin County Children's Task Force, Nicole Ditata, Healthy Community Coalition, Andrea Richards, Healthy Community Coalition, Dalene Sinskie, Evergreen Behavioral Services

**Representation:** Peer Leaders, Law Enforcement/Corrections, Treatment, School/Academic, Hospital, Prevention

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**Describe your district and highlight any general assets and challenges: e.g., culture, rural geography, health disparities, employment etc.**

Assets include Healthy Maine Partnerships (HMPs), which worked effectively together through the District Coordinating Council for a while. A good level of communication was established. Programming at different HMPs represents good strands of initiatives. Healthy Maine Partnerships are good at pulling resources together and were a huge asset.

Substance use disorder is one of the top issues for all 3 counties, shared on a district level.

The hospitals in the district are involved. Stephens Memorial Hospital in Oxford was involved in the coalition/task force. The hospital recently concluded a community health needs assessment, and an implementation plan that specifically includes working with community partners on the heroin/opiate addiction issue was named. The Rumford Hospital is supportive of Project SAVE ME, a Rumford PD program. St. Mary's offers detoxification.

Oxford County Wellness Collaborative, an SUD/mental health subcommittee, is providing background support for the Western Maine Addiction Task force, to align efforts for greater impact. This is a relationship that will continue to grow. In Oxford, the Western Maine Addiction Task Force was launched one year ago, laying the foundation for intervening around addictions. The diversity of the key stakeholders involved was impressive. In Franklin County, the Substance Abuse Prevention Coalition has been meeting since 2006 and is comprised of a wide group of key stakeholders.

Law enforcement is involved and very supportive of getting people treatment instead of incarceration. Law enforcement is represented in the task force meetings. In Franklin County, in February, five law enforcement groups came together to launch the beginning of a Hope program and will be working to engage other law enforcement entities across the area in that initiative.

The lack of employment is an issue across the district. CN Brown as an employer has been involved from the beginning in Oxford County and talked about how substance use is impacting business and the employer sector. They wanted to step up and help. They worked with a task force on procedures for people in recovery being eligible for employment at a Big Apple store. In Franklin County, Healthy Community Coalition and Western Maine Area Health Education Center (AHEC) are hosting the first annual Prevention Advocacy Training Health Careers (PATH Program) in November, which is designed to introduce youth to careers in SUD treatment and prevention.

Within the district there is lot to do, including outdoor activities and recreation. Successful fundraisers have been made for SUD efforts in Oxford County. There has been discussion in Oxford about using natural resources, land trusts, etc., as opportunities for people in recovery to "give back" with possible internships/positions, etc. A bike share program might also be an opportunity for employment.

Lewiston is the second largest urban area in Maine, at 110,000 people. There are two hospitals that are the biggest employers in the county. There is a significant New Mainer population from central and eastern African. There are high rates of poverty and extreme poverty. There is an influx of khat and other substances native to regions from which New Mainers are emigrating.

There are lots of SUD services in Lewiston–Auburn. However, many people do not have insurance. The treatment services in the rural areas are limited. Family members often bring in someone to detox in Lewiston–Auburn, but then find there is no residential or intensive medication management for them after detoxification in their home communities. Often insurance won't even pay for opioid detoxification. Also, there are transportation issues across

the district that pose barriers to accessing treatment. Even in the city, the bus only travels in some areas. There is a fund for people in financial crisis at St. Mary's that is often used for getting people back home to distant area but sometimes people just don't get help at all. After significant planning, Evergreen Behavioral Health in Franklin just opened an intensive outpatient level of care program in July.

Medications for Medication-Assisted Treatment are inaccessible for many patients because of the lack of insurance and lack of providers across the district.

There is a large population of sex offenders in the Lewiston–Auburn area, as many are being sent by bus from Windham state prison for treatment. They have no jobs, no transportation, and many need SUD treatment.

100 Pine is the co-occurring club house in Lewiston, and it is closing. There is the Friends Together social club in Livermore Falls. The new RFP is daunting and other entities are not coming forward to submit. In the RFP, Rumford, Farmington, and Lewiston all need to be in one district but there is no transportation in between.

### **Challenges:**

- The district consists of 3 very different counties, urban to very rural with a large geographic spread of 1200 square miles.
- Transportation issues are huge across the district which impacts access to services and recovery, specifically in Oxford and Franklin Counties, and rural Androscoggin County.
- Lack of employment and job opportunities. Many people lack insurance and cannot access treatment services.
- Lack of different levels of care in the district. Intensive outpatient services, residential, and detoxification services are very limited. Once an individual has gone through detoxification, there are limited residential program to transition into.
- Lack of Medication-Assisted Treatment providers
- It is hard to start 12-step groups due to transportation barriers. Only Franklin County has Narcotic Anonymous meetings

### **To what extent do you think community members know or understand how substance use is affecting the community?**

The perception is that it is the homeless who have SUD, but in reality is it cuts across classes and social structures. Some in the community may not want to talk about it — if it's not impacting them personally, they feel it's not their problem. There is still stigma for those with addiction and a need for the general public to have more understanding around SUD and to address stigma. This can affect people wanting to access treatment and the ability to speak out about their own substance use recovery. Primarily it is the family members affected by overdoses that are speaking out about the issue. The general public has awareness but there is still work to do around understanding the issues around SUD, and to address stigma.

The medical community needs more education around prescribing. Some doctors and surgeons will work with the provider community on making sure people in recovery are not being prescribed opiates, but others still prescribe because it's standard procedure. There are not enough Suboxone providers and there is reluctance to start providing it because of the perception that clients with SUD can be challenging, and the need to connect clients to treatment. Some clients just want the meds and not the counseling, skill building, etc. In Franklin County there are a couple of Suboxone prescribers and there are those that have their waivers but are not yet prescribing.

In Androscoggin County it was noted that there is no understanding of the difference between abstinence-based programs and harm reduction or alcohol versus opiate addiction. The nature of substance use disorders and the recovery process is not widely understood.

Forums were held across the district and had strong attendance. In Oxford County forums were held in Rumford and South Paris. Fryeburg has agreed to have one, as well as West Paris. Lewiston/Auburn held forms. There were three forums locally organized in Franklin County.

The Western District has held an Annual Alcohol and Addiction Conference which has drawn over 1,100 people over the years.

Other evidence that shows that people are knowledgeable include the following:

- Project SAVE ME
- A recovery event planned for September for Oxford County
- Two successful fundraisers in Oxford
- There is media coverage across the district. Reporters are following the efforts and writing articles regularly. In Franklin there is an online news site.
- Obituary coverage has begun to be shared about the nature of deaths from overdoses
- Meetings with Senator King have happened in Oxford
- Community education efforts are being made by the HMPs around SUD. There are robust SUD prevention work plans.
- Prescription drug safety. There are dropboxes in all 3 counties, and take-back events.
- Presentations at Bates College
- There is work going on with the elderly population on medicine safety
- Marijuana education — every school in the service area gets prevention education/presentations
- Student Intervention Reintegration Program (SIRP) in Auburn
- Active Restorative Justice program in Oxford Comprehensive School
- Piloting a prevention program in schools in Oxford in 6 homerooms. The goal is to create safe environment, and promote peer-to-peer education.
- Great presence on social media — lots of posts around recovery information and other SUD information. People are getting the word out if a “bad batch” of heroin is out in the community creating ODs.

- The River Valley Drug-Free Coalition, Healthy Androscoggin Drug-Free Coalition, and Substance Abuse Prevention Coalition in Franklin
- The Wellness Collaborative provided training for law enforcement around trauma and crisis, as well as addiction as a disease.
- Training for and dispensing of Narcan is occurring across the district
- Oxford County Mental Health does ride-alongs with PDs
- Insight Vision — strategy maps, these are being finalized with metrics (e.g., how many recovery coaches trained). The info will be put on their website, etc.

**Data:**

- TDS data, WITS is more challenging — treatment data, and MIYHS data are being used for planning purposes and monitoring
- Law enforcement frequently have information on arrests, ODs, etc. Data is shared as task force meetings.
- County Health Rankings — keeps flagging that SUD is an issue in districts. The results are reviewed and communicated annually, shared through coalition gatherings, and incorporated into wellness collaborative gatherings.
- In Franklin County, SUD is in the top 5 risk factors identified in child protective cases

**What community efforts have taken place to address SUD in your district?**

- NA meetings — Norway, Franklin but not on the weekends
- AA is available. There is an active AA/recovery community in Lewiston and Auburn and in other areas of the district.
- The composition of the boards of the task forces includes people in recovery and affected others/family, but not in all areas of the district
- A mother started an Nar-Anon meeting
- Oxford County Mental Health has a drop-in center in Rumford — Beacon House — for co-occurring
- SAD 17 — restorative justice trained faculty
- St. Francis has a residential program that has been there for many years
- There is an abundance of agencies doing outpatient services for chemical dependency, Intensive Outpatient services, and case management, but these services are not available universally. Evergreen Behavioral Health started an Intensive Outpatient program in Franklin County in July of this year.
- St. Mary's has outpatient, detox and counseling services. Many services are available, but are inaccessible to many because of lack of insurance
- There have been sober houses in the past, though some are only boarding houses that are sober and not really sober houses. Others have closed down. There is one for sex offenders to maintain sobriety, live, and meet.
- There was the 12 Hour club in Lewiston, which has moved from downtown Lewiston–Auburn to the suburbs

- The Behavioral Emergency Department at St. Mary's has made St. Mary's somewhat of the safety net for the region around SUD
- Androscoggin Jail is getting lots of people with SUD. Many are going into detox in the jails, but there is a lack of services for them.
- Healthy Androscoggin has prevention efforts, medicine take-back programs, medicine safety education, Prime for Life at Auburn School Dept., and various presentations and programs in schools. There are issues surfacing around immigrants and prescription confusion and sharing. Healthy Androscoggin is developing new tools to help explain medication usage and rules with this community.
- April Take Back — had over 700 people participate in Androscoggin
- Boxes in 6 locations in Androscoggin County
- Neighbor to Neighbor with the New Mainer community — education around alcohol, tobacco, and SUD
- Project Unite task force in Lewiston–Auburn
- In Franklin County, an operation Hope program began in February with 5 law enforcement departments participating, and more participation is being developed.
- In Franklin County, Healthy Community Coalition and Western Maine Area Health Education Center (AHEC) are hosting the first annual Prevention Advocacy Training Health Careers (PATH Program) in November, which is designed to introduce youth to careers in SUD treatment and prevention.

### **How knowledgeable are community members about efforts or programs?**

The average community member is not knowledgeable about the efforts. It is a complex system. Shame is still high around these issues and among people using these services, so they do not share their experiences or want to access the services for fear of being seen at those services. It is a very private illness due to the stigma still associated with it. The community generally is aware of the treatment agencies but access can be limited.

- Task Forces, Drug-Free Coalitions and other collaborative efforts have wide and diverse representation such as in the Western Maine Alliance Task Force with representation from education, social services, media, health, clergy, peers, district attorney, lawyers, restorative justice, civic and elected leaders, law enforcement, renters association, transportation, pharmacy, public health, and students.
- Attitudes toward efforts seems to vary across the district
- CN Brown got a lot of positive feedback. There was a lot of support expressed for businesses stepping up to support people in recovery. Interns will be learning from CN Brown protocols and the company will disseminate their learnings to other businesses to grow efforts.

### **What is the prevailing attitude of the community toward the issues and efforts?**

Stigma is still a significant issue. There is stigma about getting support and being branded for doing so. Those in the community may not want to talk about it, and feel that if it's not

impacting them personally then it's not their problem. There is a line in the sand: opiates are bad but other things will sort themselves out. There are thoughts of, "there is a difference between them and me." Culturally, marijuana and alcohol use are accepted. People associate SUD with criminals and with homelessness. Law enforcement's involvement has helped to combat stigma and promote public acknowledgement to support treatment and get help for families affected.

### **Describe the resources and linkages to leveraging existing initiatives and resources.**

There are many linkages occurring in different areas across business, law enforcement, schools, public health and treatment. An example is Healthy Androscoggin's Project Unite which is their substance use prevention steering committee. It has 23 members representing 11 different sectors.

Law enforcement is engaged on this issue across the county, from prevention work with alcohol enforcement teams to programs such as operation Hope.

Primary Care settings have become integrated with behavioral health clinicians and their ability to respond to substance use disorders is growing stronger. It was noted that Central Maine Medical Center and St. Mary's systems can do 2 or 3 counseling sessions and then will refer.

### **What activities are occurring to support recovery in your district?**

- There are not that many peers working in the Lewiston–Auburn community now. Older peers are overstretched and not that many young peers are stepping up to volunteer.
- There are no peers involved in the Substance Prevention Coalition in Franklin. One of the agencies in Franklin County tried to develop a peer advisory board, but it didn't happen as there wasn't enough interest and follow-through from the peers.
- Peer leaders, however, are involved on the Western Maine Addiction Task Force, and Wellness Collaborative
- Peer recovery coaches are being trained in Oxford
- Some businesses are more open than others. CN Brown is notable as a leader in this effort in Oxford. In Franklin, jobs are hard to find and people generally don't talk about their recovery because they want and need the job.
- In the Lewiston–Auburn area peers are working at TOGUS, but not as much in urban Lewiston–Auburn
- Peers come to visit and speak at St. Mary's, but it is challenging to keep people engaged and there is a lot of work needed to recruit them

### **Is there a Peer Recovery Center for people with substance use disorder in your district?**

No. Lots of people are talking about peer centers in different areas within the district but this discussion is not present in each of the counties within the district. There has been no specific development for a Peer Recovery Center to date. It was noted that it would be impossible to serve the entire district through one location. Multiple locations would be ideal, in the most

densely populated areas. In Franklin it was noted that a peer center ideally would start out small and be attached to another organization so people would be comfortable going to the center, and it would then add and extend its current resources. Privacy was noted as being important. Some of the partners in the district have expressed an openness to be a fiscal agent for a recovery center. If an RFP comes out, Oxford felt confident they would easily find someone to step up as a fiscal sponsor, and would need to start a nonprofit to oversee the center as consumers want a recovery center to have a safe space to socialize and network.

### **Where might a peer center be located?**

- Lewiston–Auburn for the district — many people are coming to Lewiston–Auburn from Norway and Rumford looking for services, and it could be a hub
- Norway/South Paris area
  - Volunteer transportation networks could help people get to the center
- Farmington — Franklin. It was discussed that it could be connected to an existing provider. It was also noted that there are many existing empty spaces.
- Rumford — it has a need for services and peer involvement
- Possibly repurposing an existing location — e.g., 100 Pine Street, Lewiston — could link people with other services such as groups, homeless centers, transportation, etc. 100 Pine was a clubhouse for mental health services and has space to have groups, etc. Similarly, Friends Together, an existing social club, was mentioned in the Franklin focus group, or vacant space at a hospital could be used.
- NIMBY *might* be a challenge, but can be addressed. People would need help with transportation and access.
- A clubhouse model that comes with a van
- Location is key — it needs to be within service hubs with the most available services to address the population. Transportation issues will need to be solved.
- Virtual support would help with privacy

### **Resources to Link With:**

- Employers — casinos, LL Bean, etc.
- Food banks/kitchens, healthy eating
- SNAP education
- Local restaurants for services or volunteer opportunities
- Corrections, therapists, job training, social security office, legal services, employers that are open to hiring people in recovery
- Hospitals
- Career centers

### **What Would It Offer?**

- Educational opportunities for outreach to the community to teach about recovery and address stigma

- Recovery coaches. A recovery center could provide a safe place for recovery coaches to do their work and meet with referrals.
- Support to individuals on a one-to-one basis for those striving for recovery. This might include outreach.
- Space for vocational rehab to use one day per week
- Employment services, health services, 12-step meetings, recovery support groups
- Space/services for family members/affected others
- Art classes/yoga classes
- Coordination of volunteer opportunities
- A mechanism to get everyone on the same page and knowledge about all of the services available in the area
- Access to technology and online resources

## *District 4 — Midcoast*

Peer Support Recovery Centers  
Key Stakeholder Focus Group  
Lincoln/Knox/Waldo/Sagadahoc — July 18, 2016

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**Attendees:** Vyvyene Ritchie, Healthy Waldo County, Marilee Harris, Damariscotta Baptist Church, Patrick Walsh, Healthy Waldo County, Michael Morse, Maine Behavioral Healthcare, Kyle Canada, Two Bridges Regional Jail, Chris Young, Deputy Chief Rockland Police Department, Bruce Bardenici, Rockland Police Department, Jasmin Pike, Young People in Recovery, Ira Mandel, Knox County Recovery Coalition, Bruce Hodsdon, Knox County Recovery Coalition, Peter Lehman, Knox County Recovery Coalition, Kyle P., Maine Behavioral Healthcare/ Knox County Recovery Coalition, Connie Putnam, Knox County Community Health Coalition, Melissa Fochesato, AccessHealth/Midcoast Hospital, Al May, Maine CDC, Jerome Weiner, Maine Coastal Regional Re-Entry Center, Erin Hustus, Knox County Recovery Coalition /Penquis, Amy Winston, Boothbay Region Community Resources Council, Kate Marone, Healthy Lincoln County, Paul Klainer, MD.

**Representation:** Peer leader, Law Enforcement/Corrections, Treatment, Career Resources, Medical Provider, Hospital, Prevention, Clergy

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### **Describe your district and highlight any general assets and challenges: e.g., culture, rural geography, health disparities, employment etc.**

There have been problems in access to treatment, and in the past a lack of organized approach to the opiate problem. Quantitative data shows that the Midcoast District has significantly higher rates of youth misusing prescription drugs. The Rockland area itself has assets and challenges. There has been a standing room only community forum (“we know there’s a problem”) and the NIMBY issue (“not in my backyard” and “we don’t want to help right now”). There are not a lot of similarities within communities of the Midcoast District; there is a lot of diversity. The peninsulas make communication, transportation and centralization difficult.

- Absence of organized effort for treatment in Knox County
- Sagadahoc and Lincoln Counties have Mid Coast Hospital Addiction Resource Center (ARC) for treatment
- Community is an asset and a challenge. We would like to find a way to come together, but the community can be apprehensive to seek help.

### **To what extent do you think community members know or understand how substance use is affecting the community?**

SUD is documented in obituaries and a lot of people are learning from the media about the problem. In the Boothbay area, there hasn’t been a community-level conversation. Jails are full

and community members recognize the problem, and realize there is a lack of resources. Hospitals are treating more overdoses and SUDs. The data for substance exposed infants (drug affected babies) is telling — health care services are strained in the Midcoast.

There are 4 coalitions in the county — Knox County Recovery, Knox County Community Health Coalition, Lincoln County Recovery Collaborative and another related to the Knox Free Clinic. Data can be provided about the increase in number of crisis visits due to SUDs, as well as the number of beds used at inpatient units devoted to SUDs, and the addition of an “observation bed” for people requesting services. A new treatment center, Recover Together, has just arrived in the area. We are still not able to meet the community demand.

The Knox County arrest rate for trafficking in controlled substances has increased about 29% in the last 3 years. Before 2008–2011, there was more diversion of prescription drugs, currently there is more heroin.

### **What community efforts have taken place to address SUD in your district?**

In 2004, a Waldo county community task force was developed and made recommendations about service delivery, prevention, law enforcement, treatment, and Drug Court. This was received positively but the Task Force disbanded after 8 months. In May 2014 a community viewing of the documentary Hungry Heart was attended by about 250 people and resulted in follow-up discussions. Those discussions led and led to the formation of We Care (Waldo Encourages Community Assisted Recovery Efforts) which has declined in participation but is currently being reinvigorated. Healthy Waldo County has made efforts, most recently an opiate forum in February 2016. More follow up conversations have been made about continuing to improve efforts in prevention and treatment.

Mid Coast Hospital Addiction Resource Center has been working to increase the number of Suboxone providers using the hub-and-spoke model. Maine Behavioral Healthcare is working with ARC and PenBay to develop that model in the Rockland area.

The Knox County Recovery Coalition (KCRC) formed 5 different weekly work groups who are looking at different aspects of the problem and how to address them, e.g., having a drug court, recovery center access point, etc. They are trying to be an “umbrella” for efforts in Knox County. KCRC can also be an “umbrella” and make it easier for people who want to get help. At KCRC the focus is on friends and family, they are starting a Friends and Family group.

There is also a Lincoln County Recovery Collaborative.

Sagadahoc County has a substance abuse prevention coalition that includes treatment partners & had a very strong turnout when they hosted a community forum to discuss local opioid prevention, treatment and law enforcement strategies and needs.

ARC serves both Sagadahoc County and Lincoln County. Locally, the ARC coordinates/hosts several recovery support groups, including a family affected others group and one for pregnant and post-partum mothers.

Sagadahoc County has a strong Adverse Childhood Effects initiative, being led by local pediatricians, Mid Coast Hospital and United Way of Midcoast Maine, including strategies to prevent ACEs and increase resiliency.

### **What is the prevailing attitude of the community toward the issue and efforts?**

The real yearning is for something to be done. There are still negative attitudes and stigma, but most people feel we are long overdue to do something meaningful. Regarding MAT, there are still people who don't recognize this as something we should be doing.

There was a meeting in April 2016 with almost 100 people who talked about peer involvement, e.g., Restorative Justice.

Lincoln County MOU (LE-Healthcare) spent time understanding and identifying SUD as a medical disease. There is interest in "putting a face on addiction". Senator Johnson responded to constituents and brought people together.

- Attitudes are all over the board
- Better shift to understand the issue
- Community is talking about peer activities
- Shifting to managing SUD as health condition not a crime, a moral issue
- People want to get involved

### **Describe the resources and linkages to leverage existing initiatives/activities/business/volunteers that are available in your community- people, time, money, potential space, etc.**

Knox County Recovery Coalition has invited everyone to get involved. There is a drain on public assistance — how can we augment those services/resources? (Knox County is looking at grants, etc.) Penquis (District 6) is looking for funding outside "mainstream" — e.g., using Maine Street Finance for emergency needs.

There are 2 groups focusing on Adverse Childhood Effects/Resilience through provider coalitions in Waldo and Knox Counties. Waldo is forming Children and Recovering Mothers (CHARM) with Seaport Community Health Center/Waldo County Hospital to support pregnant women/young mothers in recovery. Boothbay is doing something similar to CHARM and is also working on a holistic approach to housing, employment, etc. The Ecumenical Council out of Damariscotta provides assistance in linking people to Tedford Housing and other daily needs, the Open Door Café (meet, greet, find resources), and a volunteer driving service. Homeless shelters

in the area are full and there is no place to send people; Knox County now has a homeless shelter. Rockland homeless shelter offers a resource room, case management.

Access to Career services can be a challenge, Rockland has vocational counselor to address this. Two construction companies in Rockland are a part of the effort. A coalition is starting to work with New Ventures and the career center. New Ventures goes to Boothbay to create a one-on-one coaching relationship.

Law enforcement met with the Rockland Superintendent and created a task force. The University of Maine provides a program on SA in Rockland and many students are in recovery themselves. Lincoln Academy works with restorative justice; Brunswick Landing has hub of educational; Sagadahoc has vocational school with access to a SUD counselor.

### **What activities are occurring to support recovery occurring in your district?**

- AA, NA
- Waldoboro Baptist Church and Freedom Church (Wiscasset), Celebrate Recovery groups
- Freedom Center in Dresden offers housing and peer support, works closely with Two Bridges
- Living in Freedom Everyday
- Alanon, Nar-Anon
- Boothbay Harbor has a program to assist people navigate services and works with law enforcement
- Waldo County reentry has a peer recovery group (most men going through have SUD issues) and want to train trainers to grow program
- Lincoln County started their version of Operation Hope utilizing Lincoln County Healthcare, ARC and work with volunteers, including people in recovery. Restorative Justice Program (Lorraine Brown is the ED)
- Lincoln County Recovery Collaborative

### **Who have been leaders in peer support efforts?**

- Lincoln County- Chief of Boothbay, Senator Johnson, Lincoln County Healthcare, steering committee
- Project Hope
- Pinny Beebe-Center
- Living in Freedom Everyday offered Teen Challenge which is based on people in recovery
- Restorative Justice (SUD often comes up) in Lincoln and Knox counties. Serves as education and prevention

### **Is there a Peer Recovery Center for people with substance use disorder in your district?**

Freedom Center (Dresden) is like a Peer Recovery Center, and Celebrate Recovery in Wiscasset. The only thing that ties the district together is the DHHS office in Rockland; many people in the district access this office. Transportation is a real problem.

- Recovery Center in Brunswick
- Ground work with Celebrate Recovery in Wiscasset
- Freedom Center (Dresden)

### **Where would your district consider a recovery center?**

There may be a possible donation of land on Old County Road in Rockland. There have been several meetings to discuss the possibility. Included in the discussion about what is wanted/needed: a place that provides resources, drop-in center, vouchers for cabs (transportation), rooms for therapists and other groups (12-step, support group) meetings, space run by/supported by peers, train volunteers/recovery coaches.

To provide regional services for 4 different counties, we need a clearinghouse/office that serves as coordinator for services/resources throughout the district. A way to have one mechanism for sharing information would be helpful, but also have something where people live, where they work, where their support is. Key people who connect in a community network together in one central place.

- Tough decision for a district this size and shape with limited transportation; peninsulas are hard to access
- DHHS office in Rockland is the only district-wide resource
- Impossible to serve 4 counties with 1 center. How do we bring the center to the people who need it? A mobile center? One center with outreach to each county? Satellite locations?
- Still want a venue for sharing information, resources, relationships, etc. (quarterly call)
- Office/clearinghouse with an individual that served as a coordinator that knew what was offered in each area that could connect people to services. Networking is a part of it. Different than 211.

### **What would you want state to know to put into RFP?**

There are not a lot of similarities within communities of the Midcoast District; there is a lot of diversity. One size doesn't necessarily fit all, and a single center may not work. Rather than looking at where the populace is and trying to get people there, look at where they are and try to meet that. Write the RFP in a way the district can tell the state what is needed, not the state prescribing what will happen.

- Include flexibility to adopt model to the unique challenges and resources that exist
- Need to consider shift from opioid to heroin use
- Funds allocated for transportation, not just say need to address "access"

### **Who are we missing? [not sure if these are missing from the community conversations or from the forum? Or both]**

- Education (RSUs)
- Restorative Justice
- Police Departments — Damariscotta, Boothbay

- Homeless Coalition (Knox County)
- United Way
- PenBay Medical Center
- YMCAs (have been active on local level)
- Lincoln Health (Part of MaineHealth)
- Addiction Resource Center (active in Lincoln County)

## *District 5 — Central*

Peer Support Recovery Centers  
Key Stakeholder Focus Group  
Kennebec/Somerset — July 6, 2016

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**Attendees:** Rob Rogers, Kennebec Behavioral Health, Bill Zimmerman, SPH/RFGH, Magdalena Linhardt, University of Maine Augusta, Jeff Jarell, MaineGeneral, Malindi Thompson, MaineGeneral, Natalie Mon, MaineGeneral Medical Center, Peter Wohl, Behavioral Health Resources of Maine, Mike Bennett, WCC, Shaylee Sibley, Discovery House, Jim Mello, Discovery House, Paula Thompson, Maine Center for Disease Control, Peter Diplock, Department of Labor/Career Center, Neill Miner, Healthy Communities of the Capital Area, Joanne Joy, Healthy Communities of the Capital Area, Bob Long Kennebec Behavioral Health, Jodi Beck, Kennebec Regional Health Alliance, Mike Bennett, WC Coalition

**Representation:** Peer leaders, Treatment, Career Resources, Schools/Academics, Hospital, Prevention

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**Describe your district and highlight any general assets and challenges: e.g., culture, rural geography, health disparities, employment etc.**

This is a huge district with little public transportation. This is a challenge for resources — to be located in an area that benefits everyone in the district. There is no connection between Somerset and Kennebec. Volunteer transportation in 3/5 town clusters is trying to address some of the transportation needs. We need an evaluation of transportation in western Kennebec county — and how to provide transportation services to treatment.

Central was the first district to identify SUD and mental health as a priority through a public health district needs assessment. We advocated to SCC that SUD needed to be addressed at the state level through a state public health plan. We have had a mental health and SUD workgroup since 2011. The difficult part is that the need must be identified and that we state what we want to do, but resources have been limited to HMP funding make acting on solutions extremely challenging. There were limited discussions on recovery services at Central DCC due to resources.

**Unique features:**

- TOGUS, Riverview Psychiatric Hospital, being the state gov't seat, creates unique perspective and challenges to communities.
- Very collaborative district, good and long history in working together to address public health issues.
- People say yes and what can I do to help out.

## **To what extent do you think community members know or understand how substance use is affecting the community?**

Over 600 people participated in forums in Augusta and Gardiner in 6 separate events around SUD/Opiates. We can give data in each of these and people explore the issues in these settings.

### **Data identified to substantiate the need:**

- MeHAF grant — to look at greatest health issues, produced data reports for this project: interviews of providers and individuals with lived experiences, state data on treatment, MIYHS (2015), BRFSS summaries
- District level: health assessment, county health rankings. SUD in top 6 public health issues for District Public Health Improvement Plans.
- Patients report stigma with SUD is “terrible” (e.g., provider located near a car dealership and feeling not wanted there is palpable).
- Somerset forums — people said they wanted more knowledge and information. Population was there who didn’t really know what was going on but wanted to learn more. There is a need to get more information out there.
- MaineGeneral community needs assessment — SUD prevention and treatment as major priorities as a system. MaineGeneral gets calls from people looking for recovery services, multiple calls daily. This includes people in recovery moving to the area looking for transition services. A lot of people know there is a great need and the health system is supportive.
- At last Central DCC SUD & mental health meeting, priority for moving forward was recovery services.
- Priority of MeHAF-funded group — reducing stigma and increasing connectedness to community

### **What community efforts have taken place to address substance use in your district?**

There was a community forum (105 in attendance) with a focus on opiates/heroin. An alternative SUD program, operating since 2010, came out of the Somerset SUD task force. It started at the Office of Child and Family Services and opiates were ID’d as the key issue affecting family welfare. ASAP was created from this group when it was learned that a Drug Court was not possible in this area. We need to look at identifying “wrap around” services — piloting Prime For Life for adult population for people seeking employment but facing challenges because of current or prior drug use.

Since 2014, MaineGeneral has been providing and hosting waiver training for suboxone. It has also provided 5 total training programs for providers. More are planned in July and August and will continue to build community capacity for treatment.

Other efforts:

- Attempted to build community coalition in Waterville to involve people in recovery and include Kennebec Club, tried to connect with Faces and Recovery and BRSS TACS.
- Peer Recovery coaching training — a dozen people trained in southern Kennebec. Three are quite active in linking with people. Augusta PD initiated how to get people into treatment or recovery instead of incarceration. There has been a partnership amongst Augusta PD, MaineGeneral Outpatient, Crisis and Counseling, and MAAR to create a “low-key system” to get people to services.
- Kennebec Jail/Sheriff’s Department, Criminogenic Addiction & Recovery Academy (CARA) program
- Somerset county offers a CARA-like program
- Some “bones” for peer support but with no funding.

### **How knowledgeable are community members about those efforts or programs?**

In Kennebec there is a 3-year planning process on how to reduce the impact of SA on the entire community (Augusta/Gardiner). There is leadership from Augusta PD, the sheriff, MaineGeneral, and many other sectors, including education, family violence project, etc. There are twenty active leaders looking for additional funding for reducing stigma and increasing connection to community.

- Other leaders in district who have spoken out about needs for action: Sheriff, Augusta PD Chief, Darren Ripley, MAAR, CEO, So. Kennebec Child Development Center, many MaineGeneral Departments, DFC coalition, University of Maine at Augusta (UMA)
- In Somerset parents are involved — parents impacted by SUD (themselves or their children)
- 50 people who receive email notices 15–20 are consistently showing up for programs
- Across the district, political leaders have stepped forward publicly and under the radar. Mayor Rollins, Augusta, is helping the Sheriff create housing options for people graduating from CARA program.
- Department of Labor — Augusta Career Center connected with CARA. Vocational rehabilitation services (transportation is a barrier).
- More jobs than job seekers in Kennebec County.
- Career Center not seeing outreach from providers in terms of linking people in recovery to career services.
- Somerset — employment — met with business after hours, talked about Prime For Life pilot, looking at policies around interviewing/employing people in recovery. Working with economic development.
- Child Abuse and neglect, workforce development, etc. Food insecurity is tied to recovery issues.
- Poverty coalitions working with people not in workforce to give them skills to get back into the workforce.

- UMA — prepare students for CADC licensing exam. Education programming around SUD. No peer supports for students at UMA. Have experienced issues with students relapsing, leading to significant number of incompletes.
- Groups of students within UMA to do and promote prevention.
- New Nar-Anon meeting in Skowhegan for affected others.
- Medical staff leadership looking at treatment capacity. A subgroup within MaineGeneral is meeting to look at what they can do as a system to increase capacity under leadership of Steve Diaz.

When thinking about resources, we need to think about developing resources to maintain and sustain recovery long-term, not just the short-term window between treatment and recovery (e.g., parent who just gets children back and needs transportation to get to stores, etc.) These resources are primarily for people getting to appointments, etc. We need to build out a broader system.

### **What is the prevailing attitude of the community toward the issue and efforts?**

Stigma is present, even within the recovery community, and was a barrier to building a recovery coalition in Waterville. There is stigma and bias even within health care. Stigma is more “unexamined stigma”. There is still fear and prejudice around hiring people in recovery. People in recovery are found keeping it a secret from employers for fear of stigma. There is negativity surrounding people in recovery from within the health care systems. There is a cultural bias.

Providers are judged for prescribing narcotics. This also contributes to issues of stigma. There is a myth that Suboxone providers are subject to more law enforcement and that people in recovery are more criminal, so providers feel serving Suboxone patients may impact other patients. The Winthrop health center had two Suboxone providers, and a lot of worry about waiting room situations of “mixing” Suboxone patients with “regular” patients — the worry is not substantiated in practice.

There are growing positive attitudes in some areas. Some support is seen from banks/foundations, and radio stations to develop PSAs. A series of PSAs produced around recovery, and addressing stigma, featured patients from Discovery House. It is very hard to find resources to do this. News coverage is raising awareness but is raising fear in some situations. Kennebec Journal focused on recovery presentations in forums.

More and more people are recognizing that they are linked or impacted by the opiate/addiction crisis, which leads to less “othering” of people with addiction. In context of readiness for a recovery center, the attitudes are better than they have been, progress is being made in terms of readiness to address the issues, and to support peer recovery services.

Fear has been strong for a long-time, law enforcement and others are trying to get messages out to reduce this anxiety. We can see a change over the past two years. Community is talking differently about the issue — “It’s their children, it’s their future”. There has been a shift

amongst some employers to loosen up restrictions on prior offenses, e.g., some employers for CDLs only looking back for 7 years now.

**Describe the resources and linkages to leverage existing initiatives/activities/businesses/volunteers that are available in your community — people, time, money, potential space, etc.**

- Harm reduction program — needle exchange, brings people in recovery.
- District Coordinating Council— implementation money, hiring a staff person to move forward things at DCC level.
- Career center — services and grants available for workforce development. There are Centers in Augusta — Skowhegan, administer all the workforce development grants, public with Waterville public library.
- Two clubhouses in Kennebec County — run by Kennebec Behavioral Health for co-occurring.
- Career Center director has collegiate recovery community background.
- Director of transportation at Kennebec Valley CAP part of DCC leadership — working on transportation issue as they can with volunteers. They are in a good position to work on transportation and know where the gaps and problems are. They are in good position to address these barriers.
- Housing resources — women’s sober house opening in Hallowell, others have closed because of lack of referrals (e.g., sober house for vets)
- We have to think outside the box for linkages with a recovery center (e.g., telemedicine).

**What activities are occurring to support recovery in your district?**

We need to think holistically about recovery, and recovery as multi-generational, supporting grandparents and whole families — a family recovery-oriented center. One challenge is with people maintaining jobs, etc., who are in recovery and want to be involved in leadership/advocacy, etc. It’s difficult to find the time.

- We are somewhat underdeveloped in level of peer engagement. Barriers for 12-step programs to step up to provide peer recovery leadership.
- SMART Recovery group meeting in Augusta. One is a family SMART Recovery group started within last 6 weeks. The group involves about 30 people, half are local, half travel from outside the district. It’s a real mix of people in terms of ages, etc.
- We need funding to pay recovery coaches to resolve the tension between needing to maintain employment and getting involved in providing peer recovery.

## **Is there a Peer Recovery Center for people with substance use disorder in your district?**

We need to be mindful that Somerset is more than Skowhegan. There is only one local PD in Somerset, located in Skowhegan. We need to remember the underserved in geographically remote areas of Somerset.

- We need an organizational structure that works across the hubs. We can locate a center in one hub, but we need organizational structure to broaden services across the district. There can be a strong “virtual” component.
- We need to somehow look at having some kind of physical setting in each of the hubs vs. one big center in one spot, and look at how to creatively link them. It has to be very easy for people to access when they are ready. We need to think about telephone/telemedicine services.
- Centralized anchor — separate programs from the buildings, at satellite sites — with central coordination. If we had the resources we could cover the district.
- Needs to be 24/7 in some way.

## **What resources could it link with?**

It could link with transportation, law enforcement, career development, housing, businesses for employment, education, ongoing family supports.

## **General Note**

There is a lot of talk about examples in other New England states for Peer Recovery Centers in rural areas. We can look to these New England states for examples of how to do this in Maine.

It is important that considerations for different geographies of different districts are involved in the RFP.

Families, no matter their income, hold on as long as possible to their telephones/cell phones, because they use this technology to stay connected with family, etc. When people don't have a lot of resources the last thing they hold onto is their telephone. Virtual support is going to be impactful for more people than may be thought.

People are very geographically located. To assume a recovery site will serve the district is unrealistic, unless there is formal capacity outside the geographic area where the recovery center is located, e.g., one central site, but with satellite offices/sites, and including a person at the satellite sites.

- Augusta Church of Nazarene working on expanding peer recovery support programming.
- Fundraising — working with people in recovery to work on fundraising, development for recovery center.

- Preliminary contacts with businesses interested in how to deal with marijuana due to filing drug screens — dealing with issue of finding employees.
- There are businesses that can be engaged in building, supporting, and sustaining a recovery center.
- Augusta/Gardiner City Councils around housing — both councils may be open to discussing housing, drug-free neighborhoods, zoning to make it easier for a sober house, etc. Interest has been expressed by city councilors to engage around this.
- Transportation — any RFP should require applicants to describe how a transportation system would be expanded to support getting people to recovery — “not that much money” needs to be included, “how will you get people to the recovery center” should also be a requirement around a technology component.
- Career centers — have employers involved in their work — have access to grant funds to train up people for industries with needs to hire — working toward virtual training platforms.
- Scholarship opportunities — people in recovery need this information.
- RFP should incorporate a plan to engage people in recovery who are in leadership roles.

## *District 6 — Penquis*

Peer Support Recovery Centers  
Key Stakeholder Focus Group  
Piscataquis/Penobscot — June 28, 2016

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**Attendees:** Patty Hamilton, City of Bangor, Jamie Comstock, City of Bangor, Kayla Kalel, Young People in Recovery, Bruce Campbell, BARN, Pat Kimball, Wellspring, Robert Polovina, Young People in Recovery, Ashley Homstead, Young People in Recovery, Joanna Russell, BARN & Northern Workforce Development Board

**Representation:** Peer leader, Treatment, Prevention

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### **Describe your district and highlight any general assets and challenges: e.g., culture, rural geography, health disparities, employment etc.**

Penquis is only one of two districts in Maine with a public health department. We have 3 methadone clinics. We have the Group with hospital CEOs focusing on SUD issues in the region — Community Health Leadership board (CHLB). The Penquis region also includes partnership with the Northeastern Workforce Development Board (NWDB) which covers Aroostook, Washington, Penobscot, Piscataquis and Hancock counties. Their primary goal is to assist job seekers who have multiple barriers. There is a diverse range of partnerships through the public health advisory board. Being a resource for all of northern Maine can be a challenge and overwhelming.

- Penquis has a continuum of care outside of detox. People can't get into treatment in a timely manner, not enough available.
- HMP - DFC grant
- SUD task force
- Reduction in availability. Manna, a faith-based program, is closing its program — extended shelter and care facility (licensed facility)

### **To what extent do you think community members know or understand how substance use is affecting the community?**

Our community is aware and is also feeling the effects of the work accomplished this far within the community. There is recognition that there are issues, but also a coming together to address the problems. We have switched from "we don't want these people" to be more accepting of "this is a disease and we need to help".

- #healthyregion blog with Bangor Daily News
- BARN is doing awareness activities and had a candlelight vigil with hundreds attending

- The NWDB is working with the Chambers of Commerce to help educate our business partners about recovery resources
- Forums with Poliquin, King, Botticelli
- United Way of E Maine doing impact study and asking questions of the community. SUD comes up over and over again as a top issue. Coming out soon, a \$10,000 donation to Leadership Board's campaign
- Shared Health Needs Assessment & Planning Process (SHANPP) data
- Other data sources: BARN utilization data, ERs, AG data on OD deaths by county, SAMHS data - all substantiating the need

### **What community efforts have taken place to address SUD in your district?**

- Botticelli has been to Bangor twice.
- Public awareness - early detection and treatment, detox, workforce development program, reentry workforce development
- BARN held summit on addiction recovery in 2008, continued with an annual summit and develop the recovery support base, opened center in 2010, advocacy coalition has grown out of this. Part of the regional infrastructure to address SUD.
- Community is willing to talk about it. Bangor Area Recovering Community Coalition (BARCC) started the summit and eventually merged with BARN
- Linking Partnership - group of 30 orgs together to support families identified with SUD. From that wrote a fed grant to do work more intensively - Linking Project - Eastern ME neonatal involved, supports from public health nursing when babies are discharged - Collaborative Home Alternative Medication Program (CHAMP) clinics. Drs. Brown and Mark Moran, MSW have data. CHAMP work on supports to get babies out of NIC U to wean/taper at home.
- Older population Eastern Areas Agency on Aging - research on SUD and older populations, struggle because of injuries and medication. Educate population on resources and supports to address their SA.
- Peer center - BARN - training for peer recovery coaches, Penobscot county jail - orientation so coaches can go into jail on regular basis, providing contact to recovery coaches who will meet in person at BARN center or talk on the phone w/ people who want to connect w/ recovery. Develop social- supports.
- BARN has built physical infrastructure - purchased on old furniture store that can host multiple events simultaneously and includes a cafe. Secure capital grant to pay off mortgage, purchase and renovate a house for sober housing for women. All done on volunteerism and no state dollars. Want to see YPR take off in the region. "Can't do what we really want to do" because of working on volunteers and not dedicated staff. BARN is a cherished placed in the community, named an Agency of Distinction. "Pride of the Community". No NIMBY-ism attitudes in the region. Growing but all volunteer and outgrowing capacity.
- County commissioners requesting information on BARN activities
- Aroostook and Hancock wants to learn from BARN development.

- Accessibility is fine. Formal linkages not present because don't have the internal staff for meetings during the day. Workforce Development Board - 1 MOU with jail.
- Community relies on BARN formally and informally.
- Serves as a gap in many ways because of lack of treatment options.
- Links with YPR, Peer Recovery Centers, career center and businesses attached, Bangor Region Chamber support BARN. BARN has volunteers that go into the Jail every Fri for 1 hour, provide information and contacts for BARN, career center, direct link to counseling.
- Would love to have these services come to the site itself at BARN. Have the space but not the capacity to organize that within BARN. Informal workforce - some employers will hire people in recovery.
- Eastern Maine Development Collaborative (EMDC) - Work readiness trainings - resume writing, interviewing tips, etc. Work done through cohorts. Can access training dollars for support up to an Associate's Degree. Assistance w/certificate programs.
- Relationships with employers: treat everyone as a job seeker. No specific outreach from BARN to employers.
- Participate in AmeriCorps VISTA program
- BARN wants regular presence of EMDC at BARN but need staff infrastructure
- EMDC also in Ellsworth, Millinocket, Dover-Foxcroft, etc.
- Educators - connected to Adult ED, Community colleges, high schools, etc. working on growing relationships with Adult ED (with BARN)
- Public Health Advisory Board has Ed representatives.
- Bangor Public School system not actively engaged. Doesn't participate in the MIYHS
- Housing: Women' sober house BARN, Oxford House (Men), Penobscot Community Health Care (PCHC) put together transitional housing, need more,
- Civic Leaders: Indirectly involved, city councilors involved, woven into different boards and capacities.

### **What community efforts have taken place to address SUD in your district?**

In our district some people still have a "self-inflicted disease" attitude. Attitudes seem to be changing (acceptance of BARN), but there is still work to do. Stigma associated with addiction is very intense because Bangor has a high proportion of methadone clinics. There is an attitude of "clinics are just in it for the money". There is an overlay of stigma because of drawing in so many people from surrounding areas. This is changing with some people. — invitations from Chambers, and deaths amongst "middle-class white people" is opening some eyes. Also seeing that BARN is helping people they know. BARN is seen favorably because of celebration of Recovery.

- In Bangor, OD deaths, task forces, etc., has risen the profile of the issue and also the solutions.
- Young people in group comment on feeling empowered to be part of the conversation.
- Bangor Daily News raising awareness through coverage.

- Restorative Justice annual conference. We were pleasantly surprised at conversations at everyone from different sectors being on the same page.
- Law enforcement - Police Chief (Bangor) very involved. LEAD planning grant in Bangor, from Open Society held by Health Equity Alliance

**Is there a Peer Recovery Center for people with substance use disorder in your district?**

- 501(c)(3), Advisory board, more than 50% on board in recovery, member of ARCO/Faces & Voices, represented on Faces and Voices public policy committee. 1500 visits per week, 600–900 volunteer hours per month. Would like to have a robust recovery coach program, expand into tele-services, expand into social media presence, inroad to support MAT community, better linkages with Veteran community. Disproportional National Guard. Recovery support w/senior community. What BARN can do really well - serve as regional hub for recovery supports. Staff - One half/time volunteer coordinator, volunteers receive training.
- Services: 12-step programs, periodic parenting classes, educational workshops, community education, sober social activities (dances, BBQs, etc.). Supporting development of YPR, safe place to go for people in recovery. Vegetable garden.
- Connections: law enforcement, workforce development, BARN sits on multiple committees and advisory boards. They house 110 recovery-oriented meetings per month. Solid linkage with district public health infrastructure

**What would you want state to know to put into RFP?**

Staffing infrastructure at BARN, and help other communities in the region for center/recovery services development. Through technology, BARN could have interactive television-type meetings in other areas. We could connect technologically with other areas. Recommendation in this region would not be to start a new center, but to use the RFP to build the staffing, etc., infrastructure for BARN.

Annual report on BARN website states that BARN was awarded, Agency of Distinction Award WLBZ 2 and United Way 2015. Awards/Recognition: Grassroots award, women leadership in recovery award, recovery advocacy, key to the city from Brewer. BARN works because it sought the needs and was able to go to bat. BARN was included in the 4th of July parades.

- Pilot project: A dozen people were trained with CCAR but there was no infrastructure to coordinate it afterwards. We are still working on how to coordinate recovery coaches after they are trained.
- Readiness: We have the bones, need some support but could launch pretty quickly and effectively. Assets: People at the table, community buy-in.
- Uniqueness of Bangor is the draw from large geographical areas in northern Maine.
- Transportation: Bus system, CAP agencies provide transportation for qualified residents, e.g., rides to clinics. The city changed bus routes to get to Discovery House.

- Acute in rural areas: The industry base has dried up, entry-level employment barriers tougher than they used to be. In the last 3 years 4,500 unemployed.
- Bangor and Portland are 2 biggest places where people are re-entering from correctional facilities. These people are seeking employment and other services.
- Wellspring Race for Recovery, 19 corporate sponsors raised nearly \$20,000.
- Other considerations for RFP: Childcare, providing a deposit would be tough

## *District 7 — Downeast*

Peer Support Recovery Centers  
Key Stakeholder Focus Group  
Washington/Hancock Counties — July 8, 2016

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**Attendees:** Rocky Alley, candidate for Senate, Al May, Maine CDC, Terri Woodruff, Healthy Acadia, Angela Fochesato, Healthy Acadia, Paul Trovarello, Arise Addiction Recovery, Laurie Hayward, Down East Community Hospital, David Burns, Maine Senate, Brian Fruteley, RH Foster, Rose St. Louis, Community Health and Counseling Services, Clement Deveau, AMHC, John Fitzgerald, Your Place/Chem-Free Ellsworth, Grace Bowe, Health Equity Alliance, Denise Black, Healthy Acadia, Wendy Roy, Maine Pretrial Services, Kevin Sample, Eastport Health

**Representation:** Peer leader, Civic/Elected leader, Treatment, Medical Provider, Hospital, Prevention

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### **Describe your district and highlight any general assets and challenges: e.g., culture, rural geography, health disparities, employment etc.**

The Downeast district has the highest unemployment rate in the state. They also have severe travel challenges due to their remote location. Downeast district also has more SUDs per capita than any other district in the state.

In Hancock County youth data shows that the perception of harm from marijuana is on the decline, and marijuana use has tripled since 2013 for 9<sup>th</sup> grade students. They have seen a spike in High School senior prescription drug misuse, and heroin use is 12% higher than the state overall (6%). Vaping has increased, and 40% of High School students are multiple users of marijuana and tobacco. This is a troubling issue as it appears to set up the 18–25 age group for future use.

On the asset side, Hancock County has a strong recovery community. Training for Recovery coaching is being planned, and they are developing a recovery messaging campaign. As they wait for hub-and-spoke to be developed, the Hancock community is mobilizing, developing a recovery resource guide, and offering resources that they do have. The new Ellsworth Police Chief Harold “Pete” Bickmore is coordinating with Health Acadia for a project Hope effort in Hancock County.

There are many challenges in treatment access. The district is poor in peer recovery supports and treatment overall but efforts to utilize and build more services and improve access are underway.

## 1a. Community Knowledge

Hancock County: There has been over the past few years, meeting to create a hub-and-spoke model for MAT to mobilize the prescribing community. A similar group has organized in Washington County. The opiate listening sessions had 81 people attending in Ellsworth and another one was held in Jonesport with around 40 to 50 people. In Calais, a meeting was held last February and then a second in May with 65 people, offering breakout groups on topics such as law, treatment, and education. Locally another forum was organized for Washington County and was held at the Washington Academy High School convening close to 500 people. Two convening. May 2 Calais 65 people with break out Law, Educational Treatment. People also came to Quality County MAT forum held this spring. The community is coming out in droves to try to address this significant challenge.

### **What community efforts have taken place to address SUD in your district?**

The Arise Program, opened in January, is a 12-bed 6 month program for men, and it is full. They had their first graduation July 12. Faith-based recovery groups have been started in Calais and Jonesport and in the jail. The group in Calais started with 6 people and now has 80 people attending. An MOU with hospital has been developed to hold people for 24 hours and peers drive them to Portland (Milestone). Washington County is working on getting a detox facility locally. Arise is hoping to have a women's 10 bed facility in Calais by September up and running.

During a fund raising campaign, this community has been supportive, hiring people, and making donations. Advocacy is occurring. The group told a story about a man who lives in Machiasport who met with Govern LePage and shared his story about his sons. One son died and the other son is addicted to heroin and has been in and out of jail and treatment. The governor was supportive and indicated that he would provide a donation.

Pockets of activities are happening district-wide. A variety of organizations and individuals started to talk about planning,

- Maine Health Access Foundation proposal is in development to create a road map in six areas. The community is mobilized and ready and wants to be involved. Health Acadia will be submitting.
- Washington opiate has an informal planning committee and has held three meetings (similar to Hancock), help to develop strategic plan
- Your Place, Inc., a 501(c)(3), has a community center which has been in existence for 20 years and hosts weekly 12-step and has 2700 and 3000 visits yearly.
- Hancock County has been working on the Hub-and-spoke model with three hospitals serving as the hub- MDI, Blue Hill and Ellsworth. All of the CEOs of the hospitals and treatment agencies have been active leaders. The PCP will be expanding their MAT services and are working jointly with treatment providers. Comprehensive and array of

services will be offered. Peers have been active in these planning efforts. Recover coaching is being developed. The effort includes an efforts to address stigma.

- The Hungry Heart film was shown and drew a large crowd.
- Eastport has been offering family support meetings.
- Recovery, treatment and prevention efforts that are connected with law enforcement are occurring. Four officers are in the DARE program (Keeping It Real) and two are school resource officers who will be imbedded in the middle school. A effort to develop an Operation Hope is being undertaken.
- Washington County does not have a Drug-Free Communities grant, but the county and state are choosing to keep the Drug Court here. Regional Medical Center at Lubec has a program that connects to Pleasant Point; there are always transportation issues. Eastport also serves the tribal community. The recovery community is integrated with the emergency room at Lubec; people are withdrawn from substances in the emergency room then are supported to enter Arise program and/or connected to the recovery community. The Indian Township and Pleasant Point population are coming to Arise meetings and relationships are being built.

### **How knowledgeable are the community members about those efforts or programs?**

The community has come out in mass to the forums. The various sections are developing connections and approaches. Connections across the counties for joint planning has not occurred. Washington County and Hancock County has had for the most part separate planning efforts.

### **What is the prevailing attitude of the community toward the issues and efforts?**

The community is wanting to address the issues and more and more people are willing to share their stories about how SUD has impacted themselves and their families/relationships.

### **Resources to Link With:**

- Law Enforcement: There are activities which current exist or planned. Healthy Acadia and Ellsworth are developing an Operation HOPE model coordinating a model which will includes peers, providers and law enforcement. The Ellsworth drug court has integrated a peer into their drug court team and has developed a peer housing model associated with the court.
- Career Development/Resources: Bangor Saving has offered to do course/training in financial literacy.
- Business for employment: Arise has worked with employers in Washington County to create supportive employment options for people in recovery.
- Housing Resources. A local landlord is connected to Arise (Washington County) and supporting the development of sober housing as there is a need for more sober peer-based housing.
- Educational Institutions — The Prime for Life curriculum is being offered in the Machias High School and there is a 4–6 hour program in place at Princeton Elementary School. Educations efforts have occurred regarding prescription educations.

**What activities are occurring to support recovery occurring in your district?**

See above. Peer supports are being connected to a local emergency room. Employers are activity hiring people in recovery. There is a sober free community center. Peers leader in Arise and Your Place are outspoken and being included in community meetings.

**Is there a Peer Recovery Center for people with substance use disorder in your district?  
Where might a peer center be located?**

Your Place, Inc. is a sober free community center in Ellsworth that hosts 12-step support groups and a chem-free environment. The board of five or six directors has about half who are in recovery themselves. There are no paid employees. This might be a location or site for expansion with funding. However, one peer center won't serve the two counties in the district. Thought need to be given about how to serve the whole district. Ideas might include two sites linked to each other, satellite services at the FQHC with virtual connections, etc. Transportation is an issue and needs to be addressed. Peer services and support should reflect the community needs and evolve over time. It is important to capitalize on the energy and what exists now but also have it local.

The types of services that a peer center would offer might include:

- Something for the hands and mind, people need a purpose and a path for change
- Meetings (12-step, faith-based, etc.)
- Budgeting courses
- Working out/exercise
- Sponsorship
- A gathering place, a place to connect peer to peer, a place for the community to become involved
- Link the recovery center to treatment services
- A place to create opportunities to work in community or rotating opportunities and link to support recovery-focused employment

*District 8 — Aroostook*

Peer Recovery Centers  
Key Stakeholder Focus Group  
June 30, 2016

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**Attendees:** Carol Bell, Healthy Aroostook, Laura Turner, Aroostook Medical Center, Sharon Graham, UMRK, Stacy Boucher, Maine CDC/District Liaison, Michele Chase, Community Voices, Peter McCorison, AMHC, Rebecca Miller, Link for Hope

**Representation:** Treatment, Schools/Academic, Hospital, Prevention

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**Describe your district and highlight any general assets and challenges: e.g., culture, rural geography, health disparities, employment etc.**

The district is huge, what is experienced in Houlton might be different than Presque Isle, Mars Hill, etc. Transportation is always a challenge here. People in Aroostook have to travel to Houlton for services. Ashland has a Federally Qualified Health Center, but that area is still remote from services. Youth Voices in the Valley is active. We have an older population here with a high percentage of poverty. Aroostook Community Action Program (ACAP) provides services to migrants, but there is not a lot of connection with the migrant worker community.

The northernmost districts are far away from existing peer recovery services. On the plus side, the isolation places the county with a long history of good collaboration, and how to figure out how to manage situations. In terms of SUD, there are areas where we do well, but other areas of concern.

There is an integration of physical/behavioral health — Aroostook pioneers in Maine and Nation (Pines, HMPs, AMHC, hospitals collaboration, rural health centers — all have behavioral health staff embedded). There are resources in Patten, Katahdin and Danforth rural health centers, and Lincoln. Collaboration with law enforcement (TAMC, etc.) is ongoing. Community Alcohol and Drug Education Team (CADET) is a community group for prevention and law enforcement. We see law enforcement very involved in prevention.

In terms of employment, mills are closing and people are losing jobs, businesses are not coming this far north, and the jobs available don't pay enough to keep people free of the welfare system. Natural resource-based jobs in forestry and farming do not employ as many people as in the past.

- We are further away from NY, CT, and urban centers (e.g., sources of drugs), but drugs are passing through the international border
- Communities coming together to work across the spectrum
- HMPs

- The University of Maine covers the whole county
- There are gaps in internet services
- Utilities, not connected to state of Maine in terms of electricity
- One opportunity — wind power

**To what extent do you think community members know or understand how substance use is affecting the community?**

A lot of people don't believe it's as bad as it is. People seem to misunderstand and not "get" it unless they are impacted in some way. There is a general recognition of the issues, but people show up more to "hot button" drugs such as bath salts and meth, not really as much with alcohol. Van Buren pharmacists took Sudafed off the shelves because it was too uncomfortable having the product available.

Meth is a growing challenge in the southern and central Aroostook areas. It seems a much larger issue than opiates. There is a feeling that Aroostook data is underreporting the issues, particularly the self-reporting data.

- The Anonymous People are showing up as well as focus groups. There is a clear message that the community needs a recovery center.
- Opiate forums — Fort Kent (50) was well-attended but not Presque Isle (25)
- Link for Hope (prevention, treatment, recovery group) has been engaging their community for great length of time
- CADET in Caribou has a long history. It still exists but needs new life — community coalition in the charter
- Youth Voices — coalition in the Valley
- ER doctor, Houlton Regional Hospital — changing patterns and attitudes around prescribing

**What community efforts have taken place to address SUD in your district?**

Law Enforcement provides a Prescription Drug Return. Every Police Department in Aroostook has drug return services. There has been work in the jails around treatment and recovery. AA is working to strengthen Bridging the Gap, a residential center in Limestone. The NA community is ebbing and flowing, mostly in central Aroostook. In terms of education, UMFK is engaging in dialogue around models for education and prevention through the student affairs branch.

Kelly Staples is a lead for intentional peer support for mental health, dialogue around SUD, and opportunities to provide education. An IOP in the Houlton area has a Matrix model. A peer recovery group is associated with this. Peer recovery is stronger within the mental health community than substance use in terms of organization. There is no organized peer support but lots of individualized peer support. There is a stigma with attending groups because of the tight-knit nature of the communities, but this can be a strength because of the social connections. Link

for Hope (a community coalition) is working on developing a peer center, Houlton is seeking grants and rents.

- Celebrate Recovery group — Wesleyan Church in Presque Isle
- Military Street Church in Houlton offers a recovery group
- Marijuana work groups — central and northern Aroostook — are meeting regularly, provide presentations, etc.
- Opiate forums
- Annual parent forums — alcohol, and other substances
- Youth work in the Valley
- Implementation of Prime for Life and SIRP
- Aroostook Teen Leadership Camp — AMHC — 6, 7, 8, and HS on healthy living and making choices, regionalized weekender programs — the staff consists of students who design and implement programs
- Pines and AMHC bringing MAT to Aroostook county and came out of a community engagement process that was facilitated by a CADET Suboxone/Vivitrol clinic
- Dr. Connor is providing Medication-Assisted Treatment/Medication-Assisted Recovery
- Diversion Alert — Claire Derosiers, prevention initiative ASAP

### **How knowledgeable are community members about efforts and programs?**

Awareness of efforts is low (e.g., Link for Hope) despite media coverage, but people come when invited. Coalitions have structures, subcommittees, and representation for most of the community sectors. Governing structure at Link for Help has similar representation across all sectors, Chairs for each committees are on a steering committee and they meet once a month. DCC has full sector representation with substance misuse one of the top 3 priorities, policy level. They have great support and meet quarterly. UMFK advisory council to be made aware of what's going on in the region. They will work on developing an SUD concentration in response to what's going on in the region in terms of SUD.

Peer leaders are involved in coalitions. There are peers and peer recovery in Aroostook, but they are not necessarily using these specific terms.

Engaging businesses is a good path to follow. Employers will hire and support people in recovery, but not necessarily advertise. Construction companies will strategically place people. Twin Rivers has a functional employment assistance program (EAP), with policies and procedures for people to get services, make changes, etc. We need to support their staff.

### **What is the prevailing attitude of the community toward the issue and efforts?**

There is a level of readiness to decrease stigma, and engage in peer recovery work. There is more hope to see things change, but frustration at the same time.

- People are getting frustrated and tired with Meth, and the opiate issue isn't getting better. We still have a lot of support for treatment, prevention, and recovery.
- There was a program recently about needles showing up in different places which made people very uncomfortable.
- For some Meth manufacturing is making money to fuel use, but also to pay bills

**What activities are occurring to support recovery in your district?**

- Covered in previous questions — under development, trying to build buy in for peer recovery coach training, momentum for peer center, etc. People at the table but need resources for sustainability
- ACAP has a grant for people coming out of jail to help them with employment. ACAP through workforce development working with providers to connect case managers with people in treatment. Connected with Aroostook County jail working with people being discharged.
- Housing — one shelter but it's a dry shelter, tough for people who relapse to find shelter (recovery center would help increase resources for housing, employment, etc.)
- Individual in Houlton trying to develop a sober housing location.
- Long-term plan in Presque Isle as well (from an individual), but nothing that will happen overnight
- Efforts to create a social detox, could not find the funding and site.
- Housing is a need, big challenge, transitional housing.
- Years ago there was sober housing (Houlton), not aware of any at this time in Aroostook.

**Is there a Peer Recovery Center for people with substance use disorder in your district?**

- Not only one center but a minimum of 3
- Houlton (Link for Hope) has some infrastructure in place, support from the community, and is connected to services and the recovery community.
- Entertain the idea of satellite sites (maybe once a month/week point of engagement in other parts of the county)
- Develop use of technology to facilitate access
- Presque Isle/Caribou
- Fort Kent/Madawaska

**Services:**

- Medication-Assisted Recovery/Medication-Assisted Treatment services
- Career Services
- Education
- Co-operative Extension — learn about healthy eating and gardening
- SNAP Program
- Tobacco Cessation
- ACAP — Workforce Development — employment coaches

- HIV/Hepatitis C/TB Testing (potentially)
- Have information on hand to give people services to help with employment/career center services
- 12-step and other group meetings
- Education information
- Peer support — phone number, telephone services, outreach services (staff or volunteers)
- Social times (potluck dinners, etc.), sober social activities

### **Challenges of Developing Peer Center**

- Long-term funding/sustainability
- Generating the community support in the rest of the County
- Peer recovery may become a billable service, so look at how to get those providers certified to bill for services if that happens
- Work with Sheriff and Aroostook County Jail — exploring their resources for supporting peer recovery
- Engage the community on what the role of peer recovery is, and how it becomes the continuum of care in the region. Partner with media (WAGM, Channel X radio) and local newspapers
- Get businesses engaged to support financially

*Tribal Public Health District*

Peer Support Recovery Centers  
Key Stakeholder Focus Groups  
Tribal Public Health — April 21, 2016  
Penobscot Nation Tribal Court — August 10, 2016  
Houlton Band of Maliseets (HBMI) — August 23, 2016  
Aroostook Band of Micmacs (ABM) — August 24, 2016

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**Attendees April 21:** Jill MacDougall, Penobscot; Carol Francis, RN, Indian Township; Clarissa Sabattis, RN, Wabanaki Public Health; Sandral Yarmal, Passamaquoddy Pleasant Point, Brian Altuates, Sr, Passamaquoddy Pleasant Point, Theresa Cochran, MicMac, Sharon Tomah, Wabanaki Health Wellness

**Representation:** Health Directors, Treatment, Health, Leadership, Prevention

**Attendees August 10:** Eric Mehnert, Penobscot Nation Tribal Court, Gabriel Paul, Cultural and Historic Preservation Dept., Jill Tompkins, Penobscot Nation Judicial System, Alina Moore, Penobscot Nation Dept. of Social Services, Zachary Brandmer, Public Defender, Matt Erickson, Prosecutor, Bob Bryant, Penobscot Nation Police Dept., Rhonda Decontie, Penobscot Nation Tribal Court, Patricia Kelleher, Penobscot Nation Health Center, Brianna Geary, Penobscot Nation Tribal Court

**Representation:** Peer leader, Schools/Academic, Treatment, Other: Social Services

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**Describe your district and highlight any general assets and challenges: e.g., culture, rural geography, health disparities, employment etc.**

Wabanaki Public Health was created in statute in 2011 and serves all five tribal communities in Maine: Aroostook Band of Micmacs, Houlton Band of Maliseets, Penobscot Nation, Passamaquoddy Tribe at Indian Township and the Passamaquoddy Tribe at Pleasant Point. Each of these five federally recognized tribes, consisting of five tribal communities, maintain their own governments, cultural centers and schools, and manage their respective land and resources. Passamaquoddy, Penobscot, and Maliseets have their own Health Centers, and Micmacs have a service unit through Indian Health Services. Although most of the Native population of Maine belongs to one of these five tribes, and reside on tribal lands, there are still many who live in towns and cities across the state. Unique to this district is that the district is based upon tribal communities and crosses geographically the other public health districts. Therefore, it has the widest geographic spread of any of the other public health districts in the rural areas of the state.

The Wabanaki Public Health district is culturally rich and recognizes native and tribal identities. Recovery and empowerment initiatives must reflect culture and help people reconnect with

traditional ceremonies and heritage. Moreover, intergenerational historical trauma, oppression, and social justice issues significantly impact the quality of treatment and health disparities. These issues must be addressed.

Wabanaki Tribal Health Needs Assessment identified that drug/substance problems is one of the five biggest health problems facing the communities being ranked #1 or #2 by the Wabanaki and Penobscot Nation participants respectively. The Tribal Public Health District health indicator identified binge drinking of alcoholic beverages in the tribal district was 43.8% compared to 14.5% for Maine as a whole.

In the Opiate listening notes it was identified that the tribes have become illegal drug havens due to no tribal policing and very few law enforcement resources.

**To what extent do you think community members know or understand how substance use is affecting the community?**

The tribes are well-aware of the effects of drugs and alcohol on their communities and people. Although alcohol has historically been an issue and continues to be, tribal health officials are seeing heroin use increasing over the past few years. There is also a *meth* problem with clandestine laboratories springing up in rural areas and community members are seeing more as it become more severe. Community cleanup activities with youth are being stopped because of the dangers of needles and “shake and bake” bottles along the roadside.

The Wabanaki Community Opiate Forum was held on May 13, 2016 and tribal members and Chiefs participated and identified the need for prevention, treatment and support. They identified the need for a peer-to-peer wellness program.

The Tribal Health Directors and Liaisons meet regularly to discuss and develop strategies to address health concerns, as well as Wabanaki Public Health Tribal Leaders.

**What community efforts have taken place to address substance use in your district?**

From the DHHS CDC website there are five Tribal Health Facilities:

- Micmac Service Unit, Presque Isle - Aroostook County
- Houlton Band of Maliseet Health Department, Littleton - Aroostook County
- Indian Township Health Center, Indian Township-Washington County
- Penobscot Nation Health Department, Indian Island- Penobscot County
- Pleasant Point Health Center, Sipayik —Washington County

Penobscot Houlton Band of Maliseet Indians (HMBI) offers a Suboxone program. Penobscot provides the Suboxone free for eligible clients but HMBI does not cover the cost of the

Suboxone. Pleasant Point did offer Vivitrol free to eligible clients. Only 43% of the population using these meds have some type of insurance coverage.

For certain tribes, members can receive care once in their lifetime at an out of state Indian Health Service facility, such as Partridge House in New York for SUD (Partridge house is Tribal). But the cost for transportation to and from IHS facilities, for which the tribe is responsible, is often a barrier. Tribal members also participate in other treatment programs outside of the tribes or Native American communities, for example Indian Township most currently use treatment resources in Machias, “The Farm” in Limestone through AMHC or intensive outpatient therapy program.

There is a Teen Center on Indian Island and youth are involved in after school and community activities. Located in Bangor, Wabanaki Health and Wellness is a not-for-profit organization for tribally-enrolled Native Americans serving the Penobscot, Washington and Aroostook Counties of Maine. The agency provides case management, administers free HIV testing and hosts Wellbriety meetings, among other services. The staff of the agency have been trained in CIPS. The peers in recovery are hired in that program to work with others and to lead Wellbriety meetings.

There is a Wellness court which integrates cultural responsive approaches and other areas of needs such as nutrition, housing and vocational support.

Wellbriety, a culturally responsive model for recovery, was utilized by the tribes and there are efforts to reinvigorate. White Bison has come and done training on Wellbriety over the years. There are indigenous healing ceremonies, such as the sweat lodge ceremonies. A Prayer drum circle has been used for a couple of months to bring people together for support, collaboration and to engage youth and build community. There is also a men’s gathering once a month for fellowship and build intergenerational bonds. An AA group has been meeting for 40 to 50 years. Healthy Wabanaki is the Healthy Maine Partnership that has been serving the communities of the Tribal District when it comes to substance use prevention, particularly amongst youth. Efforts, through funding from SAMHS, now Maine CDC, have included programs aimed at reducing underage drinking, prescription drug misuse, and marijuana. Healthy Wabanaki has worked with communities in the past to offer the Prime for Life curriculum and has identified new individuals to become certified Prime For Life Instructors. Plans are in place to have new offerings of Prime for Life at Indian Township and Pleasant Point.

### **How knowledgeable are community members about those efforts or programs?**

There is a flyer that is disseminated once a month and all the events are included and delivered to each home. There is a social media presence with Facebook as well. The community readiness assessment helped to address substance use needs but it was not widespread and more awareness is needed.

## **What is the attitude toward SUD, toward empowerment and recovery?**

Stigma, bias and shame is present in the Tribal communities and by those tribal members with SUD. MAT is being offered and more education is needed about the various approaches. There is a perception that addiction is a weakness, not an illness. There is also too much attention of the substance use itself and not on the underlying trauma which lends itself to shame and blame while not addressing the roots of things. Education is needed for the community and for support on how the community can come together instead of a focus on how the counseling department can fix the problem. Relationships are important for raising awareness. There is an effort underway to build interest for people to go through the Peer Recovery Support training. Through the Wellness Court there is an effort underway to build ways for peers to stay connected and service as peer mentors. The peer to peer support and empowerment through the court has provides incentives for recovery for others.

## **Resources and Linkages in your Community:**

### **Law enforcement/Corrections:**

- Not all of the tribal communities have law enforcement. Those that do not have law enforcement work with local authorities.
- Pine Tree Native American unit provides legal services to members of the Micmac, Maliseet, Penobscot and Passamaquoddy Tribes and to other Indians residing in Maine.
- There is a Tribal Healing to Wellness Court.

### **Career development:**

- The Tribes collectively have a Vocational Rehab program that is based at The Houlton Band of Maliseet Indians; it also serves Penobscot, Passamaquoddy, Micmac and Maliseet members.

### **Education programs/Institutions:**

- Education about SUD and treatment is needed.
- The Wellness Court has an education director on the team to work with those in the court or after completion to pursue education programs.

**Housing:** Wabanaki has been working to support housing.

## **What activities to support recovery/peer engagement**

The expansion of traditional and culturally responsive treatment to address SUD and help the people reconnect and heal the injury to their spirit. The Wellbriety model, sweat lodge ceremonies and MAT are in place but need expansion.

**Where might a peer center be located, resources could it link with, challenges, how would you address those challenges**

A Center might be placed in any one of the communities; however, there would be a need to address how the center can meet the needs of the district as a whole and respond to different languages and have sure it has cultural components. The cultural component would need to be a core of the Peer Recovery Center. The Wabanaki Health and Wellness agency in Bangor has had a community room since 2014 which might be able to be expanded but ideally it would be on Tribal lands to serve all Tribal people. The Old Town area was also identified with the recommendation that it not be on Indian Inland to help with privacy away from the Island. Telecommunication would be helpful but there also are challenges in cell phone services through much of the district.

Peer Support Recovery Centers  
Key Stakeholder Focus Group  
Houlton Band of Maliseets (HBMI) - Public Health, District 9 — August 23, 2016

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**Attendees:** Lon Jewell Iaswla, HBMI/JCWA, Linda Raymond, HBMI/Tribal Council, Susanna Wright, HBMI/Social Services/Housing Coordinator, Suzanne Desiderio, HBMI/Tribal Council Member, Brenda Commander, HBMI, Alissa Black, HBMI/Health Department, Chris Phillips, HBMI/Asst. Grant Writer/Project Manager, Jessica Huff, HBMI/Domestic-Sexual Violence, Darcy Gentle, HBMI/American Indian Vocational Rehabilitation Program, Amber Wire, HBMI/Education Department

**Representation:** Peer Leaders, Civic/Elected Leaders, Career Resources, Schools, Prevention

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**To what extent do you think community members know or understand how substance use is affecting the community?**

Leadership in the community is aware that the problem is widespread. It is the biggest issue in the community. The Youth Council has identified it as the top concern and focus. Many people in the community know that there is a problem, but don't know what to do about it. Many don't realize it is an illness, but see it more as a moral failing. Data in district report but need permission.

**What community efforts have taken place to address substance use in your district?**

They recently held a community forum and 25 people came. They are doing a lot of prevention activities — youth group babysitting training, mental health first aid training, mentorship programs. They are nine months into the Community Health Implementation Plan and identified many issues/barriers/assets and next steps for this problem. They are looking at the social determinants.

They have terminated their outside contracts and brought behavioral health into their own health center with their own resources — 40 hours a week — an MSW therapist. They are building the department up with support groups etc. being added. They have Meth and suicide prevention. Patient navigator is a new position — sort of like case manager. A resource directory is being developed.

They held a large community gathering with a national tribal group called Eagles Wings. These youth came to speak with their youth, peer to peer. The whole community came out to hear the stories and it was very successful.

They are looking into doing peer training for peer recovery coaches.

Naloxone grant was received for all the tribes in district and training to administer it.

They have been doing notices and mass mailing to get the word out about these efforts. Family members talk to each other so there is good word of mouth. They feel they could do more on this with strategic thinking to share the information. A resource guide is being developed.

### **What is the attitude toward SUD, toward empowerment and recovery?**

More education is needed to help spread awareness. People might have a barrier to getting help as they don't want to admit to having a problem. Plus if you grow up around it seems the norm and not an issue.

The Community Health Improvement Plan (CHIP) has identified the need to address stigma in the district. Even if they had more recovery meetings, people don't want to attend as they will be seen. They feel that people do want to know that their community supports them — they don't want to be seen as “less than” if they come forward. It lifts the load off shoulders.

Families are struggling with SUD issues. The community can see how it has brought the whole community down. They want to see it better, want to see better access to treatment and recovery supports. Folks in recovery can see the impacts and want to see resources to help so the whole community can heal.

### **What activities to support recovery/peer engagement**

Need to keep doing the forums and reach out get participation. Work on wording to get more people to attend, and maybe use drumming or something to bring people out.

The youth program has committees set up and SUD committees already talking and gathering about it. Planning on other support groups already.

There are vocational program that help link people in recovery to jobs with a goal to help them get independent. Law enforcement have submitted some joint grant applications and are interested in understanding the culture and barriers. They are working on ways to reduce fear against law enforcement and are very interested in working with them.

There are no real peer recovery support resources right now but have many in the plans. It is definitely an identified need.

Some attending outside community but not many.

### **Where might a peer center be located, resources could it link with, challenges, how would you address those challenges**

They have a goal to get recovery supports on-site due to transportation issues. Also it would be culturally sensitive priority if it was done by them. There are many spaces that could be used — elder center/gym/ etc.

Once people identify a need for treatment and support, there is nowhere to go locally for detox or treatment. They need to have something in place to grab them when they hit the point of reaching out for help. Now people have to go far from home to get treatment.

They want to see a recovery center to be linked to treatment and detox, with cultural programming and a friendly environment. A real community center that is more home-like and not institutional. With some natural attributes to sit in like outdoor spaces. They want to invest in peer recovery coaching to have people in community support each other.

An asset is that they own their own land, so don't have to look for other places. They can adapt or build as wanted and needed.

Have been talking throughout the Wabanaki District about doing one center to serve them all for a couple of years.

Peer Support Recovery Centers  
Key Stakeholder Focus Group  
Aroostook Band of Micmacs (ABM) - Public Health, District 9 — August 24, 2016

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**Attendees:** Nicole Francis, ABM/Education, Dena Winslow, ABM, Kristi Ricker, Wabanaki Public Health, Norman Bernard, ABM, Kim Michaud, ABM, Kandi Sock, ABM, Theresa Cochran, Micmac Service Unit/Indian Health Services, Luke Joseph, ABM/ICWA

**Representation:** Peer Leaders, Civic/Elected Leaders, Schools, Medical Provider, Prevention

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**To what extent do you think community members know or understand how substance use is affecting the community?**

Many felt that most people are not quite aware of the tremendous impact SUD is having on the community as a whole. Some people live in their own bubble and don't see how it impacts everyone around them. Everyone knows at least one person struggling in their family or neighborhood, but people all keep their secrets and don't want children or family member in jail or taken by the state. They often choose to keep it quiet. Also people who are suffering are so self-absorbed and they don't realize how it impacts those around them. People also see it but they don't have time to deal with it nor know what to do about it. There is not a lot of intervention — no one wants intervention — it has a bad history with the tribe.

But at the same time it seems everyone knows what others are doing, so they see it but don't know what to do, so do nothing. Sometimes people are enabling through trying to help but it doesn't help. Many people know they are struggling and that they are hurting others, but don't know how or where to go to get help.

**What community efforts have taken place to address substance use in your district?**

The Tribal Health is looking at a grant for a navigator to help people connect with the resources that are there. They are trying to help keep people in the mindset for treatment to actually get it more rapidly before they change their mind. But there are very few resources committed to get treatment, either in the tribe or in the greater community.

They have a Maine Health Access Foundation grant have done a number of things — had several speakers come to talk about SUD — including a doctor who was an opiate addiction expert came to hold a community meeting. There was so much interest she spoke for 2 hours not the one planned.

They held an SUD science fair for the youth — local TV reporters came and reported live from event. The youth were very involved and interested.

They have done the mental health first aid training with the youth as well. And have Meth and suicide prevention grant for community engagement night and conduct an evidence-based curriculum with adult and youth. There is an active youth council.

A lot of what is happening are programs with staff and youth. Outside of that there are not a lot of adult oriented sessions such as mutual aid — AA etc. No community resources for them. They see a huge gap between the youth and elders. Lots of youth focus and many supports for the elderly, but in the 18–50 age group there is no programming.

Peer recovery has been identified as an issue to address and they are looking for training for Wellbriety and recovery coaches.

The administrative office and health departments are sending out flyers, and quarterly and monthly paper newsletters, using Facebook also. In trying to get information out to the community, some felt that the personal touch has been lost. “We rely on texting and email, etc. or flyers and don’t call to follow up.”

### **What is the attitude toward SUD, toward empowerment and recovery?**

Having an addiction is embarrassing and the anonymity in seeking treatment is not always kept. Some felt that more would go if they could be assured anonymity — stigma is very prevalent. It is still very misunderstood that it is a disease and not a moral failing. People still feel that “they make the choice”.

Others normalize addiction and many are de-sensitized to it. They want to not act like it is not a problem. Some people just accept that this is the way it is. People also want to protect those struggling with addiction and just accept them to not get them in trouble. Many are trapped by the cycle of addiction — and don’t even realize they need help.

Ceremonies are important in their culture for empowerment. But it is hard to get people who are actively using to attend and participate in sweat lodge ceremonies

### **Resources and Linkages in your Community:**

Transportation is a huge issue in trying to link people to services. They received a grant to fund transportation planning for the community. \$66K coming in TA to help the planning. Also in finding the funds to implement the plan they come up with.

There is a job bank. Tribal members can put their name in the job bank — and they rotate the individuals who receive the assistance. It also includes job training. There is workforce investment monies that come in and vocational rehab available. It is based in Houlton but serves all the tribes.

## **What activities to support recovery/peer engagement**

There are minimal current activities to support and sustain people in recovery. There is no peer support training or movement yet, but it is identified as a key need they are beginning to plan around. It is seen as a global problem needing a global solution.

## **Where might a peer center be located, resources could it link with, challenges, how would you address those challenges**

Any center would need to be mobile to some degree. Maybe a central location with peer outreach. Programs and tribal members are throughout Aroostook County. As an asset they have lots of places with housing and community spaces that could be utilized. They could either try to transport people to a central location or make it mobile out to outer areas.

Due to stigma, public outreach and education about SUD is needed to allow people to come forward to be peer leaders. They are seeking a grant for a navigator who could help to address linkages to other supports.

They feel that there would be a need for mutual aid support groups throughout the community and outlying areas.

Maybe they could hold feasts and sweat lodge ceremonies to bring people in — do programming or support groups before the meal.

They envision that when someone comes back from detox or treatment, there would be an appointment already set up for housing and social services and health clinic. That the HR job bank and vocational rehab, etc. would already be in place. Any resources we have on-site already set up and ready for them. As well as a peer support to connect with them from the community. Also the navigator (they are hiring) showing what linkages there are in the greater community.

They realize that they also need to be more aware about what each other does internally in the administration of services. Maybe develop an internal directory or cross training program. They are developing a packet of what all the services are for the community.

They want to utilize the success stories and celebrate the people actively in recovery — want to have them be peer leaders for Wellbriety and other support services.

## **Appendix F: Peer Focus Group Reports**

*District 1 — York*

Peer Support Recovery Centers  
Peer Focus Group  
July 17, 2016

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**Attendance:** One man, one woman. Age range 25–30.

**Location:** Elliot Congregational Church

**How much do you think community members know or understand how substance use is affecting the community? Give examples**

- Most people are aware that there's a problem, but they don't know what to do about it.
- Many people are touched by it, but because of stigma, people do not know how to respond. As an example, the methadone clinic in Sanford recently closed, and that was the only resource for people with opioid use disorders.

**What community efforts have taken place to support substance use recovery and how much do community members know about those efforts or programs? Please be as detailed as possible.**

- Sanford Police Department is interested in modeling the HOPE program of the Scarborough Police Department.
- The York Opiate Task Force ran forums to educate the public, and they were well-attended, but there were not concrete ways for people to get involved.
- Biddeford and other towns have created task forces.
- Counseling is available, but recovery supports are lacking.

**How much peer support is in your community, and what is the community's attitude toward peer recovery support? Please give examples.**

- There are some 12-step programs, but not much else.
- Community leaders have been supportive of starting a YPR chapter in Sanford.

**How are people in recovery linked to resources like career development, employment, resources and education. Please give examples.**

- In most areas, people are not linked to resources.
- One or two agencies work with a small number of clients; there is a pre-release program for people leaving York County jail.

**Is there a Peer Recovery Center for people with substance use disorder in your community? If yes we'd like to know about it.**

- No. Possible locations include Alfred or York.
- Stigma may influence people outside the recovery community, and they may not welcome the idea of a recovery center in their area.

*District 2 — Cumberland*

Peer Support Recovery Centers  
Peer Focus Group  
July 28, 2016

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**Attendance:** Five men, seven women. Age range 26–45.

**Location:** Westbrook Community Policing Office

**How much do you think community members know or understand how substance use is affecting the community? Give examples**

- With all of the press coverage, the general public knows there is a problem, but many think it's a drug problem (not an addiction problem).
- Some people recognize it as a community problem.
- There is still stigma, but it is slowly breaking down.
- Service providers have come a long way in understanding substance use disorder.

**What community efforts have taken place to support substance use recovery and how much do community members know about those efforts or programs? Please be as detailed as possible.**

- The Family Restored is a local nonprofit based in Portland that raises money for scholarships for people to get treatment.
- Portland Recovery Community Center is a great resource, if you can get there.
- There have been community forums to discuss heroin.
- At a recent community event, the Chief of Police and the people putting on the carnival wore "This is What Recovery Looks Like" T-shirts in solidarity and to raise awareness.
- There is energy in some groups and individuals volunteering time to change stigma and advocate for more services.
- Drew Gattine, State Legislator, is a champion.
- Losing the Mercy Recovery Center has left a huge hole in recovery supports and community efforts.
- There are events in Portland like the Rally 4 Recovery and overdose vigils.
- The Westbrook Community Policing office is starting to raise awareness.

**How much peer support is in your community, and what is the community's attitude toward peer recovery support? Please give examples.**

- There are 12-step programs, but not much to support other pathway to recovery. There can be stigma if you are on medication; different pathways, including MAT, need to be supported.
- There are trained recovery coaches in the area.
- There is a great community of people in recovery who are supportive of each other.
- Telephone support through the Portland Recovery Community Center is available.

**How are people in recovery linked to resources like career development, employment, resources and education. Please give examples.**

- Sober houses in Portland link people to education and work possibilities.
- The Portland Recovery Community Center has life skills trainings, connections with a career center and vocational specialists, a job board, resume writing trainings, and workshops on how to apply to college or university.
- YPR is working to convince business owners of the value of recovery in people's lives, so they will hire people in recovery (including people with felony convictions).
- 

**Is there a Peer Recovery Center for people with substance use disorder in your community? If yes we'd like to know about it.**

- Portland Recovery Community Center is in Portland. If you're talking about the whole county, maybe locating a center in Windham would be a good idea.
- No matter where the center is, transportation will be a problem for some people.
- Westbrook is ready, and the Westbrook Community Center would be an ideal location.
- Every town needs a center.
- What about a hub-and-spoke model?
- What about a mobile recovery center?

*District 3 — Western*

Peer Support Recovery Centers  
Peer Focus Group  
Western District 3 — Aug 26, 2016

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**Attendance:** Two women

**Location:** Recover Together

**How much do you think community members know or understand how substance use is affecting the community? Give examples**

- People are aware of the issue, but they don't want to talk about it. They don't know how bad it is.
- People don't know about recovery. They need to be educated.

**What community efforts have taken place to support substance use recovery and how much do community members know about those efforts or programs? Please be as detailed as possible.**

- There's not much. Recover Together started about a year ago.
- St. Mary's has a detox bed and an IOP.
- Grace Street has a suboxone program.

**How much peer support is in your community, and what is the community's attitude toward peer recovery support? Please give examples.**

- There is no peer support except for peers you meet at meetings and support groups (like at Recover Together).

**How are people in recovery linked to resources like career development, employment, resources and education? Please give examples.**

- There's not much, except for what case managers can do.

**Is there a Peer Recovery Center for people with substance use disorder in your community? If yes we'd like to know about it.**

- There's no Peer Recovery Center. The best place would probably be Lewiston or Auburn, because that's where the biggest problems are.

*District 4 — Midcoast*

Peer Support Recovery Centers  
Peer Focus Group  
July 14, 2016

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**Attendance:** Four women and three men, ages 20–35.

**Location:** Breakwater Building, Rockland

**How much do you think community members know or understand how substance use is affecting the community? Give examples**

- The community is naive and in denial about the problem.
- There is a lack of awareness in the community - people don't understand addiction, treatment or recovery.
- There is a lot of stigma in the community.
- Low-income people with SUD are treated differently than wealthy people with SUD.

**What community efforts have taken place to support substance use recovery and how much do community members know about those efforts or programs? Please be as detailed as possible.**

- Not much community effort in Rockland.
- No community support for people in recovery. (Note particular problems for people coming out of Maine State Prison who stay in the area.)
- Dr. Mandel is trying to get some recovery support started.

**How much peer support is in your community, and what is the community's attitude toward peer recovery support? Please give examples.**

- AA and NA are the only form of peer support available, and most AA/NA meetings in Rockland are closed (require member invitation to attend).

**How are people in recovery linked to resources like career development, employment, resources and education. Please give examples.**

- Nothing
- Recover Together is a new agency in Rockland that may provide services.

**Is there a Peer Recovery Center for people with substance use disorder in your community? If yes we'd like to know about it.**

- No Peer Recovery Center in the Rockland. Transportation is a problem, which makes it difficult for people to go to ARC in Brunswick.

*District 5 — Central*

Peer Support Recovery Centers  
Peer Focus Group  
July 28, 2016

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**Attendance:** Two men, eight women. Age range 29–77.

**Location:** Kennebec Behavioral Health (Skowhegan)

**How much do you think community members know or understand how substance use is affecting the community? Give examples**

- The general public doesn't know about how addiction works and how they can help. A lot of people are touched by the opioid epidemic, and they want to do something, but they don't know what to do.
- Poverty and addiction go hand-in-hand here.
- Family members don't know what it means to be in recovery and take relapse personally. Suboxone prescribers could help more by talking to family members. Family members are supportive, but they need to be educated about a wholistic approach to recovery.
- We could help educate people by inviting them to (12-step) meetings. If we don't incorporate the community into our lives, we are going to stay a separate entity.
- There is stigma attached to being an addict.

**What community efforts have taken place to support substance use recovery and how much do community members know about those efforts or programs? Please be as detailed as possible.**

- 12-step meetings, detox programs, IOPs, and suboxone programs.
- There was an opioid forum where the community came together to discuss the issue.
- There have been a few showings of The Anonymous People.

**How much peer support is in your community, and what is the community's attitude toward peer recovery support? Please give examples.**

- There are some 12-step programs, but not much else.

**How are people in recovery linked to resources like career development, employment, resources and education. Please give examples.**

- People are not linked to resources.

- Note that linking to resources should include opportunities to volunteer, and should include making accommodations for people with disabilities.

**Is there a Peer Recovery Center for people with substance use disorder in your community? If yes we'd like to know about it.**

- The Kennebec Club in Waterville has dwindled in participation and lacks leadership.
- More and better public transportation will be needed if there is a recovery center in the area.

*District 6 — Penquis*

Peer Support Recovery Centers

Peer Focus Group

July 7, 2016

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**Attendance:** Five women and five men from the towns of Bangor, Brewer, Orrington, Eddington, and Indian Island. Age range 25–59.

**Location:** Bangor Area Recovery Network

**How much do you think community members know or understand how substance use is affecting the community? Give examples**

- Stigma is a real problem. Community members have a negative view of people with substance use disorder.
- Community members need more information. They hear about the negative aspects of drug use, but not about the positive aspects of recovery. They don't understand that you can't do it (recovery) alone. They think people with addictions go away for 30 days treatment and then they are better.
- There is more awareness now, and the stigma is getting better.

**What community efforts have taken place to support substance use recovery and how much do community members know about those efforts or programs? Please be as detailed as possible.**

**How much peer support is in your community, and what is the community's attitude toward peer recovery support? Please give examples.**

- BARN has done a lot to support people in recovery, including recovery coach trainings.
- Recovery coaches go into the jail and meet with inmates; now some inmates leave the jail and go straight to BARN for help. Other efforts: Bark Summit, Heroin alert, Circle of Caring at Brewer Field- 200 people came.
- For people new to recovery, it's hard to find the resources that are available. There needs to be more awareness of what programs are already in place.
- In terms of treatment, there are not many options.

**How are people in recovery linked to resources like career development, employment, resources and education. Please give examples.**

- BARN
- PenQuis Community Action Program
- Emergency Medical Technicians

- Wellspring
- Higher Ground
- Bangor City Reach
- PCHC
- Resources are spread out and not interconnected; service providers don't know what resources are available for people in recovery.

**Is there a Peer Recovery Center for people with substance use disorder in your community? If yes we'd like to know about it.**

- BARN
- People come from all over to attend meetings and events at BARN.
- Satellite sites to reach outlying areas are needed.

*District 7 — Downeast*

Peer Support Recovery Centers  
Peer Focus Group  
August 3, 2016

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**Attendance:** Four men, six women. Age range 24–73.

**Location:** Your Place, Inc. (Chem-free community center in Ellsworth)

**How much do you think community members know or understand how substance use is affecting the community? Give examples**

- Younger members of the community do not seem to know about the effects of addiction on the community.
- Older members of the community do not understand how addiction is caused and what can be done about it
- Hospital staff have very low awareness of how addiction works.
- Family members have hardly any awareness at all of the level and causes of addiction in their family members.
- There is a big stigma around SUD.
- There is a huge need for education in the community about substance use.
- In the professional community, there seems to be recognition of the size and scope of the problem, but the community is not prepared for the level of care needed. This problem is not unique to Ellsworth or to Maine.

**What community efforts have taken place to support substance use recovery and how much do community members know about those efforts or programs? Please be as detailed as possible.**

- Community fundraisers, 5-K run, candlelight vigils to raise awareness and de-stigmatize substance use disorder.
- Considering implementing something like the ANGEL program (Gloucester Police Department).
- Providers coming together to understand the problem and what to do about it.
- Several small groups are trying to address the issue, but they are not coordinated.

**How much peer support is in your community, and what is the community's attitude toward peer recovery support? Please give examples. How are people in recovery linked to resources like career development, employment, resources and education. Please give examples.**

- There is an IOP where people get some links to resources.
- Some people have been working on a resource list and ways to distribute it.

**Is there a Peer Recovery Center for people with substance use disorder in your community? If yes we'd like to know about it.**

- No Peer Recovery Center now, but Your Place, Inc. is a place to start forming one.
- There needs to be at least one in each county (Hancock and Washington).

*District 8 — Aroostook*

Peer Support Recovery Centers  
Peer Focus Group  
July 15, 2016

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**Attendance:** Five women and three men from the towns of Houlton and Littleton. Age range 29–69.

**Location:** Houlton Regional Hospital

**How much do you think community members know or understand how substance use is affecting the community? Give examples**

- People know about it, but they don't want to deal with it.
- The community knows about the problem, but doesn't know what works, what to do about it.
- Meth is a big problem, but no one wants to address it.
- Kids have problems with drugs and some parents know about it, but no one wants to do anything about it.
- Stigma is a big problem.

**What community efforts have taken place to support substance use recovery and how much do community members know about those efforts or programs? Please be as detailed as possible.**

- There was a community forum that was well-attended.
- After a prominent person in the community died from a drug overdose, there was a lot of interest, but no one knew what to do after the forum.
- Annual walk for recovery in the spring.
- A community coalition called Link for HOPE (sectors: business, health care, law enforcement and people in recovery)

**How much peer support is in your community, and what is the community's attitude toward peer recovery support? Please give examples.**

- AA and NA are the only peer supports available.
- There is family support for some people. For other people, recovery is just personal (no support except at AA/NA).
- There was an effort to get peer support into the jail, but that didn't work out.

**How are people in recovery linked to resources like career development, employment, resources and education. Please give examples.**

- Nothing

**Is there a Peer Recovery Center for people with substance use disorder in your community? If yes we'd like to know about it.**

- No Peer Recovery Center in Aroostook County. People go to BARN in Brewer.
- There is a huge need for a center with satellite sites to reach outlying areas.

*Tribal Public Health District*

Peer Support Recovery Centers  
Peer Focus Group  
Tribal District 9 — Aug 23, 2016

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**Attendance:** Six women (1 not with SUD — mentor in Wellness Court); eight men (1 affected other)

**Location:** Wabanaki Health and Wellness

**How much do you think community members know or understand how substance use is affecting the community? Give examples**

- Many people are aware of the issue, but they don't acknowledge it as a community. The destruction of our culture, connection, and family create isolation in our own selves.
- There is a lot of stigma about people in recovery. There is a need for education about recovery and the fact that substance use recurs. Some people want to help, but they don't know what to do.
- There is a lot of stigma on tribal people and a lack of correct education for the "outer community" about Indians, so we are trying to navigate living in a society where we are being treated less than people. It is important to bring forward a better sense of identity into the recovery community as indigenous people.

**What community efforts have taken place to support substance use recovery and how much do community members know about those efforts or programs? Please be as detailed as possible.**

- There is a suboxone program on the island, a Tuesday night support group for suboxone patients, and a group at the Court House for the community to get support and show people how they are doing. There is Wellbriety on Fridays at Wabanaki Health and Wellness, and a Health and Wellness fair at Sockalexis Center that included info on Wellbriety. There is a methadone program in Bangor.
- Penobscot Nation has Community Wellness Court (used to be drug court), which is a year-long program for people "in the system." Participants have mentors who take them to native ceremonies, "sweats," meetings, and meals that connect them to their root being. It's OK to be part of your culture and find yourself spiritually.
- Wellness Court has sort of started a movement. You can also show up and ask for help.
- There is a barrier between Indians and others. There aren't many resources, and some that exist aren't accepting of Indians, and we don't feel safe there. Some people have to go to New York or South Carolina or Nova Scotia (Eagle Nest).
- There's not enough help, and people get sober alone. Many people can't go to rehabs because of lack of MaineCare

**How much peer support is in your community, and what is the community's attitude toward peer recovery support? Please give examples.**

- There is some peer support in the Wellness Court, at Wellbriety meetings, and at Wabanaki Health and Wellness.

**How are people in recovery linked to resources like career development, employment, resources and education? Please give examples.**

- Wabanaki Health and Wellness has caseworkers to help out, get services, go to hearings, and link with services.
- Salvation Army and Goodwill help.
- Wellness Court links people to services. Toward the end of the program, there are opportunities to get involved in the community, get jobs, help others, ask for help, and learn how to live right.

**Is there a Peer Recovery Center for people with substance use disorder in your community? If yes we'd like to know about it.**

- Wabanaki Health and Wellness is a place where people in recovery go, and Bangor is a good location.
- Indian population is spread out, and lack of transportation is an issue.
- Biggest hindrance to a single Peer Recovery Center is the division among the tribes.

**Appendix G: Maine Opiate Collaborative Listening Session Reports**

*District 1 — York*

York Community Forum  
**Maine Opiate Collaborative**  
January 21, 2016

Participant Recommendations

**Prevention/Harm Reduction**

- Resources for youth and community supports and partnerships
- Youth supports
  - Youth meetings (including web-based)
  - Teen centers
  - Student advocacy/sobriety groups
- Screening and early intervention
  - Identify high-risk students
  - More conversations (e.g. family histories) with students
  - Train educators in assessment
  - More intervention programs - only have [SIRP \(Student Intervention & Reintegration Program\)](#)
- Schools need to use evidence based curriculum for health and prevention – for example, schools should not use scare tactics or speakers to educate youth
- Pay attention to the precursors of opiates that our youth are using: prescription pills, marijuana, and alcohol
- Coordinate with hospitals to work with pregnant moms so they can get education and help around drug use
- Prescriptions
  - Doctors prescribing alternative therapies for pain
  - Integration of prescription monitoring across state lines
  - Education, including proper prescription disposal
- Support for people in recovery
  - Job fairs
  - Mentoring
  - Local advocacy groups – helping people in recovery with employment, housing, education, and using their skills/creativity for the good of the community
  - Recovery messaging training
- Oppose the legalization of marijuana which would increase access to marijuana and lead to more addiction

**Treatment**

- More treatment options

- More suboxone prescribers
- More intensive outpatient programs like the [“Cottage Program”](#) at York Hospital
- More in-patient programs
- More Recovery Centers
- Expand Medication Assisted Treatment (MAT) to increase retention by folks in treatment
- Address co-occurring disorders
- Affordability
  - Expand MaineCare insurance coverage
  - More free help

### **Law Enforcement**

- Project HOPE
  - Find ways to keep people local
  - Partnerships “across the river” in New Hampshire
- Establish therapeutic communities in jails to provide supports before and after release
- Narcan programs
- Local resources for detectives, partnerships, dogs – investigating drug dealing is expensive and labor intensive
- Regional resources for technology, partnerships

Alfred Community Forum  
**Maine Opiate Collaborative**  
March 14, 2016

York County's Treatment and Recovery Resources: Inventory and Gaps

**Resources to help people access treatment and recovery**

- WHAT WE HAVE:
  - “Recover Together” computer app – this could be embedded on partner websites and provided to 211
  - “Out of the Shadows” – in-person meetings in Eliot
  - “Young People in Recovery” – Biddeford chapter recently started
  - Kennebunkport: information packets (signs/symptoms, skills, resources) being distributed to church, library, police
  - NAR-ANON: in person meetings on Sundays at 7pm at the York County Sheriff's office
- WHAT WE NEED:
  - Insurance companies could create a simple flyer for members who call (does MCHO do this?)
  - More resources for the uninsured

**Points of entry/triage (gateways) to treatment**

*NOTE: (95% of people in treatment start with an external motivator)*

- WHAT WE HAVE:
  - York County Shelter Programs (key to success is the point-to-point support/transfer in real-time)
  - Hotlines
  - Law enforcement (there may be a secondary motivation, like jail avoidance)
  - Schools – youth, adult education, college
  - Domestic violence agencies
  - DHHS
  - Employers
  - Hospitals
  - Primary care/community health centers
  - Pain management providers
  - OB/GYNs
- WHAT WE COULD ADD:
  - Skill building for law enforcement with treatment providers

- Ask treatment resources to save a couple slots each for free-care – we need to get creative
- More aggressive dissemination of information for individuals and families at points of entry

### **Emergency departments**

- Emergency departments can provide short-term comfort packs
- WHAT WE HAVE:
  - Southern Maine Health Center (SMHC) – Biddeford, Sanford, Tele-Psychiatry
  - York Hospital
  - Portsmouth Hospital
  - Maine Medical Center
  - Mercy Hospital
  - Frisbie Hospital (Rochester, NH)
  - Wentworth-Douglas Hospital (Dover, NH)
  - Nasson Health Center
- WHAT WE COULD ADD:
  - Expand comfort packs at urgent care sites to eliminate referrals that may be barriers for patient
  - Suboxone induction via tele-psychiatry

### **Partial hospitalizations**

- WHAT WE HAVE:
  - SMHC (includes co-occurring and has some free-care)
  - McGeachey Hall at Maine Medical Center (has some free-care)
  - Portsmouth Regional Hospital (probably has some free-care)

### **Intensive Out-Patient (IOP)**

- WHAT WE HAVE:
  - Maine Behavioral Health Care – Springvale
    - Sliding scale – accepts federal and state funds
    - Primary diagnosis must be substance abuse but includes co-occurring treatment
    - 4 weeks, 9AM-12PM, Mon/Tues/Thurs
  - Central Maine Counseling – Key3West – Biddeford
    - Sliding scale – accepts MaineCare
    - Abstinence-based (except suboxone)
    - 12-3PM Mon-Thurs and 5-8PM Mon-Thurs

- SMHC
  - Grace Street – Sanford – 11-2:30PM Mon/Tues/Thurs
  - Crossroads – Kennebunk – daytime hours
- York Hospital – Cottage Program (Phase One)
  - Abstinence-based except MAT
  - Weekly individual counseling
  - 6 weeks, 3-7PM Mon/Wed/Thurs
- Addiction Recovery Center – Portsmouth
  - 10-1PM and 4-7PM
- Portsmouth Hospital
- Day One
- Affordable prescriptions for uninsured
- LogistiCare (Non-Emergency Transportation) through MaineCare
- WHAT WE COULD ADD:
  - Child care
  - Transportation
  - Medication-assisted treatment (MAT) providers
  - Connectivity between phases/types of treatment
  - Navigators/Operators in order to never “drop a hand”
  - Funding
  - More synchronicity with recovery resources, including NAR-ANON

### **Residential Rehab**

- WHAT WE HAVE:
  - Our Father’s House
  - Day One
    - Youth 6-18 months
  - Milestone
    - Detox 3-7 days
    - 12-18 months (Old Orchard Beach), male only
  - York County Shelter Programs
    - Half-way house, 6 months, male only
    - Co-ed, Alfred campus
  - Recovery Inc.
    - Half-way house
    - Sober living
    - Male only
  - Green Mountain Treatment Center, Effingham

- Detox
    - 28-day
    - Male and female
  - Crossroads, Windham
    - Women only
  - Back Bay Cove
    - 2 beds on scholarship
- WHAT WE NEED:
  - Adolescent treatment
  - Detox unit
  - Half-way house for women
  - Re-entry house
  - More beds overall
  - More county-wide coordination
  - More MAT
  - System revamping – it is totally broken

### **Medication Assisted Treatment**

- Suboxone prescribers can have 30 patients in year one and 100 patients after that
- Only physicians can prescribe but Congress looking at adding Nurse Practitioners
- WHAT WE HAVE:
  - Recovery Together
    - Suboxone, group counseling, no Vivitrol
    - About 24 months
    - Biddeford (2 prescribers)
    - Portsmouth coming soon
  - Key3West
    - Suboxone, psychiatry (mental health prescribers), no Vivitrol
    - No hard timetable
    - Biddeford (2 prescribers)
    - Lewiston
  - SMHC
    - Vivitrol
    - Good hand-offs with primary care providers
    - 2 prescribers
  - Sanford methadone clinic – in process
- WHAT WE NEED:

- More prescribers (including a strategic targeting plan with exact numbers and locations)
- Higher patient cap for suboxone prescribers
- Support primary care providers with other treatment resources (MaineHealth is starting to do this)
- Help with costs of prescriptions
- Education of non-psychiatric providers and staff re: MAT bias (could offer CMEs)
- Educate the general public
- Transportation
- Utilize empty seats in IOP

### **After-care and preventive care for individuals and families**

- WHAT WE HAVE:
  - York Hospital - Cottage Program (Phase Two)
    - Abstinence-based
    - Individuals, affected others, women's trauma
    - 18 weeks
  - York County Shelter Programs
    - Re-entry
    - Housing
  - Maine Behavioral Health
    - Family, group counseling
    - Sliding scale
  - Key3West
    - Assessment, treatment, co-occurring, case management
    - Federal probation grant
    - Individuals, couples, families
    - 12 weeks after-care
  - Esther House
    - Re-entry
    - Women only
  - Pre-trial services
  - AA, NA, NAR-Anon, AL-Anon
- WHAT WE NEED:
  - Funding
  - Homeless resources
  - More options for uninsured

## Recovery Support

- WHAT WE HAVE:
  - Young People in Recovery
  - AA, some NA
  - New state funding?
- WHAT WE NEED:
  - Eliminate stigma – we need vocal support for people who are entering or in recovery
  - A network of volunteers connecting with people in treatment by phone (United Way?)
  - Peer recovery center
  - Mentoring/coaching
  - More Narcotics Anonymous in jail and in the community (transportation is a huge barrier)
  - Community resource hub
  - SMART Recovery
  - Rational Recovery
  - Heroin Anonymous meetings
  - Respecting all pathways to recovery

## Other Needs

- Therapeutic community inside jail
- Bigger workforce
- More health insurance coverage
- School prevention and early intervention programs
- Data collection and analysis to get to evidence-based best practice
- More focus on relationships and not just a model

## Next Steps

- **Public Health Council**
  - Keep conversations going
  - Keep planning going, building on SHNAPP assessment
- **Diane and Deb**
  - Look at recovery center grant and design to fit York County needs
- **Quality Counts, Jennifer (researcher)**
  - Strategic plan and targeting for getting more prescribers – hospitals can take the lead

- **Community Care Team**
  - Case review

Biddeford Community Forum  
**Maine Opiate Collaborative**  
April 8, 2016

Observations & Recommendations

**General Observations**

- We all need to be advocates
- We all need to get involved!

**Prevention/Harm Reduction Needs:**

- Reduce bias/stigma
  - Educate providers and their staff
  - Educate on importance of using “person first” language
  - Engage the recovery community in humanizing the issue
  - Stop vilifying people and providers
- Supports for youth/students
  - Fund early childhood education
  - Fund more DHHS staff
  - Funding for counselors of kids with trauma
  - After school programming
  - Later school start times
  - Funding for prevention work in schools
  - Engage community groups, like Red Ribbon Committee of Biddeford Rotary, to work with kids
  - Engage recovery community in programs to empower kids, help them cope and find hope
  - Training/skill-building for health care and social service professionals re: ACEs
  - Forums just for young people
  - More chances to share stories, like Project Aware
  - Peer to peer support among teens
- Supports for communities/families
  - Host more community conversations
  - Support programs that help people find hope
  - Promote community compassion
  - Compassionate communities and systems
  - Engage recovery community in educational programs
  - Create a community network/system to share information about local resources

- Prescribing interventions
  - Prescribing criteria/protocols/guidelines
  - Institute the Prescription Monitoring Program (PMP) regionally and with other problem states
  - Provider/patient partnership and communication in deciding treatment (use of opioids)
  - Help people be more active in their health care
  - Integrate pain/prescribing/addiction professionals and approaches
- Addressing chronic pain
  - Train doctors in chronic pain and treatment options/alternatives
  - Insurance coverage of alternative treatments to chronic pain
  - Peer support groups
- Reduce access to opioids
  - More Drug Take-Backs (next York County take-back is 4/30 at Sheriff's office)
  - Confront the growing use of technology (internet) to get drugs
- Harm Reduction
  - Expand access to Narcan

### **Treatment Needs:**

- Reduce financial barriers
  - More free-care slots
- Insurance
  - More affordable insurance coverage options, including MaineCare
  - More coverage of co-occurring disorders
- Treatment infrastructure
  - Education and incentives for providers to work in the field of addiction medicine
  - Fund and support a full spectrum of Medication Assisted Treatment
  - Therapeutic communities in jails
  - Keep funding mental health and addiction treatment
  - More methadone treatment options, including counseling
  - More detox beds in York County
  - Support cross-system linkages, like between mental health and addiction treatment
  - More residential rehab for youth, especially for girls
  - Warm hand-offs between treatment levels, including using peers/people in recovery
- Support for people in recovery

- Build self-esteem to get quality of life back
- Create grassroots networks, like Young People in Recovery, to engage with community
- More resources for basic supports
  - Jobs
  - Housing
  - School
  - Workshops

**Law Enforcement Needs:**

- Coordinate/communicate across law enforcement
- Educational films for professionals and students at [www.fbi.gov](http://www.fbi.gov)
- More court capacity to try the 70% of inmates who are pre-trial in York County Jail
- Partner with treatment and recovery communities to create therapeutic communities in jails (especially for women, who tend to have more challenges due to family/children responsibilities)
- More resources to follow-up with folks who have over-dosed and been saved – need the resources/staff to follow Narcan interventions
- Diversion/drug courts

Waterboro Community Forum  
**Maine Opiate Collaborative**  
April 14, 2016

Observations & Recommendations

**General Observations**

- We need to all get involved however we can!
- We need to follow the model of accountability, treatment, support

**Prevention/Harm Reduction Needs:**

- Reduce bias/stigma
- Youth/student education and supports
  - Deliver positive messages to kids, not scare tactics (e.g. “Above the Influence” program)
  - Educate kids about signs of opiate use among family members
  - Talk to your kids
  - Break silences
- Community/parent education and supports
  - Support for NAR-Anon and similar groups
  - Know your kids’ friends and families
  - Parent education program
  - Build connections among family/community
  - Community partnerships and engagement to show we care
  - Donate time and money
  - Education that addiction changes the brain
  - Prevention as a community (schools, parents) to keep kids from starting
    - Reduce access
    - Mentoring
    - Protective factors for kids – help them feel better about themselves
    - One-on-one helping kids
    - Accountability if caught
- Prescribing practices
  - Mandatory use of Prescription Monitoring Program (PMP)
  - Improve functionality of PMP
  - Change the culture of how we treat pain
  - Educate and promote alternative treatments for chronic pain
- Harm Reduction

- Over the counter Narcan, including public education on side effects

### **Treatment Needs:**

- Reduce financial barriers – need more no/low cost treatment options
- Need more affordable insurance coverage, like MaineCare, because when people lose insurance, heroin use increases
- Treatment infrastructure
  - More/easier access to treatment options for people getting out of jail
  - Use existing infrastructure (e.g. underutilized hospitals)
  - Engage volunteers to help folks in withdrawal
  - Educate and promote use of nutritional supplements to support treatment
  - Affordable and local treatment options without delays
  - More medication assisted treatment (MAT)
  - More outpatient options
  - Resources for mental health services (more affordable options)
  - Treatment option for women and men with children
- Support for people in recovery
  - Peer to peer programs
  - Supports for people in recovery getting out of jail

### **Law Enforcement Needs:**

- Staff/resources to get drugs out of prisons
- More law enforcement resources – people and money – especially in rural areas
- Citizens as eyes and ears for law enforcement – systematized information collection
- Operation HOPE model
- Resources so law enforcement can follow up with people who overdose
- More drug courts

*District 2 — Cumberland*

South Portland Community Forum

**Maine Opiate Collaborative**

February 4, 2016

Observations & Recommendations

**General Observations**

- We need to balance our investments in reducing demand (prevention and treatment) with our investments in reducing supply (law enforcement)

**Prevention/Harm Reduction Needs:**

- Access to employment and housing supports for people in recovery
- Reduce access to prescription drugs
- Community education and skill building – build a community of “caring adults”
- Promote and build resiliency skills in the community
- Help everyone become engaged in their own health care
- School supports and staff training/skill-building
- Keep talking and keep sharing in the community
- Address the overlap of mental health issues
- More access to Narcan/naloxone by the public
- Support adequate sleep
  - Educate about the importance of adequate sleep in preventing risky behaviors
  - Start school later
- Provide after-school activities for kids

**Treatment Needs:**

- More affordable health insurance options, including MaineCare
- More treatment options
- Longer detox – 30 days is better
- Restore treatment funds (40% cuts recently)
- Funding to support transportation to treatment beds

- More peer recovery centers (especially in rural areas)
- Expand suboxone to Nurse Practitioners and PA's
- Expand limits on number of suboxone patients per provider

**Law Enforcement Needs:**

- Funding for law enforcement efforts that support transitions to treatment programs
- Limit arrests following overdose reporting because more arrests means less reporting will happen
- Arrest traffickers more than users
- More people should use the tip line in South Portland  
    Educate law enforcement personnel about addiction, stigma, etc.

Portland Community Forum  
**Maine Opiate Collaborative**  
April 6, 2016

Observations & Recommendations

**General Observations**

- We need to provide resources for a balanced approach - prevention, treatment, and recovery – we can't arrest our way out of the problem
- We need to follow the federal shift in resources and make more funding available for prevention and treatment
- We all need to be strong advocates for federal, state, and local programs and funding
- Local/community efforts should feed into a shared and ongoing statewide conversation/dialogue

**Prevention/Harm Reduction Needs:**

- More funding for prevention
- Reduce bias/stigma/shame
  - Put a face to recovery
  - Humanize the issue
  - More community conversations
  - Marketing/branding of stories and a blueprint for action/change
- Youth/students
  - More school programs and more time dedicated to reducing stigma/shame and providing support
  - Connect young people with people in recovery (e.g. Young People in Recovery model)
  - Push for more ways for kids to be/stay connected
  - Engage youth, including video storytelling (Project Aware model)
  - Teach kids how they can help other kids
  - Teach kids where they can get help
  - Educate youth that this can happen to anyone
  - Screening and early intervention in schools and community settings
  - School forums tailored for young people with young people on the panel
- Communities/families
  - More forums/meetings for discussion, sharing, education, connecting to resources
  - Resource dissemination
  - Supports for people who are feeling disconnected and/or hopeless

- Engage businesses
- Create HOPE
- Educate patients who are prescribed opioids
- Change our approach to chronic pain management
- Reduce access to opioids
  - Educate public on safe storage and disposal of prescriptions
  - More disposal options
- Harm Reduction
  - Needle exchange
  - More public access to Narcan
  - More first responders (not just EMTs) trained to administer Narcan (e.g. state troopers, police departments)
  - “Safe Sites” – Supervised Injection Sites (Vancouver, Ithaca NY models)

**Treatment Needs:**

- More funding for treatment
- Collaborative efforts to expand access to treatment within existing resources (Greater Portland Addiction Collaborative model)
- Engage recovery community in supporting people with substance use disorder who are getting out of hospital or jail
- Treatment infrastructure
  - More detox beds
  - More residential care
  - More beds for women
  - Compassionate, walk-in care, including needle exchange, for people without insurance (India Street model)
  - Group therapy and suboxone (Recover Together model)
  - More treatment for single parents (women and men) where they can bring their kids (there is currently no place for men and limited beds for women)
  - More treatment options at every level of care
  - More treatment options to which law enforcement can refer
- More collaboration between providers
  - Focus on retention - keep people in the system
  - One size doesn't fit all
- Integrate mind, spirit, and community into healing
- Recovery supports

- More sober housing (bigger is better: more people = more support for anyone struggling)
- Engage housing developers/resource people – they want to help but may not know how to plug in
- Help folks in recovery access:
  - Life skills
  - Employment
  - Housing
- Health insurance coverage
  - Expand MaineCare
  - Require better coverage from private insurance plans

**Law Enforcement Needs:**

- Diversion/LEAD model
- Operation HOPE model (like Scarborough) with local treatment options
- Mental health/substance use disorder professionals embedded in police departments (Portland LEAAP model)
- Drug courts
- Deferred adjudication

*District 3 — Western*

Lewiston Community Forum  
**Maine Opiate Collaborative**  
March 31, 2016

Observations & Recommendations

**General Observations**

- We need to accept federal funds and have a plan for when new resources become available
- We need to do some analysis to figure out what successful states are doing to get federal funding

**Prevention/Harm Reduction Needs:**

- Break down bias/stigma
  - Reduce shaming of providers and people getting help
  - Spread the Word program – community education and understanding
  - Involve the recovery community in public education/conversation
  - Change our language – focus on addiction, not the person
- Consistent funding for prevention and early intervention
  - Head Start
  - Home Visiting
  - Early Childhood Education
- Six-month maternity leave to reduce stress on parents and give babies a strong start
- Confront poverty and social issues
- Youth/young adults
  - More staffing and funding for prevention in schools
  - Minimize trauma - provide family/community education and support
  - Help kids and young adults feel connected and find community
- Communities/families
  - More community and parent groups
  - More community connections and relationships
  - Educate parents on how to educate kids
- Comprehensive school and community programs like Project Unite in Lewiston

- Faith-based support
- Intervention in the physician's office
  - Change prescribing culture
  - Mandate PMP use
- Harm reduction
  - More access to naloxone
  - Educate providers on higher resistance levels to pain medicine if someone with substance use disorder is in hospital

### **Treatment Needs:**

- Resource hub – where people can go for education and assistance
  - Online (Maine.gov needs to be easier and updated)
  - Walk-in option (e.g. storefront)
- Normalize hospitals as points of entry – it shouldn't be law enforcement
- Treatment infrastructure
  - More detox beds
  - More residential rehab beds and with longer-stays
  - More treatment options for people getting out of the hospital
  - More suboxone providers
  - More options after detox
  - Longer treatment periods
  - System inefficiencies are a burden and a barrier to someone with addiction
  - Integrate mental health/behavioral health with substance use disorder in treatment
- Support for people in recovery
  - Integrate recovery community into support systems
  - Counseling and self-help groups
  - Case management
  - Wrap-around services
  - Establish communities of healing for women (like Thistle Farms, [www.thistlefarms.org](http://www.thistlefarms.org))
  - Support in finding
    - Housing
    - Employment
    - Reconnection with family/community
  - Women for Sobriety ([www.womenforsobriety.org](http://www.womenforsobriety.org))
  - Programs for gender-specific needs and healing processes

- Support for families of people in recovery
  - Counseling and self-help groups
  - Help finding resources and navigating the system
  - Drop-in support center
  - Online supports
  - NAR-Anon, AL-Anon, other groups
  - Learn2Cope program
- More proactive and restorative (like Gloucester, MA)
- More insurance coverage

**Law Enforcement Needs:**

- Public should alert law enforcement to dealers/traffickers
- Fix system that prevents folks in jail from getting treatment out of state upon release

Mexico Community Forum  
**Maine Opiate Collaborative**  
April 20, 2016

Observations & Recommendations

**General Observations**

- This problem needs a community response – we all need to sign up to help!
- EMS, law enforcement, and treatment providers should work as a team

**Prevention/Harm Reduction Needs:**

- Reduce bias/stigma
  - Educate: it's a disease
- Youth/student education and supports
  - Parents: talk to your kids!
  - Mentoring - engage coaches and other non-parents in supporting kids
  - Tell kids about the impacts on their families/loved ones
  - Add health to school curriculum at all high school grade levels
  - Expand DARE to grades K-12
- Community/parent education and supports
  - Need to educate providers, families, teachers, employers, law enforcement, public – all sectors of community
  - Education that treatment works
  - Parents need to be open-minded about what your kids might be doing (trust other parents), and need to tell other parents what their kids might be doing/going through
  - Support for parents and loved ones – educate on what recovery looks like
- Screen children regularly for trauma and mental health problems
  - At schools
  - At pediatrician's office
- Marijuana policy
  - The perception of lower risk of marijuana could increase use/experimentation
  - Limits on location/venting of medical marijuana production/sales
  - Concerns about expanded use/scope of medical marijuana without adequate evidence (e.g. treating opiate addiction)
- Harm Reduction
  - Access to Narcan including education for family/friends

**Treatment Needs:**

- Reduce financial barriers
  - Project Save ME model (including local fundraisers) for people with no insurance or ability to pay
- More community conversations/forums to help encourage people who are actively using to get into treatment
- Treatment infrastructure
  - More funding to support infrastructure – state cuts are very problematic
  - Transportation to treatment
  - More detox options in Maine and region
  - More counseling and treatment options
  - More Medication Assisted Therapy (MAT) options locally
- Explore use of other accountability tools, including new technology/bio-monitoring
- Support for people in recovery
  - Support with employment, housing
  - More NA/AA options, including hotlines and web-based
  - Social activities after NA/AA meetings
  - Recovery Community Center/Club
    - Walk-in resources – counselors available
    - Safe, peer-to-peer engagement
    - Regular outreach calls to folks who go there – checking in from volunteers
    - Engage landlords, businesses, volunteers to find space and resources
    - Education on how to use/navigate existing resources
    - Education on resources available to others

### **Law Enforcement Needs:**

- Need treatment options as alternatives to jail
- Education – build understanding
  - Host meetings between law enforcement and people in treatment/recovery
  - Understanding addiction as a disease
- Funding to support EMS and law enforcement
- Ways for public to provide anonymous information to law enforcement
- Connect “walk-ins” with a hospital assessment and a recovery coach
  - Barriers are financial capacity of person seeking help and availability of treatment options
  - Emergency rooms could be set up to do the same thing
- Make law enforcement part of the solution – be a friend

*District 4 — Midcoast*

Rockland Community Forum  
**Maine Opiate Collaborative**  
February 4, 2016

Observations & Recommendations

**General Observations**

- Substance use disorder and opiate/heroin addiction exacts a huge cost on families, local economies, and the jail system
- Right now the majority of drug-related arrests are people with addiction problems, not hardened criminals. Law enforcement professionals would much prefer to get adequate prevention and treatment resources in the community so they can focus their efforts on real criminals, like the people trafficking heroin/opioids in order to make money off other people's addiction.

**Prevention/Harm Reduction Needs:**

- Funding for prevention/harm reduction
- More community collaborations
- More community education – this is a brain disease
- Reduce stigma and isolation
  - We need to talk more as a community
  - We need to put a face on this disease
  - Use person-first language
  - We need to help our neighbors – show that we care
- Public education about paths/solutions
- We need to prevent the legalizing of marijuana
- More early childhood support, including having specialists go into schools regularly
- More options for teens – healthy, safe activities
- Housing for people in recovery
- Employment for people in recovery
- Community support for people in recovery
- Invest and focus our time – volunteer
- Drug regulation rather than drug prohibition
- More funding for needle exchange programs

### **Treatment Needs:**

- Funding for more treatment options
- More providers willing and able to treat disorder and addiction
- More medication assisted treatment
- Dialogue with providers and hospitals
- Expand the types of providers who can treat (e.g. Nurse Practitioners, Physician Assistants)
- Require doctors who prescribe more than 21 day supplies to also prescribe suboxone
- More coordinated system between clinicians, hospitals, insurance companies
- More and longer-term rehab options (this is cheaper than jail)
- Counseling should be part of treatment 100% of the time
- We need ALL treatment options because the path to good health will be different for different people – we should not be pitting one approach against another approach
- Public education about treatment options
- Physician medication management
- More access to acupuncture
- Support for the spiritual aspects of treatment
- Reduce bias among health care providers – create an easier path for accessing treatment
- More affordable health insurance options

### **Law Enforcement Needs:**

- Funding for law enforcement efforts
- Programs like Project HOPE that create resources for law enforcement to help people access treatment
- Drug court diversion programs
- Extended probation times – probation is an important piece of the support system
- Treatment in jails and support for those being released

Belfast Community Forum  
**Maine Opiate Collaborative**  
February 10, 2016

Observations & Recommendations

**General Observations**

- Our jails are filled with people who've committed drug/alcohol related crimes
- Our emergency rooms are being used by people who can't access treatment
- Our culture has normalized the use of substances
- Mental health is a major related/contributing factor to substance use disorders
- Waldo County's "[WeCARE](#)" (Waldo Encourages Community Assisted Recovery Efforts) is very important but more must be done
- The marijuana ballot question is concerning

**Prevention/Harm Reduction Needs:**

- We need to build relationships and restore connections – school, family, neighbors, employers/employees - these are the fabric of a strong community
- We've got to work together as a community, including using the resources/expertise of folks in recovery
  - Reduce stigma
  - Use person-first language
- Support kids and parents
  - Start early, including kids aged 0-3
  - Talk to young people and find out why they are using drugs/alcohol
  - Funding to support parents and parent education, like Head Start
  - Look at the family court system and the child protection system
- Schools
  - More funding for school programs
  - Make the time in the school day and make space in the curriculum for more school programs
  - Teacher/staff education and skill-building
  - More parent engagement/involvement
  - More police presence at schools as a deterrent
- We need to get a lot more young people involved and educated
- Health care providers
  - Education and skill-building
  - Reduce prescribing of opioids
- Support and education for families and others affected

- Educate and support businesses so they can support their employees
- Support for people getting out of treatment and/or jail
  - Jobs
  - Housing
  - Re-entry centers
  - Mentoring
- Eliminate “chem-free” floors on campus, which just condone substance/alcohol use by others
- Limit marketing of prescription drugs

**Treatment Needs:**

- More funding and support for WeCARE
- Increase availability of treatment options, including beds for people without health insurance
- More suboxone treatment providers
- More funding for continuing care - clinics and services (beds are not always needed)
- We need to mobilize the recovery community to help/support others
- We need places in the community for people in recovery to live and gather, including a sober living house, coffee house, recovery centers, other substance-free group spaces
- Help people in treatment access art and music programs

**Law Enforcement Needs:**

- Restorative justice
- Make suboxone treatment the first stop in the judicial system
- Support for prosecution

*District 5 — Central*

Skowhegan Community Forum

**Maine Opiate Collaborative**

April 13, 2016

Observations & Recommendations

**General Observations**

- We need to educate, enforce, and treat
- We need to advocate for allocation of resources
- No one group can solve this alone – the community must come together
- We all need to sign up to get involved!

**Prevention/Harm Reduction Needs:**

- Reduce bias/stigma and denial
  - Bring stories of recovery forward
  - Engage recovery community to lead discussions at schools
  - Educate on value of caring, kindness, and compassion
  - Educate that:
    - Addiction is a brain disease
    - Choice is lost
    - Treatment works
    - Recovery happens
    - There's a difference between a person who's using and person in recovery
- Youth/student education and supports
  - Open up conversations in schools
  - Al-A-Teen – support for kids in families with addiction
  - Peer-to-peer programs
  - Mandated curriculum in junior high and high school
  - Get involved in other kids' lives
  - Educate teachers on ACEs, brain development
  - Identify and put programs into other prevention settings for youth and young adults
  - Break the “no talk” rule for kids – break the silence
- Community/parent education and supports
  - Break through with parents
  - Break the generational cycle
  - Community meetings

- Online resources
- Match the right messengers for the audience
- Educate and engage employers – they can be the key to all pieces coming together
- Resources for NAR-Anon and similar groups
- Educate families and friends about setting clear and healthy boundaries
- Primary care doctors should screen for ACEs (Adverse Childhood Experiences)
- Break down information silos – create ways for teachers, law enforcement, and providers to share information
- Harm Reduction
  - Narcan available from all first responders
  - More needle exchange programs

### **Treatment Needs:**

- Reduce financial barriers
  - Local fundraising for scholarships (e.g. walks, 5K, etc)
  - Local treatment is less expensive – we need to shift resources to local solutions
- Insurance
  - More affordable insurance options
  - MaineCare expansion
  - Require private insurance plans to cover treatment
- Support from employers
  - Time off for appointment times
  - Provider insurance coverage and make sure insurance plan covers treatment
- Treatment infrastructure
  - Funding for more counseling – group and individual
  - More safe housing/sober living options
  - More local treatment options with counseling in Somerset County - especially Medication Assisted Therapy
  - More resources for longer-term in-state treatment
  - Sober housing with peer support
  - Skowhegan needs an intensive outpatient program
- Support for people in recovery
  - More work/live settings for people in recovery
  - Help with employment
  - Help with housing
  - More NA, AA type programs that are free
  - Peer to peer recovery coaches/mentors

- Engage community in providing volunteer supports
  - Rides to appointments
  - Rides to meetings
  - Buying lunch
  - Build community relationships
  - Create hope

**Law Enforcement Needs:**

- Funding for treatment in jails that continues when released, including a warm handoff
- Diversion programs
- Funding for a drug court program and a judge
- Educate law enforcement on how to be proactive

## *District 6 — Penquis*

Bangor Community Forum  
**Maine Opiate Collaborative**  
March 30, 2016

### Observations & Recommendations

#### **General Observations**

- Primary care must embrace addiction as a chronic disease
- State government must apply for federal funds when available – we can't get more resources if we don't apply
- The answer is different for every person – we need a full complement/tool box of resources
- The pharmaceutical industry drove the problem by marketing drugs to providers and consumers
- A lawsuit like the tobacco settlement could reduce drug marketing and bring money into states to pay for the fallout of addiction
- In the process of addressing heroin/opioid addiction, we can't lose track of other drug/alcohol threats
- We need to advocate and vote

#### **Prevention/Harm Reduction Needs:**

- Increase empathy and compassion
- Address bias and stigma in providers, communities, lawmakers, law enforcement
- Youth/students
  - Education and staff training in schools for trauma/ACEs (Adverse Childhood Experiences)
  - Adults need to create healthy environments for kids
  - Kids want to know how substances will affect their hopes and dreams
- Communities/families
  - More community education and conversations to break the cycle of addiction
  - Venues for support and story-sharing
  - Engage recovery community in community education
  - Support for families with kids
- Faith-based support
- Addressing chronic pain
  - Treat function, not chronic pain

- Alternatives to narcotics to address/control pain
  - Acupuncture
  - Tai chi
  - Massage
  - Cognitive Behavioral Therapy (CBT)
  - There is a long list (Dr. Noah Nesin)
- Reduce access to opioids
  - Pharmacies shouldn't be able to fill prescriptions written at out of state pain clinics
  - Insurance companies shouldn't be able to cover prescriptions written at out of state pain clinics
  - Mandate provider and pharmacist adherence to Prescription Monitoring Program (PMP)
  - Make the PMP more user-friendly
  - Educate primary care providers on reducing number and dosage of prescriptions
  - Change the culture of prescribing (too often and high doses)
- Screening
  - Screening in schools for trauma/ACEs
  - Robust screening in primary care setting, including asking “what *happened* to you”
  - Screening by pharmacists
- Harm Reduction
  - More access to naloxone

### **Treatment Needs:**

- Reduce financial barriers to treatment
- Treatment infrastructure
  - Social detox center
  - Sober housing/early recovery
  - Resource center/hub
  - Treatment options to which law enforcement can refer
  - Comprehensive support with warm hand-offs between all aspects of treatment and recovery
  - FQHCs can support each other in order to bring more funds and sites into the mix (4 FQHC's are getting new HRSA funds for screening and treatment)
  - Integrate mental health and substance use disorder providers and response system (St. Joseph Hospital model)

- More suboxone prescribers
  - More Medication Assisted Treatment (MAT) plus counseling
  - Long-term treatment
- Peer to peer support for people in recovery
- More affordable insurance coverage options, including MaineCare

**Law Enforcement Needs:**

- Comprehensive pre-release programs
  - Support
  - Housing
  - Employment
  - Skill-building
- Alternatives to jail
- Drug court
- LEAD (Law Enforcement Assisted Diversion) – pre-diversion program

Dover–Foxcroft Community Forum  
**Maine Opiate Collaborative**  
April 19, 2016

Observations & Recommendations

**General Observations**

- We are seeing a lot more heroin and less about prescription opioids
  - Heroin is cheaper and becoming more available
  - Emergency Room data shows big increase over last year
- We're seeing more fetal alcohol syndrome
- We need to find the common sense middle ground – stop the extreme pendulum swings in our responses – they can lead to unintended consequences

**Prevention/Harm Reduction Needs:**

- Get at the root causes
  - Trauma
  - Pain
  - Poverty/hopelessness/insecurity
  - Brain changes
- Invest in kids early
  - Early childhood education
  - Home visiting
  - Public health nursing – add capacity and restore scope of services, population
- Reduce bias/stigma
  - People in treatment who have babies feel shunned
  - Educate providers and community members
  - Public education to reduce stigma of mental illness
- Youth/student education and supports
  - Fatherhood Initiative
  - Create safe space to talk about feelings
  - Normalize the conversation around trauma
  - Teach the teachers about trauma and addiction
  - Teach life/coping skills
  - Federal funding can flow into HUD Zones (like Piscataquis County)
- Community/parent education and supports

- Education for community members, social service agencies (e.g. domestic violence hotline staffers), families: what is addiction like and how can we support people
- Group therapy for families
- Education: setting boundaries, how best to help people actively using, in treatment or recovery
- Promote the statewide crisis line (1-888-568-1112) – this keeps people out of the emergency room
- Education on the problem and the scope of the problem
- “It takes a village” – get involved – create community collaboratives
- Community ACEs training
- Chronic pain
  - Alternative treatments (e.g. acupuncture)
  - CMS evaluation change – how is pain handled – consider quality of life
  - Change our cultural response to pain (the “fifth” vital sign)
- Reducing access
  - Drug take-backs are working
- Explore whether making drugs legal would prevent initiation. Consider how the brain is impacted with the use of drugs.
- Marijuana policy
  - Concern about normalization of marijuana use
  - Concern about broadening scope of medical marijuana for treating opiate addiction
- Harm reduction
  - Needle exchange program in our region

### **Treatment Needs:**

- Data collection
  - Improve understanding of scope of problem by refining hospital reporting guidelines/protocols
- More insurance coverage options
  - Medicaid expansion would permit more people to access treatment
- Funding – we need to reassess our priorities for government spending
- Treatment infrastructure
  - More MAT plus counseling options
  - More focus on treating mental health issues with addiction
  - More local options for treatment

- Methadone clinic
    - Expanded physician capacity for suboxone
  - Help with transportation
  - Protocols for assessments and treatment (understanding everyone is different)
    - Step-down protocols for suboxone and methadone
  - Resources for detox, especially out of hospital/ER with no delay
  - Resources to help emergency department connect patients with someone in recovery
  - More intensive outpatient (IOP) resources
  - Create a facility that focuses on addiction
  - More mental health treatment
  - Engage recovery community as mentors, peer-to-peer for folks in treatment
  - More funding for hospitals/providers
    - Higher reimbursement rates
    - Base reimbursement on actual costs
    - Eliminate sequester
  - FQHCs with federal expansion grant network with other FQHCs to extend reach
  - More needs assessment and wrap-around services
  - More suboxone providers (current MAT wait list is over 75 people)
    - Educate providers in order to break down stigma of providing MAT
    - Training for physicians
    - All primary care providers, not just doctors, should qualify (60% of primary care providers in Piscataquis County are not doctors) – pass the federal TREAT Act
    - Build infrastructure, including actual space
- Support for people in recovery
  - Build hope
    - Re-build our sense of community
    - Engage people in recovery in community activities
  - Help with long-term debt incurred due to addiction
  - Employment (this is part of a cycle with law enforcement – a record often prevents employment)
  - Housing
  - Transportation to NA/AA meetings
  - Narcotics Anonymous/faith-based options
  - Use technology to connect people in recovery
    - With folks in jail
    - With people without transportation

- Promote success stories

**Law Enforcement Needs:**

- Tip line – engage community to report what’s happening
- Share drug arrest data (Diversion Alert model)
- More funds for law enforcement to follow drug cases and root out dealers – follow the drugs up the supply chain
- Need treatment options in jail – counseling plus MAT
- Resources to help law enforcement connect people with someone in recovery

Lincoln Community Forum  
**Maine Opiate Collaborative**  
May 10, 2016

Observations & Recommendations

**General Observations**

- 80% of law enforcement/police time is drug-related

**Prevention/Harm Reduction Needs:**

- Reduce bias/stigma and denial
  - Public education – it's a disease
- Youth/student education and supports
  - Education in schools
  - Screening for trauma
  - Add brain education to curriculum
  - Build hope, reduce stigma
  - Start in Middle School or earlier
  - Mentoring programs
  - After-school gathering places that are safe and supportive
  - Engage recovery community
- Community/parent/family education and supports
  - Stress reduction strategies
  - More funding for trained support/prevention staff
  - More individual and group therapy options
  - Community education/supports for trauma
  - Skill-building to eliminate enabling behaviors
  - Local NAMI (National Alliance on Mental Illness) group
  - NAR-Anon group
  - Build hope, reduce stigma
  - More training in the use of dogs to identify drugs in home/business/community settings
  - Engage recovery community
- Train teachers in what to do when they know there is substance use disorder at home
- Providers
  - Primary care doctors should screen for ACEs (Adverse Childhood Experiences)
  - Educate providers and the public on alternatives to chronic pain- yoga, acupuncture, etc.

- [“Living Well”](#) – Stanford University – chronic pain coaching
  - Peer-to-peer communications to help reduce stigma
  - Mentoring, shadowing to reduce stigma, fears about treating people with substance use disorder
  - Engage recovery community
- Break down information silos – create ways for teachers, law enforcement, and providers to share information
- Change the culture around prescribing and pain as the 5<sup>th</sup> vital sign
- Prescribing
  - Require use of prescription monitoring program
  - Reduce overall amount of opioids prescribed
  - Provider collaborations (EX: Penobscot Community Health’s Controlled Substances Committee)
  - Engagement of pharmacists – proactive calls from pharmacists to providers
  - Education of consumers
  - Give prescribers the option to fill a prescription with a smaller quantity – need legal and insurance changes to support this
- Safe storage of prescriptions
- Stop the import of opiates

**Treatment Needs:**

- Reduce financial barriers
- Insurance
  - Change the reimbursement for primary care so there is more incentive to be a PC provider rather than a specialist
- Treatment infrastructure
  - Bring more providers on board with providing Medication Assisted Therapy (MAT)
  - Tie prescribing of opioids and MAT – require providers who prescribe to also do MAT
  - More counseling options, including in tandem with MAT
  - More treatment for co-occurring disorders, including more mental health beds in Maine and locally
  - More long-term/extensive treatment options, including outpatient
  - More local treatment options – reduce wait times
  - Create system outside of primary care offices (burnout levels high) – clinics that provide MAT and counseling

- Peer-to-peer hotline
- Support for people in recovery
  - Create jobs that support people in recovery – they would be plentiful and not require advanced degrees
  - More promotion of recovery resources
- More funding for communities, including federal and state dollars

**Law Enforcement Needs:**

- Change jail policies to ensure safer access to existing prescriptions
- More collaborations: police, DEA, sheriff
- Engage the public = report what you know
- More funds for law enforcement staffing
- Update the rules of evidence – how to collect and use

**What can the community do immediately?**

- Mentoring/sponsors
- After school with transportation
  - Volunteer staffing
  - Talk to school board
- School curriculum/programs
  - Engage the recovery community, especially young people
- Write letters to providers (from public)
- Advocate
- Training for the public – how to do interventions and bring in teams
- Save a Life Coalition – 1<sup>st</sup> Thursday of every month from 12-1

*District 7 — Downeast*

Ellsworth Community Forum  
**Maine Opiate Collaborative**  
March 28, 2016

Observations & Recommendations

**Ongoing comments and questions:**

- [Elsie@healthyacadia.org](mailto:Elsie@healthyacadia.org)
- [Denise@healthyacadia.org](mailto:Denise@healthyacadia.org)

**Prevention/Harm Reduction Needs:**

- Funding
- Collaboration
- Give parents the tools and information to make good choices
- Culture shift
  - Move away from “a pill for everything”
  - Change the culture of prescribing for both providers and patients
- Reduce stigma!
  - This is a chronic, recurring disease
  - More community conversations
  - Education, not judgement
  - Adjust our language/vocabulary
- Community engagement
  - We need to stop minding our own business
  - Get involved, pay attention, help, call law enforcement, talk more, have compassion
  - Get involved to create a solid foundation for kids
- Reduce trauma and deep-seated pain
- Role of pharmacies
  - Patients should get their PMP summary at the pharmacy when they pick up their prescriptions – this gives them information to discuss directly with their providers
- Marijuana
  - Education that marijuana has no benefits before age 20 – actually can increase psychoses
  - Counter the growing perception problem – the normalization that marijuana is medicine

- Harm Reduction
  - More individuals should carry Narcan
  - Good Samaritan policy to incentivize 911 calls

### **Treatment Needs:**

- Distribution of community resource list
- Treatment infrastructure
  - More funds for treatment
  - More treatment options
  - Build a “hub” treatment center
  - Require that providers with a license to prescribe must do so
  - More safe hospital-based detox that includes education about recovery and a direct transfer to a treatment center
  - Acupuncture options, including NADA (National Acupuncture Detoxification Association): [www.acudetox.com](http://www.acudetox.com) (local contact: Jean Guyette, 565-3891)
- Support for a faith-based approach
- More insurance options, including MaineCare
- Support bills in the legislature

### **Law Enforcement Needs:**

- Jail the dealers
- Diversion to treatment: jail is not the place for people with a sickness or illness

Calais Community Forum  
**Maine Opiate Collaborative**  
May 2, 2016

Observations & Recommendations

**General Observations/Concerns**

- Concerned about the implications of legalizing marijuana

**Prevention/Harm Reduction Needs:**

- Reduce bias/stigma – change the culture
- Youth/student education and supports
  - More time in schools for prevention education
  - Create safe and supportive places for youth to gather in each town
    - Start with what kids already like to do
    - Give kids something they can control
    - Create inventory of options (community spaces) for youth to meet after school
  - Engage adults in supporting/volunteering/mentoring
  - Peer counseling
  - We also need to support people working with kids
- Community/parent/family education and supports
  - More information for parents
  - Education that opiate addiction can be treated – it's a disease
  - Education on breaking the generational cycle of addiction
  - Need very robust public communications effort
  - More support for community partnership efforts like:
    - Community Caring Collaborative
    - Healthy Acadia: Partnership for Success
    - Integrated Behavioral Health Collaborative
  - Create a NAR-Anon group – can build on the AA system in place
- Recruit volunteers
  - Community volunteers get burned out – recruit on Election Day and other community gathering days/events
  - Engage employers to support volunteerism (e.g. Machias Savings, Bangor Savings)
- Need a community strategic plan
  - What's our vision

- What's our collective story to raise funds
- Prescribing
  - More/universal use of Prescription Monitoring Program (PMP)

**Treatment Needs:**

- Resources
  - Maine.gov offers online resources
  - Need county specific resource hub and asset map
    - MAAR Community Asset Map
    - Washington County Addiction Resource Page
  - Need a county or public health district resource hotline that is 24/7 – not just AA line
  - Build a network for people looking for help, in crisis, or leaving jail – need structured programs available on demand
  - Recovery community could reach out to people who haven't reached their "bottom" – create opportunities to socialize and support them in moving into treatment and recovery
- More affordable insurance options
- Treatment infrastructure
  - More access to treatment services in real-time
  - More transportation options
  - Need a crisis hotline
  - Need residential rehab that offers Medication Assisted Therapy (MAT) – currently there is only one location in the county and it is abstinence-based
  - Can hospitals take on detox? (currently hoping to do 3-day alcohol detox in hospital but not thinking about narcotics at this point)
  - Currently only three suboxone providers in the county
- Support for people in recovery
  - Support from the community – need a community response
  - Help with employment
    - Career centers
    - Employers willing to hire – especially folks just getting out of jail

**Law Enforcement Needs:**

- Train law enforcement to help people find treatment
  - Before jail
  - In jail
- Support law enforcement by reporting what you see/hear

Jonesport Community Forum  
**Maine Opiate Collaborative**  
May 3, 2016

Observations & Recommendations

**General Observations**

- It's time for the community to come together

**Prevention/Harm Reduction Needs:**

- Youth/student education and supports
  - Need more adult mentors – trusting, caring adults without judgement
  - Kid/parent programs (like “Primed for Life” program at Jonesport Beals High School)
  - Model: Courage to Speak Foundation
  - Engage the recovery community in school programs
  - “Teen Challenge” programs
  - Be careful of language – all drugs (nicotine, alcohol, etc.) are different and affect us all differently
  - Provide hope
- Community
  - Educate to reduce bias/stigma – it's a disease and it can be managed (like diabetes, for example)
  - Education on trauma and brain changes
  - Parenting programs
  - Support for families and friends of people in recovery, including how to best help people in recovery
- Prescribing
  - Educate providers on alternatives to treatment for chronic pain
- Change the culture around using drugs to treat pain of all kinds

**Treatment Needs:**

- Change federal law that limits who can provide Medication Assisted Therapy (MAT) and how many patients they can work with
- More support and resources from Augusta
- Help people access recovery
  - Resources/support to track folks looking for help
  - Provide hope

- Treatment infrastructure
  - Need a full range of options for treatment – different things work for different people
  - More residential rehab/recovery, especially for women
  - More treatment with structure
  - More local treatment options
  - More suboxone providers
  - Add a methadone option, including testing for other drugs as well as peak/trough therapeutic dose before leaving clinic
  - Transportation, including more resources for Logisticare
  - Child care
- Providers
  - Build trained provider workforce
  - More collaboration among providers, including wraparound services
  - Education to reduce stigma
- Support for people in recovery
  - Peer-to-peer counseling
  - NA/AA
  - Life skills
  - Employment – employers can provide jobs and mentoring
  - Housing
  - Create community blog/forum to post need and place to donate or hire
  - Community fundraisers to support people in recovery
  - “I Care Too” program – it has to start in the community

**Law Enforcement Needs:**

- Support groups for people in jail
- Work together to create safer communities
- Education to reduce stigma
- Stronger penalties for drug dealers
- More law enforcement resources for smaller towns

*District 8 — Aroostook*

Fort Kent Community Forum  
**Maine Opiate Collaborative**  
March 7, 2016

Observations & Recommendations

**Prevention/Harm Reduction Needs:**

- Education and speaking up/out:
  - Educate about addiction – it’s all about the brain!
  - Break down stigma and misplaced belief that “it doesn’t happen here – not by people from here”
  - People need to hear, “this person with an addiction is your neighbor”
  - We need to be speaking as communities in supporting families, including sharing stories
  - We need more venues for people in recovery to tell their story
  - Break down secrecy
  - More community conversations
- Prescribing
  - There are alternatives to prescribing for pain – for example, Physical Therapy, Cognitive Behavioral Therapy – and we need to make sure providers and consumers know this
  - We need to de-link patient satisfaction from pain management – this has created a disincentive to limit opiate prescribing
- What health care providers can do:
  - Put more emphasis on improving function, not eliminating pain
  - Put more emphasis on holistic approaches to managing pain
  - Conduct universal screening and early intervention
  - Educate patients on long-term risks of opiate/opioid use
  - Get better at using the PMP (Prescription Monitoring Program)
  - Pill counts
- We need to involve the recovery community in our prevention efforts
- Get prescription ads out of the media

**Treatment Needs:**

- Need real-time treatment options – no delays
- More longer-term recovery resources
- We need to privatize long-term recovery facilities

- More insurance options (no insurance is a barrier to treatment)
- More peer recovery/support resources
- More MAR (Medication Assisted Recovery) and community support
- Help families change behaviors and reorganize in order to help people in recovery
- Use empty facilities for rehab space
- Support individuals and providers to people with addiction to wean off prescription drugs
- Skill-building for providers to help them help people who aren't ready to stop using
- Work with Canada, where there is more open access to prescription medication

**Law Enforcement Needs:**

- Rehab first, not jail first
- Expand drug court
- Train/connect law enforcement to treatment options (see Aroostook County resource flyer)

Presque Isle Community Forum  
**Maine Opiate Collaborative**  
March 7, 2016

Observations & Recommendations

**General Observations**

- We need to be collecting data that measures overdose experiences that don't end in death
- We need a community strategic plan!
- We need to talk to decision-makers – state and federal – to let them know how we feel
- Presque Isle has a Drug-Free Community grant – the next meeting is March 31<sup>st</sup> from 9:30 – 11AM at Aroostook County Action Program (ACAP)

**Prevention/Harm Reduction Needs:**

- Youth/students
  - More screening and early intervention – maybe a pilot program for best practice
  - Increase education and awareness before high school
  - More outreach and education at schools and Boys/Girls Clubs
  - More role models, especially men
  - Parents have to talk to their kids
  - Law enforcement collects a lot of information that goes unused – we need more resources to make the linkages between what law enforcement knows and what schools know (e.g. truancy and family situations) in order to support children
  - More youth programs to build skills and confidence
  - More peer-to-peer programs
  - Resources to put police officers in schools to talk to kids
- Young adults
  - More employment options so drugs aren't a lucrative business
  - Engage people in their 20's and 30's – not just kids
- Communities/families
  - More relationship-building and support, including appropriate messaging, for families and communities
  - Community partnerships and information sharing– no one entity can solve this alone
  - More community and family education regarding the magnitude of the problem and nature of the disease
  - Al-Anon underutilized – more promotion of options
- Faith-based support
  - Educate faith-based folks on how to plug in

- Engage faith-based communities to confront the sense of hopelessness
- Church spaces are often available for free to hold meetings/gatherings
- Reduce demand and reduce access
  - Stop prescription advertising
  - Do not legalize more drugs – don't add legal options for substance use
  - Round the clock prescription take-back programs
- Harm Reduction
  - Increase access to take-home Naloxone
  - Increase law enforcement access to Naloxone

### **Treatment Needs:**

- Treatment infrastructure
  - Real-time treatment options: we need a quicker way to get people into outpatient services
  - There are not enough rehab beds/facilities in Maine
  - More recovery houses – at least two (male and female separate) per region
  - More care coordination
  - More mental health resources
  - More providers doing MAT/MAR (medication assisted treatment/recovery)
  - More social detox (like Bangor) – approximately one week, then treatment plan (including medication assisted treatment options)
- Support for people in recovery
  - Resources to train peers for peer recovery programs
  - Housing and employment for people getting out of prison
  - We need to show people in recovery that we care, that they are needed, and that they have community support; we need to stop the ways we enable them
  - Reduce stigma and increase compassion
    - Adopt-A-Block (Houlton adopted Los Angeles model)
    - Link for Hope (Houlton model) – breaks down anonymity
  - Support for the emotional side of what people who are misusing opiates are going through
  - More “clubhouses” – storefronts that serve as meeting places and resource hubs
- Support for families of people in recovery
  - More support, including education and peer-to-peer networking, for families of people trying to enter treatment
- More affordable insurance coverage options

### **Law Enforcement Needs:**

- Expand drug courts
- Educate communities so they can assist with tips
- More resources so all enforcement cases can be pursued
- Federal bill should include Diversion Alert
- Expand authority and funding to go after the dealers

*Tribal Public Health District*

Wabanaki Community Forum

**Maine Opiate Collaborative**

May 13, 2016

Observations & Recommendations

**General Observations/concerns**

- We need to treat opiate addiction with compassion, just like any other disease
- Preventing and treating substance use disorder is the number one priority in community and youth surveys
- Tribes have become illegal drug havens due to no tribal policing and very few law enforcement resources
- Maine Opiate Collaborative Task Forces need to include people in recovery in ongoing planning efforts

**Prevention/Harm Reduction Needs:**

- Community education
  - Reduce bias/stigma/shame
  - Be careful of the language we use – it can inadvertently add to stigma and disempower people
  - Raise community awareness about suboxone programs
  - Community support groups with consistent meeting days/times
- Get to deeper issues in families and the community that underlie substance use disorder
- Reduce/eliminate over-prescribing
  - Model: Bangor Area Controlled Substances Workgroup
  - Create standards for prescribing and patient education
  - Put a ceiling on opioid prescribing
- Provider education and supports
  - Support “Caring for ME” initiative that gives providers tools/resources
  - Train providers in using alternatives to chronic pain treatment (e.g. chronic pain collaborative)
- Overdose prevention education
  - Public
  - People with substance use disorder
  - Friends and family
- Third party access to naloxone

### **Treatment Needs:**

- More physical, mental, spiritual supports
  - Reconnect folks with traditional ceremonies and heritage
  - Help people overcome emotional pain
  - Help people with trauma to reconnect and heal the injury to their spirit
- Treatment infrastructure
  - Expand access to suboxone - more providers doing MAT
  - More beds for real-time treatment – eliminate wait times
  - Need local treatment option that is culturally competent
    - IDEA: Wabanaki Rehabilitation, Treatment, and After-Care Center
      - Would the Maine Medical Association support this idea?
      - Is this an idea for a pilot that could be replicated?
      - Can a meeting be set up to discuss this further?
  - More resources for clinics – both funding and staffing
- Safer suboxone dispensing
  - Help people in Medication Assisted Therapy (MAT) program to resist peer pressure to sell/share
  - Reduce diversion, including “compassionate diversion”
  - Sign contract
  - Urine tests
  - Pill counts
  - Require office visits
- Support for people in recovery
  - Wellness education
  - Supports to avoid relapse
  - Life skills
  - Mentoring – short and long-term
  - Support from the community
  - Engage the recovery community in a peer-to-peer wellness program – help connect people in recovery
  - Reduce stigma, shame

### **Law Enforcement Needs:**

- Create pathways to treatment first – not jail
- More resources for drug investigations

- Currently not getting help from Bureau of Indian Affairs or Maine DEA (must have a player on the team to get help)
  - Need to create partnerships with Maine DEA, county sheriffs, and other agencies
- Treat like a natural disaster – need an emergency operation plan
- Train law enforcement on use of naloxone

## **Appendix H: Annotated References, Glossary, and Endnotes**

## *Peer Center Resources: Annotated References*

Along with the References cited in the notes to this paper, the following citations provide a guide to some of the most useful readings and websites related to the description and development of Peer Recovery Centers.

### **1. Access to Recovery (ATR) Approaches to Recovery-Oriented Systems of Care: Three Case Studies**

Gaumond P., & Whitter, M., (2009). *Access to Recovery (ATR) Approaches to Recovery-Oriented Systems of Care: Three Case Studies*. HHS Publication No. (SMA) 09-4440. Rockville, MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration. Retrieved from:

[http://www.samhsa.gov/sites/default/files/partnersforrecovery/docs/ATR\\_Approaches\\_to\\_ROSC.pdf](http://www.samhsa.gov/sites/default/files/partnersforrecovery/docs/ATR_Approaches_to_ROSC.pdf)

This White Paper from SAMHSA describes the projects of three states, Connecticut, Washington, and Wisconsin, on an Access to Recovery Grant. Such grants require the development of recovery support services generally, and peer-based services especially. Each case study outlines how the state did it, providing multiple perspectives on peer center design.

### **2. Addiction Recovery Peer Service Roles: Recovery Management in Health Reform**

Faces & Voices of Recovery (2010). *Addiction Recovery Peer Service Roles: Recovery Management in Health Reform*. Retrieved from:

[http://www.nattc.org/userfiles/file/GreatLakes/RM%20Articles/9\\_11\\_10\\_PRSS\\_health\\_reform\\_f  
inal.pdf](http://www.nattc.org/userfiles/file/GreatLakes/RM%20Articles/9_11_10_PRSS_health_reform_f<br/>inal.pdf)

This paper synthesizes and integrates the insights, challenges and ideas generated at the July 1, 2010, White House Office of National Drug Control Policy and Faces & Voices of Recovery Roundtable on Peer Recovery Support Services. It is a fully developed description of principles of peer center development, including issues such as who pays for services, what a peer is, how a center is to be developed, what differentiates peer services, what credentials a center should have, what peer coaching is, and where peer centers are located. It is a highly useful compendium of material that developed out of the earlier stages of development of the peer center model.

### **3. Anti-Stigma Toolkit: A Guide to Reducing Addiction-Related Stigma**

Landry, M. Central East Addiction Technology Transfer Center and The Danya Institute (2012). *Anti-Stigma Toolkit: A Guide to Reducing Addiction-Related Stigma*. Central East Addiction Technology Transfer Center. Retrieved from:

<http://www.attcnetwork.org/RegCenters/productDocs/2/Anti-Stigma%20Toolkit.pdf>

This easy-to-use toolkit provides the substance use disorder treatment and recovery community with practical information and tools to enhance their capacity to engage in effective stigma reduction efforts. The guide is based on research evidence, practice evidence, and the lessons learned from SUD prevention, public health communication, and mental health anti-stigma efforts.

#### **4. Best Practices Identified for Peer Support Programs**

Money, N., Moore, M., Brown, D., Kasper, K., Roeder, J., Bartone, P., & Bates, M. (2011). *Best Practices Identified for Peer Support Programs*. Defense Centers of Excellence for Psychological Health and Trauma Brain Injury. Retrieved from:  
[http://www.dcoe.mil/content/Navigation/Documents/Best Practices Identified for Peer Support Programs Jan 2011.pdf](http://www.dcoe.mil/content/Navigation/Documents/Best_Practices_Identified_for_Peer_Support_Programs_Jan_2011.pdf)

While this resource is focused more on mental health peer support, it provides invaluable resources related to work with veterans. It outlines the major issues confronted by those in the military and can provide an overlay for those recovering from substance use disorders. Its focus on military trauma is especially useful.

#### **5. Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS) Webinars**

Substance Abuse Mental Health Services Administration (2016). *Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS) Webinars*. Retrieved from:  
<http://www.samhsa.gov/brss-tacs/webinars>

BRSS TACS is the technical assistance arm of SAMHSA for all things related to recovery. This site highlights webinars from BRSS TACS that cover new knowledge areas, and cutting-edge programs and models promoting recovery-oriented care and supports. From here, other BRSS TACS resource pages can be accessed.

## **6. CCAR Recovery Centers in Connecticut**

Great Lakes Addiction Technology Transfer Center (ATTC). *Peer-based Recovery Support Services: The Connecticut Experience: An Interview with Phillip Valentine By William L. White, MA*. Retrieved from:

[http://www.williamwhitepapers.com/pr/Interview\\_With\\_Phillip\\_Valentine%20Interview.pdf](http://www.williamwhitepapers.com/pr/Interview_With_Phillip_Valentine%20Interview.pdf)

Connecticut Community for Addiction Recovery (CCAR). (n.d.). CCAR recovery centers in Connecticut: Core elements of a peer recovery center. <http://ccar.us/>

These sites provide an interview with Phillip Valentine, Executive Director of the Connecticut Community for Addiction Recovery, conducted by William White. The CCAR site is also referenced because it describes their programs, including peer centers and peer coach training programs. CCAR has become internationally known as a model for peer centers and peer recovery support and many states use their training model to train peer coaches.

## **7. Consumer-Operated Services KIT**

Substance Abuse and Mental Health Services Administration (2011). *Consumer-Operated Services: How to Use the Evidence-Based Practices KITs*. HHS Pub. No. SMA-11-4633, Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services. Retrieved from:

<http://store.samhsa.gov/product/Consumer-Operated-Services-Evidence-Based-Practices-EBP-KIT/SMA11-4633CD-DVD>

This is a mental health-focused tool kit but nevertheless provides some useful material on how to build a consumer-run program. It offers principles of recovery and larger systems relationships and guidance grounded in evidence-based practices. A CD-ROM/DVD includes 10 booklets.

## **8. Recovery Community Organization Toolkit**

Faces & Voices of Recovery (2012). *Recovery Community Organization Toolkit*. Retrieved from:

<http://www.facesandvoicesofrecovery.org/sites/default/files/resources/7.13.15%20FINAL%20Recovery%20Community%20Organization%20Toolkit.pdf>

This is a toolkit for building a recovery community organization. Such an organization supports or even spearheads the development of Peer Recovery Centers and provides advocacy, education, and support to the many facets of the recovery community. This toolkit covers the core principles of such an organization and describes different types of programs. It describes organizations in various states and the centers they have supported or developed. There are many practical tips for organization-building here, along with descriptions of recovery support.

## **9. How to Build Your Own Peer-to-Peer Recovery Center from the Ground Up!**

Grasmere, J. with Martell, J., Andersen, R., & Parker, D. (2006). *How to Build Your Own Peer-To-Peer Recovery Center from the Ground Up!* The Recover Project, A Program of the Western Mass Training Consortium. Retrieved from:

[http://bha.dhmh.maryland.gov/POPULATION\\_BASED%20BEHAVIORAL%20HEALTH/Documents/StateCareCoordination/WMass\\_RCCenter\\_Manual.pdf](http://bha.dhmh.maryland.gov/POPULATION_BASED%20BEHAVIORAL%20HEALTH/Documents/StateCareCoordination/WMass_RCCenter_Manual.pdf)

A highly useful, hands-on manual created by a group who developed their own peer center. It covers each step of the process, including recruitment of volunteers, developing and furnishing a center, and policies and ethics.

### **10. Integrating Substance Abuse Treatment and Vocational Services.**

Center for Substance Abuse Treatment, Integrating Substance Abuse Treatment and Vocational Services, Treatment Improvement Protocol (TIP) Series, No. 38. (2000). *Chapter 4: Integrating Onsite Vocational Services*. Rockville (MD): Substance Abuse and Mental Health Services Administration (US). Retrieved from: <http://www.ncbi.nlm.nih.gov/books/NBK64313/>

While this TIP (Treatment Improvement Protocol) is not specific to Peer Recovery Centers, it does offer invaluable information about providing vocational services that are integrated into programs. This particular chapter describes the basics of onsite programming. Many peer centers are currently hiring or using peer volunteers for onsite vocational services and this chapter can be helpful, as can the whole TIP, with ideas for creating functional and useful vocational support.

### **11. Recovery Coach Manual**

The McShin Foundation (2009). *A Recovery Coach Manual*. Richmond: VA. Retrieved from: <http://mcshin.org/mcwp/recovery-resources/recovery-coach-training-manual/>

This manual is one of many that are developed by organizations who have instituted peer centers and have trained their own staff (see Connecticut, CCAR for instance). Each entity has its own approach to recovery coaching but most have some strategies, principles, and interventions that are consistent across programs. This manual describes, step-by step, the goals, strategies and ethics of coaching and provides hands-on exercises, forms and principles. It is one of the more comprehensive manuals available and can be useful as a prototype for recovery coaching in new peer centers.

## **12. Recovery Support Resources in Rural and Frontier Areas: A Call for Research and Action**

White, W. (2011). *Recovery support resources in rural and frontier areas: A call for research and action*. Retrieved from:

[http://www.facesandvoicesofrecovery.org/sites/default/files/resources/2011\\_Rural\\_Recovery\\_Resources.pdf](http://www.facesandvoicesofrecovery.org/sites/default/files/resources/2011_Rural_Recovery_Resources.pdf)

This paper by William White outlines the critical differences in recovery in rural areas. It discusses prevalence of need in these areas along with innovations in supporting recovery. It discusses barriers, indigenous supports, and issues of access to both treatment and recovery support. “Promising areas of future innovation” is a particularly useful section for the development of programs in a rural state, suggesting many ideas that involve co-location of services and sharing of resources.

### **13. What Are Peer Recovery Support Services?**

Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration (2009). *What are Peer Recovery Support Services?* HHS Publication No. (SMA) 09-4454. Rockville, MD: Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services. Retrieved from:  
<https://store.samhsa.gov/shin/content/SMA09-4454/SMA09-4454.pdf>

This document explains peer recovery support services designed and delivered by people in recovery from alcohol and drug addiction. It discusses the multiple types of peer support, the adaptability and value of peer recovery support services, and the cross-cutting core principles. It provides a basic primer for developing a peer support program.

## *Glossary of Acronyms*

AA — Alcoholics Anonymous

AAMHS — Alliance for Addiction and Mental Health Services, Maine

ACAP — Aroostook County Action Program

ACE(s) — adverse childhood experience(s)

AdCare — AdCare Educational Institute of Maine, Inc.

AMHC — Aroostook Mental Health Center

ARC — Addiction Resource Center

ARCO — Association of Recovery Community Organizations

ATR — Access to Recovery

BARCC — Bangor Area Recovering Community Coalition

BARN — Bangor Area Recovery Network

BRFSS — Behavioral Risk Factor Surveillance System

BRSS TACS — Bringing Recovery Supports to Scale Technical Assistance Center Strategy

CADC — Certified Alcohol and Drug Counselor

CADET — Community Alcohol and Drug Education Team

CAP — Community Action Program

CARA — Criminogenic Addiction & Recovery Academy

CASH — Community Approach to Stopping Heroin

CCAR — Connecticut Community for Addiction Recovery

CCSME — Co-Occurring Collaborative Serving Maine

CRP(s) — collegiate recovery program(s)

CSAT — Center for Substance Abuse Treatment

DA — district attorney

DCC — District Coordinating Council

DEA — U. S. Drug Enforcement Administration

DFC — Drug-Free Communities

DHHS — Department of Health and Human Services

FQHC(s) — Federally Qualified Health Center(s)

HMP(s) — Healthy Maine Partnership(s)

HRSA — Health Resources and Services Administration

HUD — U. S. Department of Housing and Urban Development

IOP(s) — intensive outpatient program(s)

KBH — Kennebec Behavioral Health

LEAAP — Law Enforcement Addiction Advocacy Program

LEAD — Law Enforcement Assisted Diversion

MAAR — Maine Alliance for Addiction Recovery

MAR — medication-assisted recovery

MAT — medication-assisted treatment

MBH — Maine Behavioral Healthcare

MeHAF — Maine Health Access Foundation

MHFA — Mental Health First Aid

MIYHS — Maine Integrated Youth Health Survey

MOU — memorandum of understanding

MSW — Master of Social Work

NA — Narcotics Anonymous

NAMI — National Alliance on Mental Illness

NIMBY — “not in my backyard”

PCHC — Penobscot Community Health Care

PCP(s) — primary care provider(s)

PD — police department

PHD(s) — public health district(s)

PMP — Prescription Monitoring Program

PRC(s) — peer recovery center(s)

PRCC — Portland Recovery Community Center

PRO-ACT — Pennsylvania Recovery Organization - Achieving Community Together

PRSC(s) — peer recovery support center(s)

PRSS — peer recovery support services

PSS(s) — peer support specialist(s)

RCO(s) — recovery community organization(s)

RFP — request for proposal

ROES — Recovery Oriented Employment Services

ROSC(s) — recovery-oriented system(s) of care

SAMHS — Maine Office of Substance Abuse and Mental Health Services

SAMHSA — Substance Abuse and Mental Health Services Administration

SBIRT — Screening, Brief Intervention, and Referral to Treatment

SHNAPP — Shared Health Needs Assessment & Planning Process

SIRP — Student Intervention Reintegration Program

SMHC — Southern Maine Health Care

SNAP — Supplemental Nutrition Assistance Program

SUD(s) — substance use disorder(s)

TOA — The Opportunity Alliance

UMA — University of Maine at Augusta

UMFK — University of Maine at Fort Kent

UNE — University of New England

USM — University of Southern Maine

WITS — Web Infrastructure for Treatment Services

YPR — Young People in Recovery

## *Endnotes*

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