

INTRODUCTION

“No one gets into drugs or alcohol intending to become addicted,” Dr. Eric Brown advised the Community Working Group at its first information session. But as Dr. Brown explained, approximately 10% do become addicted, their systems quickly “hijacked” by changes in brain chemistry and continued drug or alcohol dependence, while their ability to resist and respond is compromised by anxiety, fear and the stigma associated with dependence and addiction.

As the Working Group learned over the course of six weeks in presentations and conversations with local providers, treatment specialists, prosecutors, law enforcement officers and businesspeople, Bangor has become the eye of what presenter described as a “perfect storm” of demand throughout central and northern Maine for successful treatment for opioid drug abuse, an illness that unfortunately is characterized by relapse and complex issues of mental health and often, childhood trauma.

Beginning in 2001 with the opening of a clinic based at Acadia Hospital, and now with two for-profit clinics, Bangor has a licensed total of 1,500 patients, the equivalent of 5.145% of the city’s population of 33,000 people, receiving a daily dose of methadone. In comparison, Portland, South Portland and Westbrook, each with one clinic, and a combined population 108,690, has a total of 1700 patients, or the equivalent of 1.56% of their total population.

For Bangor, according to businesspeople, law enforcement and healthcare providers, the burden placed on the community over the past 10 years to properly care for the influx of opioid patients, and related issues of social services and crime is straining the community’s carrying capacity as a service center, while the lack of a cohesive state policy for properly addressing issues of addiction and dependence seriously encumber efforts to provide effective treatment and recovery support.

While other states, New Hampshire, Vermont and Massachusetts have used Medicaid expansion funds to improve their care of drug- and alcohol-dependent residents, Maine’s response has been to cut reimbursement, resulting in increased provider patient load and reduced funding for essential counseling and therapy sessions to support recovery.

That is where we are. The recommendations we offer to the Community Health Leadership Board are steps we believe will get us to a far better place in treating our drug- and alcohol-dependent citizens. Our objective, which we hope will be shared by the CHLB, is to develop an integrated, holistic, economically sustainable and efficient system that encompasses the entire region, and treats addicted and dependent citizens like any other person who is ill and deserves our care, compassion and support.

The work of the CHLB begins here. These recommendations are our call to action for the CHLB to review the recommendations, establish priorities and move the community forward. And the working group’s efforts do not end here. Those of us who prepared these recommendations pledge our continued support and assistance to the CHLB as it brings the region together so we can address the challenge of addiction/dependence together.

RECOMMENDATIONS

A. PREVENTION

- 1) **Recommendation: Launch a public awareness media campaign that provides education and decreases the stigma around substance abuse addiction, treatment and recovery.**

Background: The community at large would benefit from an education process that is sustained and consistent. This community public awareness effort would also target the medical community and must involve media, houses of worship, day care centers, malls and grocery stores. The message should focus on addiction, treatment and recovery and address stigma as a barrier to those who wish to break their dependence on drugs or alcohol as addiction does not discriminate. The Bangor Daily News participation in the successful Town Hall Forum is an example of how media can help convene and educate the community, but all media—print, TV, radio and social media—must be engaged in this effort to maximize success and effectiveness.

Potential Action Steps:

- a. Engage media partners from print, TV, radio and social media.
- b. Develop consistent prevention/education and anti-stigma message
- c. Develop a communications plan

Desired Outcomes:

- a. Ongoing community education campaign in place

- 2) **Recommendation: Develop a community-wide opioid prescribing protocol based on best practice, including diversion prevention that can be instituted across all primary care provider and other medical provider offices. Track adherence with the Prescription Monitoring Program (PMP).**

Background:

Maine has made progress in reducing over-prescribing of opioids, but the state is number one in the country in the quantity of drugs collected at drug-take-back events, further evidence of the need for additional changes to provider prescribing practices. There is also a wide range of prescribing practices using inconsistent models. A community-wide prescribing protocol based on best practice, including diversion prevention that can be instituted across all primary care provider and other medical provider offices is needed. This community protocol should include training in patient risk assessment for all prescribing providers, including dentists, oral surgeons and others who routinely prescribe drugs for pain. Tracking adherence to the protocols can be accomplished through the Prescription Monitoring Program (PMP) in a community monitoring system.

Potential Action Steps:

- a. Research and decide upon an evidence based best practice prescribing protocol that considers diversion prevention (Diversion Alert)
- b. Engage prescribers from primary care offices, specialty physicians, dentists, oral surgeons and anyone prescribing narcotics across the community to implement the protocol
- c. Train prescribers on risk assessment, abuse, diversion and addiction
- d. Train prescribers to reference the PMP before prescribing
- e. Track adherence to protocols with the PMP
- f. Advocate for continuing education requirements for prescribing narcotics for pain management
- g. Advocate for medical, nursing and dental school curriculum to ensure competency in knowledge of addiction

- h. Build upon foundation of the Maine Care policy (6/14) to audit all cases where multiple categories of addictive substances are prescribed (opioid, stimulant, benzodiazepines).

Desired Outcomes:

- a. Standardized community prescribing practice
- b. Decreased number of narcotic prescriptions
- c. Decreased dosing (unnecessary prescriptions, i.e. 30 day supply for 3 day post-operative procedure)
- d. Better assessments/surveillance of prescribing practices
- e. PMP is utilized to track adherence
- f. PMP is referenced by providers before prescriptions are written

3) Recommendation: Create an environment for children age 0-5 and their parents that nurtures their development and reduces Adverse Childhood Experiences (ACEs) that are often precursors to opioid and alcohol dependence.

Background: The region must acknowledge the critical importance of early education for children and parents on the effects of drugs and the need to reduce ACEs. Nurturing resiliency in children to overcome ACEs is also effective and can be achieved through community supports for the child and parent outside the home.

Potential Action Steps:

- a. Advocate for increased funding for Healthy Maine Partnerships and services such as Head Start, home visits and public health nursing.
- b. Start parent education in the OB/GYN office with assessment, screening and literature, followed up on a consistent and continuing basis during visits to all providers, including pediatric dentists and pediatricians and primary care givers. Tools be designed for each of those groups to use

Desired Outcomes:

- a. Decrease number of opioid dependent births
- b. Increase number of Head Start slots
- c. Increased readiness of children for Pre-Kindergarten and Kindergarten
- d. Increased health and well-being of children age 0-5

4) Recommendation: Continue to support the work of the Healthy Maine Partnerships in limiting youth access to and availability of alcohol and drugs in the range of settings in which young people grow up so that use isn't normalized.

Background: Many community conditions contribute to youth substance use. According to the 2013 Maine Integrated Youth Health Survey 70% of high school seniors in Penobscot County report that alcohol is 'easy to get'; 62% believe they would not be caught by their parents if they drink alcohol and 88% believe they would not be caught by the police if they drink alcohol. Less than 50% of high school seniors in Penobscot County believe they risk harming themselves if they have one or two drinks of alcohol every day. 65% of Penobscot County high school seniors believe that marijuana is easy to get, and 55% perceive low or no risk if they regularly smoke marijuana.

Potential Action Steps:

- a. Advocate to increase and stabilize funding for coalition-based prevention efforts

Desired Outcomes:

- a. Schools have evidence based substance abuse prevention curriculum and school policies that prevent and reduce youth alcohol and drug use
- b. Parents have the supports they need to set clear guidelines regarding their child's expected behavior; parents model healthy behaviors and monitor their teens behavior
- c. Support and implement policies that reduce access and availability of alcohol and other substances in the community using the 4 Ps: price, promotion, and product, placement (such as regulations, zoning, and hours of operation).

B. TREATMENT

1) Recommendation: Open a community based social detox center.

Background: At the critical moment that drug/alcohol dependent individuals present to hospital Emergency Departments wanting detox they currently receive only medical evaluation and short term medications to address acute symptoms. The Emergency Departments, having addressed the medical issues have nowhere to send them to complete the 3-5 day detox process. According to police and providers, the emergency room is not the right place to manage detoxification of individuals who have drug or alcohol problems. This however is currently the practice. Steps should be taken promptly to assess the potential for making detox available in Greater Bangor.

Potential Action Steps:

- a. Research and choose an evidence based best practice model for a social detox center
- b. Identify a sustainable funding source
- c. Hospital Emergency Departments can create a "fast track" process to rapidly assess individuals seeking detox, to prescribe standard detox medications and refer for immediate entry into the social detox facility.
- d. Create a 12 bed social detoxification facility which can receive individuals who have been medically cleared. Individuals who choose to participate in recovery programs available at the facility may remain for the 3-5 days to complete detox and enroll in a recovery network of services.

Desired Outcomes:

- a. Decreased ER costs and wait times for services
 - b. Decreased jail cost and census
 - c. Decreased pressure upon Psychiatric hospital beds because patients will no longer need to declare suicidal thinking in order to receive detoxification
 - d. Alternative available to law enforcement
 - e. Individuals in need can seamlessly transition from detox into treatment and recovery
- 2) Recommendation: Distribute and implement training for the use of Narcan/Naloxone nasal spray to counteract opioid overdose to all first responders, community members with an identified need and eligible providers.**

Background: Narcan nasal spray has demonstrated its effectiveness in saving the lives of overdose victims. Our community's goal should be to keep people alive. Widespread distribution of Narcan to first responders and those supporting recovery in the opioid addicted/dependent community will help us do that. Training for those that may administer Narcan/Naloxone is vital. Patients can come out of overdose violently and Narcan/Naloxone has a short half-life. Increased availability is going to have a benefit in rural areas too where distances for first responders to travel are farther, there are fewer paid law enforcement entities and more volunteer departments.

Potential Action Steps:

- 3) Identify cost, logistics, possible funding for wide distribution of Narcan.
- 4) Identify best practices for training and distribution of Narcan.

Desired Outcomes:

- a) Reduce negative outcomes from opioid overdose
 - b) Improve recovery for individuals that overdose
- 3) **Recommendation: Adopt best practices for MAT with Methadone and Suboxone with regard to dosage and duration of treatment and counseling to ensure positive treatment and ongoing recovery outcomes.**

Background: Improve the quality and monitoring of Medication Assisted Therapy (MAT) programs and adopt best practices on dosage and duration of treatment, and therapy. Ensuring MAT centers are using the lowest possible doses of medication will help avert diversion and over-treatment. MAT centers also need to provide enough counseling time to change individuals behavior. The State Statue requirements for licensed professionals to achieve behavioral modification is one counselor per 35 individuals in treatment.

Potential Action Steps:

- a) Research other States and regions for models and policies for dosage, duration and counseling best practices
- b) Identify, train providers on and implement best practices
- c) Utilize a 'contract of accountability' for those in MAT to help maintain their sobriety
- d) Include nutritionists/dieticians in MAT framework
- e) Change the State policy to allow MAT clinic counseling ratios be returned to 1 counselor for every 50 people in treatment from the current ratio of 1 to 150.
- f) Change the Federal guidelines to include MAT information in the PMP.

Desired Outcomes:

- a) MAT practices have a consistent standard of community prescribing for Methadone and Suboxone
- 4) **Recommendation: Expand Medication Assisted Treatment (MAT) with Suboxone and Methadone into rural areas. Explore potential of FQHCs, rural health centers and veteran's centers to provide or assist in providing MAT.**

Background:

Stigma begins in the communities from which those in treatment commute to Bangor or where they formerly resided before moving to Bangor to be close to clinic-based treatment. Due to supply and

demand, Bangor has become a hub for treatment and for drug dealers and drug crime. Adults are not the only ones impacted. Students in Bangor and Brewer have the highest mobility rate of children in the State.

Potential Action Steps:

- a) Convene a working group to engage local, state and federal representatives that will result in the opportunity for those needing opioid-dependency treatments to receive it in their home community, close to family support and jobs.
- b) Look to Vermont's hub and spoke model that is working effectively and not placing undue stress on any one community, as is the case in Bangor.
- c) FQHCs and local hospitals and clinics can become sites for treatment by staff providers and therapists or they can become sites for treatment administered by mobile provider/therapist teams.
- d) Change federal guidelines that would allow Physicians Assistants and Nurse Practitioners to provide MAT services.
- e) Change State policy to allow the use of mobile MAT vans.

Desired Outcomes:

- a) People are treated in their home community
- b) Decrease transient families and children

5) Recommendation: The Bangor community does not expand licensing at high volume, for profit clinics for medication assisted treatment (MAT) with Methadone and Suboxone, instead maintaining the number of current treatment slots. This does not limit community providers from prescribing Suboxone.

Background: Maine and the Bangor region need a rational, integrated system to respond to opiate dependence, one built on best practices and designed to adequately support and guide the addicted/dependent population through detox, treatment and recovery. This program should support treatment of patients in their own communities wherever possible. This will allow for maintenance of social support structure within the community and remove a potential barrier to obtaining or maintaining jobs. The alternative, increasing patient numbers at clinics dedicated solely to MAT treatment, both increases the burden on public services for Bangor and similar service center communities, and increases the stigma on patients by treating addiction in a separate place and manner from other medical conditions.

This recommendation should be considered as part of an integrated effort with the other recommendations so enough treatment slots are available in the metropolitan area, but not solely in the City of Bangor. In the past 12-to-13 years, Bangor police have seen the amount of drugs seized on the street soar from fractions of a gram to ounces of heroin and pounds of cocaine. The people dealing the drugs on our streets are no longer just local people, but documented dangerous gang members from large cities out of state. Bangor PD emphasizes that the gangs are not located here, but we do have gang members here dealing drugs. A few Bangor police officers conducted a survey for six months where they asked their non-traffic-related arrestees three simple questions: Where are you from? Are you employed? Are you a drug user? In response, 79% of the people arrested for non-traffic-related crimes admitted to being a drug user, 45% were unemployed (36% wouldn't answer), and only 41% were from Bangor.

Potential Action Steps:

- a) Advocate with City Council to see if there are zoning, land use or other policies that can help achieve this goal
- b) Advocate with clinics to limit expansion

Desired Outcomes:

- a) The City of Bangor does not add additional licenses to current medical assisted treatment (MAT) centers for Suboxone or Methadone.
- b) Individuals in need of MAT services receive them in their home community or return to their home community to receive these services.

C. RECOVERY

1) Recommendation: Invest in a comprehensive, community-based, continuum of recovery support services.

Background – Recovery Housing:

The lack of sober/abstinence-based housing in the region is an obstacle to the development of effective recovery programs. Sober housing could include new construction, or repurposing of existing structures, including abandoned properties available in communities throughout the region, from Bangor to Millinocket. Residents of sober housing should sign a “contract of accountability”, which stipulates what constitutes appropriate conduct for continued residence at the sober house, and allows the sober house management to terminate the agreement if there are violations of the contract. This protects both resident and management and encourages accountability on the part of the resident in recovery.

Potential Action Steps – Recovery Housing:

- a) Convene a regional study group that includes members of the recovery community, code-enforcement and law enforcement, and public health representatives to assess the extent of need for, and the availability of appropriate properties for sober housing.

Background – Recovery Networks, Life Skills & Education:

To succeed, an integrated system dealing with detox, treatment and recovery must have sustained support from this community for critical components such as the Bangor Area Recovery Network (BARN), which can serve as a model for other recovery community-based organizations (RCOs). In developing regional programs based on successful local programs in Bangor and Brewer, communities should be encouraged to take advantage of support networks that already exist in local churches or service organizations. Those recovering from drug or alcohol dependence need help re-integrating into society, including finding jobs, writing resumes and filling out applications. Life-training skills for those in out-patient settings, including education on proper nutrition, can promote health and wellbeing and a way out of poverty and homelessness, as well as building confidence and purpose in life.

Recovery community organizations (RCOs) are the heart and soul of the recovery movement. In the last ten years, RCOs have proliferated and are demonstrating leadership in their towns, cities, states as well as on the national landscape. They have become major hubs for recovery-focused policy advocacy activities, carrying out recovery-focused community education and outreach programs, and becoming players in systems change initiatives. Many are also providing peer-based recovery support services. RCOs share a recovery vision, authenticity of voice and are independent, serving as a bridge between diverse communities of recovery, the addiction treatment community, governmental

agencies, the criminal justice system, the larger network of health and human services providers and systems and the broader recovery support resources of the extended community.

Potential Action Steps - Recovery Networks, Life Skills & Education:

- a) Launch more Recovery Network Centers (like BARN) in communities outside Greater Bangor, aligning with treatment centers
- b) Identify funding for BARN and other networks so staff can be hired to offer expanded services
- c) Encourage churches outside of Bangor to offer support systems for recovery using the United Methodist Church and the Columbia St. Baptist Church in Bangor as models
- d) Launch a volunteer effort to help those in recovery with finding employment, writing resumes and filling out applications with the goal of removing these obstacles for those in recovery.
- e) Convene partners from educational institutions to look at the “Washington DC Kitchen—Food Fighters” initiative as a model for a program that educates people in recovery and fast tracks them into jobs. Consider a local need such as training to fix up the older housing stock.
- f) Advocate for nutrition education to be included in the treatment and recovery process

Desired Outcomes - Recovery:

- a) Homeless shelters see less need from those in recovery or those relapsing due to unstable living conditions
- b) People in recovery are more successful: maintaining sobriety, staying healthy, finding jobs and being productive community members

D. POLICY AND OTHER STEPS

- 1) Recommendation: Develop a regional resource map of the continuum of care covering what services are available from prevention to treatment and recovery.**

Background: In the interest of making efficient use of scarce resources and building a case for new funding, a regional inventory/resource map of available services for prevention, detox, treatment and recovery is needed. Identifying available regional services is a first step in identifying both the funding stream that supports these services, and the potential for new funding. The resource map can be the first step leading to establishing a regional “policy of investment” where demonstrated cost savings will be reinvested to sustain programs that have proven value to the region.

Potential Action Steps:

- a) Partner with local universities to research and develop a resource map and identify existing models that will promote collaboration and wise investment of available funds.
- b) Look at current resources such as the map developed by Mobilize Eastern Maine

Desired Outcomes:

- a) Providers and community members can see what resources are available and access those services directly or give referrals to them efficiently
- b) Gaps in service can be identified and plans are made to fill them
- c) Funding sources are identified

- 2) Recommendation: Implement evidence-based criminal justice diversion programs.**

Background: Prosecutors and courts must be engaged in moving this forward, but the re-establishment of Drug Court in Bangor is one approach to divert the recovering population from the

criminal justice system. Bangor's Drug Court lost its funding. Ellsworth and Lewiston have Drug Courts.

Potential Action Steps:

- a) Restart Drug Court in Bangor. Drug Court's experience in Penobscot County, including the reasons for its success and discontinuance, need to be examined and discussed, along with funding models that would allow it to be reinstated.
- b) Develop a Youth Court
- c) Launch a Youth Alternative to Suspension Program
- d) Initiate 'contracts of accountability' for those facing charges and are willing to be drug free with consequences for breaking the contract or incentives for maintaining it (i.e. training, housing)

Desired Outcomes:

- a) Reduced jail days
 - b) Reduced pretrial jail time
 - c) Youth diverted from the criminal justice system
 - d) Fewer youth making high risk choices
- 3) **Recommendation: Connect the criminal justice system with treatment and recovery resources and work with the Penobscot County Sheriff and others to develop pilot programs with the jail system.**

Background: Helping people transition from jail to the community is a fragile and vital time period that can lead to relapse and homelessness. Getting opioid users back into the workforce after leaving jail can reduce the likelihood of these negative outcomes. Job training similar to what is offered in Washington D.C. for the food service industry might be considered here in carpentry and home repair to fix up our older housing stock.

Potential Action Steps:

- a) Start a discussion of conditions placed on those convicted of drug offenses which do not promote treatment and recovery, but only guarantee perpetuation of the cycle of dependence and criminal offense.
- b) Engage education institutions to link their offerings with this population.
- c) Consider a pilot project for inmates to receive treatment beginning at the time of incarceration.

Desired Outcomes:

- a) Reduced jail days
 - b) Shorter timeframe for transition from jail to treatment
 - c) Begin recovery in jail and get connected to recovery resources out of jail while serving time
 - d) Look at all available sources of funding
- 4) **Recommendation: Increase access to treatment through MaineCare expansion and by exploring other sources of funding.**

Background:

Expansion of MaineCare (Medicaid) will extend coverage to residents who currently require treatment but who cannot contribute to the cost of their care. Eliminating coverage, as Maine has done, is false economy because the need for medical intervention—detox, treatment and recovery-support—for alcohol and drug dependent residents continues, and left unaddressed adds to societal costs in

welfare, housing and crime. Medicaid expansion will allow Maine to follow the lead of other New England states, including neighboring Massachusetts, New Hampshire and Vermont, which have taken advantage of increased Medicaid funding to establish successful programs designed to deal effectively with the community challenges of detox, treatment and recovery. Without ability to pay for treatment, treatment will not occur.

Potential Action Steps:

- a) Document the costs of not providing treatment

Desired Outcomes:

- a) More people receive the treatment they need
- b) More people access the healthcare they need to stay healthy

5) Recommendation: Develop strategic regional partnerships with towns and health centers to address substance abuse prevention, treatment and recovery over the long-term.

Background:

Regional leaders and the administrators of regional service providers are needed to look beyond addiction at the local level. Addiction/dependence, whether to opioids or alcohol, and the response of detox, treatment and recovery is a regional problem. In the absence of a statewide policy, our efforts must have a regional approach to be successful. Addressing addiction also requires a long-term commitment from the region. New policies and programs need to make lasting, enduring changes that will promote better health in our general population, restore families and return people to productive employment.

6) Recommendation: Engage educational institutions, workforce and economic development specialists and the public.

Background:

There are many aspects of addiction in our region that can be studied to ensure evidence based best practice solutions are implemented and the cost/benefit of them is quantified. A regional body should be developed to coordinate a study and comprehensive response to the regional challenge of addiction/dependency. The cost of addiction/dependency should be examined, including recurring hospital admissions due to opioid and alcohol dependency. Everyone has a stake in the quality of the study and its process, the response, and the outcome. This work can support a community 'policy of reinvestment' where identified cost savings are reinvested in sustaining effective services.

7) Recommendation: The City of Bangor and other municipalities implement a policy requiring employees of entities applying for a liquor license be trained in Responsible Beverage Server Training.

Background:

Requiring employees who dispense alcohol to successfully complete training in the proper dispensing of alcohol is a valuable, front-line policy that can have a significant positive impact on alcohol abuse at the point of sale. Similar training requirements are in force in other jurisdictions and are supported by law enforcement and first-responders that deal with avoidable instances of alcohol abuse.

8) Recommendation: Advocate for statewide plan for proportional distribution of MAT.

Background:

Bangor's disproportional concentration of Medication Assisted Treatment patients—daily doses of methadone and suboxone in high-volume clinics are administered to approximate 5% of the city's population—stresses the community's carrying capacity for services and does not represent the best approach to treatment for residents seeking treatment for opiate dependency. Best practice would be for those seeking treatment to receive that treatment as near as possible to where they live, close to jobs and family support. The state should examine the census of where opiate-dependent residents reside, and design a MAT response (as Vermont and other states have done) geographically and consistent with best practices and proportional distribution of those needing treatment.