RFP G104272

ROCKLAND PEER SUPPORT SERVICES

SUBMITTED BY:

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Proposal Narrative

B. Demonstration of Peer Run or Managed

NAMI Maine, in collaboration with Recovery Peer Support and Development, Inc. (RPSDI), will establish the Rockland Recovery Center, a peer support learning community. Rockland Recovery will be peer-run, directed and managed.

C. Targeted Population's Need for the Program

Target Population: Rockland Recovery's target population will be the 2000+ adults living in the greater Rockland area who have been diagnosed with or self-identify as persons with mental health problems and those with co-occurring substance use problems. A special focus of the program will be helping people who have been discharged from institutions (hospitals, jails, or prisons).

Need: The Maine Health Data Organization indicates there were 176 adult substance abuse patients and 278 patients with mental illnesses discharged from medical facilities in the Rockland service area in 2002. Most of the 1419 men and 338 women in the Knox County Jail were released to the local community in 2002 (Knox County Sheriff's Department.) National statistics tell us that at least 16% of these individuals have mental health issues; 35% substance use problems).[1] Almost 200 men are released from the Maine State Prison and the Bolduc Correctional Facility in Warren each year and an estimated 40 return to or stay in the mid-coast area. Studies in Maine show the incidence of mental health problems and/or substance use problems for Maine's incarcerated are some of the highest in the nation.[2]

Mid-Coast Mental Health Center provided services to over 2,000 adults in 2003. In April of 2004, over 100 are waiting for service; some receive limited interim care. There is research documenting high rates of serious trauma in persons with addictions -- issues which often require treatment for co-existing disorders.[3] Most of the detoxification patients at Penobscot Bay Medical Center are placed in the PARC Unit for co-existing disorders. Moreover, a relatively high proportion of people with other mental illnesses develop substance abuse problems.[4]

Ample evidence exists that discharge planning from Maine's jails and prisons is inadequate.[5] Hospitals and crisis units, too, are often forced to discharge to homeless shelters or to waiting lists. Transitional assistance for people in the Rockland area is limited. The only peer support

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[1] Prisoner reentry is a major public policy concern which should not be limited to those with lengthy incarceration. "It is useful to note that reentry is a nearly universal experience for criminal defendants, not just returning prisoners. Everyone who is arrested, charged with a crime, and then released from custody moves from a state of imprisonment to a state of liberty. Everyone who is released on bail, placed on probation after a period of pretrial detention, sentenced to weekend jail, or released to a drug treatment facility experiences a form of reentry." (Jeremy Travis, "But They All Come Back: Rethinking Prisoner Reentry," National Institute of Justice, 2000) See also, Center for Substance Abuse Treatment, *Continuity of Offender Treatment For Substance Use Disorders from Institution to Community* (SAMHSA, 1998)

[2] Department of Justice, Bureau of Statistics.

[3] See, for example, K. Evans and J. M. Sullivan, *Treating Addicted Survivors of Trauma* (Guilford Press, 1995) and Center for Substance Abuse Treatment, *Substance Abuse Treatment for Persons with Child Abuse and Neglect Issues* (SAMHSA, 2000).

[4] For example, see New York State Office of Mental Illness, "Integrated Treatment for Co-Occurring Substance Abuse and Mental Health Disorders."

[5] NAMI Maine report on jails and prisons. 2002

group for people with mental illness is run by NAMI Maine, and meets just twice a week for one hour. The new Maine Reentry program of the Department of Corrections serves men under 25, and provides limited support to transitioning inmates, primarily through a community-mentoring program.

The need for peer support has been documented in Maine and across the country[6]. In 2001, Sweetser reported that consumers participating in focus groups for the previous four years said the most important gap in support for recovery was the ability to talk to someone who had been through a similar experience. A June 2001 Report to the Department of Mental Health, also indicated a need for peer run services and support for people transitioning out of the hospital.[7] *In Their Own Words*, a 1997 report from the Maine Trauma Advisory Groups noted that consumer empowerment through funded peer-run, peer-evaluated recovery services was needed. Several 2001 consumer support group surveys[8] conducted by NAMI Maine indicated that without peer support recovery is more difficult and relapse more likely. Lack of support and relapse is one of the major reasons offenders recidivate. (Travis, *op cit)*.

Although Alcoholics Anonymous is available in the Rockland area, it provides very limited peer support to people with mental health issues. In addition, stigma, lack of mental health education, and hostility to medications among many members, means the necessary environment of empathy and acceptance may not be present for mental health consumers.[9]

The authors of this grant conducted a non-random sample of dozens of people in the Rockland area who are going through the transition from institutional care to the community. Those people confirm that there is a lack of peer support available in the area and few places to share ideas, fears, strategies, hopes and frustrations, or to simply gain support from those who have or have had the same experiences. Most often mentioned in these conversations are the dimensions of company, hope, education, tools/skills of recovery, and self-esteem reflected in autonomy and empowerment issues such as employment, housing, education, and helping others. As Bullock, *et al*, put it, "Critical ingredients for recovery such as hope, empowerment, self-determination, and a new valued sense of self, are clearly in double- or triple-jeopardy for the mental health consumer who is also a criminal offender." [10]

D. Organizational Capacity and Key People

NAMI Maine, RPSDI, Mid-Coast Mental Health Center, Sweetser, and Amistad will collaborate to create the Rockland Recovery Center. NAMI Maine is the administrative and fiduciary agent for the project, responsible for meeting all grant requirements. RPSDI, primarily through its advisory board, will assist with fund raising and coordination with community organizations and agencies and provide on-going support and assistance. RPSDI will design the Center, manage the Center, and oversee day-to-day program mission, service, and quality. Sweetser's Peer

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[6]Multiple studies (see attached) document the positive outcomes of per support programs

[7] Shery Mead, Report for the Department of Mental Health, June 23, 2001

[8] NAMI Maine, 2001.

[9] Double Trouble in Recovery, a New York City self-help group for dually diagnosed people, notes that these issues are a fairly common. See the article in New York City Voices, September/October 2000 at www.newyorkcityvoices.org.

[10] Wesley Bullock, PhD., Gayle H. Wuttke, Melissa Klein, and Heidi Bechtoldt, "Effectiveness of a Forensic Diversion Program in Promoting Recovery." (presented at the State Mental Health Agency Services Research, Program Evaluation, and Policy Conference, Washington, DC, 2001)

Center and Amistad will train RPSDI's Board, Steering Committee, and Center staff in their program models and consult over time with Board and staff to assure fidelity, share valuable expertise, and assist with problem solving related to process and product. They will also assist in annual evaluations. Ongoing access to these two respected peer support and recovery organizations will ensure that the program embodies the values and tenets of self-directed learning and recovery, as well as the wisdom that comes from experience. Mid-Coast Mental Health Center is a member of the Steering Committee, along with Penobscot Bay Medical Center, and Choice Skyward. All have agreed to serve as referral sources for the Center. Mid-Coast will provide start-up housing for the Center, until permanent housing is obtained. A description of each organization and key people in those organizations follows.

NAMI Maine. NAMI Maine is a membership organization representing people with mental illness and their families. Established in Maine in 1984, the organization has five full time staff, an annual budget of $600,000,and a board of directors composed of one-third peers, one-third families, and one-third other professionals. NAMI's mission is to improve the lives of all people affected by mental illness through support, education, and advocacy. NAMI's support programs include the operation of a warm line that provides support, information, and referral during business hours and the operation of 19 support groups across the state. Five are pure peer support groups. Peer volunteers and peer boards of directors run each group. Facilitators are accessible by phone in-between meetings. Both group-based and individual support is provided to members and all others in the local community who identify a need for help. Groups meet at least once a month – several meet weekly. All support groups are designed to provide a setting where people can share their experience, receive interpersonal support and respect, and assist one another to identify and utilize recovery skills. Rockland's current NAMI peer support group will be integrated into the Rockland Recovery Center.

NAMI Maine's role will be fiduciary and administrative. NAMI will oversee all spending, reporting, and share oversight of program process and outcomes. NAMI brings many years of experience as a peer support service provider, fiduciary agent, and contract manager. NAMI Maine has consistently met its contract obligations with BDS and successfully administers a number of private grants.

Carol Carothers, Executive Director of NAMI Maine will be responsible for all administrative aspects of the program. Carol has over ten years of experience in the mental health and substance abuse field and over 20 years of experience as a program manager, evaluator, and administrator.

RPSDI. RPSDI is a fledgling organization established by two former inmates of the Maine State Prison and a number of long-term advocates and peer support volunteers from the Rockland community. Their steering committee includes representatives from the local hospital, the Department of Corrections, mental health and substance abuse service providers, and peers. The breadth of this committee is designed to insure buy-in from referral sources as well as strong links between peers and formal systems of care, including local institutions that transition people back into the community.

RPSDI is 100% peer run. Marian Todd will serve as President and Vice President of RPSDI's initial Board (which will be formed from members of the Center). RPSDI will direct the project, recruit volunteers and members, design and implement programs, and manage the Center day-to-day. Marian Todd is a long-time peer support volunteer from the Rockland area. Marian has a Masters in Special Education and a B.S. in Elementary Education from the University of Rochester. Her work in peer support has included serving as an Alcoholics Anonymous volunteer at the Maine State prison, the Lincoln and Knox County jails, and as a member of

Bridging the Gap, a program that links people to early sponsorship in A.A. She has also been a volunteer at Youth Promise, a mentoring program for young people who are doing community service and for the Merrymeeting AIDS program. Marian brings over ten years of recovery, advocacy, and peer support experience to this project. Ultimately, Center staff and volunteers will be responsible to the Center's Board and to the requirements of the grant.

Sweetser Peer Support Center. Sweetser's Peer Support Center is a peer support and learning center in Brunswick. Kelly Staples from the Sweetser Peer Support Center, and a member of the NAMI Maine Board of Directors, has agreed to consult with RPSDI in the design and development of the Rockland peer support program. Kelly has worked at Sweetser running the peer program for the past three years. Prior to that she was a trainer about consumer and family perspectives and ran peer focus groups. Kelly is in recovery from mental illness and is the parent of a child with a mental illness. She has received training from Shery Mead in the management and design of peer support centers. This links the program to the Mead model of peer support and recovery.

Amistad. Amistad is Maine's largest peer support and recovery center, with over 400 members. Amistad offers a broad range of peer support and recovery services. Brian Wallace, Director of Peer Support Services at Amistad has agreed to consult with RPSDI in the design and development of the Rockland peer support program. Brian has been overseeing Amistad's in-hospital peer support program for the past two years and is currently overseeing the implementation of peer support services at AMHI. Prior to this, Brian served as the staff person to the MCLU prison project, which assisted inmates to understand their rights and to obtain medical and mental health services. Brian's involvement will link Rockland Recovery Center to the Maryellen Copeland model of peer support, as well as bring an understanding of and strong links to the criminal justice system to the project.

Mid-Coast Mental Health Center. MCMHC is Rockland's community mental health center, providing behavioral health services to Knox, Waldo, and parts of Lincoln Counties. MCMHC serves on RPSDI's steering committee and has agreed to serve as the physical location for Center meetings, until permanent housing can be identified. Preliminary discussions indicate Coastal CAP may have housing available in the summer. Should the grant be funded, the first order of business will be to obtain rental or purchased space.

E. Incorporation of Elements of Recovery and Self-Directed Recovery

Integrated and Inclusive. RPSDI has already established a steering committee that is comprehensive, inclusive, and links mental health and substance abuse service providers, providers of institutional care, and peers. Consultation from existing peer support and learning centers will further integrate the Center with experts in the field.

Consumers to Benefit. The Rockland Recovery Center will provide a drop-in facility and learning center for adults diagnosed with a mental illness and/or those with co-occurring substance abuse issues and histories of trauma. As detailed in the needs section, the Center will focus on recovery-based peer support for the almost 2000 adults each year who move from institutional settings into the Rockland area community and who have serious chronic mental health problems including, and especially, addictions issues. This transition from institution to community is a crucial and delicate moment in the recovery process. The Center intends to target these consumers because of the data described in the needs statement, which included consumer focus groups, Maine reports documenting the needs of consumers, non-random surveys of Rockland area peers, and waiting list and service data from Mid-Coast Mental Health Center. Consumers have been involved in all aspects of project development. RPSDI began

organizing a steering committee and peer advocates over six months ago. Many discussions, surveys, and meetings across the state with other peer support centers have contributed to the submission of this proposal.

Strategies and Services to be offered. In order to foster and enrich the process of change that is the recovery process, The Rockland Recovery Center will provide a sense of hope, support, and empowerment that is part of a learning community. Center members will select and serve on the Center's Board, oversee the day-to-day operation of the Center, and assure adherence to peer support standards. The Center will be low to no cost and available to anyone who self-identifies as in recovery or seeking recovery and makes a commitment to the orienting principles of the Community.

There will be regular Fellowship meetings—peer support recovery groups—where members can check in about their lives, share their experience, strengths, hopes and challenges, and discuss topics of concern to those in the meeting. The Community will have on-going peer facilitated, collaborative programs on recovery skills and strategies, such as WRAP sessions, education programs about mental illness, and a peer support-training program. The Community will also provide programs on issues such as employment, housing, and self-support life skills. The Community will develop and maintain close relationships with other resources in the community so that it can be a resource center for members in search of specific assistance and opportunities. Governance and programming decisions of the Community will be through regular membership meetings, Board meetings, and ongoing assessment and evaluation of program and process.

The Rockland Recovery Center is committed to the recovery of all its members through mutual support. We believe that recovery is possible. We believe in the dignity and worth of each person and that each person has the strengths, capacities, and potential for recovery. This is a learning community where we can be safe and draw on each other's strengths, joys and sorrows, where we respect each other and help each other learn and grow. We believe that if we have the honesty to accept the need, the courage to hope, the willingness to learn, the strength to change, the openness to share the journey, and a commitment to celebrate our progress we can restore ourselves to healthy productive lives.

The Center's programming will be based on emerging standards of peer support including the following:

Promotion of critical learning and re-naming of experiences.

Providing a sense of community.

Flexibility in the kinds of support provided by peers.

Activities, meetings and conversations that are instructive.

There is mutual responsibility across peer relationships.

Peer support is clear about and sets limits.

Peer support involves sophisticated levels of safety.

There is ample evidence[11] that peer projects that incorporate these principles are highly effective in producing the desired outcomes of consumer empowerment, decreased levels of use of formal systems of care, community integration, and cost savings.

[11] See attached list of citations

The Rockland Recovery Center will build these essential elements into the following services and strategies.

Self directed learning activities. The Center will offer drop-in and scheduled programs for those who wish to engage in directed and self-directed learning experiences. These peer-facilitated activities may include learning to prepare for stressful situations; building self-esteem; learning to recognize and manage urges, including using substances; making and keeping friends; speaking out for yourself; recognizing and managing danger signs and triggers; dealing with the effects of trauma; handling on the-job problems; investigating and expanding social supports, employment opportunities, or leisure time skills; developing a more open recovery; and developing a recovery and wellness lifestyle.

Peer support workers will assist members in formulating their personal learning and development plan beginning at orientation and periodically on a continuing basis. These plans will not only help guide the member and provide a sense of progress and accomplishment but also help guide the Center as an on-going needs assessment for developing and providing programs.

Recovery program. The recovery program will be based in models designed for co-occurring mental heath and substance abuse as well as traditional 12 step models. The "double trouble model", the Dual Disorders Recovery Book[12] model, and the "Houses of Healing[13] model"(a manualized recovery program for prisoners) will be used. Mary Ellen Copeland's Wellness Recovery Action Plan program and the Recovery Workbook[14] will also guide program activities and strategies. Fellowship Meetings will also be offered several times a week. This is a model based on Zackon, McAuliffe and Ch'ien, Recovery Training and Self-Help (National Institutes of Health, 1993).

Warm drop in and phone. The Rockland Recovery Center will operate a warm line and warm drop-in center during the hours it is open. When closed, referrals will be made to the NAMI peer support volunteer phone, the MCMHC warm line, and AA, NA, and Alanon volunteer networks. Traditional sponsorships, like those in AA will be promoted for those who wish to identify a buddy who is available for support and mentoring on a regular after-hours basis.

Resource Center. Because recovery takes place within the context of real lives and real problems, members have pressing needs for housing, transportation, and employment. They may have needs for the services of mental health professionals and programs. In many cases, members lack experience and skills to locate and utilize community resources, including navigating the Human Services labyrinth, and the day-to-day skills of maintaining housing and employment. The Center will address these issues in four ways. First, the collective experience and expertise of its members will provide guidance and support. Second, the Community will develop and maintain an extensive network of connections with agencies, organizations, programs, and individuals and actively link members through these connections. Third, Peer Support Workers will be available to assist and even accompany members in connecting with resources. Fourth, the Community will offer regular workshops on accessing and utilizing resources and day-to-day skills. NAMI Maine's information and referral services will

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[12] The Dual Disorders Recovery Book. A 12 Step program for those of us with addiction and an emotional or psychiatric illness. Hazelden. 1993.

[13] The Houses of Healing Training manual. A prisoners guide to inner power and freedom. Casarjaian. The Lionhart Foundation. 1995.

[14] The Recovery Workbook. Practical coping and empowerment strategies for people with psychiatric disability. Spaniol, etal. Center for psychiatric Rehabilitation. 1994. Boston University.

compliment these efforts. Coupled with these, we also hope to develop a local version of the excellent guidebook, developed by Alex Myhaver, *The Housing Source: Finding and Keeping the Housing You Want in Greater Portland* (Amistad, 2003).

5. *Outreach*. Because the Recovery Center has a strong commitment to improved transition from institutions to the community, the Center intends to reach out to local institutions. Depending on staffing, funding, and the availability of trained volunteers, the Center eventually intends to provide peers who can visit emergency rooms, jails, and the prison to make sure information about available services is available to consumers and their families and to ease entry and discharge. Amistad's in-hospital peer support program will serve as a model for outreach activities.

Anticipated outcomes.

- Consumers will have increased skills in managing their lives and the symptoms and problems that effect them
- Consumers will form supportive relationships with others who are recovering from mental illness, substance abuse, trauma, and the effects of institutionalization.
- Consumers will experience emotional healing and improved self worth through expanded "community" and improved coping skills.
- Consumers will expand their relationships with the broader community.
- Consumers will identify life goals and make progress in achieving these goals.
- Consumers will decrease their episodes of crisis by building supportive and helpful peer relationships and a community.
- Consumers leaving institutions will receive early and helpful connection to others who have experienced what they have experienced.
- Rockland service providers and institutions will have a place to refer consumers for peer support services as well as access to consumers to serve on their boards and assist them to understand peer perspectives and improve the quality of their service delivery.

Attraction and Retention.

The Rockland Recovery Center will attract and retain consumers in a fashion similar to that used to establish the steering committee and prepare this proposal – outreach and ongoing development. The steering committee includes representatives from all major service providers and discharging institutions in the area. We anticipate referrals from each. The steering committee also includes many peers – who are currently involved in outreach to people with substance abuse, mental health, and criminal justice backgrounds. NAMI Maine is one of Maine's largest providers of information and referral and will publish information about the Center in its resource directory, affiliate list, newsletter, and make phone referrals. Retention is a factor of performance. Consumers will be members of the Center, participate in its development and over time, as peer supporters, volunteers, board members, and staff. Consumers will play a variety of roles, flexibly determined based on choice, and become part of a community in which they feel safe, supported, and valued. The Center will only retain consumers if it adheres to the tenants and outcomes spelled out in this request for funding. Ultimately, it is the quality of service that retains customers.

How do we know this service is needed by the target population? The organizing understanding of this project draws on three distinct yet overlapping literatures and experiences. First, there is rich and extensive recovery and relapse prevention tradition and literature in the substance abuse field including and notably Zackon, McAuliffe and Ch'ien, *Recovery Training and Self-Help* (National Institutes of Health, 1993). Second, there is a rich and developing recovery peer support and self-help literature in mental health, including and notably the work of Mary Ellen Copeland and Shery Mead, that draws upon and has much in common with the addictions literature. And, third, there is a rich literature on adult learning, peer and collaborative learning, and learning communities, drawing on the tradition of Malcolm Knowles among others and developed by organizations such as New Horizons For Learning.

These three literatures and experiences have in common a conviction 1) that change is a process, 2) that change is possible and 3) that an essential component of successful changing is peer-to-peer collaborative support and learning. This research, the focus groups, other reports cited earlier, and the start-up efforts of RPSDI's founders and steering committee document a need for this service.

Delivery Strategy in terms of place, time, partners, interactions with consumers and related matters

Place: Initially, the Rockland Recovery Center will operate from Mid-Coast Mental Health Center. Permanent housing will be identified and obtained within the first 3 months of funding.

Time: Initially available during a varied schedule, based on availability of space at MCMHC, if funded, the Center intends to expand to six days a week, with service availability between Noon and 9, and support groups and sponsors/mentors available after hours. The expanded hours will depend on peer staffing and finances. Evening hours are important because they are vulnerable times, especially since social norms and personal habits associate evenings with social activities, comfort, and social bonds. Thus, these hours can easily trigger feelings of loneliness, rejection, worthlessness, and hopelessness and result in crisis. Moreover, traditional mental health providers and programs are generally not available in the evenings. Finally, evening hours allow a valuable opportunity for a wider range of members to interact—for example employed and unemployed members.

Partners: NAMI Maine and RPSDI are the organizations that will operate the Center, should the grant be awarded. Additional partners include Mid-Coast Mental Health Center, Sweetser, and Amistad. Steering Committee members include local advocates and peer support volunteers, Choice Skyward, Mid-Coast Mental Health Center, Penobscot Bay Medical Center, the Department of Corrections, the Rockland Career Center, Coastal Economic Development, and Probation and Parole. Recruitment of additional steering committee members is underway. RPSDI is seeking representatives from the church community, the Knox County jail, and local employers, such as MBNA and the Rockland Chamber of Commerce in order to enhance employment linkages for Center members.

Interactions with customers: The basic strategy of the program will be the development of a cadre of trained peer support workers recruited from the membership. Some of these workers will be paid a modest stipend for their responsibilities. Workers will receive an initial training followed by continuing training/education sessions. Training will focus on education about recovery and relapse prevention and the skills identified by Copeland and Mead and delivered in trainings and job shadowing at Sweetser and Amistad, as well as additional attention to co-occurring programs specific to RPSDI. Initially, training will be provided through program partners including Amistad and Sweetser. Eventually, with experience, the Center will offer in-

house training and continuing education while remaining in close collaboration with other resources.

Peer support workers will provide the day to day operation of the community as well as core functions such as orientation of new potential members, assisting in the operation of the programs, facilitating learning, and providing special peer guidance in other areas such as through our arrangement with the Rockland Career Center. There will be regular meetings of the peer workers to discuss issues, concerns, and help formulate plans and recommendations for the Community. They will play a key role in the governance and direction of the community as well as the continuing evaluation of the process and outcomes of the Center.

The peer support worker strategy has advantages for the workers themselves as well as for the community. For the workers it provides a sense of personal empowerment and hope and deepens and broadens their own recovery through helping others as well as through advanced recovery training opportunities. For the Community, the peer support worker strategy creates a culture of recovery, mutually supportive relationships, and collaboration, not the least of which is through modeling recovery and hope. It also provides a mechanism for developing and broadening the leadership in the community as well as vital input into the Community's conduct and development. In short, the peer support worker strategy promotes inclusiveness, broadens peer involvement and celebrates hope and restoration.

Each new person who comes to the Community will receive an individual orientation from a peer support worker. They will find out a little about the person and their situation, needs, and interests and will discuss the program and philosophy of the Community and answer any questions. As part of this process the new person will be asked if they are willing to make a commitment to recovery and become a member.

The purpose of the orientation is to individually welcome the new person, affirm their importance, give them a sense that recovery is possible and that they are not alone, empower them by offering them choices, model the collaborative quality of the Community, and provide their first connection to the Center. In addition, the orientation process will allow collection of basic information about the new member and their needs.

Relationship between needs and characteristics of intended consumers. Data cited earlier describes how these programs relate to the needs of consumers. To summarize:

Supports and learning opportunities are provided in hours where there is little available from the traditional mental health and substance abuse community.

Consumers indicate they most want decent housing and work, the center will offer learning opportunities and linkages to help consumers meet these goals.

Consumers express a need for safety, support, sharing, and community where they are accepted and valued for who they are and where they are. The Center's services and supports are designed to meet these needs.

Unlike traditional provider-run services, the Center will offer services based on self-directed learning theory.

Consumers express a need for "warm" supports that link them with others who have experiences similar to their own. The Center is designed to do this.

The Center will combine successful peer support models from three communities – substance abuse, mental health, and corrections, offering a flexible and comprehensive range of supports for people transitioning out of institutions.

Consumers seek mechanisms to reduce their social isolation and reliance on the service provider system, and the Center provides this opportunity.

Comparisons with other approaches.

The Rockland Recovery Center builds on the research about what works in peer support and recovery, utilizes models that have been successful in other states and in Maine, and relies on consultation with experienced peer support leaders and their organizations. Unlike others, the Rockland Recovery Center will integrate models from three systems that have not always worked well together: mental health, substance abuse, and corrections. This approach responds to current circumstances – deinstitutionalization has resulted in transinstitutionalization. Increasingly, people bounce between mental health services, substance abuse services, and criminal justice settings. The State of Maine has been involved in several year-long planning efforts to increase the use of integrated treatments. The federal government has recently published information about evidence-based practices they wish to see replicated. Two of these are peer directed recovery and integrated treatment. The Center will be implementing both.

As the leading experts on change processes put it: "Self-help groups send out a powerful message to isolated precontemplators who are embarrassed or ashamed that they have personal problems. The very existence of these groups says, "You are not the only person in the world with this problem; we can help you to accept yourself as a person with a problem and to do the best that you can to change it."[15]

The hierarchical structure of traditional mental health and education is often disempowering by promoting passivity and dependency. "The instructing and professing model … asserts that …the student…is essentially a passive and isolated recipient of knowledge."[16] The Rockland area needs a collaborative learning community, such as envisioned by Knowles and others[17], which promotes and celebrates peer-to-peer and experiential learning, especially about recovery and life skills. Collaborative learning seeks "to re-form the learning enterprise by empowering students and making them responsible for their own learning." (Lehman, 1997). The collaborative model …asserts that learning takes place when knowledge is assimilated and becomes part of the student's repertoire for viewing, understanding, and performing. This is an active process—learning is an activity. Learning is conceived as something a learner **does**, not something that is done to the learner. The collaborative model shifts the focus from the teacher to the learner. (Lehman, 1997.

Such a learning community is not only the most effective method for learning but actively promotes independence, autonomy, and self-responsibility—empowerment to take control of your own life and make change. The Rockland Recovery Center will become such a learning community.

Marlatt and Gordon's seminal work, *Relapse Prevention* (Guilford, 1985) among many other things, links relapse prevention to broad lifestyle change. Coupled with Prochaska and DiClemente's work with the stages of change (1994), the relapse prevention model, more positively conceptualized as "recovery," forms the foundation for extensive development in a variety of areas including substance abuse, anger management programs, Copeland and Mead's

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[15] Prochaska, Norcross and DiClemente, *Changing For Good* (Avon, 1994), p.101.

[16] Peter M. Lehman, "Notes on Collaborative Learning," American Sociological Association, 1997.

[17] See, for example, Malcolm Knowles, *The Adult Learner: A neglected species, 4th ed.* (Gulf Publishing, 1990) and K. Patricia Cross *Adults As Learners.* (Jossey-Bass, 1981)

Wellness Recovery Action Plan (WRAP), and a series of self-help pamphlets developed by Copeland for SAMHSA.

Linked to existing community need, efforts, and programs and builds on existing resources and develops linkages.

Earlier sections of this proposal document the linkages that have already been formed in preparation for the submission of this grant. The Center plans a comprehensive approach that does not replicate existing programs, but coordinates with them. The proposal links or has a plan to link together families and consumers, local service providers, state government, institutional service providers, employers, vocational service providers, local area advocates and peer support volunteers.

Consumer involvement in development, implementation, and evaluation.

Consumers in the Rockland area developed this proposal. Those individuals recruited and assembled a steering committee, traveled the state to meet with successful peer support center leaders, and identified an administrative entity for their project. Should the project be funded, this same group will develop, manage, and participate in the evaluation of the Center.

Program Objectives in Measurable Terms

Objective	Target/Outcome	Measure
1. Consumers will have increased skills in managing their lives and the symptoms and problems that affect them.	1. 85% of consumer members will report improved ability to manage their lives and symptoms.	1. Self directed learning plans document improvements 2. Annual surveys of members document impact on quality of life.
2. Consumers will form supportive relationships with others.	1. 90% of members report establishment of at least one supportive relationship.	1. Annual survey of attendee satisfaction and outcomes.
3. Consumers will experience healing and improved self worth through expanded community and coping skills.	1. 60% of members report improved self worth and new skills.	1. Lists of group attendees 2. Schedule and agenda for learning skills groups 3. Participant evaluations
4. Consumers will expand their relationships with the broader community.	1. 20% of consumers will report increased work or other community linkages.	1. Notes will document monthly progress on goals in learning plans. 2. Consumer surveys document new linkages.

Objective	Target/Outcome	Measure
5. Consumers will identify life goals and make progress achieving these goals.	1. 50% of consumers will have a learning and development plan and report progress toward those goals.	1. Written learning and development plans document goals. 2. Consumer surveys
6. Consumers will decrease their episodes of crisis by building supportive and peer relationships and a community.	1. 60% of members will utilize fewer days of crisis service.	1. Consumer surveys include self report re: use of crisis.
7. Consumers leaving institutions receive early and helpful connection to supports.	1. 80% of Center members who have recently left institutions report connection with helpful supports.	1. Consumer surveys.
8. Rockland service providers have a place to refer consumers for peer support and access to consumers to be involved in their service delivery.	1. Steering committee members report making referrals to Center and utilizing Center members for service delivery improvements and insights.	1. Consumer surveys document how they were referred and if they have been involved in provider efforts to improve service delivery.
9. The Rockland Recovery Center is peer managed, peer directed, and includes ongoing mechanisms for quality review and program modification.	1. 95% of members, board, and steering committee members report that Center services are respectful, peer centered, and consistent with mission, goals, and outcomes.	1. Board meeting minutes, consumer surveys, quarterly evaluations.

The chart above constitutes the Center's evaluation plan. Goals and outcomes are identified, as well as measures to evaluate attainment of projected outcomes. As shown, consumers will be constantly involved in reporting on how the Center's programs are working. A participatory approach will be used which includes input from all consumers, including those who are program staff/volunteers. Quarterly surveys will identify what is working, what is not, and modifications will be consumer designed and driven. The consumer voice will determine what is success and what is needed.

The first year's evaluation will involve not just consumer input regarding their goals and their progress on those goals, but will also assess process. How did the Center's start up progress, what was difficult and why. Ongoing evaluation will be built into all Center routines, making evaluation and refinement routine, not an end-of-year event. Because the Center will be peer run and managed, the Center Board, elected by the members, will meet regularly to discuss outcomes

and quality. Board meetings will be similar to "town meetings". All wishing to participate will have input into Center process, service, and product.

The following standards will guide all evaluations:

1. Do peers run the center? Do center members participate in hiring and training of staff?
2. How are members and staff oriented and trained? What is the process for feedback on staff performance?
3. How are relationships developed internally between staff and peers, between peers and peers, and between providers and other community members? What is the quality of these relationships?
4. How does information sharing within the Center staff, Center members, and outside providers and community members occur? Is information sharing respectful, inclusive, and within legal boundaries?
5. How are Center services delivered, prioritized, and monitored? What processes exist for self-monitoring and reflection? How are differences of opinion aired and resolved?
6. What are the expectations for learning plans, support and recovery groups, and linkages to outside communities? How are bridges developed, supported, and maintained?
7. How does the Center build capacity?

To insure objective-outside review, the Center intends to invite Amistad and Sweetser Peer Center managers and members to assist in an annual evaluation. They will be invited to visit the Center, review Center documentation, interview Center members and staff, and report their findings.

G. Reasonable Cost and Budget

NAMI Maine requests $58,728 to operate the Rockland Recovery Center. The chart below documents project activities in terms of cost:

YEAR ONE – START UP

Activity	Who	Cost
Recruitment advertising @ $800;	RPSDI, Sweetser, Amistad	$800
Training & travel		
Staffing @ x 40 hours/week x 52 wks		$4,420
Benefits and Fringe	RPSDI	$20,800
		$4,160
Housing @ $1,000/month x 9 mos.	RPSDI	$9,000
	RPSDI	
Peer volunteer stipends @$125/wk	RPSDI	$6,000
Equipment, furniture	NAMI	$4,000
Supplies		$1,200
Total Program:		**$50,380**
Insurance		$4,000
Administrative management @ .08%		$4,348

RPSDI and NAMI Maine, if funded, intend to raise additional funding and to seek donations for the Center. Steering Committee members are in the process of approaching MBNA for donations of equipment and furniture, possible now due to the downsizing of their Camden offices. Mid-Coast Charities will also be contacted for contributions. A fundraising plan will be developed by staff during start-up.

YEAR TWO ANNUAL BUDGET

Activity	Who	Cost
Staffing @ x 40 hours/week x 52 wks	RPSDI	$20,800
Benefits and Fringe		$4,160
Housing @ $1,000/month x 12 mos.	RPSDI	$12,000
Peer volunteer stipends @$125/week		$6,000
Training		$1,076
Travel		$1,000
Equipment maintenance		$800
Supplies & Phone	NAMI	$4,508
Insurance		$4,000
Administrative management @ .08%		$4,384

The key assumptions about the Rockland Recovery Center's budget are:

- Fringe benefits are calculated at 25% of wages and include payroll and other taxes, insurance, holidays.
- Administrative costs and insurance are the responsibility of NAMI Maine. NAMI intends to add the Recovery Center to its liability insurance contract. The administrative rate includes payment of bills, staff time, travel to and from Rockland, postage, and other costs associated with evaluation, reporting, monitoring, and oversight of the project.
- Ongoing fundraising will be needed to obtain equipment for the club as well as to meet the cost of living increases that are anticipated with each year of operation.
- NAMI Maine's contribution will far exceed the reflected administrative rate, as the Executive Director will provide oversight, assistance with evaluations, and assistance in raising additional funds.
- Assuming that 250 individuals visit the Center each year, the cost per person is $234.91/person/year, Assuming 5 visits per person, the cost per visit is $47 per visit.
- Membership revenue is not reflected in the budget, but once designed by members, will supplement revenues.