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The Largest Hidden Tax: Substance Abuse in Maine

***The Final Report of the Task Force on Substance Abuse—
A Partnership of the Joint Select Committee on Substance Abuse
and the Substance Abuse Services Commission***

November 18, 1998

Table of Contents

	<u>Page</u>
<i>Preface</i>	i
<i>Executive Summary</i>	
The Hidden Tax	1
The Task Force	2
The Recommendations	3
<i>I. The Task Force Process</i>	
Combined Effort	9
Meetings and Structure	9
This Report	10
<i>II. Substance Abuse in Maine</i>	
Extent of Alcohol and Other Drug Use in Maine	11
Substance Abuse and Criminal Behavior	15
Overview of Substance Abuse Services in Maine	17
<i>III. Discussion and Recommendations</i>	
The Substance Abuse Services System	20
Strategies and Services Embracing <u>All</u> Groups	23
Publicly Intoxicated People at Risk	30
Prevention	32
Services for Juvenile Offenders	38
Services for Adult Offenders	42
Public Safety	44
Private Sector Responses to Substance Abuse	46
<i>Endnotes</i>	50
<i>Attachments</i>	
A. Joint Order Establishing Joint Select Committee on Substance Abuse	
B. Task Force Members	
C. Subcommittee and Coordinating Committee Members	
D. Subcommittee and Coordinating Committee Process	
E. Definitions of Continuum of Care Components and Services	
F. Contributors to the Task Force’s Hearings and Comments Process	
G. Important Information about Substance Abuse in Maine	

Preface

This report outlines a series of recommendations developed by many participants over the summer and fall of 1998. The context of these recommendations is the story of a hidden side of Maine—a side of struggle and despair, of hope and recovery—the hidden side of Maine.

In the summer of 1997, the Substance Abuse Services Commission began to review its mission and role. These 17 community members are appointed by the Governor to advise the Executive and Legislative Branches on the status of substance abuse in Maine. The Commission decided that it was time to create a comprehensive plan for substance abuse services across the State.

In March 1998, the Legislature created the Joint Select Committee on Substance Abuse. Its mission was to look at Maine's substance abuse services and recommend needed changes in the system. Also in March 1998, local community study circles were launched to look at substance abuse and develop local action plans. The study circles were an outgrowth of a series of articles in *The Portland Newspapers* in October 1997 entitled "The Deadliest Drug: Maine's Addiction to Alcohol."

In April 1998, the Commission and the Select Committee decided to join forces to take a comprehensive look at Maine's substance abuse system and to develop a plan to address gaps in the system. The Task Force on Substance Abuse was the result of that decision. The Task Force is a unique joining of a committee of the Legislature and an advisory group to the Executive Branch. This extraordinary collaborative effort, carried out over the summer and fall of 1998, has resulted in this report.

The substance abuse services system in Maine had its official beginnings in 1974 with the creation of the Office of Alcohol and Drug Abuse Prevention. The system struggled to provide alcohol and drug abuse services through multiple reorganizations, the latest being the merger of the Office of Substance Abuse (OSA) within the Department of Mental Health and Mental Retardation in 1996.

Throughout more than 20 years of system development, the toll of substance abuse in financial and human terms has been staggering. Today, the economic cost of substance abuse is \$1.2+ billion or two-thirds of the entire budget of Maine State Government. This can be considered a hidden tax: it includes medical costs, costs of incarceration and crime, lost productivity, welfare, and social support costs.

Recent studies show the result of investing in prevention and treatment services for substance abuse. For every dollar invested a minimum of four dollars is saved in all of the categories listed above. Such a high return on investment would be a success on Wall street.

Members of the Task Force on Substance Abuse hope Maine will be willing to make this wise investment in Maine's future.

Co-Chairpersons, Task Force on Substance Abuse:

Representative Michael Brennan

Senator Beverly Daggett

Emanuel Pariser

Executive Summary

The Hidden Tax

The Dollar Impact

We've tracked fire, auto, boat safety but we've not tackled booze, which is the cause of these things. We have a fire marshal. Why don't we have an alcohol marshal? Why don't we keep count of something that is killing hundreds of people each year and costing us millions? Dr. Erik Steele, Administrator of Emergency Trauma Services, Eastern Maine Medical Center.¹

The annual cost of substance abuse in Maine is estimated to be \$1.2+ billion—\$916 for every man, woman, and child in Maine.² This hidden “tax” on the people of Maine is two-thirds the size of the State’s annual budget. This does not begin to account for the suffering and burden on those whose well-being is affected directly or indirectly by substance abuse. The State collects \$64 million in annual taxes from alcohol, but spends only \$7.4 million on the budget for Maine’s Office of Substance Abuse (OSA). In 1997, OSA spent \$14.3 million in state and federal dollars on substance abuse prevention and treatment services.

Studies have shown that preventing problematic substance use can be an important component in helping reduce both the social and economic costs of substance abuse. Research suggests that for every dollar spent in preventing illicit drug use, there is a fifteen dollar savings in dealing with the consequences of drug use and addiction.³ Studies also have shown that the cost savings from providing substance abuse treatment to juvenile offenders are significant compared to the costs of incarceration (up to 16 to 1 in financial savings alone).⁴ Studies in California, Illinois, and Missouri have shown that criminal activity of adult offenders is reduced after substance abuse treatment, thus resulting in financial savings.⁵

The Human Impact

It's the vastness of the problem that's overwhelming... We see a huge number of lives destroyed... Paul A. Fritzsche, Superior Court Judge, State of Maine.⁶

The gifts that this program has given me cannot possibly be measured in dollars and cents... What I thought was the end of my life, actually became a brand new start...

I was given the tools and ...the love and understanding I need to lead a happy, productive life free from addiction. Without programs like [this one] many lives would be lost in the maze of senseless addictive pain, and never-ending torture...It saved my life.
Letter by resident of halfway house to United Way.

This hidden tax takes its toll on the lives of individual Maine people. According to the Secretary of State and the Maine State Police, operating under the influence has significant human impact. In 1996, 37.5% of all traffic fatalities in Maine involved alcohol. Drivers with a blood alcohol content of 0.15 or more are 200 times more likely to be involved in a fatal crash than the average non-drinking driver.

People in Maine's general population have more education and more money than people receiving substance abuse services. Twice as many people in Maine's general population (40%) receive at least some college education, than do people entering OSA-funded services (19.6%).⁸ The per capita income of all Maine people (\$20,105 in 1995) is at least two and a half times greater than the income (\$7,992 or less a year) reported by the people entering OSA-funded services who report household incomes.⁹

Two-thirds of the people receiving OSA-funded services are involved in the legal system (probation, awaiting trial, incarcerated driving under the influence). An estimated 47% of adult probationers were under the influence of drugs or alcohol at the time of their offenses!¹⁰ Over the past two years, OSA has screened 1,300 juvenile offenders, of whom 72% required further substance abuse intervention. However, only about 20% were referred for screening. An estimated 68% of Maine's incarcerated adult offenders require intervention for substance abuse, yet fewer than 8% of those who need treatment receive it.

Maine's substance abuse services mitigate the devastating effects of substance abuse; often they are life-saving to those trying to recover from alcoholism and other drug addiction. However, over seven times as many people need substance abuse services than those who actually receive services. For example, OSA estimates that in 1997, 75,600 adults needed substance abuse treatment, but only 10,607 adults were admitted for it.

<i>The Task Force</i>

Concerns about this hidden tax led to the creation of the Task Force on Substance Abuse. This has been a combined effort of the Joint Select Committee on Substance Abuse of the 118th Maine Legislature and the Substance Abuse Services Commission, an advisory committee to the Office of Substance Abuse (OSA) in the Maine Department of Mental Health, Mental

Retardation and Substance Abuse Services. The Task Force came together in the spring of 1998 to conduct a comprehensive study of substance abuse problems in Maine. Its charge was to review issues related to substance abuse, to determine how to address these issues in a coordinated fashion, and to recommend changes in policies which affect substance abuse prevention and treatment. The Task Force worked throughout the summer and into the early fall to complete its work.

The Recommendations

This Executive Summary highlights the Task Force's 42 recommendations. These are not listed in order of priority. Beginning on page 20 there is more in depth discussion of the recommendations.

The Substance Abuse Services System

1. Expand resources to fund substance abuse initiatives by: reallocating state General Fund revenues; making changes in state tax policies; successfully applying for federal grants; building municipal support; and obtaining private sector grants from businesses, foundations, and other philanthropic organizations.
2. Implement mechanisms to ensure that OSA is appropriately positioned in State Government and that substance abuse issues receive an appropriate level of attention in both the Executive and Legislature Branches. Ensure full compliance with current Maine law that requires state agencies to cooperate with OSA. Ensure that all state agencies which spend funds on substance abuse services notify OSA at least annually about all expenditures of state, federal, and other dollars for these services. Require that OSA report directly to the Legislature's Joint Select Committee on Substance Abuse and/or other Joint Committees on the substance abuse services budget and the use of substance abuse resources, as well as the status of Maine's substance abuse system.
3. Continue to bring together representatives of the Legislature's seven key policy committees into the Joint Select Committee on Substance Abuse so they can address substance abuse issues in a coordinated manner and examine:
 - The status and outcomes of primary prevention programs across Maine, how these programs are funded, and how they can collaborate more effectively and efficiently. See recommendation 20.
 - Training regarding substance abuse, including substance abuse prevention, as a requirement for educators, law enforcement personnel,

medical care providers, mental health providers, and social workers to obtain or renew licenses and certifications.

- The need for certification standards for prevention specialists. See recommendation 21.
 - Screening for alcohol and drug abuse as part of drug testing by employers. See recommendation 42 .
 - The capacity to perform research in substance abuse, including strengthening OSA's link with Maine's universities, colleges, and researchers at the federal level.
4. Support the development of an independent consumer initiative in Maine to play an active role in the discussion and resolution of substance abuse issues.

Strategies and Services Embracing All Groups

5. Assess which substance abuse services are needed in each region of Maine. Provide funding, in proportion to population and geography, to support all components of the continuum of care in each region.
6. Increase access to and availability of substance abuse screening tools and assessments for youth. Establish a long term treatment facility for adolescents, as well as alternative services for youth that are geographically accessible (including but not limited to intensive outpatient treatment, family therapy, home-based family therapy, and gender-specific treatment.) Increase the availability of transitional housing for youth.
7. Recruit and retain appropriate and adequate staffing throughout the continuum of care. Coordinate resources to help non-profit substance abuse service agencies retain competent staff and to prevent the migration of their staff to other private sector organizations.
8. Address barriers to treatment and ensure the existence and consistency of support services throughout the continuum of care.
9. Institute action-oriented outreach programs that target isolated populations. Target substance abuse education and training programs to members of special population groups.
10. Develop and carry out a media campaign to encourage respect for diversity. Develop a standard curriculum that focuses on cultural diversity

and make licensing of substance abuse providers contingent upon completion of this curriculum.

11. Maximize the use of Medicaid funding to support the costs of substance abuse services for Maine's low income people. Design managed care for Medicaid recipients that is based on outcomes research and on the substance abuse treatment system developed by OSA.
12. Provide training for Department of Human Services caseworkers and supervisors, as well as assistant attorneys general to improve their recognition of substance abuse, to make sure they understand confidentiality, and to underscore their responsibility to refer people for substance abuse treatment. Increase referrals to substance abuse treatment by DHS.

Publicly Intoxicated People at Risk

13. Enact legislation to allow the involuntary commitment of individuals in need of substance abuse services who are a danger to themselves and whose lives are at risk.

Prevention

14. Create opportunities for youth to participate in the development of legislation and policies that affect their lives.
15. Expand substance abuse prevention programs in traditional and alternative schools and communities statewide.
16. Develop and maintain a revolving loan fund at OSA to assist communities with start up funds for substance abuse prevention.
17. Develop a system to ensure that technical assistance in program development, grant writing, and coalition building in relation to substance abuse issues is available to all Maine communities. See recommendation 3.
18. Develop funding partnerships involving OSA and other public and private organizations to support the continuation of coalitions involved in efforts such as the study circles.
19. Conduct a public information campaign to develop awareness about the devastating effects of alcohol and other drug abuse and to encourage individuals and communities to take action.

20. Review the status and outcomes of primary prevention programs across Maine, how these programs are funded, and how they can collaborate to work more effectively and efficiently. See recommendation 3.
21. Study the issues related to certification standards for prevention specialists in Maine. See recommendation 3.
22. Establish a Task Force comprised of representatives from Maine's public and private post-secondary schools with the mission to address underage and abusive drinking by students.

Services for Juvenile Offenders

23. Complete OSA's development of and fully implement the comprehensive differentiated program of evaluation and treatment for juvenile offenders who are substance abusers. Ensure that the program is carried out through the regional treatment networks and the southern and northern Maine Youth Centers.
24. Provide stable, long term funding through OSA to the regional networks to increase differentiated treatment capacity to meet the unmet treatment needs of juvenile offenders who are substance abusers and living in the community. Cover the services of providers who are willing to participate in formal network operations and who specialize in the diagnosis and differential clinical treatment of juvenile offenders who abuse substances. Also use funding for:
 - Critically needed family treatment and intensive outpatient treatment services;
 - Long-term residential therapeutic communities for adolescents; and
 - The development by OSA of programs in the four regions of the Department of Corrections, based on proven national model(s).
25. Provide stable, long term funding through OSA to implement a differentiated therapeutic intervention program at the southern and northern Maine Youth Centers. Ensure that the program has differential content, duration, and intensity for addressing substance abuse clinically as a primary condition related to criminal behavior.
26. Implement Juvenile Drug Court projects in each of the four Juvenile Corrections Regions through a collaborative process involving the Judicial Department, Department of Attorney General, District Attorneys, Department of Corrections, and OSA. Use the treatment capabilities of the regional treatment networks.

Services for Adult Offenders

27. Provide stable, long term funding through OSA for a seamless, statewide comprehensive adult offender substance abuse service system, which includes:
 - Screening for all offenders;
 - A five-level differentiated therapeutic intervention program for offenders in prison;
 - A residential pre-release transitional treatment center for offenders in prison; and
 - Services provided through four regional treatment networks for adult offenders in community corrections.
28. Assess the need for substance abuse treatment for adult offenders in county jails, with special attention paid to treatment for incarcerated OUI offenders.
29. Continue the Drug Court pilot project for adult offenders in Cumberland County and expand it to three additional sites in Maine through a collaborative process involving the Judicial Department, Department of Attorney General, District Attorneys, Department of Corrections, and OSA. Use the treatment capabilities of the regional treatment networks.

Public Safety

30. Create, by executive order, a Law Enforcement OUI Task Force to develop comprehensive joint action plans for providing the most effective and efficient means possible to reduce the incidence of intoxicated drivers.
31. Report to the Legislature by January 15 of each year results and recommendations regarding the effectiveness of the Young Driver Legislation passed in 1998.
32. Develop legislation to allow more flexibility in the design of OSA's Driver Education and Evaluation Program.
33. Make training in the use of the intoxilyzer machine, Horizontal Gaze Nystagmus, and advanced OUI recognition techniques a mandatory requirement of Basic Police Training.
34. Restore funding to the Maine Drug Enforcement Agency to the 1992 level.
35. Direct the Maine State Police and Maine Drug Enforcement Agency to develop and execute a Joint Plan for Illicit Drug Flow Control, designed to

provide Maine law enforcement officers with training to enhance their skills in identifying and prosecuting offenders.

36. Expand training at the Maine Criminal Justice Academy to focus on drug trafficking, drug recognition, and expanding threats to law enforcement officers from the hazards of clandestine drug laboratories. Provide grant funds for local communities, so that they can expand Drug Recognition Training for local law enforcement officers.
37. Enhance the Maine State Police capability to track and identify suspected and convicted drug offenders and provide pertinent data to all local and county law enforcement agencies.

Private Sector Responses to Substance Abuse

38. Amend Maine's health insurance laws to require "parity" benefits for substance abuse treatment under the same terms and conditions as benefits for physical conditions and illnesses. If the Legislature does not require parity benefits for substance abuse treatment, amend the current law mandating coverage for substance abuse treatment to require mandatory coverage in HMO plans and to require coverage in all individual and group insurance policies.
39. Revise insurers' utilization review standards, based on the "medical necessity" guidelines adopted by the American Society for Addiction Medicine. Require training in substance abuse treatment for those who review and approve managed care plans.
40. Improve the quality of Employee Assistance Programs (EAPs) by encouraging the development of programs that use core technologies and by initiating state licensing for qualified and certified EAP professionals.
41. Streamline the statutory and regulatory provisions governing EAPs and drug testing policies. The Legislature should amend 26 MRSA, chapter 7, subchapter III-A (Substance Abuse Testing) to increase its effectiveness so that more employers will develop fair, equitable, and responsible drug testing and EAP programs.
42. Examine the issues related to drug testing by employers, including screening for alcohol. See recommendation 3.

I. The Task Force Process

Combined Effort

The Task Force on Substance Abuse was established in May 1998 as a combined effort of two groups charged with conducting a study of substance abuse issues in Maine—the Joint Select Committee on Substance Abuse of the Legislature and the Substance Abuse Services Commission, an advisory committee to OSA in the Maine Department of Mental Health, Mental Retardation and Substance Abuse Services.

The legislation creating the Joint Select Committee on Substance Abuse is included as Attachment A. Because substance abuse issues fall under the jurisdiction of several different committees of the Legislature, the 118th Legislature brought together thirteen representatives of these committees to form the Joint Select Committee. The charge to the Committee is to examine issues related to substance abuse and to recommend how future Legislatures can address these issues in a coordinated fashion.

The Substance Abuse Services Commission also planned to study substance abuse issues. Its charge focused on conducting a comprehensive review of demonstrated substance abuse problems in Maine, particularly alcohol abuse, and on making recommendations regarding prevention, education, treatment and research. The Commission consists of 17 members with education, training, experience, knowledge, expertise and interest in substance abuse prevention and treatment.

In the early spring of 1998, the two groups decided to combine their similar endeavors and came together as the Task Force to conduct a comprehensive study of substance abuse problems in Maine and to recommend changes in policy regarding prevention and treatment. A list of Task Force members is included as Attachment B.

The Task Force did not address the use of tobacco in its recommendations. In recent months there have been a number of public policy initiatives relating to tobacco. Not wanting to duplicate this work, the Task Force decided to concentrate its recommendations on issues and solutions relating to alcohol and other drugs.

Meetings and Structure

Working throughout the summer and into the fall of 1998, the full Task Force met five times—on May 6, June 24, September 9, October 14, and November 18. The Task Force carried out its charge through four Subcommittees: Continuum of Care; Children and Youth; Public and Private Partnerships; and Criminal Justice and Public Safety. Each Subcommittee included Task Force members as well as interested members of the community. The Task Force also formed a Coordinating Committee to facilitate the review of work emerging from the Subcommittees and to identify and develop recommendations cutting across the Subcommittees. Each Subcommittee met at least five times between June and October. Each submitted a report including their draft recommendations. A list of Subcommittee and Coordinating Committee members is included as Attachment C. A description of the process followed by each Committee is included as Attachment D.

The Task Force held hearings on the draft recommendations in Augusta, Bangor, and Portland on September 16 and accepted written comments until September 30, 1998. The Task Force finalized the recommendations and report in November 1998. The Task Force received staff assistance from both OSA and the Legislature’s Office of Policy and Legal Analysis.

<i>The Report</i>

This final report and its recommendations represent a consensus of the Task Force on Substance Abuse. There was unanimous support for almost all of the recommendations. In the few instances when there was disagreement, Task Force members put aside their individual preferences in order to support the overall report and recommendations.

Following the synopsis of recommendations in the Executive Summary, there are three sections. Section I describes the reaction to alcohol and other drug abuse that led to the formation of Task Force, as well as the people and process involved. Section II provides an overview of substance abuse in Maine, examining its effects on Maine people and taking a broad look at the system of services. Section III includes discussion and recommendations organized into eight topics: the substance abuse services system, strategies and services embracing all groups, publicly intoxicated people at risk, prevention, services for juvenile offenders, services for adult offenders, public safety, and private sector responses to substance abuse. The recommendations in Section III are numbered consecutively across all of the topics. Thus, the numbers of the recommendations are the same in both Section III and in the Executive Summary.

II. Substance Abuse in Maine

Extent of Alcohol and Other Drug Use in Maine

Broad Impact of Alcoholism

Alcohol is so pervasive that we need to rebuild society. Observation from Biddeford Study Circle.¹¹

It's everywhere. It's in all of these subtle things. It's in child neglect, it's in child abuse, it's in domestic violence, it's in depression, it's in thought disorders, it's in people who are losing their jobs. It's in people who can't keep their marriages, it's in people who are in legal trouble. It's in sexual predators. Dr. George L. Higgins, III, Chief of Emergency Medicine, Maine Medical Center¹²

Alcohol is the unreported story in homicides and accidental deaths in Maine. If, on a daily basis, we put several people in a plane and crashed them into a mountainside because the pilot was drunk, there'd be an outrage. We'd hop right on that problem. But because alcohol-related deaths are spread out geographically and chronologically, we don't grasp the full dimension of it. We see the boating accident, the car crash, the bitter spouse, the shooting incident, but we miss the booze...It's hard for us to grasp the fact that something we all do on a regular basis can kill people and cause so much destruction. Administrator of Emergency Trauma Services, Eastern Maine Medical Center.¹³

This is a major public health crisis for this state. It's an absolute scourge, a crisis. Dr. David Stuchiner, Director of Emergency Medicine, Central Maine Medical Center.¹⁴

The annual cost of substance abuse in Maine is estimated to be \$1.2+ billion—\$916 for every man, woman, and child in Maine!¹⁵ This hidden “tax” on the people of Maine is two-thirds the size of the State's annual budget. This does not begin to account for the suffering and burden on those whose well-being is affected directly or indirectly by substance abuse. In “The Deadliest Drug: Maine's Addiction to Alcohol” *The Portland Newspapers* made the case for the general public that alcohol abuse contributes to every social problem (e.g. unemployment, family violence, crimes against people and property, fires, poor health, and suicide.)

Substance Abuse by Adults

OSA's 1997 Alcohol and Other Drugs Household Estimates Study estimates that there are 647,000 adults in Maine who use alcohol over the course of a year, including approximately 88,000 heavy alcohol users.⁶ Among pregnant women, it is estimated that 5.7% are heavy alcohol users, while two-thirds report some alcohol use.

Marijuana is the most commonly used illicit drug, used by an estimated 94,757 adults. Maine has a higher rate of marijuana use among adults age 18-24, when compared to the rates in the Northeast and the nation. There is a low prevalence of other illicit drug use in Maine, though this is increasing. However, it is likely that this is under-estimated (crack/cocaine and heroin users are not likely to participate in a telephone survey.)⁷

Substance Abuse by Youth

Aimee drank "obsessively" by age 10, but she began drinking much earlier. Her childhood slipped away in a downward spiral of blackouts and drunken driving. ¹⁸

Throughout Maine, alcohol and other drugs are used by children and youth at an alarming rate. Substance abuse begins at an early age. In 1997, high school students in Maine reported that 29% had their first drink before age thirteen, 30% had smoked before age thirteen, and 12% had used marijuana before age thirteen. They also reported that⁹:

- 51% had at least one drink in the past 30 days, 34% had at least one binge drinking episode (5 or more drinks in a row) during that time frame, and 6% drank on school property.
- 39% smoked cigarettes during the past 30 days, 18% smoked on school property, 11% bought their own cigarettes, and 8% were not asked for proof of age when buying cigarettes.
- 51% used marijuana more than once in their life, 30% smoked it within the past 30 days, and 10% smoked it on school property.
- 20% tried an illegal drug other than marijuana at least once in their life and 41% were offered, sold, or given illegal drugs (including marijuana) on school property during the past year.

Information about the use of alcohol, marijuana, and cigarettes by Maine's 8th, 10th, and 12th grade students indicates that they exceed most regional and national rates.²⁰ For example, in 1995-96:

- 8th grade students were binge drinking at the same rate as the rest of the nation, while exceeding the rates for the Northeast region. 10th and 12th

grade students were drinking at rates 3-5% higher than rates for the Northeast and the nation.

- With respect to marijuana use, Maine's 10th and 12th grade students exceeded the rate for the Northeast by 8-9% and the rate for the nation by 12-13%.
- With respect to cigarettes, Maine's 8th, 10th, and 12th graders smoke at higher rates than students from the Northeast and the nation (which have the same rate) by 5%, 5%, and 7% respectively. According to a Surveillance Summary by the federal Centers for Disease Control and Prevention, Maine is ranked as the fourth highest state having high school students who are frequent smokers (20.4%) and seventh having those who currently use cigarettes (37.8%).

Increases in the rate of youth suicide have been sufficiently alarming that in 1997 Governor King commissioned a task force to study the problem. Adolescents who had attempted suicide unsuccessfully said alcohol and drug use were one of the significant factors contributing to suicide, which is the second leading cause of death of 15 to 24-year olds and the third leading cause of death for 10 to 14-year olds in Maine.

Characteristics of Maine People Receiving OSA Services

OSA gathers information about people served by the agencies it funds (including all substance abuse clients of those agencies whether or not they are supported by OSA funds), people receiving treatment as the result of an Operating-Under-the-Influence conviction, people receiving Medicaid-funded substance abuse services, and people receiving methadone treatment. The OSA data system does not include information from non-Medicaid private practices or from major hospitals (for example, Jackson Brook Institute, Maine Medical Center—other than data about methadone detoxification, and St. Mary's.)

During fiscal year 1997, the total, unduplicated number of Maine people receiving substance abuse services from OSA was 10,607, including 6% (634) who were admitted as "affected others". While 52% of the State's population is female²¹, women accounted for 26.6% of people entering treatment.

Of the people entering treatment, 80.2% reported alcohol as the primary drug abused, 44% reported a secondary drug problem, and 16.8% reported a problem with a third drug. Marijuana/hashish was the primary drug of choice for 13.4% of those admitted to treatment other than emergency shelter/detoxification and for 4.0% of those admitted for detoxification/emergency shelter.

The average age was 35.2 for persons reporting alcohol or a drug other than alcohol as a primary problem. Of the people entering treatment, 77.7% reported using alcohol before age eighteen, 10.1% were youth under the age of 20, and 34.8% completed less than 12th grade. Over 40% of Maine people receive at least some college education², compared with only 19.6% of people entering treatment.

At the time of admission, 29.4% of the people were unemployed, of whom 12.9% were not looking for employment. Others described themselves as not in the labor force (34.6%) or being unable to work or get work for physical or psychological reasons (25%). Others described themselves as homemakers (4.3%), students (7.3%), retired (1.2%), and incarcerated (5.4%).

Of the people reporting household incomes, 43% had a yearly income of \$7,992 or less. This is less than half the 1995 estimated average per capita income for Maine of \$20,105. Of people reporting household incomes, 11.7% reported welfare (Food Stamps, Temporary Assistance for Needy Families, town welfare) as their primary source of income and 12.7% reported Supplemental Security Income and Social Security Disability Income as their primary source.

Six out of ten people (60.2%) were involved in the legal system (probation, awaiting trial, incarcerated, driving under the influence). During the 12 months prior to admission, 67.5% were arrested at least once; 37.6% were arrested for substance abuse related offenses; and 44.8% were arrested for Operating-Under-the-Influence.

Of those admitted to detoxification/emergency shelters, 30.9% had a concurrent psychiatric problem, compared with 26.1% of those admitted to other services. During the 12 months prior to admission, 40.1% were treated in a hospital emergency room at least once and 11.8% were treated in a psychiatric hospital. Of those admitted, 65% had a prior treatment episode.

Of those admitted to detoxification/emergency shelter, 57.9% reported self referral to treatment and 11.4% reported being referred by the court/correctional system. For clients in all other service settings, 18.4% referred themselves to treatment; 15% were referred by the court/correctional system; 27.1% were in treatment to fulfill the requirements of the Driver Education and Evaluation Program; and 11.8% were referred by another substance abuse treatment agency.

<i>Substance Abuse and Criminal Behavior</i>

Relationship between Substance Abuse and Criminal Behavior

It's the first question you ask [when investigating a homicide]: 'Anyone been drinking?' The likelihood alcohol is going to be involved is the general ruleAlcohol is the thing that breaks down the last barrier. The drunk knows he's about to shoot a person, not a pumpkin, but what they lack is a sense of judgment, reason. They lack the ability to say to themselves, 'You're about to do something really stupid and life-changing.' William Stokes, Maine Department of Attorney General²³

I'd estimate that 75 to 85 % of all our cases have an overlay of alcohol abuse. Michael Cantara, York County District Attorney²⁴

Alcohol [is] present in 90% of the cases we handle. Everybody worries about street drugs, yet alcohol is the biggest problem we face in this state. It's rare that the victim, defendant, or both aren't drinking. Meg Elam, Cumberland County Deputy District Attorney²⁵

Studies have documented the relationship between criminal behavior and substance abuse among both juvenile and adult offenders.²⁶ This also has been observed by professionals involved in the criminal justice system.

Substance Abuse by Juvenile Offenders

Many of Maine's juvenile offenders are substance abusers and need substance abuse treatment. Research has shown that the correlation for criminal conduct and substance abuse ranges from .45 to .60 for adolescents.²⁷

Both nationally and in Maine, studies report that marijuana and alcohol are the most frequently used substances by juvenile offenders.²⁸ Studies also have shown that the cost savings for providing substance abuse treatment to juvenile offenders can be significant compared to the costs of incarceration (up to 16 to 1 in financial savings alone).

OSA provides substance abuse screening and comprehensive assessment for all adolescents committed to the Maine Youth Center. Based on eight years of statistics, the data has shown that substance abuse is clearly a dominant problem for juvenile offenders at the Center:

- Approximately 90% are involved with alcohol and other drugs.
- 60-70% have substance abuse issues requiring treatment.
- Alcohol and marijuana are the primary drugs of choice.
- 90% of the chronic users are multiple drug users.

- Over half of the chronic users never have had substance abuse treatment or even been evaluated.

Over the past two years, OSA has screened 1,300 offenders referred by Department of Corrections caseworkers and substance abuse treatment providers. Of the juvenile offenders screened, 72% required further substance abuse intervention; yet, during this same time period, only about 20% of all adolescent offenders were referred for screening.

Statistics show that juvenile offenders have more severe substance abuse problems and require greater amounts of treatment than non-offending adolescents. Between July 1, 1996 and June 30, 1997, substance abuse treatment providers reported on 962 adolescents (338 adolescents were in the juvenile justice system and 624 were not) who received treatment. In every category, juvenile offenders fared worse than their non-offending peers

- Juvenile offenders used drugs more frequently. Ten percent used drugs 4 to 6 times per week and 31% used drugs at least once a day, compared to 8% during the week and 17% daily by non-offenders.
- Only 20.3% of adolescents in the juvenile justice system completed treatment, compared to 43.9% of non-offenders.
- Offenders required more time in treatment. The average number of treatment hours per offender was 63.7, compared to an average of 42 hours for non-offenders.

Substance Abuse by Adult Offenders

An estimated 68% of Maine's incarcerated adult offenders will require intervention strategies for substance abuse, with 6% of the inmates likely to be assessed as the most severely addicted. Eighty-seven percent of crimes committed by the most severely addicted inmates are substance abuse related. Fewer than 8% of Maine's state prison population needing substance abuse treatment is receiving such treatment. Yet, studies in California, Illinois, and Missouri have shown that criminal activity of adult offenders is reduced after substance abuse treatment.²⁹

National statistics indicate that 3.5 million adults were sentenced to probation in 1996, 50% of whom previously had been on probation and 30% had served at least one prior period of incarceration. Of the felony population, 31% were convicted of a drug offense. Of adults on probation, 41% were ordered to participate in drug or alcohol treatment as a condition of probation, 38% had orders requiring use of mandated drug testing, and 37% received treatment which included crisis/emergency care, self help groups, counseling, outpatient and inpatient care.

A special report on adult probationers, prepared by the Bureau of Justice Assistance in 1995, revealed that an estimated 47% were under the influence of drugs or alcohol at the time of their offenses. The chart below categorizes the offenses and the type of substance used.

Substance Abuse by Adult Probationers at Time of Offenses

Offense	Alcohol	Drugs	Alcohol/Drugs
Sexual Assault	31.8%	10.9%	33.0%
Assault	45.5%	9.3%	47.5%
Burglary	38.5%	23.3%	49.4%
Larceny/Theft	16.3%	9.6%	20.8%
Fraud	9.7%	8.2%	13.3%
Drug Possession	14.4%	26.6%	33.5%
Trafficking	16.2%	36.6%	42.2%

Overview of Substance Abuse Services in Maine

OSA Funding and Services

The State collects \$64 million in annual taxes from alcohol, but spends only \$7.4 million on OSA’s budget. In 1997, OSA spent \$14.3 million in state and federal dollars. State dollars included \$742,438 for the Driver Education and Evaluation Program; \$5.62 million for prevention, intervention, and treatment services; and \$780,000 in Medicaid matching funds. Federal dollars included \$4.39 million in substance abuse block grant funding, \$1.78 million in Safe and Drug Free Schools and Communities Act (SDFSCA) funding, and \$886,184 in other federal categorical funding. OSA also received \$137,148 from other sources.

Funding Streams

There are at least 19 funding streams which pay for substance abuse services and prevention activities in Maine, only some of which flow through OSA. At least 15 federal funding streams flow from seven federal agencies (U.S. Departments of Health and Human Services, Education, Housing and Urban Development, Justice, Transportation, and Veterans Affairs, as well as the National Guard.) Maine’s major funding stream—the General Fund—flows through several state departments that are involved in substance abuse prevention and treatment activities (Departments of Mental Health, Mental Retardation and Substance Abuse Services; Human Services; Education; Corrections; and Inland Fisheries and Wildlife, as well as the Maine Arts Commission.) Maine has a major new source of funding—the excise tax on tobacco—that is available for school and community prevention activities.

Finally, there are unknown amounts of county, municipal, and private funds that support substance abuse services and prevention activities in Maine.

Coordination

A great deal of coordination exists among agencies involved with substance abuse services. One example of coordination is pooled funding. Maine began pooling funding for substance abuse prevention projects in 1995 when funds from the Substance Abuse Prevention Block Grant, SDFSCA Governor's Portion, and Title V of the Juvenile Justice and Delinquency Prevention Act were distributed through a collaborative request for proposals (RFP) process coordinated by OSA. In 1996, there was a second round of pooled funding, which also included the Maine Arts Commission. Forty-two programs throughout Maine have received funding for primary prevention projects through this integrated RFP process.

Another example of coordination is the Dirigo Prevention Coalition, a coalition of eight partners and twenty Executive Committee members representing diverse perspectives. Funded by a federal grant from the Center for Substance Abuse Prevention, Dirigo was created to better coordinate substance abuse prevention efforts and to make accessible what already exists. The partners include OSA, Communities for Children, the Bureau of Health, the Juvenile Justice Advisory Group, the Maine Arts Commission, the Maine State Health Education Coalition, the Maine Commission on Community Service, and the National Guard.

There also are a number of other cooperative efforts between agencies, including the following:

- Federal SDFSCA funds are administered by OSA in accordance with a memorandum of understanding with the Maine Department of Education. The Governor's portion of this funding supports a large percentage of the community based prevention programs in Maine, including funding for law enforcement partnerships which involve substance abuse prevention. Maine is the only state in the nation where the substance abuse agency has the authority over SDFSCA funds. This arrangement allows for the coordination of prevention programs and services. Maine should take pride in this unique arrangement that could be a national model for collaboration.
- There is a memorandum of understanding between OSA and the Bureau of Health to implement federal Synar requirements, which prohibit the sale of tobacco to minors. OSA also is working with the Maine Criminal Justice Academy, Maine Sheriffs' Association, and Department of Attorney General to spend funds generated by funds on underage tobacco purchases to provide police training through the Maine Criminal Justice Academy.

- OSA and the Department of Corrections are working on developing differentiated therapeutic intervention systems for adults and youth involved in the corrections system, developing regional networks of specialized substance abuse treatment providers, refining statewide juvenile offender substance abuse screening, and DARE officer training at the Maine Criminal Justice Academy. See pages 39-41 for a description of the therapeutic intervention systems and regional networks.

III. Discussion and Recommendations

The Substance Abuse Services System

Level of Attention, Funding, and Resources

The Task Force believes that adequate resources and funding are essential to the effectiveness of Maine's substance abuse services system. Maine law (5 MRSA, chapter 521) requires an integrated approach to substance abuse and designates the Office of Substance Abuse (OSA) as the single administrative unit with responsibility for planning, developing, implementing, coordinating, and evaluating all of the State's substance abuse prevention and treatment activities and services. The law specifies that other state agencies must cooperate fully with OSA and provides that OSA must report to the Legislature on an annual basis. In spite of these provisions, the Task Force finds that mechanisms are needed to ensure that substance abuse policies and issues receive an appropriate level of attention throughout the Executive Branch and at the Legislature.

The Task Force is concerned that in recent years OSA has experienced significant changes in its structure and position in Maine State Government. Previously, OSA was located in the Governor's Office. Now it is in the Department of Mental Health, Mental Retardation, and Substance Abuse Services. Substance abuse issues also are under the jurisdiction of several other state agencies, including the Departments of Corrections, Education, Human Services, Public Safety, and Transportation.

Under the current structure of the Legislature, substance abuse issues are considered by several different joint standing committees, including Appropriations and Financial Affairs; Banking and Insurance, Criminal Justice, Education, Health and Human Services, Judiciary, Legal and Veterans' Affairs, Transportation, and others. The Joint Select Committee on Substance Abuse has provided an effective mechanism for addressing substance abuse issues in a coordinated fashion.

Need for Knowledge

Also essential to the effectiveness of Maine's substance abuse services system is knowledge about substance abuse (including prevention) by those who come in contact with persons with alcohol, tobacco, and other drug problems. Educators, law enforcement personnel, medical care providers, mental health providers, and social workers all deal with the multifaceted issues of substance abuse. The Task Force believes that people receiving services from these professionals have a right to expect that all possible causes of their

problems will be considered. Substance abuse issues need to be addressed by professionals who have knowledge about substance abuse prevention, indicators, treatment, and available services. Substance abuse training currently is not included in standard curricula for these professions. Professional regulatory boards need to consider substance abuse training as a condition of licensure or certification.

One way to enrich Maine's knowledge base about substance abuse is to have Maine's university system and colleges involved in substance abuse research. Maine is a unique laboratory for testing new approaches in prevention and treatment. It is small enough in population to make research projects manageable in their focus. Maine's geographical issues mirror larger states with services to rural populations—only on a more manageable level. The Task Force is interested in increasing the capacity of Maine's university system and colleges to secure grants from the Substance Abuse and Mental Health Services Administration and other federal agencies to address barriers to services experienced by Maine people. University sponsorship often is required in order for Maine to receive certain federal substance abuse funds.

Consumer Voice

The Task Force believes that a strong consumer voice also is a key ingredient of an effective substance abuse services system. This voice includes current consumers of substance abuse services, recovering substance abusers, and family members. It needs to be a composite of the voices of people from the diverse groups affected by substance abuse. OSA already has created a formal mechanism (Quality Improvement Councils) for involving consumers in the planning and policy-making process. There also needs to be an independent consumer voice. Other New England states (Connecticut, Rhode Island, and Massachusetts) have promised public money to help develop this independent voice. The federal Center for Substance Abuse Treatment is committing \$3,000,000 over each of the next three years toward the development of local education and advocacy groups run by and for recovering people. The Task Force supports efforts in Maine to strengthen the consumer voice.

Recommendations

1. Resources and Funding Expand resources to fund substance abuse initiatives. Develop resources from all available sources including: reallocating state General Fund revenues; making changes in state tax policies; successfully applying for federal grants; building municipal support; and obtaining private sector grants and donations from businesses, foundations, and other philanthropic organizations.

2. Position of OSA. Implement mechanisms to ensure that OSA is appropriately positioned in State Government and that substance abuse issues receive an appropriate level of attention in both the Executive and Legislature Branches. Ensure full compliance with current Maine law that requires state agencies to cooperate with OSA. Ensure that all state agencies which spend funds on substance abuse services notify OSA at least annually about all expenditures of state, federal, and other dollars for these services. Require that OSA report directly to the Legislature's Joint Select Committee on Substance Abuse and/or other Joint Committees on the substance abuse services budget and the use of substance abuse resources, as well as the status of Maine's substance abuse system.

3. Joint Select Committee. Continue to bring together representatives of the Legislature's policy committees into the Joint Select Committee on Substance Abuse, so they can examine substance abuse issues in a coordinated manner. The Task Force has identified a number of significant issues requiring further study, which the Joint Select Committee should examine:

- The status and outcomes of primary prevention programs across Maine, how these programs are funded, and how they can collaborate to work more effectively and efficiently. See recommendation 20.
- Training regarding substance abuse, including substance abuse prevention, as a requirement for educators, law enforcement personnel, medical care providers, mental health providers, and social workers to obtain or renew licenses and certifications.
- The need for certification standards for prevention specialists. See recommendation 21.
- Drug testing by employers, including screening for alcohol. See recommendation 42.
- The capacity to perform research in substance abuse, including strengthening OSA's link with Maine's universities, colleges, and researchers at the federal level.

4. Consumer Initiative. Support the development of an independent consumer initiative in Maine that can play an active role in the discussion and resolution of substance abuse issues.

<i>Strategies and Services Embracing <u>All</u> Groups</i>

Quality and Availability of Services

I found myself...with an opportunity to grow and change. It was important for me to realize that I was one of the lucky ones...I was one of 13 women in the State of Maine fortunate enough to be in the house at that time. I was sober and in an environment that supported my sobriety...The staff believed in me when I wanted to give up on myself. They loved me unconditionally ...This house has been my shelter from the chaotic life I was living. I was given the time to grow and another chance at life. I'm filled with gratitude and love for this house...Now life is worth living! Resident graduating from a halfway house for women.

[I am] happier than I ever was...I don't obsess about alcohol, I don't wake up in the morning and wonder where I'm gonna get my booze...They taught me to iron clothes. To feed myself. To be honest. To trust other people. To talk to people. They taught me to live. Graduate of a treatment program for youth.³⁰

At [the halfway house], I learned how to cope, to grow, to share, to confront, to problem solve, to be responsible for myself and to others. I learned how to get a job and keep a job. I learned to be honest, I learned how to work my program and eventually to live my program...In the 13 years which have passed since I had my last drink/drug, I have returned to college and earned a bachelor's and master's degree. I have a meaningful career. Friends have died drunk, sober, and even committed suicide. Others have continued in their struggles—in and out of detoxes; in and out of psychiatric hospitals. Others have maintained sobriety and gone on to do excellent work in their respective careers... No matter what has happened, I have not needed to drink or drug. Graduations, weddings, funerals, super bowls, college, camping, 4th of July, New Year's Eve, Christmas, etc.—all sober—every time. It's very possible and very much worth all of your effort, all of your tears, all of the pain. Former resident of a halfway house for women.

As the preceding statements attest, Maine's substance abuse programs and services are not only important, but often are life-saving to the people trying to recover from alcoholism and other drug addiction. Unfortunately, there has been a decline in availability of these services. The lack of resources is a barrier for many Maine people—particularly those who are uninsured (the working poor). The key to improving availability is to increase or reallocate funding for substance abuse strategies and services.

Defining Continuum of Care

The Task Force reviewed Maine’s substance abuse prevention and treatment system in terms of its completeness and seamlessness, based on valuable input from diverse groups from throughout the State. The Task Force has defined *continuum of care* as a comprehensive network of prevention strategies, treatment modalities, and other services designed to meet the changing needs of the community and embracing all of its population groups, and has identified the continuum’s components, as illustrated on page 25. The components are described in greater detail in Attachment E.

Gaps in Continuum

The Task Force believes that Maine’s substance abuse services are effective for the people they help. The problem is that there are major service gaps in the continuum of care, which means that many people do not receive the care they need.

In 1997, 10,607 adults were admitted for treatment, while an estimated 75,600 needed treatment.³¹ Thus, an estimated 64,993 adults did not receive treatment. Programs throughout Maine have waiting lists, as illustrated in the following examples as of early November 1998:

- In Limestone, there is a long-term residential facility with capacity for 11 adults and children. There are 7 people on a one month waiting list. The people who seek the services of this facility are generally poor and on the street with no other alternatives.
- At a small youth program in Hallowell, no openings are expected for many months—unless a current resident runs away.
- In Portland, there is a 31-bed halfway house for men. There are 14 people on the waiting list who can expect a 4-6 week wait before being admitted.

Gaps in the continuum of care are the most alarming problems that exist in Maine’s substance abuse service system. The Task Force believes that a complete continuum is the foundation of an effective service system.

Continuum of Care: Definition and Components

A comprehensive network of prevention strategies, treatment modalities, and other services designed to meet the changing needs of the community and embracing all of its population groups.

- I. PREVENTION**
 Information Dissemination
 Education
 Alternatives

Problem Identification & Referral
Community-Based Process
Environmental Focus

II. INTERVENTION

Driver Education & Evaluation Program
Employee Assistance Programs

III. SHELTER

Emergency
Extended Shelter
Support Services

IV. DETOXIFICATION

Medical
Support Services
*includes: Referral Services
Transportation*

V. TREATMENT

Residential Rehabilitation
Long Term Treatment
*includes: Therapeutic Communities
Halfway Houses
Extended Care*
Outpatient Services
*includes: Individual Counseling
Group Counseling
Intensive Services
Family Therapy*
Support Services
*includes: Child Care
Transportation*

VI. CONTINUING CARE

Transitional Housing
Consumer Run Housing
Support Services

Managed care has affected the methods, location, and duration of substance abuse services. In addition, changes in OSA's priorities over the past several years and legislative cuts in funding have contributed to abbreviated levels of inpatient treatment.

Inpatient stays are shorter (four to seven days), and most treatment now is provided on an outpatient basis (for example, day treatment, partial hospitalization, and group or individual therapy.) There often is a delay between the time an individual leaves one level of inpatient care and moves to the next, because there are no beds immediately available at the next level of inpatient care due to long waiting lists. For this individual, residential

rehabilitation, extended shelter, and/or other supportive service is required so that treatment can be continued. Without the needed inpatient resource available, the individual who has begun treatment will not succeed in maintaining long-term recovery and will find it more difficult to achieve a healthy lifestyle.

Gaps for Children and Youth

The Maine Children's Alliance has reported that prevention programs continue to be inadequate in size and scope. Adolescents, especially in rural areas, indicated the need for safe, drug-free places to socialize.²

Prevention programs in Maine are primarily aimed at children and youth. Effective prevention programming needs to look at the norms, values, and policies in place in communities, families and schools regarding alcohol and other drug use. Prevention needs to address adult and community behavior, as well as youth behavior. Without a serious attempt to change the norms and behaviors of the adult population, no long term impact is going to be made on youth regarding their use of alcohol or other drugs. Therefore, prevention programming needs to be expanded to include all age ranges and not just concentrate on youth.

As described on page 39, when youths enter the juvenile justice system, they are referred for an initial screening and then an assessment, depending on the severity of their use. The Task Force found that screening and assessment generally are not available for youth who are not part of the juvenile justice system. In order to determine the need for and level of treatment, screenings—using a thorough assessment tool—need to be available to all identified youth in need, whether they are in the juvenile justice system, school, or a recreational facility. By increasing the access and availability of this early intervention, young people will receive referrals to appropriate counseling and treatment.

In Maine, 54 agencies are licensed to provide adolescent substance abuse outpatient treatment. However, there is only one OSA-funded long term treatment center located in southern Maine. Its twelve-bed capacity is inadequate to meet the needs of Maine's adolescents who need long term treatment. Existing outpatient treatment capacity for adolescents also is limited. Finally, there is a lack of transitional housing opportunities. Without intensive support from their peers and the community at large, adolescents are likely to relapse into addiction.

Diversity

Alcohol is such a devastating thing in our community. I've carried a lot of caskets to

the grave and it's heartbreaking because most of them were preventable. Clayton Cleaves, Health Planner, Passamaquoddy Tribe at Pleasant Point³³

In this report “diversity” is an inclusive term used to highlight the fact that there is no typical person who needs substance abuse services. The Task Force heard from representatives of many special population groups affected by substance abuse: adolescents (including alternative school students and at risk youth); elderly persons; gays and lesbians; homeless persons; methadone users; Native Americans; opiate addicts; persons who are deaf and hard of hearing; persons who have a dual diagnosis of substance abuse and mental illness; persons with mental retardation; and women.

The Task Force learned that there is not a complete continuum of care for the members of any of these groups and that they often are isolated from the rest of the community. This isolation has an impact on their tendency to abuse substances, as well as on their level of comfort in seeking treatment in the mainstream community.

Those who are members of special populations often are left out of the continuum of care completely. For example, a substance abuser who is deaf and seeking treatment often finds it difficult to find a safe place for treatment where s/he can be counseled by someone who is trained in substance abuse services and is a member of the deaf community or is culturally sensitive to that community.

The Task Force learned that there is a strong need for greater understanding of and respect for diversity. The substance abuse provider community needs to be more inclusive and responsive to the needs of people from diverse groups. The Task Force believes that diversity awareness is essential to effective services. Often substance abuse services are not well suited for the members of special population groups.

Medicaid

The Task Force has two primary concerns relating to Maine's Medicaid Program. First, the State is not taking full advantage of Medicaid funding to support the costs of substance abuse services for Maine's low income people. Second, the Task Force is concerned about how substance abuse will be addressed as part of managed care for Medicaid recipients. As Medicaid moves toward managed care, the use of research-based outcomes is important to the development of the substance abuse treatment system that will be available to the members of these plans. Research-based outcomes are useful

in developing best practices regarding assessment of need for and appropriate type and length of treatment.

Protection Connection

The problem is overwhelming. We see everything from parents who spend all their money on booze to parents who use alcohol to loosen their inhibitions and have sex with their children. Sandy Hodge, Supervisor, Maine Department of Human Services³⁴

Be totally honest? Tell them how bad I messed up? DHS will never let me have my children home...I worried sick about how I'd ever find a place to live or pay for stuff in storage. My children needed me. I had to find a way to talk to DHS. Resident of a halfway house for women.

Many children and adults involved in the Department of Human Services (DHS) protective systems, as well as their parents or guardians, have substance abuse problems. As the table on page 29 indicates, a number of those needing treatment are referred to substance abuse providers by DHS caseworkers.

However, those referred by DHS for substance abuse treatment are a small portion of those in need. Recent welfare reform legislation limits welfare payments for most recipients to five years. Of the approximately 16,000 people receiving Temporary Assistance to Needy Families (TANF), about 1,600 are in need of substance abuse services.

DHS has the statutory leverage to refer people into treatment, but existing enforcement mechanisms are not being utilized fully. OSA and substance abuse providers need to work with DHS and the Department of Attorney General to increase training for caseworkers and supervisors in order to increase their recognition of substance abuse, as well as their enforcement of and referrals to substance abuse treatment.

DHS Referrals to Substance Abuse Treatment

	1994	1995	1996	1997
Adult Protective				
Inpatient	0	2	0	2
Outpatient	10	7	11	21
Detoxification	2	0	1	0
Subtotal	12	9	12	23

Child Protective				
Inpatient	11	34	32	25
Outpatient	217	215	215	220
Detoxification	1	3	3	0
Subtotal	229	252	250	245
Substitute Care				
Inpatient	0	1	0	2
Outpatient	8	10	9	15
Detoxification	1	0	0	3
Subtotal	9	11	9	20
Total	250	272	271	288

These numbers are unduplicated and include both primary substance users/abusers and other affected clients.

Recommendations

5. Assessment and Funding Assess the extent to which substance abuse services within each component of the continuum of care are needed in each region of Maine. In order to ensure access to substance abuse strategies and services by diverse groups of Maine people, provide funding and other assistance, in proportion to population and geography, to support all components of the continuum of care in each region.

6. Youth Screening and Services Increase access to and availability of substance abuse screening tools and assessments for youth. Establish one additional long term treatment facility for adolescents, as well as alternative services for youth (including but not limited to intensive outpatient treatment, family therapy, home-based family therapy, and gender-specific treatment). Increase the availability of transitional housing for youth. Make sure that all services are geographically accessible to all youth in need.

7. Staffing. Recruit and retain appropriate and adequate staffing throughout the continuum of care. Coordinate resources to help non-profit substance abuse service agencies retain competent staff and to prevent the migration of their staff to other private sector organizations.

8. Barriers and Support Services Address barriers to treatment and ensure the existence and consistency of support services throughout Maine and throughout the continuum of care. Help substance abuse providers establish or link up with support services that meet the needs of the people they serve (for example, transportation, child care, and interpreter services). Develop a statewide model to provide guidance to substance abuse providers about how

to secure support services, how to address the needs of special populations, and how to avoid stereotyping.

9. Reaching Special Population Groups Institute action-oriented outreach programs that target isolated populations, in order to open avenues to treatment for population groups that are isolated from mainstream programs and services. In order for members of special population groups to access treatment from someone who shares their special needs and culture, target substance abuse education and training opportunities (for example, scholarships, internships, university-level courses, and training provided through OSA programs) to these groups.

10. Respect for and Training in Diversity Develop and carry out a media campaign to encourage respect for diversity. Develop a standard curriculum that focuses on cultural diversity and make licensing of substance abuse providers contingent upon completion of this curriculum.

11. Medicaid. Maximize the use of Medicaid funding to support the costs of substance abuse services for Maine's low income people. Design managed care for Medicaid recipients that is based on outcomes research and on the substance abuse treatment system developed by OSA.

12. Protection. Provide training for DHS caseworkers and supervisors, as well as for assistant attorneys general to improve their recognition of substance abuse, to make sure they understand confidentiality, and to underscore their responsibility to refer people for substance abuse treatment. Increase referrals to substance abuse treatment by DHS.

Publicly Intoxicated People at Risk

Legislation and Study Group

The 118th Legislature considered but did not enact legislation (LD 753) to allow law enforcement officers to take into custody persons who are publicly intoxicated if those persons refuse to be transported to a safer place. The primary impetus for the bill was a lawsuit against Westbrook involving a person who was publicly intoxicated, refused transport except to a coffee shop, and ultimately was injured fatally by an automobile.

At the Legislature's request, OSA formed a group of representatives from the Maine Sheriffs' Association, Maine Chiefs of Police, Maine Hospital Association and Maine Association of Substance Abuse Providers (including persons in recovery and their families) to assess the magnitude of the problem. During the summer and fall of 1997, the group conducted an

inventory of existing resources; carried out an assessment of the extent of the problem of public intoxication in Maine, and developed recommendations. Fifty-six (43% of all) sheriffs and chiefs of police responded to a survey developed by OSA.

Survey Results Concerning Adults

The survey revealed that for adults, public intoxication does not involve large numbers, but is widespread in both rural and urban areas. There were approximately 5,283 cases, of which 2,436 (46%) were repeat offenders. York, Cumberland, Kennebec, Somerset, Androscoggin, and Penobscot counties accounted for 80% of these reported incidents. Except for Androscoggin, they also accounted for the highest number of repeat offenders.

The survey revealed that the current service system cannot meet the needs of these people. Current treatment resources for publicly intoxicated adults include detoxification services, emergency shelter, and extended shelter. State funded detoxification programs/shelters are available in only Cumberland and Penobscot counties. Extended shelter is available only in Androscoggin, Cumberland, and York counties. There are 85 beds statewide for people who are indigent. The survey revealed that of the publicly intoxicated adults picked up by police over the course of a year, approximately 238 were transported to shelters or detoxification programs. Another 742 were transported to their homes and the rest were transported to hospitals, police stations, or elsewhere. While an additional 89 detoxification beds are available in Maine, they generally are available to clients who have a source of reimbursement (usually Medicaid, sometimes insurance)—not to indigents.

Survey Results Concerning Adolescents

The survey indicated that approximately 1,833 juvenile offenses (of which 655 were repeat offenders) came to the attention of sheriffs and police due to public intoxication. Most were in Androscoggin, Cumberland and York counties. Approximately 64% of these cases were resolved by returning the juveniles to their parents or guardians. There are no shelters for intoxicated adolescents. In any event, adolescents require a different response than adults.

Involuntary Commitment Option

Prior to the late 1980s, there was an option in statute for the involuntary commitment of people whose substance abuse represented a danger to themselves. The statute was used infrequently, in part because the receiving facility—the place to which to commit a person—was not defined. There have been several requests to reconsider this option. In 1991, model legislation was developed to create an involuntary commitment law for substance abusers

who were a severe and imminent danger to themselves. Although the legislation had broad support, both in 1991 and again when it was reintroduced in 1994, it did not become law.

The Task Force believes that involuntary commitment is necessary for very small number of people to ensure that they receive needed substance abuse treatment. Narrowly crafted legislation is needed to allow the involuntary commitment of people who abuse alcohol or other drugs, who are a danger to themselves, and whose lives are at risk. The legislation also needs to protect the civil rights of substance abusers.

Recommendations

13. Involuntary Commitment Enact legislation to allow the involuntary commitment of individuals in need of substance abuse services who are a danger to themselves and whose lives are at risk.

Prevention

Why Do We Need Prevention?

Substance abuse is costly, harmful, and damaging to youth. Nationally, it is estimated that the direct monetary costs of alcohol and illicit drug use are approaching \$200 billion and tobacco use is estimated to cost another \$88 billion. As noted previously, the annual cost of substance abuse in Maine is estimated to be \$1.2+ billion—\$916 for every man, woman, and child in Maine.³⁵ This does not begin to account for the suffering and burden on those whose well-being is affected directly or indirectly by substance abuse.

Studies have shown that preventing problematic substance use can be an important component in helping reduce both the social and economic costs of substance abuse. Research suggests that for every dollar spent in preventing illicit drug use, there is a fifteen dollar savings in dealing with the consequences of drug use and addiction.

Risk Factors and Domains

With my father having left us when I was 7, and with most of my childhood blank, I can say that the biggest influence was that of being lost...What I learned I learned either from friends, the streets, my mother, other relatives (male), or occasional men in my mother's life. The end result of all that 'random education' was that I was so screwed up I really didn't have any kind of grasp of what being a man was. I've always wondered who I was, whether anything I thought or

anything I held as values was me or a jumble of thoughts and emotions gained by osmosis from the environments and the people encountered from there to here. What part of me was me? It's been a deep hole to dig out from. At least though, I'm starting to see a faint light...I've got a long journey ahead.
A young resident of a group home for men.

In the past, substance abuse prevention programs have focused primarily on children and youth. The issue of substance abuse prevention is complex and needs to be addressed on many fronts. Simply targeting children and youth for prevention programs will not adequately address the issue. Research has shown that effective prevention programming needs to target four domains: family, school, community, and individuals/peers³⁶. OSA has carefully analyzed the extent of risk factors for the use of alcohol, tobacco, and other drugs (ATOD) statewide³⁷:

- In the community domain, two-thirds of 6th to 12th grade students believed that alcohol, tobacco, and marijuana were easy or very easy to obtain. Eighty percent of adolescents believed they would not be caught by the police for marijuana or alcohol use.
- In the family domain, a third of adolescents reported a family member with a severe alcohol or drug problem, which may be under reported. The same study found that half of all adults had an alcoholic family member and 20% had a family member who use illegal drugs. Interestingly, 96% of parents said they had clear rules for ATOD use by their children, while 80-90% of junior high and only 73% of senior high students said their families had clear rules.
- In the individuals/peers domain, the study found a strong correlation between ATOD use and both early initiation of drug use and friends who used ATOD. There is also a clear attitudinal shift as youth move from elementary to junior and senior high school. Almost all elementary school students say that ATOD use is wrong. For 6-12th grade students, only 54% thought that drinking was wrong, 55% thought that smoking cigarettes was wrong, and 69% thought that smoking marijuana was wrong.

Healthy Conditions for Healthy Children and Youth

[Adults must help children] have a sense of power and purpose in their lives—we must find ways to allow a kid to turn to the light.
Michael Clifford, Director, Safe and Drug Free Schools, Portland³⁸

Raising happy and healthy children and youth in Maine requires close collaboration among adults who create the conditions in which young people

must live. Families, schools, communities and peers create a context in which children and youth thrive or fail on their way to maturity.

There are four requirements essential to the healthy development of children and youth:

- Community norms that promote connectedness and bonding among families;
- Meaningful participation in the larger life of the community;
- Clear and consistent policies followed by logical consequences; and
- Appropriate interventions for youth struggling with alcohol, tobacco, and other drug problems, as well as treatment of substance abuse.

Other conditions important to the healthy development of children and youth include:

- Supportive relationships with caring adults and peers;
- Services to support youth newly in recovery from substance abuse problems;
- A mutual and observable respect between youth and adults; and
- Efforts focused on youth involvement in a responsible, productive society.

Current legal and social conditions preclude meaningful youth participation in the legislative process. Unable to vote and lacking the resources to hire lobbyists, young people typically are passive recipients or targets of legislation. Leading prevention research recommends meaningful participation in community affairs as a strategy for increasing youth bonding to community values and raising self-esteem.³⁹ Through schools and libraries, the means are now available for youth to be informed about legislation that affects them. Youth input on proposed legislation not only would offer legislators useful insights, but it also would help Maine youth develop citizenship skills.

Alternative Schools

Dropping out of school correlates with other negative outcomes including substance abuse and violence.⁴⁰ Alternative schools and programs provide opportunities for students to complete school successfully and to break the cycles in their families and communities which engender substance abuse. Prevention interventions that focus on creating conditions for social bonding are beneficial to youths at the highest risk of drug abuse. Enhancing opportunities, skills, and rewards for positive social involvement increase the likelihood that these youths will become socially bonded to “pro-social” people and to “pro-social” courses of action.

Alternative schools and programs have demonstrated their effectiveness in providing opportunities for youth at-risk to break out of the cycle of failure and despair. A 1990 survey of Iowa's alternative school graduates indicated that⁴¹:

- 72.2% of graduates whose families had been receiving public assistance were not themselves receiving public assistance since graduation and were living independently;
- 54.4% of graduates were employed full time and 17.2% were homemakers (in contrast, 58.3% of school dropouts were unemployed); and
- 45% of graduates had completed some form of post-secondary education.

An alternative school here in Maine has produced the following outcomes⁴²:

- 75% of students with former criminal justice involvement do not recidivate after graduation;
- 80% of students (who are former dropouts) graduate; and
- 75% report a decrease in all high risk behaviors in three years after graduation.

Support for Communities

There are limited federal and state grants available for communities that want to develop substance abuse prevention programs. However, the Task Force finds that there is a need not just to maintain current levels of funding, but to expand opportunities for prevention education programs in traditional and alternative schools and in communities.

Along with additional grant funding for prevention programs, a revolving loan fund would be helpful, from which communities could borrow money at a low interest rate. Communities could use loans as start-up money for prevention initiatives. The amount of each loan could be capped and available on a first come, first served basis. As money is repaid, it would become available for other community programs. Communities would be expected to sustain programs on their own as they repaid their loans.

The Task Force believes one role of Maine State Government should be to continue to assist communities in their substance abuse related prevention efforts. At one time, responding to individual community requests for technical assistance, training, and community organizational issues was a function of OSA's Prevention Team. Due to several factors, including downsizing, current staffing does not allow for onsite consultation and technical assistance to all the communities that request such services. OSA should continue to be a leader in providing up to date, effective, and cutting

edge information and technical assistance to Maine citizens and communities as they address substance abuse related prevention issues. OSA needs to redevelop a system of technical assistance to boost existing levels of community knowledge and experience and to help them plan and implement prevention efforts.

As evidenced by the turn out at the study circles throughout the state, there is great interest in addressing substance abuse related problems and issues. However, communities and individuals cannot do this alone. They need assistance in defining the nature of the problem in their particular community, effective strategies to deal with the issues, and appropriate methods of evaluating programs. A system of service delivery needs to be redeveloped to maintain and improve the quality of prevention programming to meet increasing demands within the state.

Study Circles

During October 1997, *The Portland Newspapers* ran a series of lead articles about alcoholism in Maine. Readers responded with many letters, calls, and requests for reprints. A coalition began to meet to plan a statewide response. Called “Maine Communities Face Alcohol”, the response provided an opportunity for communities to host one or more series of study circles, which were a group of people who met for a 4-week period to discuss the newspaper series. Each study circle had a trained facilitator whose job it was to keep the group on task and to make sure that meeting ideas were recorded. The goals of the study circles were to discuss the nature and extent of the problems within individual communities and then to develop action plans to address the problems.

There have been approximately 70 study circles. On October 4, 1998, there was a summit of people involved in the study groups to celebrate and develop next steps. The Task Force believes that the study circles have been an important and valuable community effort. They need modest continued financial support in order to continue and thrive.

Need for Inventory

At the same time, there needs to be an inventory of Maine’s prevention efforts and dollars. The Task Force believes that there is an interconnectedness of prevention across disciplines. For example, the elements of effectiveness for substance abuse prevention are the same as the elements for HIV prevention, violence prevention, crime prevention, and a host of other social problem and disease prevention. Several state agencies currently promote prevention activities. There is a need to: 1) identify the funding sources of all existing primary prevention efforts, including dollars allocated by public, non-profit,

and private sources; 2) identify prevention efforts across all disciplines and all state agencies; and 3) determine how prevention programs can build networks, increase funding opportunities, and work together more effectively.

Prevention Certification

Nationally, there is an effort to develop standards to certify “prevention specialists.” This has occurred as the field of prevention has gained standing as a profession requiring specific skills, knowledge and abilities. The expansion of managed care demands that prevention program providers be qualified as a condition of reimbursement by insurance companies. The development of credentialing standards will enhance the credibility and professional stature of those working in the field of prevention.

Underage Drinking

Drinking by underage youth, and associated problems that arise as a result of that behavior, have not been addressed adequately on a unified, state level. Programs currently exist which could be implemented statewide in private and public universities, colleges and technical schools. A task force needs to be formed to assess existing programs and to recommend how to slow down the momentum of abusive drinking at the post-secondary level.

Recommendations

14. Youth Participation Create opportunities for youth to participate in the development of legislation and policies that affect their lives.

15. Prevention Programs Expand substance abuse prevention programs in traditional and alternative schools and communities statewide.

16. Revolving Loan Fund Develop and maintain a revolving loan fund at OSA to assist communities with start up funds for substance abuse prevention.

17. Technical Assistance Develop a system to ensure that technical assistance in program development, grant writing, and coalition building in relation to substance abuse issues is available to all Maine communities. See recommendation 3.

18. Study Circles Develop funding partnerships with other public and private organizations to support the continuation of coalitions involved in efforts such as the study circles.

19. Public Awareness Campaign Conduct a public information campaign to develop awareness of the devastating effects of alcohol and other drug abuse and to encourage individuals and communities to take action.

20. Inventory. Review the status and outcomes of primary prevention programs across Maine, how these programs are funded, and how they can collaborate to work more effectively and efficiently. See recommendation 3.

21. Prevention Specialists Study the issues related to certification standards for prevention specialists in Maine. See recommendation 3.

22. Drinking by Post-Secondary Students Establish a Task Force comprised of representatives from Maine's public and private post-secondary schools with the mission to address underage and abusive drinking by students.

Services for Juvenile Offenders

Need for Substance Abuse Treatment

Many of Maine's juvenile offenders are substance abusers and need substance abuse treatment. The current treatment capacity cannot provide services to all of the juvenile offenders in need of treatment. In addition to the availability of a continuum of services and monitoring, substance abuse treatment providers with the clinical skills to work effectively with the juvenile offender substance abusing population are not generally available and easily accessible in the four Juvenile Corrections Regions of Maine⁴³

During the current fiscal year (beginning July 1, 1998), OSA and the Department of Corrections have committed to screening 2,000 juvenile offenders who remain in the community and 220 who are remanded to the Maine Youth Center. Based on previous screening results, 70%, or 1,550 of these adolescents, will need substance abuse treatment. In 1997, treatment providers served 962 adolescents in total. A third of these are already juvenile offenders. Even assuming that the treatment system's capacity is under used, an annual expansion of 460% in the number of adolescents needing substance abuse treatment is impossible to absorb with current resources.

Although the existing substance abuse treatment resources provided by OSA and the Department of Corrections at both the community and institutional levels are impressive and among the most innovative in the nation, these resources are not adequate to reduce substance abuse and its related criminal behavior by juvenile offenders.

Regional Treatment Networks

Fifty-four agencies are licensed to provide adolescent substance abuse treatment in Maine. Most of these agencies also serve adults. Existing capacity for all age groups at any given time, however, is used fully or almost fully. In

response to the unmet need for treatment, OSA, the Department of Corrections, and community-based treatment providers have formed four regional networks to increase treatment capacity. The elements of these networks are as follows:

<i>Elements of Regional Treatment Networks</i>
1. Standardized substance abuse screening for treatment needs for all juveniles entering the system.
2. Centralized data collection and analysis.
3. A differentiated evaluation and treatment system based on three factors (treatment need, criminal risk, and responsiveness to treatment).
4. Improved communication between treatment providers and Department of Corrections juvenile caseworkers.
5. A cross-training program to establish research-based best practices.
6. A collaborative model for addressing identified groups in the treatment system.

Most treatment providers are part of the networks and these providers serve most of the offenders receiving community-based treatment. The networks provide treatment for community based juvenile offenders and continuing care for juvenile offenders released from the Maine Youth Center. During 1997, an average of 31% of network caseloads consisted of juvenile offenders. They report that they cannot increase capacity for juvenile offenders unless they significantly decrease capacity for other adolescents or adults.

There are three major issues of concern relating to the networks. First, there is inadequate treatment capacity to meet the substance abuse treatment needs of juvenile offenders. Second, within the networks there is no standardized evaluation and referral component to insure client matching with treatment services and to facilitate client access to treatment. Third, there are inadequate long-term residential therapeutic community resources (only one, in Hollis).

National Model

The Task Force identified a national model that has been bridging the gap between substance abuse and corrections for over twenty-five years (Treatment Alternative to Street Crime). This model provides for uniform evaluation of all juveniles identified by the screening system; client matching with the proper network treatment provider; and facilitation of access to treatment for the youth and family. This or other models could be modified to meet Maine's needs and could be an integral component in the existing treatment networks.

Maine Youth Center

For the youth at the Maine Youth Center, OSA is funding a differentiated substance abuse treatment program, designed as indicated on page 41. There are four major issues of concern related to this treatment program.

First, chronic substance abusers (about 20% of the Youth Center’s population) are not provided the intensity of treatment necessary to address their substance abuse. Substance abuse is not considered a primary treatment issue. Second, there is inadequate transitional housing available for youth leaving the Youth Center designed to treat substance abuse as a primary issue. Third, existing transitional housing has inadequate substance abuse treatment services and often is not linked to the comprehensive network of providers. Fourth, additional treatment capacity will be needed when the northern Maine Youth Center opens.

<i>Differentiated Substance Abuse Treatment Program</i>
1. Screens for substance abuse in all youth admitted to the Youth Center.
2. Provides a full evaluation for those identified by the screening.
3. Assessments consider three factors critical to treatment placement (treatment need, criminal risk, and responsiveness to treatment).
4. Has developed a differentiated model that includes education and awareness programs, a brief intervention program, and an intensive treatment program for chronic users.
5. Is highly motivated and cognitive-behavioral in approach.
6. Provides for transition into community-based treatment networks.

Recommendations

23. Differentiated Program Complete OSA’s development of and fully implement the comprehensive differentiated program of evaluation and treatment for juvenile offenders who are substance abusers. Ensure that the program is carried out through the regional treatment networks and the southern and northern Maine Youth Centers.

24. Funding for the Networks Provide stable, long term funding through OSA to the regional networks to increase differentiated treatment capacity to meet the unmet treatment needs of juvenile offenders who are substance abusers and living in the community. Cover the services of providers who are

willing to participate in formal network operations and who specialize in the diagnosis and differential clinical treatment of juvenile offenders who abuse substances. Also use funding for:

- Critically needed family treatment and intensive outpatient treatment services;
- Long-term residential therapeutic communities for adolescents;
- The development by OSA of programs in each of the four Department of Corrections regions, based on proven national model(s); and
- Data collection and program evaluation.

25. Funding for the Institutions Provide stable, long term funding through OSA to implement a differentiated therapeutic intervention program at the southern and northern Maine Youth Centers. Ensure that the program has differential content, duration, and intensity for addressing substance abuse clinically as a primary condition related to criminal behavior.

26. Juvenile Drug Court Implement Juvenile Drug Court projects in each of the four Juvenile Corrections Regions through a collaborative process involving the Judicial Department, Department of Attorney General, District Attorneys, Department of Corrections, and OSA. Use the treatment capabilities of the regional treatment networks.

Services for Adult Offenders

Inadequate Substance Abuse Intervention

It's troubling, if not alarming, that in a state where 79% of the inmates have some connection to alcohol abuse, we don't offer them any treatment. Michael Cantara, York County District Attorney⁴⁴

Maine's adult prison population is not receiving adequate substance abuse intervention and treatment. Maine's adult corrections system is in need of a comprehensive, differentiated substance abuse treatment program in combination with defined regional networks of providers having a specialty in working with the substance abusing adult offender. Maine's criminal justice system does not have a comprehensive strategy for ensuring that substance abusing or addicted offenders are compelled to undergo programs of treatment during their arrest and incarceration time. In addition, community-based substance abuse treatment is needed for adult offenders on probation.

Comprehensive Services Needed

The Task Force finds that there is a need for comprehensive substance abuse services for adult offenders who are substance abusers or addicts. At a minimum, these components are required:

- Every offender is screened within 30 days of intake and is scheduled and designated to the most appropriate substance abuse differential level of treatment.
- For offenders who are incarcerated, there is a five-level differentiated therapeutic intervention program. Levels I-IV are in each adult prison facility. Each level differs in content, duration, and intensity. Offenders who are substance abusers are assigned to the appropriate level based on differential diagnosis. Level V is an in-prison Intensive Residential Therapeutic Community, serving the entire prison system, that is located within a host prison but operated separately from the general population. It treats the adult offenders diagnosed as being at a severe level of addiction; having a high correlation between substance abuse and criminal behavior; and having a therapeutically acceptable level of motivation for treatment. The offender spends twelve of the last eighteen sentence months in Level V.
- For offenders who have received treatment at Level III, IV or V, a pre-release residential transition treatment center provides six months of treatment.
- For adult offenders in the community, including those in need of continuing care when released from one of the prison-based treatment programs, the four regional treatment networks offer differential diagnosis, differentiated clinical treatment, relapse prevention, intervention, and other treatment. As described under the discussion about juvenile offenders, a network of substance abuse providers is located in each of the four regions of the Department of Corrections (DOC). Each network is an affiliate of the DOC's Regional Resource Centers. Network functions need to be augmented by emergency substance abuse services contracted through OSA.

Drug Court

Maine has only one Drug Court, which operates in Cumberland County under a federal grant. Known as Project Exodus, the Drug Court serves a corrections function, since program participants either are on probation or would be on probation if they were not legally participating in treatment pursuant to post-conviction bail.

Recommendations

27. Comprehensive Services Provide stable, long term funding through OSA for a seamless, comprehensive adult offender substance abuse service which includes:

- Screening for all offenders;
- A five-level differentiated therapeutic intervention program for offenders in prison;
- A residential pre-release transitional treatment center for offenders who are in prison;
- Services provided through regional networks for adult offenders in community corrections; and
- Process and outcome evaluation.

28. Assessment. Through collaboration involving OSA, the Maine Sheriffs Association, and the Department of Corrections, assess the need for substance abuse treatment for offenders serving sentences in county jails. Pay special attention to treatment for incarcerated OUI offenders. If necessary, develop best practices models for substance abuse treatment in county jails.

29. Drug Court. Continue the Drug Court pilot project for adult offenders in Cumberland County and expand it to three additional sites in Maine through a collaborative process involving the Judicial Department, Department of Attorney General, District Attorneys, Department of Corrections, and OSA. Use the treatment capabilities of the regional networks.

Public Safety

Operating Under the Influence

Until I got the OUI, I was able to keep up the appearance of being a successful attorney. After my arrest, I realized I was no different from the bum on the street with the same disease. John McElwee, recovering alcoholic and former Aroostook County District Attorney⁴⁵

According to the Maine Secretary of State and the Maine State Police, operating under the influence is a significant problem. In 1996, 37.5% of all traffic fatalities in Maine involved alcohol. Maine drivers with a blood alcohol content of 0.15 or more are 200 times more likely to be involved in a fatal crash than the average non-drinking driver. Operating under the influence (OUI) of alcohol is most serious among drivers between 15 and 44 years of age. The use of alcohol by underage people while operating vehicles remains

a problem within Maine. OUI “minor administrative suspensions” increased by 55.6% from 1995 to 1997 (from 531 to 826). It should be noted that the law changed from .02 blood alcohol content to zero tolerance and that there has been stricter enforcement with the new law.

The chronic drinker and driver and the driver who continues to drive following license suspension, create a serious threat to highway safety in Maine. Hard-core drunk drivers who are also repeat offenders, constitute a very small number of drivers, but account for a disproportionately large share of drunk driving problems. According to Maine’s Secretary of State, the severity of drunkenness and numbers of repeat offending drunken drivers appears to be increasing.

Illicit Drugs

According to the U.S. Department of Justice, the use of illegal drugs is an increasing problem throughout Maine:

- Marijuana is the most widely used illicit drug in Maine. Like tobacco and alcohol, it is considered a gateway drug leading to the use of other drugs and the commission of other crimes.
- Heroin availability and use is increasing in Portland and Lewiston and has begun to appear in Bangor, Brunswick, and Rockland. Law enforcement estimates that there are 500-1,000 heroin users in Portland.
- Crack cocaine use is increasing in Portland and Lewiston with some now in Bangor. Among people receiving OSA-funded services, the number of cocaine/crack users increased by 27.0% over a three-year period from 189 in 1994 to 240 in 1997.
- Methamphetamine is appearing in Maine. Wholesale quantities recently have been seized in Aroostook County. Maine is considered an ideal location for the manufacture of this substance because of its rural population.

Recommendations

30. OUI Task Force Create a Law Enforcement OUI Task Force, comprised of representatives of the Secretary of State, State Police, and county and local law enforcement agencies, to:

- Develop comprehensive joint action plans to combat the alcohol and/or other drug intoxicated driver.
- Investigate policies and procedures adopted by other states regarding chronic drunk drivers who operate a motor vehicle after license suspension.

- Determine the extent to which the use of marijuana and other drugs is involved in motor vehicle accidents and fatalities in Maine.
- Submit a plan to the Governor and legislative committees having jurisdiction over transportation and criminal justice matters by September 1, 1999, and report on the effectiveness of the plan by January 1st of each year thereafter.

31. Young Driver Legislation Require the Secretary of State and Bureau of Highway Safety to report to the legislative committees having jurisdiction over transportation and criminal justice matters by January 15 of each year on results and recommendations relating to the effectiveness of the Young Driver Legislation passed in 1998.

32. DEEP Legislation Develop legislation to allow more flexibility in the design of the Driver Education and Evaluation Program, so that changes can be made when indicated by research, best practice, and evaluation.

33. Training Make training in the use of the intoxilyzer machine, Horizontal Gaze Nystagmus, and advanced OUI recognition techniques a mandatory requirement of Basic Police Training.

34. Drug Enforcement Funding Restore funding to the Maine Drug Enforcement Agency to the 1992 level of \$1.72 million, to support the Agency's efforts on behalf of local communities.

35. Drug Flow Control Direct the Maine State Police and Maine Drug Enforcement Agency to develop and execute a Joint Plan for Illicit Drug Flow Control, designed to provide Maine Law Enforcement Officers with training to enhance their skills in identifying and prosecuting offenders.

36. Training Expand training at the Maine Criminal Justice Academy to focus on the recognition of drug trafficking, drug recognition, and expanding threats to law enforcement officers from the hazards of clandestine drug laboratories. Provide grant funds for local communities, so they can expand Drug Recognition Training for local law enforcement officers.

37. Tracking and Information Enhance the capability of the Maine State Police to track and identify suspected and convicted drug offenders and to provide pertinent data to all local and county law enforcement agencies.

Private Sector Responses to Substance Abuse

Health Insurance

One fourth of Maine adults who need substance abuse treatment do not have health insurance. Among those who needed treatment, 60.6% had private insurance coverage (though it is not known if substance abuse services are covered) and 12.3% had government-funded insurance (Medicare, Medicaid, and Veterans Administration benefits):⁴⁶

Health insurance policies typically provide less coverage and benefits for substance abuse and mental illness than for physical conditions and illnesses. Recently, some states and the federal government have begun to require that mental health and/or substance abuse treatment have "parity" with treatment for other medical conditions. "Parity" means that mental health and/or substance abuse treatment must be covered by insurance companies in the same manner as other medical care.

Maine is one of twelve states that has enacted a "parity" law for mental illness. The law requires that group insurance coverage for groups of twenty or more persons provide benefits for biologically-based mental illnesses, like schizophrenia and major depressive disorder, under the same terms and conditions as physical illness. "Parity" is also necessary for substance abuse treatment so that health insurance companies provide substance abuse benefits in the same way that benefits are provided for physical conditions and illnesses. Currently, five states have "parity" laws for substance abuse treatment: Arizona, Maryland, Minnesota, North Carolina (for state employees only) and Vermont. The Task Force believes that Maine should be the sixth state to enact such a law.

A recent study conducted for the federal Substance Abuse and Mental Health Services Administration on the costs and effects of providing parity for mental health and/or substance abuse estimated that the average insurance premium increase for substance abuse parity only would be 0.2%. The premium increase for full parity for both mental health and substance abuse was estimated to be 3.6% on average.⁴⁷

While current Maine law does not require "parity" for substance abuse treatment, the law does require a minimum level of benefits for alcoholism and drug dependency treatment to be provided in traditional fee-for-service group health insurance policies covering twenty-one or more persons. However, there is a deficiency in the law because it does not apply to the managed care plans of health maintenance organizations (HMOs).

Managed Care

Maine, like the rest of New England and the nation, has experienced a shift in health insurance coverage from traditional fee-for-service plans to managed care. More and more people in Maine are receiving their health insurance

through HMOs. Statistics show that at the end of 1997, 21.25% of Maine's insured population was enrolled in managed care plans. Based on the higher percentage of HMO penetration in the other New England states, that number can be expected to increase to as much as 45% in the future⁴⁸

As more Maine people have become enrolled in managed care, the frustrations of both enrollees and health care providers have grown. Substance abuse service providers are often frustrated with the utilization review standards used by managed care plans and their application by utilization review case managers who frequently are not knowledgeable about substance abuse treatment issues. There is a need to revise these standards to reflect criteria that increase the chance of positive treatment outcomes and to reflect the medical necessity guidelines adopted by the American Society for Addiction Medicine.

Research has shown that length of stay in treatment is directly related to a positive treatment outcome⁴⁹, but most managed care reviewers rarely approve treatment lengths supported by the research data. Those who review and approve substance abuse treatment for various managed care plans need training in substance abuse treatment.

Employee Assistance Programs

In 1997, there were 28 Maine employers with Employee Assistance Programs (EAPs) approved by OSA.⁵⁰ The Task Force found that the quality of EAPs in Maine varies widely and that more needs to be done to encourage and support the development of EAPs that provide a variety of core technologies, rather than just counseling. The core technologies include consultation, training and assistance for managers, supervisors, and union stewards; confidential and timely assessment services for employees with personal concerns that may affect job performance; use of short-term intervention and counseling; referral services for treatment; benefits consultation to the employer with regard to mental health and substance addiction coverage; and identification of the effects of EAP services on the employer.

There have been instances where individuals and counseling agencies have held themselves out as EAPs without any EAP certification and without practicing any of the core technologies. Licensing is one method to ensure that there are quality EAPs throughout Maine. Currently, North Carolina and Tennessee have enacted laws to license EAP professionals, and legislation is under consideration in five other states. The license requirement is aimed at ensuring more consistent quality among EAPs.

The Task Force is concerned that the current Maine law and rules relating to EAPs and work place drug testing are too cumbersome and, as a result, may

discourage the development of these policies and programs by some employers.

Drug Testing

According to the state Bureau of Labor Standards, 122 employers out of a total of 147 with approved substance abuse testing policies conducted drug tests in 1997.⁵¹ A total of 13,097 tests were conducted, including 12,616 on job applicants (with 375 confirmed positive tests); 7 for probable cause (one positive test); and 474 employee random or arbitrary tests (with 16 positive tests). Of the 122 employers, 35 included alcohol as part of their test screening panel; 3,111 tests were screened for alcohol (with 8 were positive tests—7 job applicants and 1 random.)

Many people believe that it is necessary and appropriate to test employees for alcohol as part of drug testing as a means of identifying employees in need of substance abuse services. Others are concerned about the legal and privacy issues related to testing for a legal substance, especially if employers are conducting random testing of employees with no other indication that job performance is impaired. The Task Force believes that more study is required.

Recommendations

38. Insurance Laws Amend Maine’s health insurance laws to require “parity” benefits for substance abuse treatment under the same terms and conditions as benefits for physical conditions and illnesses. If the Legislature does not require parity benefits for substance abuse treatment, amend the current law mandating coverage for substance abuse treatment to require coverage in HMO plans and to require coverage in all individual and group insurance policies.

39. Utilization Review Revise utilization review standards, based on the “medical necessity” guidelines adopted by the American Society for Addiction Medicine. Require training in substance abuse treatment for those who review and approve managed care plans.

40. Employee Assistance Programs Improve the quality of EAPs by encouraging the development of programs that use the core technologies and by initiating state licensing for qualified and certified EAP professionals.

41. Streamlining Encourage employer participation, by streamlining the statutory and regulatory provisions governing EAPs and drug testing policies. Amend 26 MRSA, chapter 7, subchapter III-A (Substance Abuse Testing) to increase its effectiveness so that more employers will develop fair, equitable, and responsible drug testing and EAP programs.

42. Screening for Alcohol Examine the issues related to drug testing by employers, including screening for alcohol. See recommendation 3.

Endnotes

- ¹ “The Deadliest Drug: Maine’s Addiction to Alcohol,” *The Portland Newspapers*, Portland, ME. (Oct. 19-26, 1997).
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- ³ “Substance Abuse Prevention: Maine’s 1997 Prevention Data Report,” report by the Office of Substance Abuse, Maine Department of Mental Health, Mental Retardation, and Substance Abuse Services, Augusta, ME. (December 1997).
- ⁴ Milkman and Wanberg. (1997).
- ⁵ “Evaluating Recovery Services: The California Drug and Alcohol Treatment Assessment,” report by the California Department of Alcohol and Drug Programs and National Opinion Research Center, CA. (April 1994). Swartz, Lurigio, and Slomka, “The Impact of IMPACT: An Assessment of the Effectiveness of the Cook County Jail’s Substance Abuse Treatment Program,” Chicago, IL. (1994.) Join Together: “Fixing a Failing System: How the Criminal Justice System Should Work with Communities to Reduce Substance Abuse,” MO. (Feb. 1996).
- ⁶ “The Deadliest Drug”.
- ⁷ Census Data File STF3A, Table P57, 1990.
- ⁸ Office of Substance Abuse Data System.
- ⁹ Ibid.
- ¹⁰ Bureau of Justice Assistance in 1995.
- ¹¹ Maine Communities Face Alcohol: The Deadliest Drug, 9/98.
- ¹² “The Deadliest Drug”.
- ¹³ Ibid.
- ¹⁴ Ibid.
- ¹⁵ “Alcohol, Tobacco, and Other Drugs: Potential Savings,” report by the Center for Substance Abuse Prevention.
- ¹⁶ “Past year heavy alcohol use” means 5 or more drinks for a man or 4 or more drinks for a woman in a 24-hour period at least once a week in the past year or 4 or more days in each month. “Past month heavy alcohol use” means 5 or more drinks for a man and 4 or more drinks for a woman in a 24-hour period or on 4 or more days in a month.

- 17 “Executive Summary, State of Maine Substance Abuse Treatment Needs Assessment: Alcohol and Other Drug Household Estimates Study,” report by the Office of Substance Abuse, Maine Department of Mental Health, Mental Retardation, and Substance Abuse Services, Augusta, ME. (1997).
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- 21 Based on 1995 Population Estimates, Women Aged 18 and over.
- 22 Census Data File STF3A, Table P57, 1990.
- 23 “The Deadliest Drug”.
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- 25 Ibid.
- 26 John J. DiJulio, “Broken Bottles, Alcohol, Disorder and Crime.” (1996).
- 27 Milkman & Wanberg, 1997.
- 28 Greenwood & Deschenes, 1993.
- 29 See endnote 5.
- 30 “The Deadliest Drug”.
- 31 “Executive Summary, State of Maine Substance Abuse Treatment Needs Assessment: Alcohol and Other Drug Household Estimates Study.”
- 32 *Kids Count Data Book*, (Augusta, ME: Maine Children’s Alliance, 1997).
- 33 “The Deadliest Drug”.
- 34 Ibid.
- 35 “Alcohol, Tobacco, and Other Drugs: Potential Savings,” report by the Center for Substance Abuse Prevention.
- 36 Hawkins, Catalano, “Communities that Care.” Bernard, “Fostering Resiliency.” Lofquist, “New Designs for Youth Development .”
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- 38 “The Deadliest Drug”.

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- 41 “The Costs of Dropping Out of School and the Productivity Benefits of Returning and Graduating: A Survey of Iowa's Alternative School Graduates.” (Nov. 1990).
- 42 The Community School, Camden, ME.
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- 48 Farrah and Associates, *New England HMO Monitor* ,Volume 497.0.
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- 50 Ladd, “Report to the 118th Legislature on the Substance Abuse Testing Law for Calendar Year 1997”, report by the Maine Department of Labor, Bureau of Labor Standards, Augusta, ME (March 1998)
- 51 Ibid.

Attachment A

Joint Order Establishing the Joint Select Committee on Substance Abuse

HP 1579, as amended by Senate Amendment (S-466)

Ordered, the Senate concurring, that pursuant to Joint Rule 351, the Joint Select Committee on Substance Abuse, referred to in this order as the committee, is established and consists of 10 members of the House of Representatives appointed by the Speaker of the House and 3 members of the Senate appointed by the President of the Senate. The first Senate member named is the Senate chair. The first House member named is the House chair.

The committee shall review the issues related to substance abuse and recommend a means by which future legislatures can address these issues in a coordinated fashion.

Sponsored by: Representative E. Mitchell
Town: Vassalboro

Cosponsored by: Senator Lawrence
County: York

Attachment B

Task Force Members

From the Joint Select Committee on Substance Abuse:

Senator John Benoit
Senator Beverly C. Daggett, Co-Chair *
Representative Michael Brennan, Co-Chair
Representative Joseph Brooks
Representative Paul Chartrand
Representative Peter Cianchette
Representative Thomas Davidson
Representative Thomas Murphy, Jr.
Representative Julie Ann O'Brien
Representative Wendy Pieh
Representative Judy Powers
Representative Harry G. True *

* also a member of the Substance Abuse Services Commission

From the Substance Abuse Services Commission:

Michael Clifford
John Coffey
Pat Conner
Ray Cook
William Earle
Ray Fannin, Jr., MD.
Susan Gendron
Margaret Jones
Paul McDonnell
John McElwee
Dana Mosher
Emanuel Pariser, Chair
Sandra Scott

Attachment C

Subcommittee and Coordinating Committee Members

Coordinating Committee

Emanuel Pariser, Chair
Rep. Michael Brennan, Co-Chair
Sen. Beverly Daggett, Co-Chair
Patricia Conner
Paul McDonnell
Rep. Harry True
Lynn Duby, *OSA Director*

Children and Youth Subcommittee

Raymond C. Cook, Chair
Raquel Boehmer
Michael Clifford
Susan Ann Gendron
William Earle
Margaret Jones
Joanne Joy
Rep. Wendy Pieh
Rep. Judith Powers
Rep. Harry True
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Public and Private Partnerships Subcommittee

John Coffey, Chair
Rep. Paul Chartrand
Rep. Peter Cianchette
Rep. Thomas Davidson
Dr. Ray Fannin, Jr.
Dana Mosher
Rep. Thomas Murphy
Ross Pears
Neil Rolde
Kimberly Williams
Cherry Denno, *OSA Staff*

Continuum of Care Subcommittee

Rep. Joe Brooks, Co-Chair
Sandra Scott, Co-Chair
John Attean Davis, Sr.
Bob Duranleau
David Green
Layne Gregory
Ellis King
Gail MacMullen
Paul McDonnell
Emanuel Pariser
Luanne Rhoades
Carol Solouki
Marjorie Stone
Brenda Wentworth
Priscilla Williams
Joanne Ogden, *OSA Staff*

Criminal Justice and Public Safety Subcommittee

Sen. John Benoit, Co-Chair
Patricia Conner, Co-Chair
Nanci Bouchard
David McDermott
John McElwee
Rep. Julie O'Brien
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Attachment D

Subcommittee and Coordinating Committee Process

Coordinating Committee

The Task Force formed four Subcommittees to carry out its work. In addition, it created the Coordinating Committee to facilitate the review of work emerging from the Subcommittees and to identify and develop recommendations not addressed by the Subcommittees.

Continuum of Care Subcommittee

The Continuum of Care Subcommittee met six times during June, July and August. The first two meetings were organizational and placed some focus on defining continuum of care. The committee then held meetings to hear presentations from representatives of several special population groups, including: adolescents, including alternative school students and at risk youth; elderly persons; gays and lesbians; homeless persons; Native Americans; opiate addicts and methadone users; persons who are deaf and hard of hearing; persons who have a dual diagnosis of substance abuse and mental illness; persons with mental retardation; and women. The Subcommittee also heard from residential care providers and representatives of Mercy Hospital's Recovery Center.

The Subcommittee asked the presenters to frame their discussion around four questions which were provided to them in advance:

1. What services currently exist for your particular special population?
2. What services are working to meet treatment and prevention needs? Which are not working and why?
3. What do you perceive as the major gaps in services for this population?
4. If you had one recommendation to make, what would be your priority for treatment and prevention for this population?

Children and Youth Subcommittee

The Children and Youth Subcommittee met five times during June through August. Meetings were held either at OSA or at the Dirigo Prevention Coalition in Augusta. Initial meetings consisted of organizational tasks and the review of research, articles, and relevant data with regard to youth and

substance abuse. Subsequent meetings placed a greater focus on the development of recommendations.

Criminal Justice and Public Safety Committee

The Criminal Justice and Public Safety Subcommittee was formed to examine the issues and costs that substance abuse brings to the State's courts, prisons and community police departments. The subcommittee held five meetings, including two public hearings focusing on enforcement, sentencing, and corrections. The subcommittee heard presentations from invited participants from the District and Superior Courts, county sheriffs and jail administrators, United States Attorney's Office, Department of Corrections, Maine State Police, Maine Drug Enforcement Agency, prosecutors, and defense attorneys. The presenters provided valuable input and suggestions regarding ways to improve the State's response to substance abuse issues in the areas of law enforcement, adjudication and sentencing, and corrections.

Public and Private Partnerships Committee

The Public/Private Subcommittee was formed to examine the private sector response to the problems of alcoholism and abuse of other drugs and how this relates to efforts in the public sector. In its discussions, the Subcommittee focused on formulating recommendations in three primary areas: (1) third-party insurance coverage of substance abuse treatment and managed care's effect on substance abuse treatment; (2) access and funding to substance abuse treatment; and 3) Employee Assistance Programs. The Subcommittee met five times to complete its work.

Attachment E

Definitions of Continuum of Care Components and Services

Prevention: Includes six primary prevention strategies targeted, as appropriate, to particular groups of people. The strategies include

- *Information dissemination:* Provides awareness and knowledge of the nature and extent of alcohol, tobacco, and other drug use and addiction and their effects on individuals, families, and communities. Also provides knowledge and awareness of available prevention programs and services. Information dissemination is characterized by one-way communication from the source to the audience, with limited contact between the two. Examples include clearinghouse/information resource centers, resource directories, media campaigns, brochures, radio/TV public service announcements, speaking engagements, health fairs/promotion, and information lines.
- *Education:* Involves two-way communication and interaction between an educator/ facilitator and participants. Activities aim to affect critical life and social skills, including decision-making, refusal skills, critical analysis (e.g. of media messages), and systematic judgment abilities. Example include classroom and/or small group sessions, parenting and family management classes, peer leader/helper programs, education programs for youth groups, and children of substance abusers groups.
- *Alternatives:* Provides for the participation of targeted youth in activities that exclude alcohol, tobacco, and other drug use. Based on the assumption that constructive and healthy activities offset the attraction to, or otherwise meet the needs usually filled by alcohol, tobacco, and other drugs. Examples include drug-free dances and parties, youth/adult leadership activities, community drop in centers, and community service activities.
- *Problem Identification and Referral:* Aims at identification of those who have indulged in illegal/age-inappropriate use of tobacco or alcohol and those people who have indulged in first use of illicit drugs in order to assess if their behavior can be reversed through education. Does not include any activity designed to determine the need for treatment. Examples include employee assistance programs, student assistance programs, and driving under the influence/intoxicated education programs.

- *Community-Based Process:* Aims to enhance the ability of the community to provide substance abuse prevention services more effectively. Examples include community and volunteer training, systematic planning, multi-agency coordination and collaboration, accessing services and funding, and community team building.
- *Environmental Focus:* Establishes or changes written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of substance abuse in the general population. Includes a focus on legal and regulatory initiatives and on service and action-oriented activities. Examples include promoting the establishment and review of alcohol, tobacco, and other drug use policies in schools; technical assistance to communities to maximize local enforcement procedures governing the availability and distribution of alcohol, tobacco, and other drugs; modifying alcohol and tobacco advertising policies; and product pricing strategies.

Shelter: Provides food, lodging, and clothing for people who abuse alcohol and other drugs, with the purpose of protecting and maintaining life and motivating them to seek substance abuse treatment. Shelters are a pre-treatment service, usually operated in connection with a detoxification component. At a minimum, shelter is provided 12 hours per day.

Extended Shelter: Provides a structured treatment environment for people who are on a waiting list for substance abuse treatment, or who either have completed a detoxification program or are otherwise not in need of detoxification services, and who need a social support system to enable them to remain chemical free for a period before returning to the community or moving to another treatment modality.

Detoxification: Provides people with acute problems related to withdrawal from alcohol or other drugs with immediate assessment, diagnosis and medically assisted detoxification, as well as medical treatment for other acute illnesses. These programs must provide for appropriate referral and transportation for continuing treatment. Services are provided on a 24-hour basis.

Residential Rehabilitation: Provides a scheduled treatment program in a 24-hour setting, which consists of diagnostic, educational, and counseling services. These programs must refer people to support services, as needed. People are routinely discharged to outpatient services for aftercare counseling and support.

Therapeutic Community: Provides an age-appropriate, structured environment in a residential facility in combination with professional clinical services to support and promote recovery. Residents generally are characterized as having chaotic, unsupportive, and often abusive relationships, extensive treatment or criminal justice histories, and little or no work history or educational experience. Programs are characterized by their reliance on the treatment community as a therapeutic agent that introduces and enforces appropriate social values and behaviors, as well as by their focus on reintegration of the resident into the greater community, with particular emphasis on employment and education. Treatment is specific to maintaining abstinence and preventing relapse, but also vigorously promotes personal responsibility and positive character change.

Halfway House: Provides age-appropriate treatment and supportive services in a chemical-free, community-based residential program for people involved in a recovery process. These programs offer services which vary in intent and intensity, depending on the needs and nature of the people they serve. They prepare people for reentry into the community.

Extended Care: Provides a long-term supportive and structured environment for individuals with extensive alcohol and drug-related debilitation and, possibly, exacerbation of mental health problems. These programs require sustained abstinence and provide specialized treatment in a supervised living experience. Outcome goals range from custodial care to further treatment services and recovery. The term of residency is usually more than 180 days.

Outpatient Services: Provides assessment, treatment, case management, and referral to other services. Services may be provided to families or other concerned persons, whether or not the primary abuser is receiving treatment. Treatment may include individual and groups counseling, as well as presentations that are educational or skill building in nature.

Intensive Outpatient Services: Provides an intensive and structured program of alcohol and drug assessment, diagnosis, and treatment services. These services include a structured sequence of multi-hour clinical and educational sessions scheduled for three or more days a week with a minimum of nine hours a week.

Family Therapy: Regularly scheduled sessions for families and affected others of people with alcohol or drug problems. Sessions may be with individuals, entire families, or groups of families, and generally address coping and personal growth issues.

Transitional Housing: A community-based group living environment for people in transition from a residential treatment setting into the community or as an interim safe residence while awaiting admission to a residential facility. People may receive services outside from community-based agencies or, in some cases, may receive services within this service setting.

Consumer Run Housing: A group living environment in which people share responsibility for managing the household. Some people have co-existing disorders of mental illness and substance abuse and receive case management from community-based services.

Attachment F

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Attachment G

Important Information about Substance Abuse in Maine

“Alcohol and Other Drug Use by Adults in Maine: A Risk and Protective Factor Analysis,” report prepared for the Office of Substance Abuse by the Margaret Chase Smith Center for Public Policy, University of Maine, Orono, ME. (October 1996).

“State of Maine Alcohol and Other Drug Use: An Assessment of Students in Grades 6-12 Risk and Protective Factors,” report prepared for the Office of Substance Abuse by the Substance Abuse Services, Center for Students and Community Life, University of Maine, Orono, ME. (October 1996).

“State of Maine Alcohol and Other Drug Use: An Assessment of Students in Grades 6-12, Risk and Protective Factors,” report prepared for the Office of Substance Abuse by the Health Impact Group, Substance Abuse Services, University of Maine, Orono, ME. (August 30, 1995).

“State of Maine Substance Abuse Treatment Needs Assessment: Alcohol and Other Drug Household Estimates Study,” report by the Office of Substance Abuse, Maine Department of Mental Health, Mental Retardation, and Substance Abuse Services, Augusta, ME. (September 28, 1998).

“Substance Abuse Prevention: Maine’s 1997 Data Report, County Profiles on Risk and Protection for Substance Abuse Prevention Planning,” report by the Office of Substance Abuse, Maine Department of Mental Health, Mental Retardation, and Substance Abuse Services, Augusta, ME. (December 1997).

“The Voices of Hope” report by Maine Communities Face Alcohol: The Deadliest Drug, South Portland, ME. (1998).