Annual Report to the Maine Legislature
from the Substance Use Disorders Services Commission
Submitted to
Joint Standing Committee on Health and Human Services
Joint Standing Committee on Appropriations and Financial Affairs
Approved January 12, 2022

Submitted by

Bruce Campbell, LCSW, LADC
Chair, Substance Use Disorders Services Commission (SUDSC)

Substance Use Disorders Services Commission: Statutory Authority

Public Law Chapter 432, An Act to Amend the Laws Governing the Substance Use Disorders Services Commission was approved by the Governor on June 20, 2019. The actual appointments to the Commission were delayed but the appointments were finalized in June 2021 and a current roster of Commissioners is contained in this report.

The purpose of the Commission is to serve as advocate. review and evaluate, and inform the public on issues related to substance use disorders. The amended statute reflects that the Commission serves as an advocate and resource for the State on its four pillars of substance use disorder prevention, intervention/harm reduction, treatment and recovery.

The statute further states that the Commission shall promote and assess activities designed to meet and remediate challenges of substance use disorders in the State, and with the support of the Department of Health and Human Services, Office of Behavioral Health (OBH) the Commission shall review and evaluate on a continuing basis state and federal policies and programs relating to substance use disorders.

In cooperation with the Department, the Commission shall keep the public informed by collecting and disseminating information, by conducting or commissioning studies and publishing the results of these studies, by issuing publications and reports and by providing public forums, including conferences and workshops. The Commission, based on its activities pursuant to this subsection, shall make recommendations relating to substance use disorders to the Department and the Governor.

It further states the Commission shall report annually to the joint standing committee of the Legislature having jurisdiction over health and human services matters and the joint standing committee of the Legislature having jurisdiction over appropriations and financial affairs. This will be done on or before the last business day of each year. The report must include developments and needs related to substance use disorders prevention, intervention, treatment and recovery in the State.

This document serves as the annual report to the Joint Standing Committee of the Health and Human Services and Joint Standing Committee Appropriations and Financial Affairs of the Maine State Legislature. A current roster of committee members and summary of meetings is included as an addendum to this report.

Maine Substance Use Disorders Services Commission
Roster Effective July 1, 2022

Leg Ref	Name		Community Role	Representing
3.A	1	Sen Kim Rosen (R)	Senate District 8	State Senate
3.A	2	Sen Chloe Maxmim (D)	Senate District 13	State Senate
3.A	3	Rep Collen Madigan (D)	Representative District 110	Health & Human Services Committee
3.A	4	Rep Dick Pickett (R)	Representative District 116	Criminal Justice Committee
3.B	5	Andrea Trucali, MD	Maine Health	Physician or health care provider
3.C	6	Dwayne Conway	Principal, Maranacook Comm High School	Public secondary school administrator
3.D	7	Catherine Gross	Teacher, Manchester Elementary School	Public elementary school
3.E	8	Leslie Clark	Director, Portland Recovery Community Center	Statewide recovery coalition
3.F	9	Shawn Gillen	Aroostook County Sheriff	Criminal justice system
3.G	10	Guy Cousins	University of Maine - Augusta	Post-secondary education
3.H	11	William Lowenstein	President, Sexual Assault Crisis Center Board	Practitioner in substance use intervention
3.H	12	Jamie Comstock	Prevention Mgr, Bangor Public Health	Practitioner in substance use prevention
3.H	13	Eric Haram	Treatment Director, York Hospital	Practitioner in substance use treatment
3.H	14	Tracey Martin	Lakes Region Recovery Community Center	Practitioner in substance use recovery
3.I	15	Sheila Thibadeau	Northern Light, Employee Assistance Program	Private sector – employee assistance
3.J	16	Kate Chichester	Co-occurring Collaborative Serving Maine	Public representative: co-occurring disorders
3.J	17	Vacant	Vacant	Public representative: employment
3.J	18	Bruce Campbell, Chair	Recovery Matters, LLC	Public representative: recovery
	A	Deb Doiron	AdCare Educational Institute - Maine	Administrative support

Substance Use Disorders Services Commission (SUDSC)
Annual Report of Meetings and Presentations

Date	Location	Attendance (Members)	Nominees	Guests	Presenter(s)	Presentation
Jan 13, 2021	Via Zoom	7	5	11	Laurie McDonald (MDOL) Ben Hawkins (EMDCProj Coordinator	Connections with Opportunities Initiative
Feb 10, 2021	Via Zoom	7	6	10	Joan Klayman	Support for ME Program
Mar 10, 2021	Via Zoom	4	3	7	Leslie Clark, Dir PRCC	Portland Recovery Community Center
Apr 14, 2021	Via Zoom	5	4	9	Jim Lopatosky Dir, Contract Management Kenney Miller OBH Special Projects	Overview of the contracting process and updates Overview of Special Projects at OBH
May 12, 2021	Via Zoom	6	5	7		Updates and standing reports from OBH, CDC
Jun 9, 2021	Via Zoom	6		12	Kenney Miller OBH Black Grant Manager Dr Jessica Pollard	Americans Recovery Act, Substance Use Block Grant funding Maine Office of Behavioral Health Plan
Jul 14, 2021	Via Zoom	14		8		Updates and standing reports from OBH, CDC
Aug 11, 2021	Via Zoom	8		7	David Heidrich, Office of Marijuana Policy	Presentation on Marijuana Policy and Implementation
Sept 8, 2021	Via Zoom	14		10	LeeAnna Lavoie CDC Prevention Mgr	Substance Use 3-Year Strategic Plan
Oct 13, 2021	Via Zoom	10		10	Laurie McDonald (MDOL) Michael Freysinger OBH Recovery Support and Housing Paige Johnston Healthy Acadia, Recovery Corps	Connections with Opportunities – Update Recovery Coaching Report Americorps Recovery CORPS
Nov 10, 2021	Via Zoom	11		9	Sybil Mazzerole OBH – SUD Program Manager Kiley Wilkens, OBH Project Manager	OPTIONS Program – update Mobile Crisis Planning Grant for Mental Health and Substance Use Disorders
Dec 8, 2021	Via Zoom	12		11	Lisa Sockabasin Sharon Jordan Brittney Moon	The Wabanaki Center for Healing and Recovery

SUMMARY STATEMENTS AND RECOMMENDATIONS

The Maine Substance Use Services Commission is a cross-sector Commission comprised of legislators, medical professionals, recovery coalitions, criminal justice, educators at the elementary, secondary, and post-secondary levels, school representatives, prevention specialists, intervention specialists, treatment professionals, private employee assistance, recovery practitioners and members of the public representing employment, co-occurring disorders and the recovery community.

Two members of the Maine Senate, two members of the House of Representatives, and 14 gubernatorial appointees comprise the membership of the Commission. Bruce Campbell, representing the recovery community, serves as its Chair. The Commission meets on the 2nd Wednesday of each month from 9am – 12 noon. The meetings are open to the public. Since the COVID 9 pandemic, all meetings are conducted through zoom meetings. The meeting call-in ID is **899 0169 4058, and the Passcode: 790164.**

The following Summary Statements and Recommendation are the cumulative findings of the Commission and this report was approved by the Commission on Jan 12, 2022.

Substance Use Problems Are a Matter of Perspective

Problems associated with substance use disorders in our communities are interpreted subjectively and by the particular view one may be perched upon. This makes is very difficult to create a unified voice in addressing substance use related problems, with policies and practices often siloed within those perspectives. Examples include:

- Law enforcement where substance use problems are defined by crime, public safety and corrections;
- Education where substance use problems manifest as poor performance, with schools often seen as the nexus for primary prevention efforts;
- Child welfare where substance use disorders are interpreted with incidences of child abuse, neglect, substance-exposed infants, and often the driver for out-of-home placement;
- Business sees substance use disorders as lost productivity and potential liabilities;
- Health care systems see substance use disorders are exorbitant demands upon emergency services and first responder resources, as well and acute and chronic disease resulting from long-term substance use;
- Public health professionals see substance use disorders in the context of environmental risk where issues of access and availability to alcohol and other drugs are primary prevention concerns;
- Housing advocates see substance use disorders as significant contributors to homelessness;
- Social service agencies are frustrated by the role of substance use in rates of poverty and public assistance;

- Treatment professionals are frustrated by a dearth of comprehensive resources that can only respond to a fraction of the demand for services;
- The recovery community experiences stigma and structural barriers and discrimination that far too often contributes to members of their community to relapse, and all too often, death;
- And families experience substance use disorders in the most intimate and comprehensively tragic and excruciating painful loss of fathers, mothers, sisters, brothers, sons, and daughters, often generation after generation. Currently, there is no treatment code to support the affected others.

The substance use system at the State, local and provider levels are suffering from the same workforce shortages and workforce challenges as the rest of the State of Maine. Despite any vision or political currency the topic may have, without adequate operational capacity, any efforts for change or innovation are hindered. SUDSC recognizes this and shares concern with the rest of Maine's workforce capacity.

The hidden cost of substance use disorders is staggering, with 2010 figures estimated at $1.3B annually. The Office of Substance Abuse (the precursor to the Office of Behavioral Health) conducted studies on the Economic Impact of Substance Abuse in Maine in 2000, 2005, and 2010. The last study done in Maine was completed over 10 years ago and there is nothing to indicate those upward trendlines have decreased.

There were over 100,000 overdose deaths in the US last year, 42,000 more than all of the deaths occurring over ten years of the Vietnam War. It is easy to become overwhelmed by the complexity and magnitude of these problems. But one could easily ask, where's the outrage? Over 11 Mainers are dying every week from some type of drug-related overdose. For the past ten years and until recently, there has been little administrative leadership dedicated to addressing substance use disorders, and individuals, families, and communities that have been ravaged by the opioid epidemic.

The Commission wants to make it very clear, that as devastating as the opioid crisis is, it represents just the tip of an iceberg where the vast portion of the problems live underneath the surface, hidden from view. Alcohol and other drug problems occur across the entire lifespan, often in response to trauma that has been experienced in childhood, as the ACES study proves, but also the trauma experienced by as adults associated with lifestyles led by individuals who are involved with substance use of all kinds and at all levels.

The role of stigma is understated here, but the message is clear, particularly to those families and individuals who are experiencing the pain and suffering associated with unbridled substance use disorders. Stigma is another word for shame where individuals suffer the shame of what substance use disorders have done to their own lives, and while families/friends/co-workers experience the self-blame of "If only I had..." But stigma is also a social concept. It is stigma that shows up in discriminatory practices and in policies that expect a grossly under-resourced system to fundamentally fix an entire system that has grown weary of trying to resolve the issues

of an incredibly complex situation. And stigma shows up very clearly in different attitudes towards those who use illicit drugs such as heroin, cocaine and methamphetamine as opposed to those who use legal drugs such as alcohol, cannabis, and nicotine.

Over the past few years, and the last two years in particular, there has been a powerful emergence of the recovery community in the State of Maine, due in large part to the recognition of the value of recovery supports by the State government. Recovery supports include recovery community centers, telephone recovery supports, and recovery coaching. Recovery community centers, most easily described as a senior community center for the recovery community, have virtually exploded over the past two years. When there used to be only one State-funded recovery center in Maine, the Portland Recovery Community Center (PRCC), Maine has now adopted a "hub and spoke model" for recovery centers, with PRCC acting as a hub for 8 regional recovery community centers. The State is now supporting 18 recovery centers throughout the State.

The powerful force of volunteerism within the recovery community, a force that is historic and generative, is the spirit blood of recovery centers. For example, during the month of Sept, 2021 the number of volunteer hours generated by just two of the centers, PRCC and the Bangor Area Recovery Network (BARN) totaled 1,888 hours. The Independent Sector, cited by Volunteer Maine as its source for volunteer value, reports the value of a volunteer hour in Maine to be $25.26. Between just these 2 centers, for just that month, there is a projected value of $47,690 that the recovery community invests in itself. Projecting this figure annually, the recovery communities at those 2 centers is approximately $572,280. By this metric alone, Maine's investment in recovery community centers reaps significant returns.

The State OBH also reports that between Jan 2021 through Aug 2021 (8 months), the 9 recovery community centers coordinated through the Hub at PRCC saw 750 unique individuals, and offered 570 groups or activities attended by 4,467 individuals.

Housing insecurity is a tremendous barrier to those seeking to obtain and sustain recovery from substance use disorders. The State's Option Program reported in Oct 2021, only 25% of individuals served had adequate housing; the remaining 75% included those unstably housed (37%), homeless (25%), incarcerated (5%) and recently released (8%). The Maine Association of Recovery Residences (MARR) increased the number of certified recovery residences last year from 45 to 56 homes, providing 550 beds of supportive recovery residences. Of these, 75% of the certified homes allow people with opioid use disorders that are receiving medication assistance access to their beds.

Administrative Leadership

The administrative leadership that has been demonstrated over the past two years has been dramatic and fruitful. In its report to the Legislature last year, the Commission acknowledged the key appointments that had been made and the innovative strategies employed to address these problems. And indeed, the data seemed to indicate that these strategies were beginning to pay

off, for drug-related overdose deaths started to decline, until the coronavirus pandemic swept in to take center stage in virtually every aspect of life.

The coronavirus epidemic has caused a shift in our priorities. Despite the considerable accomplishments over the past two years in responding to substance use and opioid use, COVID-19 has taken a terrible toll on the individuals and families already vulnerable to substance use disorders. The impact of isolation and disruption can be seen in the rising use of alcohol and upward trajectory of opioid overdose deaths.

However, the pandemic has taught us about telehealth, which can exponentially expand treatment access and eliminate the transportation barriers of a rural state. And the recovery community has also rallied on line, for as much as all would like to meet in person, there is comfort in the safety and increased access created by telehealth and on-line platforms for treatment and recovery support. Supporting broadband access and development is an essential component for economic development, and for treatment and recovery support as well, eliminating our dependence for brick-and-mortar structures, and the transportation barriers confronting a rural state such as Maine.

Adopting a Business Model to Problems of Alcohol and Other Drug Use

Approaching substance use problems with a business model makes a great deal of sense. We have already shown what a terrible cost substance use disorders are to the State of Maine. One of the first things this does is to eliminate, or at least lessen, the role of stigma. Stigma, with all its value-laden charges, simply does not apply (other than a barrier) when we approach alcohol and other drug problems from a "supply and demand" structure.

First and foremost, the State as a business needs to take stock of its inventory. This has not been done in the State of Maine since 2010. In the last report on the economic impact of substance use in the State of Maine, we found ourselves spending an annual amount of $1.3B. Of that amount, approximately 4% of those costs were associated with substance use prevention, intervention, and treatment. There were no costs associated with funding recovery support services in those reports. There was also no measurement of outcomes, or the cost benefits of particular levels of intervention.

The landscape in terms of problems and policy has changed dramatically since then, as well as our understanding of outcome evaluations, technology, and the metrics of change. The fundamental recommendations of the Commission are in the areas of Planning and Reinvestment, Supply Reduction, and Demand Reduction strategies.

A. Planning and Reinvestment

The Commission supports two broad recommendations for addressing the myriad components of substance use disorders in Maine: planning and reinvestment.

The Commission supports the efforts to fund the economic impact studies being conducted by the University of Maine, but suggests it further expands the study to include the cost benefits of supporting each element of the service continuum contained in its authoring statute: prevention, intervention/harm reduction, treatment, and recovery. Funding should be earmarked to complete this benchmark study and repeat it at least every five years. This would inform policy makers and providers as to the most effective and strategic uses of additional resources as they may be available. Funding from the opioid settlement agreements and other resourced could be used most effectively when this type of data is available to guide decision-making.

The Commission also recommends the State develop a policy for reinvestment. Too often, grants come and grants go. Funding sources always talk about sustainability, and when the grant goes away, programs that have addressed sustainability from the beginning tend to succeed after a grant goes away. Unfortunately, when promising pilot programs prove to reduce savings, those savings are never "reinvested" in additional services to sustain or expand the pilot programs beyond the grant cycle.

As an example, suppose an MAT program in county jails actually demonstrates a reduction in recidivism. Provided budgets remain flat funded and are not reduced because these programs have been successful, a policy of reinvestment could utilize the State portion of the expenditures to be reinvested to keep those services in place, and even expand the scope and flexibility of surplus dollars without additional budget requests. As opposed to a strictly fee-for-service system, this creates a fiscal incentive for wellness. That's how a good, private sector business operates. The public sector can do the same as has been demonstrated in various federal pilot projects.

B. Supply Reduction Strategies

The profile of the user and substance use community has changed dramatically over the past few years. Production and distribution of fentanyl and carfentanyl have been driving the increasing rates of overdose deaths in the State, while simultaneously reaping larger and larger profits for the major illicit drug manufacturers and distributors. Efforts to interfere and disrupt the supply chain along the I-95 Corridor need to be resourced and amplified.

The features of the Maine Drug Enforcement Agency, through collaboration and combination of federal, state, county, and local law enforcement is the best strategy for interrupting the supply side of the drug problems in our State.

But ask any local sheriff or police chief and they will tell you, "We can't incarcerate our way out of this problem." Effective diversion programs and methods for alleviating the stress on county jails by diverting pre-trial populations to community supervision should be supported.

Cost savings and cost avoidance related to these measures could be reinvested to expand and further support these strategies.

C. Demand Reduction Strategies

In its simplest business application of supply and demand, unless we aggressively reduce the demand for alcohol and other drug use, we will never decrease the supply. There will always be someone who is willing to become the next distributor, or some new substance developed that will challenge us. The supply will always meet the demand, as seen in the increased presence of fentanyl, and with methamphetamine and cocaine reemerging in the community profiles of alcohol and other drugs use and lethality. In looking at demand reduction approaches, it serves us well to utilize the public health model and address issues in the socioeconomic environment, not just the psychosocial profile of the individual suffering from a substance use disorder.

Resiliency research that has emerged from the prevention field gives us language to support the entire continuum of care. The attributes of a resilient person are those who demonstrate social competence, problem-solving skills, a sense of autonomy, and hope for the future. And while you may have just described an ideal outcome for prevention, this same profile describes someone in recovery. The entire continuum of prevention, intervention/harm reduction, treatment, and recovery can benefit from using the common language of resiliency.

Resiliency research shows us the human brain is hard-wired for resiliency as an evolutionary survival mechanism that allows us to adapt and overcome adversity. And the human brain best responds to this by being exposed to environments that offer three elements: High expectations; caring and support; and opportunities for meaningful participation.

Clearly, the "environments" that foster resiliency can be supported not only in families, schools, workplaces, and formal service settings such as hospitals, jails, and treatment programs, but also within informal settings such as recovery community centers, churches and recovery residences.

Any policies that increase ***access*** and ***availability*** of alcohol and other drugs in the environment is directly in contrast to sound public health best practices. We acknowledge that the substance use prevention structure was dismantled with the dissolution of the Healthy Maine Partnership, and the administrative reporting requirements are increasingly burdensome for the depleted prevention infrastructure.

With the overarching goal of a comprehensive, integrated service delivery system, the Commission supports those programs and services that foster resiliency along the entire continuum of care, and demonstrating desired outcomes with data supported by proven metrics for success.

1. Families first – programs and services that respond to the needs of our families are the front line of prevention activities. Families are an underutilized resource as funding is no longer reimbursable through the elimination of v. codes in the DSMV. When supported, families can be invaluable supports for intervention but may also serve as potent resources of recovery capital for those in the recovery process.

2. Substance-exposed infants and children – research shows that problems associated with prenatal exposure to substances can be best mitigated with comprehensive in-home parenting and public health nursing support.
3. Schools – schools are the first social learning environment for children and where effective prevention strategies can be best deployed.
4. Adolescents – the needs of adolescents needing substance use treatment and family support is poorly resourced in Maine. Untreated and unsupported adolescents become vulnerable to involvement in the criminal justice, mental health, social services and substance use disorders systems.
5. Early adulthood – with the age of onset being one of the most recognized variables in adults with substance use disorders, young adults face the additional challenges of a spotty employment history and life skills management. For adults under 30 with a significant substance use disorder that began in their teens, they often had no life skills development over half of their lives, during the period of time in which their brains are becoming fully developed. For these individuals, support is required for habilitation skill development through the early and mid-recovery stages of change.
6. Intervention and Harm Reduction is often regarded as the most effective support for individuals to initiate their recovery process, avoid further development of their substance use disorder, and reduce harm to themselves and others.
7. Treatment services are defined by their own levels of care, from outpatient treatment to hospitalization. Typically, the least restrictive care is more plentiful, less expensive and serves more people, with the most expensive, service-laden models serving fewer people in more intensive settings.
8. The ability to address co-occurring mental health and substance use disorders needs to be incorporated in mainstream practice and workforce development.
9. The recovery continuum, from early, mid, to long-term recovery operates conversely to the rest of the continuum, with fewer formal supports being required as the recovery process evolves and is sustained more informal community and environmental supports.

Cost savings and cost avoidance related to these measures could be reinvested to expand and further support these strategies.

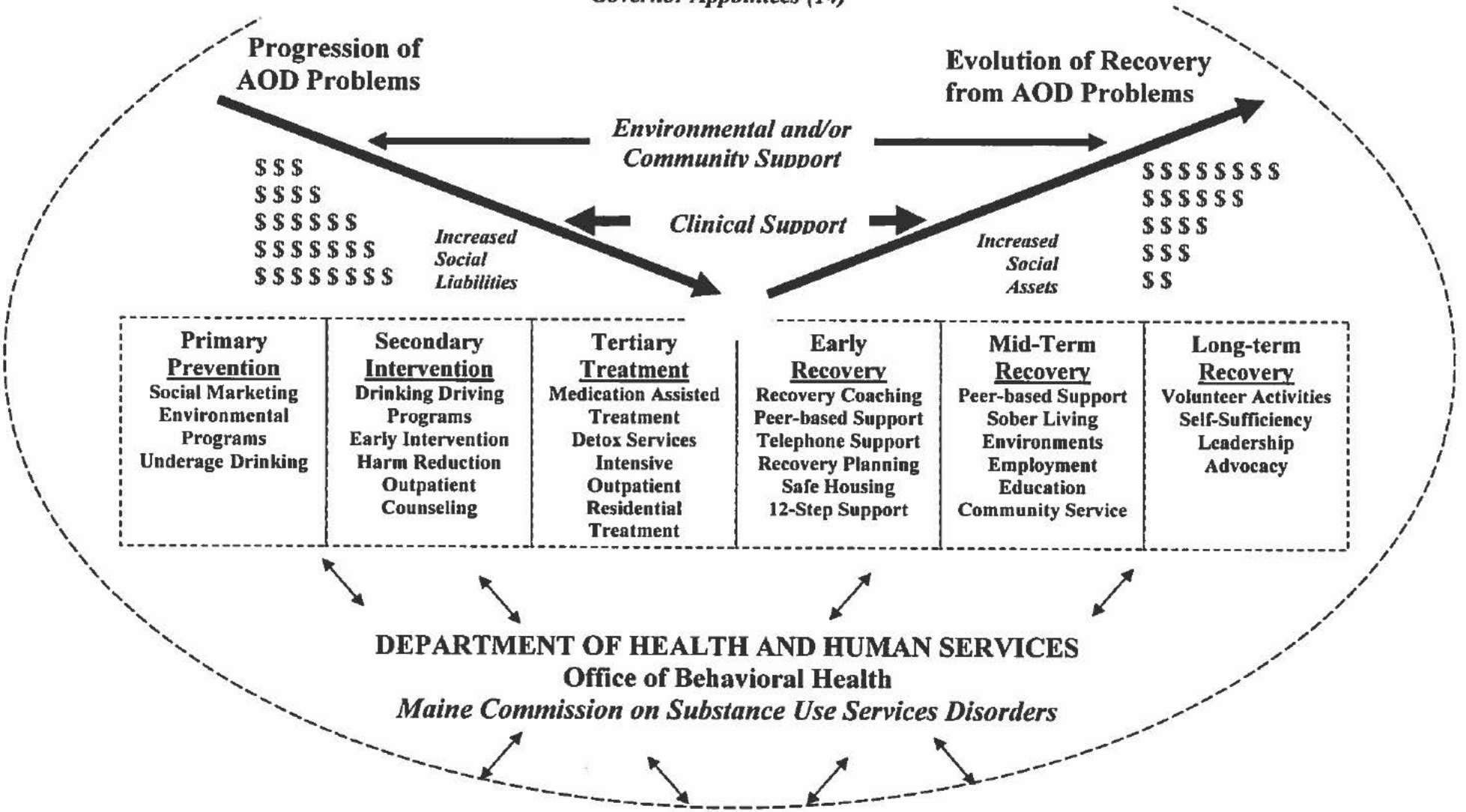
In closing, the Substance Use Services Disorders Commission recognizes that the State of Maine is in a marathon, not a sprint, and the scope and complexity of alcohol and drug use will require sustained effort over a period of time. The Commission is interested in promoting such a vision for our communities and our State, and changing the balance sheet of assets in our communities from such an approach. A graphic representation of what this could look like is attached to this report.

Respectfully submitted,

Maine Substance Use Disorders Services Commission
Approved Jan 12, 2022

The Paradigm Shift to an Integrated Wellness-Oriented System of Care

CHAPTER 432 PUBLIC LAW: H.P, 760 – L.D. 1030
APPROVED JUNE 20,2019
Senate Appointees (2) - House Appointees (2)
Governor Appointees (14)



PRESERVING MAINE COMMUNITIES
Creating A Shared Vision for Maine's Communities