

**Substance Abuse Services Commission  
Meeting of March 4, 2015  
Cross State Office Building Room 400  
Augusta, Maine**

**ATTENDANCE**

**Members Present:**

Peter McCorison, Provider, Aroostook County, Chair for SASC (phone)  
Ann Dorney, MD, Physician in Private Practice (phone)  
Scott Gagnon, Prevention, Healthy Androscoggin  
Robert Rogers, Kennebec Behavioral Health (phone)  
Ann Giggey, Hope House (phone)  
Irene Laney, Clinician in Private Practice  
Bill Lowenstein, Board of Dir. of Sexual Assault & Response Services  
Richard Malaby, Legislature, Maine House of Representatives, District 136

**Members Absent/Excused:**

Darren Ripley, MAAR  
Diehl Snyder, MD  
Tom Leonard, School Administrative Leader

**Office of Substance Abuse and Mental Health Services:**

N/A

**Guests:**

Geoff Miller, Associate Director, Office of Substance Abuse and Mental Health Services (SAMHS)  
Steven Johndro, Executive Director, Healthy Androscoggin  
Brent Miller, Program Director, Discovery House - Bangor  
Merideth C. Norris, D.O., Medical Director, Grace St Services  
Fred Millet, CEO, Simple Living, Inc.  
Bruce Bevers, Director of Edie's Place, Simple Living, Inc.  
Raya Kouletsis, Coordinator, MAPSA  
Erin Dunne, AdCare Maine, Recorder  
Neill Miner, Director, AdCare Maine (phone)

**Substance Abuse Services Commission Meeting  
March 4, 2015  
Cross State Office Building, Room 400  
Augusta, Maine**

**MARCH MINUTES**

<b>DRAFT Date:</b>	<b>March 6, 2015</b>	<b>SASC Approved:</b>	
<b>Signed:</b> Recorded by: Erin Dunne and Neill Miner, AdCare Maine			

**Meeting Convened:** 9:00 A.M.

**Adjourned:** 12:00 PM

**Meeting Convened:** By Scott Gagnon

**AGENDA**

- Introductions and Public Comments, Review of the January and February Minutes

**New Business:**

- Presentation on Healthy Maine Partnership
- Presentation on OTP

**BREAK**

- SAMHS Update, including:
  - The SAMHS Budget for 2014-2015
  - SAMHS Efforts In Relation to Child Welfare Clients
- Work on Goals

**BREAK**

- Recovery Supports
- Prepare Agenda Items for meeting on April 8th, 2015

**Adjourn meeting 12:00**

# MARCH 4, 2015 SASC Meeting Summary

**Scott Gagnon, Acting Chairperson**

**Introductions, Public Comment, and Meeting Minutes Review**

Scott Gagnon, at the request of Peter McCorison who was joining the meeting by phone, welcomed and thanked members and guests for coming to the meeting. Introductions were made. Scott asked if there were any public comments. No comments were offered.

Due to the number of presentations scheduled for the meeting review and revisions, if any, of the January and February meeting minutes was deferred until the end of the meeting. Then, due to time constraints, this agenda item was moved to the next meeting. Ann Dorney did mention at the end of the meeting that she had some edits to the February minutes. Ann will send her edits to Erin Dunne to apply to the February minutes.

**Conclusions or Actions and Responsible Lead Person; timeline if applicable:**

Ann will email her edits to February's minutes to Erin. Erin will make the edits in a new draft of the minutes.

## **I. NEW BUSINESS – March Agenda**

### **A. Presentation on Healthy Maine Partnership**

Steven Johndro, Executive Director of Healthy Androscoggin (Androscoggin County's Healthy Maine Partnership) gave a presentation to the Commission members and guests on the Healthy Maine Partnerships. The presentation can be found at the bottom of the meeting minutes.

After the presentation, Commission members asked the following questions:

Ann Dorney asked Steven if the HMP's were doing anything to reduce medication in people's medicine cabinets. Steven replied that many HMP's across the state are involved in this work. The Fund for Healthy Maine doesn't specifically fund this work but many HMP's have staff and separate substance abuse prevention funds to support this work. He mentioned that one of Androscoggin County's greatest strategies is the drug take back days and that there are many returning "customers". Scott Gagnon added that in this area, the amount received during the drug take back days has increased from 300 pounds to 1,000 pounds.

Ann Dorney asked if marijuana use is increasing or decreasing and what the HMP's are doing about this issue. Steven replied that the HMP's see marijuana use as a significant concern in Maine's communities, especially for the youth population. The HMP's are connecting with schools and communities to talk about the harmful effects of marijuana use and what they can do to prevent it. Scott added that the HMP structure allows for funding from SAMHS for education and awareness in Maine's communities surrounding marijuana use. Geoff Miller added that SAMHS will have a new Fetal Alcohol Spectrum Disorders/Drug Affected Babies coordinator will be starting at SAMHS by the end of the month and that SAMHS has materials on the impact of marijuana use on pregnant mothers and mothers who are breastfeeding.

Ann Dorney asked how much would the HMP's lose in funding if the current proposed budget goes through. Representative Richard Malaby answered that about \$10 million dollars will be cut from the budget. Steven added that from the information that has been provided by Commissioner Mary Mayhew, the governor's biennial budget would defund the HMP's and school-based health centers and redirect that money to maintain current Medicaid reimbursement rates for primary care doctors.

The Commission thanked Steven for coming to present to the group.

**Conclusions or Actions and Responsible Lead Person; timeline if applicable:**

None

**B. Presentation on Opioid Treatment Program (OTP)**

Brent Miller, Program Director of the Discovery House in Bangor and Merideth C. Norris, D.O., Medical Director of Grace Street Services gave a presentation to the Commission members regarding Opioid Dependence Treatment. Merideth provided the Commission members and guests with a handout on *Common Questions About Addiction and Medication Assisted Treatment*. This document can be found at the end of the meeting minutes. Brent provided the Commission members and guests with a packet of information on The Discovery House. Erin will keep the extra packets for members who were not able to attend today's meeting in person. During his presentation, Brent mentioned the initiative in the state budget that if passed would mean 4,000 people currently receiving methadone treatment through Medicaid would no longer receive reimbursement, with the goal that they would transition to suboxone treatments. Geoff asked how it would be possible to address the concern that not everyone will have the same success on suboxone as they do with methadone treatment. Brent noted that the Discovery House has had a suboxone program for three years now and that this program does have a waiting list. Merideth added that some people just aren't going to get better on suboxone and that it is not their fault. There are many factors that are at play for each individual during their treatment and which treatment works best for them. Brent offered that this issue of opioid dependence needs to be viewed as a disease of behaviors and currently there is a stigma and fear around this addiction and the treatment methods for it. Raya Kouletsis asked about a handout in the packets that Brent provided on the formulation of methadone and suboxone. Brent replied that these two treatments both treat opioid dependence but that each has a different formulation. He added that suboxone is not the exact equivalent of methadone and it is not absorbed in the body as much. He also added that methadone is different in that it is provided as an outpatient model where the patient comes to a clinic on a daily basis for treatment for a 90-day period.

Brent explained that the \$60 fee for a unit of service for methadone treatment, the client receives counseling, case management, urine analysis and many other supports. His program completed a cost analysis (this handout is included in the packet of information) for fee services and they found that it would cost an individual \$145 for each visit as opposed to the \$60 that is paid to receive treatment at a methadone clinic. Bill added that if methadone treatment is cut out all together, people should then go to individual or group counseling, which will cost them more money to pay for suboxone and also receive counseling and for transportation to receive these services.

The Commission thanked Merideth and Brent for joining the meeting and presenting their information on Opioid Treatment Programs. Brent offered his contact information and asked that it be emailed to the group. Erin will disseminate his contact information to the group via email.

**Conclusions or Actions and Responsible Lead Person; timeline if applicable:**

Erin will provide Brent Miller's contact information to the Commission via email.

**BREAK at 10:26 a.m.**

**C. Maine SAMHS Update:**

**Discussion:**

Geoff Miller noted that from what the budget states online, it looks like \$20 million will be shifted from the Fund for Healthy Maine into primary care settings to address those of the highest need. Geoff mentioned that there is a Fact Sheet available regarding the Fund for Healthy Maine and the reason for the shift of funds.

**a. The SAMHS Budget for 2014-2015**

- Geoff reported that, in terms of the current Maine SAMHS budget within substance abuse and mental health services, the following funds are in good standing: Substance Abuse funds, General Fund, Block Grant, and the Fund for Healthy Maine that SAMHS has within the office (the \$1.8 million is included in the proposed reallocation).
- Geoff mentioned the following regarding Maine SAMHS grants:
  - The Partnership for Success II grant ends on September 30, 2015. Maine SAMHS is applying for a new grant opportunity through SAMSHA, Partnership for Success 2015. The application is due March 16, 2015.
  - There is a Bureau of Justice Assistant (BJA) grant opportunity coming forth for drug courts. The Treatment Services division is working on this grant. The funding, if awarded, would not replace the current funding that goes out to Maine Pretrial, which ends later this summer. SAMHS will try to move this work forward with the new grant opportunity. Ann Dorney asked if this will this set up more drug courts. Geoff responded that this new BJA grant is actually a decrease in funding and its purpose will be to sustain and maintain the current Drug Court and Maine Pre-Trial contract that SAMHS is currently responsible for.
  - Bill Lowenstein asked whether or not there is anything in the new budget that impacts the maintenance of effort expectation in regard to SAMHS's Substance Abuse Prevention and Treatment Block Grant. Geoff responded that for the 2016-2017 budget Maine is compliant with this requirement.
- Geoff reported that on the substance abuse side of SAMHS funding, the organization is doing very well. Money is currently out and encumbered in contracts. SAMHS will soon assess where providers are at in terms of the spending of their funds. If providers have spent 75% in the 3<sup>rd</sup> quarter that is acceptable. If they are spending more than this amount, SAMHS will reach out to them to determine the reason for overspending. SAMHS will also examine contracts that have spent less than the

75%. If these providers are predicting spending down less than their available dollars, SAMHS may disencumber funds and move them to an alternate contract where more funding is needed.

- On the mental health side of funding, Geoff reported that there was an ask in the emergency budget for additional funds in the amount of \$1.1 million to support the Consent Decree, which has a gap in the current year. Currently, SAMHS has not heard back on this budget initiative yet.
- Geoff noted that SAMHS' proposed 2016-2017 budget included the following budget initiatives:
  - Consent Decree funding with \$4.5 million as a baseline to avoid having to ask for more money, and some requests that were not included in the final proposed budget, including
  - An initiative to try to continue or move some contracted staff to state lines;
  - An initiative for \$300,000 for prevention and mental illness/mental health promotion; and
  - \$300,000 request to maintain current level of drug court funding since the BJA grant is ending.
- Geoff updated the Commission members on the contracting process. He reported that SAMHS is always looking for grant opportunities. In addition, right now the department is going through the process of contract allocation (the plan for next year), which should have been completed by the end of February. He added that another layer in the process this year is the development of accountability templates to be used for each contract service going forth. This will ensure that each contract has performance measures and that the Rider A's are going in front of legal council for review. Geoff also noted that SAMHS is still going through the Request For Proposals (RFP) process for Crisis Services. The RFP is still in draft form with the Department of Health and Human Services and the Commissioner's office. It is unsure when that will be released but probably after the initial rate setting process for crisis services within state is completed, which SAMHS is also working on at this time.
- Regarding the status of positions within SAMHS, Geoff reported the following:
  - Kristen Fortier is currently the Associate Director for Treatment and Recovery Services, serving in an acting capacity. The hiring approval to fill the position permanently has been signed off on by the Commissioner's office but SAMHS is currently waiting on the Human Resources department before it can be posted.
  - The Crisis Services manager position will be reposted.
  - There is a posting for a Forensics Intensive Case Manager position at the Maine State Prison for the mental health wing to help with the transition of prisoners into the county jails.

- SAMHS is currently interviewing for the Legal Counseling position to help with Requests for Proposals and with Contract Oversight and Development within the office.
  - A new Prevention Specialist, Caleb Gilbert, was hired. The Prevention unit is now fully staffed.
  - The new Fetal Alcohol Spectrum Disorders/Drug Affected Babies coordinator will be starting at end of month.
  - Matthew Wells now fills the Recovery Manger position.
  - Since the Partnership for Success II grant ends on September 30, 2015, Matthew Braun, grant coordinator, will have his last day in the office on Friday. SAMHS does not anticipate re-filling that position as of yet, unless the Partnership for Success 2015 grant is secured.
- o Geoff mentioned that one of the pieces that SAMHS is focusing their efforts on is supporting connections between the community coalitions (Healthy Maine Partnerships) across the state and people in recovery and the organizations that support recovery. He stated that a person in recovery is a win for prevention and the voice of recovery is huge in trying to move this work forward and for advocacy. Bill offered the Commission's help around educating people and getting them to inform legislators and policy makers, upon their request, around this work. Ann Dorney asked if SAMHS could provide a copy of the budget to the Commission. Geoff responded that he would work with the SAMHS budget manager, David Dostie, in getting that to the Commission.

**b. SAMHS Efforts In Relation to Child Welfare Clients**

- o Geoff noted that the Fetal Alcohol Spectrum Disorder Coordinator position, which was funded through a grant from the Maine CDC for their home visiting program, would be ending soon, but SAMHS is committed to continuing this position. Christine Theriault, who supervisors that position, and Geoff have a meeting with Jim Martin from the Office of Child and Family Services (OCFS) to look at the possibility of braided funding from both OCFS and SAMHS to sustain this position and to move the work forward.
- o Geoff reported that SAMHS met with Lisa Sockabasin from the Maine CDC to discuss their application for the Project Launch grant. SAMHS will be partner with the Maine CDC through this grant and part of the funds will be used for the Fetal Alcohol Spectrum Disorder Coordinator position to support the work of that grant.
- o Geoff added that the further upstream that organizations are able to prevent an individual from adverse childhood experiences and/or biological or genetic trauma, whether it's physical or mental/behavioral, the better. He noted that families need to consider their own substance use as part of their family planning process and the more education that is out there and the more supports that are available, the better off the life of that child to be will be. Geoff mentioned that SAMHS has rack cards and posters available that educate families around alcohol use and pregnancy, and marijuana use and pregnancy. SAMHS is also looking at brain development and how substance abuse is changing society genetically.

- Geoff reported that SAMHS is continuously looking at other grant opportunities. He mentioned that on the mental health side of funding, 5% has been set aside through the Mental Health Block Grant from SAMHSA for the prevention of psychosis. Part of that money is going through the peer program located at the Maine Medical Center in Portland. This is a program that is aimed at early identification for potential of psychosis in individuals. He noted that OCFS is involved with this grant and that \$800,000 goes to OFCS and \$800,000 goes to SAMHS for a total of \$1.6 million for prevention services within children's services.
- Geoff mentioned that SAMHS is also looking at other ways to collaborate with partners because for the Office, when it comes to substance abuse and mental health the legacy, is that SAMHS primarily services adult populations. SAMHS is looking at transitional aged youth and doing a better job of addressing that population and the issues they face. He noted that there is a work group going forward to address this.
- Bill Lowenstein asked Geoff if the work that the Child Welfare and Substance Abuse Committee was working on in developing communication between clinics around child welfare and if education about the myths and myths perceptions surrounding Medicated Assisted Treatment (MAT) was still taking place. Geoff responded that these efforts are still in effect. The staff people working on this are Maryann Ryan and Christine Theriault. Since Christine was a case manager prior to coming to SAMHS, she has done a lot of training with case workers at OCFS around what substance abuse is, what prevention is, and what intervention treatment is, so that this population can try to get beyond the stigma of MAT. Christine continues to do this training for new case managers. The Commission thanked Geoff for attending the meeting and providing the updates from SAMHS.
- Geoff reported that he would now be the SAMHS representative attending future SASC meetings to present updates.

**Conclusions or Actions and Responsible Lead Person; timeline if applicable:**

Geoff Miller will work with the SAMHS Budget Manager, David Dostie, to provide a copy of the SAMHS budget to Commission members.

**D. Work on Goals**

Due to the number of presentations scheduled for the meeting this agenda item was deferred until the next meeting.

**Conclusions or Actions and Responsible Lead Person; timeline if applicable:**

N/A

**E. Recovery Supports**

The Commission welcomed Fred Millet and Bruce Bevers from Simple Living, Inc. to share information on their organization's efforts in developing sober living houses in Massachusetts and, recently, Ellsworth, Maine. Fred spoke about the development of the few sober homes, specifically for women, in the North Shore region of Massachusetts, and a men's home that was started three years ago. Fred reported that since opening its doors, the women's program has supported over 2,000 women on their path to recovery.

The program bases its recovery process in the house on having members once again becoming active members of society in order to allow them to feel a part of it, which includes paying rent and finding a job. The goal is to make it possible for members to live a prosperous life, which Fred said is the key to their recovery. He said that another key element to the homes' success is the acceptance of the neighborhood and community members. Fred wants the homes and its residents to be part of the community and for the community to be proud of what they have in their city. He mentioned that, unfortunately, there is a stigma around substance abuse and the people affected by it, which can make the start up of these homes difficult. In Amesbury, before the development of the sober living houses, Fred had to talk to the people in the neighborhood about what the organization was doing so that there were no surprises. He said the community members were very receptive to the plan and the program. He reported that in both places so far, the community has rallied around the program because they see the people who are a part of it working on their recovery.

Currently, Fred and Bruce are working on the startup of a women's home with 18 beds in Ellsworth, Maine. They are working with the city to make sure they meet all the local building and fire codes. Raya Kouletsis asked if there was a waiting list for the house and Fred mentioned that since they are still working on getting the house up to code that there is no date set for when the house will be open and therefore no waiting list.

Geoff Miller asked what sort of additional support the program provides to house members who are living there. Fred responded that the 12-step program is offered, in addition to the Red Road to Recovery Program for one of the residents. He also noted that whatever the individual may need for their own recovery and education he tries to provide to them. He has looked into using Narcan in the houses, as well, but is not yet fully informed about Maine's laws surrounding regarding this service. Bill Lowenstein suggested that Fred and Bruce connect with Bangor's Overdose Prevention Program and then asked what the average length of stay was for the house members. Fred responded that it depends on the person and what is best for their recovery. They currently have a woman who has been in the house in MA for four years. He said that her knowledge in recovery has helped inform and support many of the other women who have since come to live in the house. Raya asked if the women's children are allowed to come along and live in the houses. Fred responded that children can't stay long-term but are now allowed to come in on the weekends and have overnights with their mothers. The program educates the family on what to expect during the process of recovery.

Peter McCorison asked if Fred and Bruce are planning to share their house rules and its function with the Office of Substance Abuse, and added that the Commission would like to figure out a way to replicate their idea to support other communities in Maine in developing recovery homes. Fred noted that the house rules are on the website and in the packets that he brought to the meeting and shared with the Commission members. Fred mentioned other programs in Massachusetts that he often refers people to, including the SMART Recovery Program and the Moving Ahead Program (MAP) out of St. Francis in Boston.

Geoff, in regard to the mention of the Red Road to Recovery program that is used in one of the houses, mentioned that Maine has a relatively large tribal population where substance abuse has become a public health issue in the tribes around the state. He noted that many times treatment

involves sending individuals from tribal communities to upstate New York and that Wabanaki Health Services is used a great deal for outpatient treatment. Fred noted that he is hoping his program will one day reach the tribal communities.

Bill Lowenstein asked what are the biggest obstacles the program is facing moving forward. Fred responded that, besides working to get the Ellsworth house up to code, one of the biggest challenges is that there seems to be a number of women who apply to be a part of the program but do not have the money to pay rent during the beginning of their stay. Even though the program utilizes all of its options in trying to overcome this situation for some of the women, his biggest fear is that some will be turned away because of this, and that maybe the SMART Model might be a good model to utilize here in Maine. Bruce mentioned that transportation would be available for the women to travel to their jobs, and to other appointments. Travel is covered by their rent. Also included at the house are a phone, Wi-Fi, and two computers.

Scott and the Commission members thanked Fred and Bruce for attending the meeting and for their presentation.

**Conclusions or Actions and Responsible Lead Person; timeline if applicable:**

None.

**F. Other**

Scott mentioned that the Maine Sheriff's Association is sponsoring a Medicine Take Back Day on April 25<sup>th</sup>. The Sheriff's office in each respective county will become the point of contact for this program. There are wheels in motion to solidify continuation of this service.

**The Agenda Items for the April Meeting (Preliminary Plan)**

**New Business:**

- Review of Minutes
- Legislative Update
- Celebration of Women in Recovery Event with Women's Addiction Services Council (WASC), May 14<sup>th</sup> 2015, 7:00pm-9:30pm, Gracie Theatre, Bangor, ME
- Medicine Disposal: Review article sent via email, Inside Maine's Medicine Cabinet

**Next Meeting:**

Wednesday, April 8, 2015  
Cross State Office Building, Room 300  
9 AM to 12 Noon

**Adjourn Meeting: 12:00 PM**



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FUND FOR A  
**HEALTHY  MAINE**

HONOR THE LEGACY. PROTECT THE FUTURE.



 **OVERVIEW**

The Fund for a Healthy Maine (FHM) was created by the Maine Legislature in 1999 to receive and disburse Maine’s annual tobacco settlement payments.

Maine participated in the national tobacco settlement because many Maine people suffered disease and death as a result of tobacco use encouraged by the deceptive practices of the tobacco industry.

**Source of the Money:** All money received is by the State in settlement of or in relation to the lawsuit State of Maine v. Philip Morris, et al., Kennebec County Superior Court, Docket No. CV-97-134;

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 **FHM MISSION**

Creating Opportunity for Greater Health and Lowering Costs for Everyone

 **GOALS**

- 1. Prevent chronic disease
- 2. Improve health status
- 3. Reduce future health costs



 **75% OF HEALTH CARE COSTS ARE A RESULT OF CHRONIC DISEASE.**

*We have the tools we need to significantly reduce this number.*



## SPENDING

The Legislature established **eight categories** of allowable health program spending.

- **Smoking prevention, cessation and control activities**, including, but not limited to, reducing smoking among the children of the State [**In 2012 Obesity Prevention was added as an allowable use**];
- **Prenatal and young children's care**, including home visits and support for parents of children from birth to 6 years of age;
- **Child care for children up to 15 years of age**, including after-school care; Health care for children and adults, maximizing to the extent possible federal matching funds;



## SPENDING Cont.

- **Prescription drugs for adults who are elderly or disabled**, maximizing to the extent possible federal matching funds;
- **Dental and oral health care to low-income persons** who lack adequate dental coverage;
- **Family Planning**;
- **Substance abuse prevention and treatment**; and
- **Comprehensive school health programs**, including school-based health centers.



## MAINE LANDSCAPE

- Maine spends approximately **\$11 billion on healthcare** costs each year.
- The Fund for a Healthy Maine, Maine's only source of State funds for prevention, **accounts for only .48%** of Maine's total health care expenditure.
- Every \$1 of these vital resources **saves taxpayers** from \$5 to \$29 depending on the program.
- Smoking costs Maine **\$811 million per year in health care costs**. If lost productivity is factored in, that number is over \$1 billion.



## SUPPORTS HEALTHY MAINE PARTNERSHIPS

**HMPs fill the gaps where private healthcare falls short.**

School health, workplace wellness, youth smoking and alcohol and substance abuse, obesity, and senior wellness are some areas where HMPs deliver programmatic prevention and control strategies based on community needs.

**HMP programs affect 100% of your constituents.**

Babies, older youth, adults and the elderly benefit from HMP programs.

**HMPs have the goal of long-term prevention versus short-term treatment.**

Medicine prescribed by a doctor helps one person, while the comprehensive public health prevention programs of HMPs help thousands avoid unhealthy choices that lead to illness or chronic disease.

**HMPs are highly localized to Maine communities.** The coalition-based approach to the work of HMPs helps identify specific community and region needs. The approach also ensures that HMP funding is used efficiently and put to use where it is most needed.



# HEALTHY MAINE PARTNERSHIPS

- The Healthy Maine Partnerships form a statewide system of local coalitions with local boards and advisory committees to help prevent tobacco use, improve nutrition and increase access to physical activity, and prevent substance abuse among our youth and young adults to reduce chronic diseases. This system serves every municipality in Maine to also address other public health issues such as reducing lead poisoning. Local HMPS also implement Community Health Improvement Plans guided by local input and data. HMPs also convene community leaders to collaborate on public health and quality of life issues. HMPs and work with schools, businesses, municipalities, health care and social services to create healthier environments for all people at no cost to those partners.



## SUPPORTS HMP'S

HMP's rely on monies from the Fund to continue to support community-based outreach – otherwise they would not exist.

FUND FOR A

# HEALTHY MAINE

HONOR THE LEGACY. PROTECT THE FUTURE.

## **SUCSESSES**

Greater investment in preventive medicine and education helps to dramatically reduce chronic disease, thus decreasing long-term treatment costs to Maine and its residents.

- **91% of Maine voters feel the tobacco settlement funds should be used to promote good health for all Mainers.**



## **TOBACCO SUCCESS**

- Maine has seen a **48% decrease in youth smoking since the start of the FHM** (24.8% in 2001 to 12.8% in 2013). From 2004 until 2009 Maine young adult smoking rates dropped by 47% compared to the US decline of 20%.
- Cigarette use among **adults has decreased from 23.9% to 18.2%, a decrease rate of 24%.**
- The Tobacco Helpline has helped **over 100,000 clients** since its inception.



## OBESITY SUCCESS

- 56.2% of adults are meeting physical activity recommendations, a 12% increase since 2011.
- There was a statistically significant increase from 2009 to 2013 in the percentage of students in grades 5 (18% increase) and 9-12 (5% increase) who reported daily intake of 5 or more fruits and vegetables.
- Students who report drinking zero sugary beverages per day has increased by 5% since 2011.
- From 2011 to 2013, the prevalence of obesity and overweight for students in grades 5 and 7-12 remains steady with no statistically significant changes. While decreasing the prevalence of obesity is the ultimate goal, a positive first step is having rates remain steady.



## SUBSTANCE ABUSE SUCCESS

- **Decreased** the alcohol use rate among Maine's 6th to 12th grade students from **71% to 48%**.
- The proportion of high school students in Maine who report consuming alcohol in the past month has decreased notably since 2009- **dropping from 32% in 2009 to 26% in 2013.**
- Binge drinking in high school age youth has **declined from 19% in 2009 to 15% in 2013.**
- Alcohol and/or drug related crashes among 16-20 year olds **decreased from 151 crashes in 2009 to 82 crashes in 2013, representing a 46% reduction.**



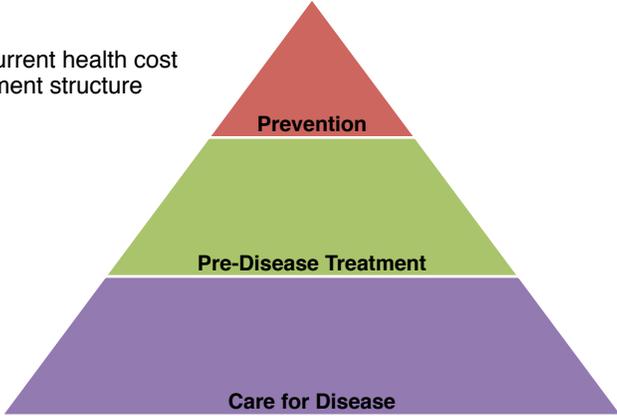
## SCHOOL BASED HEALTH SUCCESS

- The Fund helps **16 SBHC's provide access to care for close to 12,000 students**, allowing parents to stay at work and decreasing absenteeism and drop-out rates in students.
- More than one third (**35%**) of **students who smoke and were seen at a SBHC** reported that they reduced their smoking or quit smoking as a result of their visit.
- More than **half of SBHC encounters were with a behavioral health specialist** and **57% of medical visits were for preventative screenings** such as immunization or well-child visits.
- **45% of students in a school with a SBHC were enrolled with the center.**

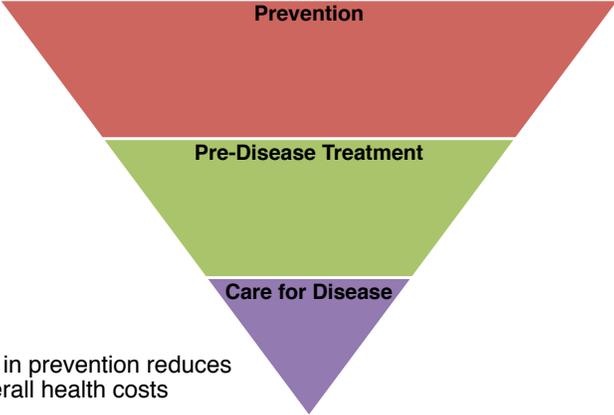


## MAINE'S MODEL

Maine's current health cost investment structure



 **WHY PREVENTION WORKS**



Investing in prevention reduces overall health costs

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[www.fundforahealthymaine.org](http://www.fundforahealthymaine.org)



[www.healthymainepartnerships.org](http://www.healthymainepartnerships.org)

 **QUESTIONS?**



 **THANK YOU!**

**Steven P. Johndro, MPH, MHA, MGH, CHES**  
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 A Local **Healthy Maine** Partnership

## Common Questions About Addiction and Medication Assisted Treatment

**Q:** Isn't addiction really the consequence of poor choices? It's not actually a "disease" is it?

**A:** Addiction is a medical condition with some behavioral symptoms. It is highly heritable; if one of your parents has addiction, you have a 50% chance of developing addiction, and if both of your parents are, it's closer to 80%. This includes people who were not raised around the addicted parent. If you have the tendency to develop addiction, and your brain is then exposed to a substance with addictive potential, like an opiate, environment pulls the trigger of the genetically loaded gun.

Another way to look at it is to think about Type 2 Diabetes. The tendency to develop diabetes is inherited. However, not everyone with those genes develops diabetes. There are certain dietary and activity behaviors that make it more likely that the predisposition will progress to active disease. Once the disease is active, sometimes it can be modified, but the change in sensitivity to sugar remains as a chronic condition.

PET scans (special imaging that shows the activity of different areas of the brain) show specific and predictable differences in addicted people vs. non-addicted people, and those differences remain long after the active addiction ends.

**Q:** So even if addiction is a disease, couldn't it just be avoided by never taking the drug that sets it off? Isn't it still really the patient's fault that they have this condition?

**A:** In theory. However, it is very difficult to control exposure to all addictive substances. Some people start using drugs through bad choices, but others make the same bad choice and don't develop addiction because they are not prone. Some people start their addiction because they were given an appropriate medication for an appropriate purpose, and their brain turned the situation around. Some people start using drugs in the context of dealing with a traumatic event, and there are a sadly large number of people who were first exposed to drugs because family members or other trusted adults administered them to keep them cooperative. Is it really important to assign "fault" to these people?

**Q:** I know people with alcoholism and they quit their drinking by going to meetings and having lots of support. Why can't people with opioid addiction do the same?

**A:** Addiction to alcohol and addiction to opioids "look" the same from the outside. However, the changes in the brain that happen with alcohol are medical different from those with opioids. Think of a brain injury, like a head trauma or a stroke. In this case, the brain injury comes from changes in the brain chemistry. Once that injury happens, the brain does not work right in the absence of something that acts like an opioid. Adding medication (Suboxone, methadone, etc) helps bring the brain back to a "normal" so that the patient can function enough to stay out of trouble, maintain work and family responsibilities, and do the hard work of recovery. Sometimes they need the medication assistance for a short period of time, and sometimes it's a longer term. But the relapse rate for people with opioid addiction who are NOT given some medication assistance is over 90% because they can't get through the day without it. If you had a life threatening illness, would you want a treatment that worked less than 10% of the time?

Q: How is this helpful? Isn't using methadone just switching one drug for another drug?

A: "Addiction" is defined by continued use of a substance despite adverse consequences. "Dependence" is defined by a physiologic need for a substance in order to function normally (think of insulin in some diabetes patients). A person who is *addicted* to opioids may be engaging in crime, failing at work, neglecting children, and having bad health problems, including inadvertent overdose due to unpredictable ingredients of the drug of abuse. A person who is *dependent* on opioids, or meds that act like opioids, functions like a regular member of society. He or she might have a full time job, exercise vigorously, and show up for all of the Little League games. They are using the opioids as a medication in a predictable amount from a safe source, accompanied by counseling and other prosocial behaviors which improve the overall quality of life.

Q: Why can't everyone go on Suboxone? It's safer and an overall better choice than methadone, right?

A: Suboxone is the right medication for the right person. It is only safer in the sense that there is a ceiling effect to its activity. However, it is less safe in that the patient can take it home, use it inappropriately, and combine it with other things that can make it dangerous. Methadone is more supervised, and even people who have earned the ability to take it home with them only get a few days' worth at a time. It remains the gold standard for pregnant patients. Methadone's lack of a "ceiling" also makes it more appropriate for people with a severe addiction, whose brains have been altered to an extent that the Suboxone can't keep up with the demand.

Q: What is so terrible about withdrawal? It doesn't kill you, right? Can't they just suffer through a few days and then be done?

A: Symptoms of opioid withdrawal include severe stomach cramping, chills, sweats, runny nose, profound body aches, and severe anxiety. Think of the worst flu you have ever had. Most people when they say they "needed" to go use drugs are doing so to avoid withdrawal, not to get high, the 'fun' part ended early on in the addiction. If you had to go to work or take care of a small child, and knew that you were about to have this kind of illness, wouldn't you at least think about doing the things that would prevent you from getting sick?

Even after the initial withdrawal is over (which can take over a week), the cognitive changes last much longer than that, up to a year or more. The brain can take a long time to heal and the individual remains foggy and mentally compromised.

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