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Committee To Study Court-ordered Treatment for Substance Use Disorder

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Office of Policy and Legal Analysis

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Committee To Study Court-ordered Treatment for Substance Use Disorder

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Executive Summary

The 130th Legislature established the Committee To Study Court-ordered Treatment for Substance Use Disorder (referred to in this report as the "committee") through the passage of Resolve 2021, chapter 183 (see Appendix A). Pursuant to the resolve, 16 members were appointed to the committee (a list of committee members can be found in Appendix B), which was charged with the following duties:

1. Review services and processes currently available in this State for persons with substance use disorder;

2. Review options offered in other jurisdictions for persons with substance use disorder, including but not limited to judicial orders for involuntary treatment as well as other treatment options that include some form of leverage to ensure adherence to treatment, and review outcomes;

3. Review the constitutional and other rights of persons with substance use disorder and how other jurisdictions protect those rights; and

4. Develop recommendations for treatment options for persons with substance use disorder, including implementation plans.

Substance use disorder is a growing problem that has touched the lives of many Maine residents. This committee was tasked with studying court-ordered treatment as a method to combat this problem. Throughout its work, the committee focused on the duties with which it was charged; however, a discussion of court-ordered treatment options necessarily includes discussion of broader policy and practical issues relating to substance use disorder. As further explored in this report, the committee learned that many challenges exist in the current treatment system in Maine that often make voluntary treatment extremely difficult to obtain. Moreover, the committee recognized that an additional court-ordered process to establish involuntary treatment might have little to no benefit if resources are not available to support that process.

Over the course of its work, the committee developed the following recommendations.

Recommendation #1: the Legislature should build on existing efforts to change how addiction is viewed in the State and should adopt statewide policies that destigmatize substance use disorder and increase compassion towards individuals with substance use disorder, including alcohol use disorder, and individuals with co-occurring disorders.

Recommendation #2: the Legislature should increase funding and continue to fund access to services at every level of treatment for individuals with substance use disorder, including alcohol use disorder, and individuals with co-occurring disorders.

Recommendation #3: the Legislature should set an expectation that each of Maine's health care facilities has an important role in treating individuals with substance use disorder, including alcohol use disorder, and individuals with co-occurring disorders and that each of Maine's health care facilities has the capacity and training to treat substance use disorder as a medical condition within available resources.

Recommendation #4: the Legislature should explore options for expanding the availability in Maine of multiple treatment modalities to provide evidence-based treatment for substance use disorder, including alcohol use disorder, and individuals with co-occurring disorders, including, but not limited to, motivational interviewing, contingency management, medication assisted treatment for all substance use disorders, home health and community-based services and recommendations for discharge planning that provide treatment outside of the hospital setting.

Recommendation #5: the Legislature should support education around the elements of the definition of "likelihood of serious harm" as it may apply to individuals with co-occurring disorders, including substance use disorder, as evaluated under the State's involuntary hospitalization and involuntary civil commitment processes.

I. INTRODUCTION

During the Second Regular Session of the 130th Legislature, the Joint Standing Committee on Judiciary considered LD 2008, sponsored by Representative Colleen Madigan. LD 2008 proposed to establish a court process to require a person with substance use disorder to participate in substance use disorder treatment. An amendment to the bill, supported by a majority of the committee and finally passed as Resolve 2021, chapter 183 (see Appendix A), changed the bill into a resolve to study court-ordered treatment for substance use disorder.

Pursuant to that resolve, 16 members were appointed to the committee: three members of the Senate appointed by the President of the Senate, including members from each of the 2 parties holding the largest number of seats in the Legislature; three members of the House of Representatives appointed by the Speaker of the House, including members from each of the 2 parties holding the largest number of seats in the Legislature; one member appointed by the Governor; one member representing hospitals, appointed by the President of the Senate; one member representing substance use disorder treatment providers, appointed by the Speaker of the House; one member representing families affected by substance use disorder, appointed by the President of the Senate; one member with lived experience with substance use disorder, appointed by the Speaker of the House; one member representing primary health care providers, appointed by the President of the Senate; one member representing hospital emergency department providers, appointed by the Speaker of the House; one member representing an organization whose primary mission is the protection of civil liberties, appointed by the President of the Senate; one member representing a statewide organization representing physicians, appointed by the Speaker of the House; and one member representing the Judicial Department, appointed by the Chief Justice of the Supreme Judicial Court. A list of committee members can be found in Appendix B.

In accordance with Section 3 of the resolve, the first-named Senate member, Senator Anne Carney, served as the Senate Chair, and the first-named House member, Representative Colleen Madigan, served as the House Chair.

The resolve set forth the following duties for the committee:

1. Review services and processes currently available in this State for persons with substance use disorder;

2. Review options offered in other jurisdictions for persons with substance use disorder, including but not limited to judicial orders for involuntary treatment as well as other treatment options that include some form of leverage to ensure adherence to treatment, and review outcomes;

3. Review the constitutional and other rights of persons with substance use disorder and how other jurisdictions protect those rights; and

4. Develop recommendations for treatment options for persons with substance use disorder, including implementation plans.

The enabling legislation charged the committee with submitting a report summarizing its activities and recommendations, including suggested legislation, to the Joint Standing Committee on Health and Human Services and the Joint Standing Committee on Judiciary by November 2, 2022. At the request of the committee, the Legislative Council approved the extension of that reporting deadline to no later than December 7, 2022.

The committee was authorized for and held four meetings, all of which were open to the public. Over the course of the first three meetings, the committee received presentations relevant to its duties from state government agencies, practitioners in the field of substance use disorder and other stakeholders. The committee also requested written public comment after the first committee meeting regarding whether Maine should adopt additional treatment options for persons with substance use disorder that involve some form of leverage to ensure adherence to treatment, including but not limited to judicial orders for involuntary treatment.[1] The fourth committee meeting was reserved for reviewing and discussing a draft study report and the committee's recommendations.

II. BACKGROUND INFORMATION[2]

A. Substance Use Disorder Nationally and in Maine

Substance use disorder is a growing problem nationally and in the state of Maine. While the headlines are often dominated by statistics related to the opioid epidemic, substance use disorder encompasses intoxicants beyond opioids, including alcohol. It should be noted that accurately capturing the full scope of the problem is challenging. Statistics providing alcohol-related fatalities are likely conservative in their estimations; alcohol may be a contributing factor in many deaths, but it may not be documented on the death certificate or other health record.

The societal costs of substance use disorder are significant, both in dollars and in human lives. In 2010, it was estimated that alcohol misuse cost the United States $249 billion and the cost of the opioid epidemic may be over $500 billion. In Maine, between 2010 and 2019, almost 2,700 individuals died from an opioid-related overdose and, in 2021, there were 631 fatal drug overdoses. Preliminary data shows that 667 Mainers died due to alcohol-related causes (disease or poisoning) in 2021.

[1] Written public comments submitted to the committee are available here: https://legislature.maine.gov/doc/9236.
[2] The data referenced in this part derives from several sources, specifically: the Maine State Epidemiological Outcomes Workgroup, www maineseow.com, and Tim Diomede's October 3, 2022, presentation: Alcohol and COVID-19 Pandemic in Maine and the Nation; Dr. Chris Racine's September 16, 2022, and October 3, 2022, presentations; the Maine Opioid Response: 2021 Strategic Action Plan; the Maine Monthly Overdose Report (August 2022); Maine's Department of Health and Human Services, Office of Behavioral Health; and Maine's Office of the Attorney General. *See* Appendices C, D, F and H-J.

The COVID-19 pandemic has impacted almost every aspect of our healthcare system resulting in both staffing and resource shortages and an increase in those seeking services. Alcohol misuse increased as well during the COVID-19 pandemic. Despite the conservative nature of the alcohol statistics, the data is alarming: nationally, one study found that deaths due to alcohol increased 25% between 2019 and 2020. In Maine, alcohol-related deaths increased more than 27% between 2019 (455 deaths) and 2020 (579 deaths). It is projected that approximately 8,000 additional deaths will occur nationally due to increased alcohol consumption during the pandemic; however, the full impact both nationally and in Maine is unknown.

B. Voluntary Treatment Resources in Maine

To combat substance use disorder in Maine, there are a growing number of resources available at various levels of care from licensed agencies and clinicians across the State. Treatment services provided on an outpatient basis include case management, treatment planning, individual and group counseling, family therapy, patient education, crisis intervention, recovery services, medication assisted treatment, medication management and discharge planning. Intensive outpatient programs are also available to provide treatment for substance use disorders and include a prearranged schedule of core services such as individual counseling, group therapy, family psychoeducation and case management.

Inpatient resources in Maine include residential program and inpatient detoxification services which are often provided by hospitals, although there are two non-hospital-based detoxification programs in Maine. Maine's residential substance use disorder treatment facilities and withdrawal and detoxification providers treat individuals seeking treatment voluntarily. The table below provides licensing data from the Department of Health and Human Services, Office of Behavioral Health for these voluntary substance use treatment facilities in Maine.

Service	Licensed providers
Medication management agencies (MAT)	66
Outpatient agencies and sites	357
Intensive outpatient providers	121
Residential facilities	19 (332 beds)
Withdrawal/detox providers	14
Methadone treatment providers	119

There are several new programs and initiatives designed to increase treatment resources in the State, which are more thoroughly described in Appendix C.

C. Involuntary Treatment Resources in Maine

i. Emergency Hospitalization and Involuntary Commitment

Involuntary hospitalization is provided by psychiatric hospitals, which are defined in statute.[3] Maine's Department of Health and Human Services currently has contracts with eight

[3] *See* 34-B MRS §3801(7-B).

"designated nonstate mental health institutions" to deliver involuntary hospitalization services, which include Southern Maine Health Care, Spring Harbor Hospital, Maine Medical Center, Mid Coast-Parkview Health, Pen Bay Medical Center, MaineGeneral Medical Center, St. Mary's Regional Medical Center and Northern Light Acadia Hospital. There are also two "state mental health institutes" – Riverview and Dorothea Dix Psychiatric Centers.

Maine law[4] provides a process for the emergency hospitalization of individuals on an involuntary basis. The application for emergency hospitalization is commonly referred to as the "blue paper." Under the law, an applicant may submit a "blue paper" stating the applicant's belief that a person is mentally ill[5] and, because of that person's illness, poses a likelihood of serious harm. "Likelihood of serious harm" in the emergency hospitalization context can be a substantial risk of physical harm to self, harm to others or "[a] reasonable certainty that the person will suffer severe physical or mental harm as manifested by recent behavior demonstrating an inability to avoid risk or to protect the person adequately from impairment or injury." [6] The application must include a medical practitioner's certification stating that the practitioner is also of the opinion that the individual is mentally ill and because of their illness poses a likelihood of serious harm. The practitioner must also state that adequate community resources are not available for the individual. The application is then submitted for judicial review and endorsement and, if the application is in accordance with the law, the individual is admitted to a psychiatric hospital.

In practice, space in Maine's psychiatric hospitals is limited and a bed may not be available when an individual receives a judicial endorsement for emergency hospitalization. An individual who has been "blue papered" may be held at the emergency room for an initial 24-hour period, and for additional periods of time subject to statutory requirements,[7] while efforts are made for placement at a psychiatric hospital. If an individual is found to no longer meet the statutory criteria for emergency hospitalization, they are released.

If a mentally ill person requires further hospitalization, the chief administrative officer of the psychiatric hospital may initiate an application for involuntary civil commitment,[8] which is commonly referred to as the "white paper." After the application is filed in District Court, a hearing date is set and the patient is examined by a medical practitioner who reports to the court on, among other things, whether the person is mentally ill and poses a likelihood of serious harm. The applicant must also show that inpatient hospitalization is the best available means of treatment after consideration of less restrictive treatment settings and modalities. The court may order commitment to a psychiatric hospital for no more than four months[9] if the court finds by clear and convincing evidence that the person is mentally ill and that the person's recent actions and behavior demonstrate that the person's illness poses a likelihood of serious harm; that

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[4] *See* 34-B MRS §3863.
[5] Mentally ill person is a defined term, see 34-B MRS §3801(5), and includes individuals suffering effects from the use of drugs, narcotics, hallucinogens or intoxicants, including alcohol.
[6] *See* 34-B MRS §3801(4-A).
[7] *See* 34-B MRS §3863(3).
[8] *See* 34-B MRS §§3863(5-A) and 3864.
[9] For a commitment proceeding after the first hearing, the time period may not exceed one year. *See* 34-B MRS §3864(7).

adequate community resources for care and treatment of the person's mental illness are unavailable; that inpatient hospitalization is the best available means for treatment of the patient; and that it is satisfied that with the individual treatment plan offered by the psychiatric hospital to which the applicant seeks the patient's involuntary commitment.

ii. Maine's Progressive Treatment Program

Maine law also establishes a process for court-ordered outpatient treatment, called the Progressive Treatment Program.[10] Patients with severe and persistent mental illness[11] that pose a likelihood of serious harm may, after application to the District Court, examination, and hearing, be ordered to comply with an individualized treatment plan. If the patient fails to comply with the conditions set forth in the court's order and is determined to present a likelihood of serious harm, the court may authorize the individual's emergency hospitalization in a psychiatric hospital.

D. Involuntary Commitment: Other States and Efficacy

As of 2018, 37 states including Maine, as described above, and the District of Columbia have adopted statutory provisions for the civil commitment of individuals because of substance use disorder. Due to their high utilization rates, Massachusetts[12] and Florida[13] are often cited as examples of state involuntary commitment programs. In 2018, the Commonwealth of Massachusetts involuntarily committed 6,048 individuals for substance use disorder. Florida involuntarily committed approximately 3,000 individuals in 2019. Additional information and other state data, including information on Kentucky's "Casey's Law" which was the model for LD 2008 as printed, may be found in Appendix D.

The committee was not charged with making a determination regarding the efficacy of involuntary commitment for substance use disorder; however, consideration of treatment data was necessary in discussing possible recommendations. As the committee discovered, the structure, utilization, data reporting and treatment approaches of state involuntary commitment programs vary, which makes evaluating efficacy data difficult. Studies often utilize small sample sizes, further complicating a meaningful comparison of state programs. Below is information received by the committee over the course of its meetings.

- A Florida study found that "successful completion" was similar between 100 involuntary and 219 voluntary participants.

- In one Massachusetts study, positive treatment experience and post-commitment medication treatment were correlated with longer post-commitment abstinence in persons who experienced civil commitment for opioid use disorder.

[10] *See* 34-B MRS §3873-A.
[11] *See* 34-B MRS §3801(8-A).
[12] *See* Massachusetts General Law Chapter 123, Section 35.
[13] *See* Florida Statutes Section 397.6811, the Marchman Act.

- In a study of patients in Minnesota, 6 out of 7 patients who were committed for substance use relapsed almost immediately after discharge.

Mental health providers hold differing opinions regarding the use of involuntary commitment. A national survey distributed by the American Psychiatric Association found that, based on responses from 739 members:

- 22% supported commitment for alcohol use disorders;
- 22.3% supported commitment for substance use disorders; and
- 62.9% supported commitment for psychosis.

The American Society of Addiction Medicine conducted a web-based survey of its physician members regarding civil commitment for substance use disorders and, based on 165 responses, found that 60.7% of addiction medicine providers supported the application of civil commitment for substance use disorder while only 21.5% reported being opposed.

III. COMMITTEE PROCESS

The committee held four meetings on September 16, October 3, October 24 and November 30, 2022. All meetings were open to the public and held using a hybrid format where committee members were able to participate either in person or by video using a remote meetings platform. Notice of each meeting was distributed to the committee's interested parties through a dedicated email distribution list available to the public. Each meeting of the committee was also livestreamed through the Legislature's webpage and materials from the meetings were posted to the committee's webpage[14] for public access. In accordance with the committee's authorizing legislation, below is a summary of the activities of the committee.

A. First Meeting, September 16, 2022[15]

The first meeting of the committee was held on September 16, 2022. The meeting began with opening remarks from the committee chairs and legislative staff provided an overview of the enabling legislation (Resolve 2021, chapter 183 in Appendix A), covering the duties, process and timeline for the committee's work. Committee members then provided extended introductions, focused on each member's perspective and connection to the issue of substance use disorder. As noted during the introductions by the committee's Senate Chair, Anne Carney, many of the members had requested to participate in the work of the committee and have personal or professional connections to the issues the committee was charged with considering.

[14] The committee's webpage is available here: https://legislature maine.gov/court-ordered-treatment-for-substance-use-disorder-study.
[15] The archived video of the meeting is available at the following link: https://legislature.maine.gov/Audio/#228?event=86478&startDate=2022-09-16T09:00:00-04:00.

The focus of the first meeting was on learning about the processes that are currently available in Maine for involuntary hospitalization and leveraged treatment. Assistant Attorney General, Molly Moynihan and Clinical Director at Dorothea Dix Psychiatric Center, Dr. Dan Potenza, provided an overview of Maine's involuntary hospitalization and civil commitment and Progressive Treatment Program laws. Attorney Moynihan described several of the key statutory definitions related to emergency hospitalization and involuntary commitment (colloquially known as the "blue paper" and "white paper" processes, respectively) and Dr. Potenza provided his perspective on how the definitions are applied in clinical practice. A copy of the presentation is available on the committee's webpage and is included as Appendix E.

The presenters and committee members focused their conversations on the applicability of the existing programs to individuals with substance use disorder, including alcohol use disorder. It was during this initial presentation that the committee began discussing the challenge that capacity represents in compelling treatment for substance use disorder, including alcohol use disorder. Dr. Potenza explained that each individual is evaluated on a case by case basis. While it is possible for an individual to continue to have reduced capacity even while receiving treatment, the committee learned that individuals with substance use disorder who initially qualify for emergency hospitalization due to their impairment often have restored capacity as the intoxicant leaves their system. When capacity is restored, there is an obligation to look for voluntary treatment options. Attorney Moynihan then provided an overview of the relevant statutes for Maine's Progressive Treatment Program (PTP) and the committee discussed how the PTP could be used by individuals with substance use disorder. For admission to the PTP, an individual must have a severe and persistent mental illness.[16] Although the statute identifies qualifying mental illnesses and does not specifically mention substance use disorder, the committee learned that the statute also provides that an individual with a combination of mental disorders sufficiently disabling to meet the criteria of functional disability may be considered to have a severe and persistent mental illness, and it is possible that this could apply to an individual with substance use disorder and a co-occurring mental health disorder depending upon their level of impairment.

The committee next received a presentation from Kevin Voyvodich, a managing attorney with Disability Rights Maine's MH Advocacy Program. Attorney Voyvodich discussed the constitutional issues that arise when an individual's civil liberties are taken away and directed the committee to several relevant Supreme Court cases[17] and a Maine Law Court case, *Doe v. Graham*, 2009 ME 88, 977 A.2d 391 (Me. 2009). Attorney Voyvodich noted that Disability Rights Maine has made available on its website an advanced health care directive for planning mental health care that, while not designed for substance use disorder, allows an individual to document their wishes in the event that they lose capacity. Materials referenced in Attorney Voyvodich's presentation are available on the committee's webpage.[18]

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[16] *See* 34-B MRS §3801(8-A).

[17] Attorney Voyvodich directed the committee to *Doe v. Graham*, Me. 88 (Me.2009), *Youngberg v. Romeo*, 457 U.S. 307 (1982) and *O'Connor v. Donaldson*, 422 U.S. 563 (1975), available on the committee's website here: https://legislature.maine.gov/substance-use-disorder-meeting-91622.

[18] Attorney Voyvodich's materials are available here: https://legislature.maine.gov/substance-use-disorder-meeting-91622.

Dr. Chris Racine, the Division Director, Emergency Psychiatry at Maine Medical Center Department of Psychiatry, and the committee member appointed to represent hospital emergency department providers, provided the committee with a presentation including statistics on the cost of substance use disorders to the United States, including alcohol misuse, and data on the utilization of civil commitments for substance use in other states. Among other things, Dr. Racine highlighted one study that found the majority of states do allow some level of civil commitment for substance use disorders and 29 states explicitly authorize it (including Maine). Dr. Racine specifically focused on programs in Florida and Massachusetts and reviewed elements of each states' applicable regulations. A copy of the presentation is available on the committee's webpage and is included as Appendix F.

Lastly, Richard Gordon, the Coordinator of Specialty Dockets and Grants with the Maine Administrative Office of the Courts, provided the committee with an overview of Maine's Treatment and Recovery Courts. He described the criteria for admission to the various programs and provided team member impact statistics for the committee's consideration. The committee learned that greater involvement by team members, including judges, treatment providers, prosecutors and defense counsel, results in improved outcomes for program participants, including lower recidivism rates. A copy of the presentation is available on the committee's webpage and is included as Appendix G.

At the conclusion of the meeting, Senator Carney asked committee members what aspects of the committee's charge they were interested in discussing at the next meeting. Members put forward the following topics and ideas:

- currently available resources in the State at various levels of care, including facilities and providers;

- new programs or initiatives that may be happening in Maine, including plans for the opioid settlement funds;

- funding for programs in other states;

- current Judicial Branch resource challenges and the potential effect of increasing numbers of involuntarily hospitalizations; and

- statistics and information specific to alcohol use disorder.

While the focus of the first meeting was on gathering information, several considerations emerged from the day's presentations and the members' questions. These included:

- conversations about substance use disorder should include alcohol use disorder and drugs other than opioids; and

- incapacity due to substance use disorder, including alcohol use disorder, often is more limited in time which can present challenges when trying to compel treatment; and

current emergency hospitalization and involuntary commitment statutes are written in such a way that they could apply to individuals with substance use disorder.

B. Second Meeting, October 3, 2022[19]

The second meeting of the committee was held on October 3, 2022. The meeting primarily consisted of a number of presentations focused on understanding the scope of substance use disorder, including alcohol use disorder, and the resources that are currently available in Maine.

The first presentation to the committee, Alcohol and COVID-19 Pandemic in Maine and the Nation, was provided by Tim Diomede on behalf of the State Epidemiological Outcomes Workgroup. The committee heard that alcohol misuse has been an ongoing public health concern in Maine, but data shows that access to alcohol in Maine is increasing and, with that, alcohol-related deaths in Maine have increased each year between 2016 and 2021. Data indicates that over the COVID-19 pandemic, alcohol-related emergency room visits have increased as well as alcohol-related ambulance responses and motor vehicle crashes. Alcohol-related mortality statistics are likely undercounted, as they rely on a list of identified international classification of diseases (ICD) codes and might not include all deaths for which alcohol was a contributing factor. A copy of the presentation is available on the committee's webpage and is included as Appendix H.

The committee then received a presentation from committee member Hon. Jed French, Maine District Court Judge and the committee member appointed to represent the Judicial Department, about Judicial Branch resources and the Judiciary's role in the current "blue paper" and "white paper" processes. He shared that, although court resources are already limited, they have seen an increase in mental health cases over the last few years: in 2017, the Maine courts handled 959 mental health cases; in 2021 that number had increased to 1,204. The creation of a new judicial process or an increase in the utilization of an existing judicial process would necessitate consideration of the impact of statutory timelines on scheduling and prioritization of cases, necessary resources including court staff and physical spaces and other resource availability such as independent examiners and defense attorneys.

The committee members discussed the challenges that are posed by a lack of resources at different points in the process and the difficulty that an increased caseload would present for those courts already handling mental health cases and those that would have to provide those services for the first time. For example, allowing family members to petition a court directly as opposed to limiting the petitioner to a medical provider or law enforcement officer could necessitate more careful scrutiny of those applications by judges which would further stretch resources. Although current law allows for the use of emergency hospitalization and involuntary commitment for individuals suffering from substance use disorder, committee members noted that they did not recall seeing it used for anyone who presents primarily with substance use disorder – it is often a comorbidity exacerbating an underlying mental health condition. Several committee members noted that the definition of "likelihood of serious harm" in 34-B M.R.S.

[19] The archived video of the meeting is available at the following link: https://legislature.maine.gov/audio/#126?event=86507&startDate=2022-10-03T09:00:00-04:00.

§3801(4-A) includes a criterion[20] which seems to be used with much less frequency but which may have broader applicability in the substance use disorder context.

The committee continued their discussions of capacity in individuals with substance use disorder. Many individuals who meet the emergency hospitalization criteria are never placed in a psychiatric hospital as they regain sufficient capacity and must be released. Due to the relapsing nature of substance use disorder, the committee struggled with the desire to establish a process that protects individuals suffering from substance use disorder from their addiction and the statutory framework that establishes a high standard for incapacity because of the individual liberties involved.

Sarah Squirrel, Acting Director of the Office of Behavioral Health within the Department of Health and Human Services, provided an overview of substance use disorder treatment resources available in Maine across each level of care and details on new initiatives undertaken by the Department and funding opportunities to expand existing care resources. The committee learned about the Maine Treatment Connection, a new behavioral health services locator tool that includes a public-facing portal as well as provider access for digital referrals. Ms. Squirrel also confirmed that currently all residential and detoxification programs available in Maine are voluntary. A copy of the Department of Health and Human Services memorandum to the committee is available on the committee's webpage and is included as Appendix C.

Committee member Dr. Chris Racine built on the presentation he provided at the first meeting and provided the committee with additional information on the efficacy of involuntary commitment for substance use disorder. The members learned that various factors make answering the question of "does it work?" very difficult. Variability in state laws, small study sizes and the differing treatment approaches for various substance use disorders all make an "apples to apples" comparison challenging. Dr. Racine noted that many of the studies comparing voluntary and involuntary treatment have similar outcome data and it appears that some individuals with substance use disorder are well-served by involuntary treatment while others are not.

As detailed in three studies cited by Dr. Racine, mental health providers themselves are of divided opinions regarding the use of involuntary civil commitment for substance use disorder. Committee member Dr. Kispert added that addiction medicine providers may not have the same experience as psychiatrists with working with patients that are involuntarily committed and that may inform some of their opinions. Dr. Racine commented that, in his experience, involuntary hospitalization is being used for individuals who present with substance use disorder as well as a co-occurring mental illness; however, there is no place to send individuals with only substance use disorder.

The committee discussed barriers to treatment including lack of transportation services in rural areas of the state; lack of adequate telecommunications access; limited capacity for existing residential and detoxification facilities; varying abilities of facilities to provide treatments (e.g.,

[20] Title 34-B MRS §3801(4-A)(C) defines a likelihood of serious harm as "[a] reasonable certainty that the person will suffer severe physical or mental harm as manifested by recent behavior demonstrating an inability to avoid risk or to protect the person adequately from impairment or injury".

not all treatment facilities accept medications for opioid use disorder); lack of supportive housing; limitations imposed by Federal law or private insurance; social barriers (e.g., stigma); and practice issues with implementing the existing laws in the context of substance use disorder. Members of the committee expressed frustration with the apparent inability of the current system to properly treat and support individuals and their families dealing with substance use disorder and a desire to understand gaps in the current process and recommend meaningful change.

Lastly, Attorney General Aaron Frey joined the committee to discuss the Maine Recovery Council and plans for funds coming into the State from recently-negotiated settlements with one opioid manufacturer and three distributors. He explained that approximately $130M will be coming into the state over the next 18 years for abatement activities to address the opioid crisis. Fifty percent of that figure will go to the Maine Recovery Council for distribution, 30% to counties and municipalities for their use and 20% to the Attorney General's consumer protection fund. To prepare for the receipt of the settlement funds, the Legislature enacted LD 1722, which created the Maine Recovery Council, a 15-member council to ensure that settlement resources are used to address the opioid crisis. After the meeting, Attorney General Frey provided the committee with details of the first disbursement the State has received.[21]

At the conclusion of the second meeting, members shared the following possible topics and suggestions for discussion at the third committee meeting:

- the definition of "likelihood of serious harm" in 34-B M.R.S. §3801(4-A), specifically paragraph C of that definition;
- capacity, including how the chronic relapsing nature of substance use disorder impacts capacity;
- what the committee can suggest to allow for quicker access to care and supported housing;
- Portugal's decriminalization of drugs and creation of a citation system;
- access to treatment and specific data regarding the number of people seeking treatment and who can access it; and
- possible statutory revisions that could better include individuals with substance use disorder.

Committee members also put forward several resources, noted below, that they believed would be helpful for the group's future discussions:

- Appelbaum's Criteria for determining capacity;
- Maine's Opioid Strategic Plan; and

[21] A copy of the disbursement information is available here: https://legislature.maine.gov/doc/9235.

- Expert Panel Consensus on State-Level Policies to Improve Engagement and Retention in Treatment for Opioid Use Disorder (in the Journal of the American Medical Association).

After the October 3, 2022, meeting, committee members were asked by email to provide suggested recommendations to be distributed to members for discussion at the third meeting. The members were also provided with background information[22] for review including:

- New England Journal of Medicine - Assessment of Patients' Competence to Consent to Treatment ("Appelbaum Criteria")
- JAMA- Expert Panel Consensus on State-Level Policies to Improve Engagement and Retention in Treatment for Opioid Use Disorder
- Transform Drug Policy Foundation - Drug decriminalization in Portugal
- Cato Institute - Drug Decriminalization in Portugal – Lessons for Creating Fair and Successful Drug Policies
- Maine Monthly Overdose Report for August 2022 (Appendix I)
- Maine Alcohol Death Tables 2022 and Alcohol Death Tables Explanation
- Maine Opioid Response: 2021 Strategic Action Plan (Appendix J)

C. Third Meeting, October 24, 2022[23]

The third meeting of the committee was held on October 24, 2022. The meeting was primarily focused on developing recommendations that would be included in the committee's final report, to be reviewed at the fourth meeting.

The committee's discussions began with questions about evaluating capacity using Appelbaum's Criteria which had been provided to the committee in advance of the meeting. Several of the committee members were able to speak to the usage of these criteria from their professional experience determining decision-making capacity. While these criteria are not the only approach for measuring capacity, they are widely accepted by practitioners. Capacity, in the medical context, means an individual's ability to make decisions about their own care at a moment in time. The committee learned that a lack of capacity does not allow a doctor to make decisions for the person; there may then be a need to find a substitute decision maker who can decide on behalf of that person unless or until they regain capacity.

[22] The committee member recommendations that were submitted prior to the third meeting and copies of the background materials are available here: https://legislature.maine.gov/substance-use-disorder-102422-meeting.
[23] The archived video of the meeting is available at the following link: https://legislature.maine.gov/audio/#126?event=86525&startDate=2022-10-24T09:00:00-04:00.

Whether the individual is experiencing impairment due to substance use disorder or mental illness, it is the impairment that impacts their decision making and the criteria do not change based on the source of the impairment. The committee learned that, unlike other forms of impairment, substance use disorder may result in more temporary losses in capacity: acute intoxication may result in a lack of capacity but it may be regained in minutes. The committee had previously heard that prolonged substance use can lead to long-term changes in brain function and, while that could result in some individuals losing their ability to make their own decisions, it is more common that the individual has the ability to make their own decisions as long as they are not actively intoxicated.

In the search for ways to ensure that individuals in need of treatment receive it, the committee questioned whether they should develop recommendations that address capacity or whether they should focus on behavior (e.g., harm to self or others). A question was asked regarding what time period is used to evaluate "recent" behavior. A member noted that medical professionals would interpret "recent behavior" in the application of the emergency hospitalization and involuntary commitment context as more than immediate behavior and that this interpretation would then be submitted for judicial review.

A committee member commented that while the emergency hospitalization process is available for individuals with substance use disorder, there are limited number of facilities that are able to take individuals involuntarily. If there is no space available, it leaves the individual in the emergency room without treatment or disposition. The member commented that it is difficult to conceptualize routinely "blue papering" individuals with dangerous substance use disorders when there is no place to put them.

As further described below, the committee discussed the frustrations and challenges experienced by individuals at each stage of the process.

- Emergency room providers are treating individuals to the best of their abilities but resource limitations put them in a position where they often have to turn individuals away who are seeking treatment for substance use disorder. Emergency rooms often have people who stay for weeks while waiting for inpatient psychiatric facility space to become available; during this time, they are contained and stabilized but may not be receiving the most effective treatment as they are in a busy emergency room. And even if space is available, individuals presenting with primarily substance use disorder would be treated at a psychiatric hospital as opposed to a dedicated substance dependence treatment facility.

- For individuals seeking treatment for substance use disorder, the lack of recovery resources may mean that an individual is released from the hospital after the acute phase of their substance use disorder symptoms has subsided while still not being in a good place to make decisions. If the system only provides treatment to the most severe cases, it may incentivize an individual to claim that they are a risk to themselves to access treatment.

- Family members of individuals with substance use disorder also feel the impact of the lack of treatment facility space. They may be put in the position of having to take on care responsibilities for which they may be ill-equipped.

The committee next discussed how these frustrations and challenges could be addressed through policy changes. Several members expressed concern that creating a new court process for involuntary treatment will not help unless resource capacity is addressed first. The committee discussed possible areas of focus including:

- increased availability of home health aides or visiting nurses to provide care outside of a hospital setting;

- consistent involvement of licensed mental health professionals in providing initial evaluations of individuals experiencing substance use disorder for emergency hospitalizations;

- increased community supports designed to give individuals a life to return to that supports sobriety (e.g., housing, health care and employment opportunities);

- reduction in stigma and change in perception that treatment of medical illnesses should take precedence over treatment of withdrawal symptoms and problems in early stages of substance use disorder;

- establishing additional facilities that can provide mental health crisis services to reduce reliance on emergency rooms; and

- increasing the available workforce to provide treatment and support which could include looking at barriers to direct care employment such as prior criminal convictions.

The committee then received its last presentation, which addressed harm reduction, from Dr. David Kispert, Addiction Medicine Physician with Acadia Healthcare and the committee member appointed to represent a statewide organization representing physicians. The committee learned that harm reduction is a set of practical strategies and ideas aimed at reducing negative consequences associated with drug use. Examples of harm reduction strategies include: Naloxone (Narcan) distribution, needle and syringe distribution programs, supervised injection sites, medication for substance use treatment, non-abstinence housing and decriminalization of the possession or use of drugs. Dr. Kispert described motivational interviewing for the committee, which is an educational initiative used broadly in the health care setting to promote independent change on the part of patients. Its focus is not on convincing a patient to follow a particular course but rather to examine the consequences of current behaviors and potential behavior changes. Dr. Kispert added that many of the most successful addiction treatment strategies are based in the principles of harm reduction.

The committee then discussed syringe service programs and the benefits of those programs, including the reduction in the spread of multiple viruses, such as HIV and Hepatitis C, and bacterial infections. The cost of these diseases to the individual and the healthcare system is significant. Dr. Kispert added that some individuals still have difficulty obtaining clean needles from pharmacies because of stigmatization.

At the conclusion of Dr. Kispert's presentation, the committee discussed whether involuntary commitment or compulsory treatment is compatible with the principles of harm reduction. Although the call for the non-judgmental and non-coercive provision of services to people doesn't appear to be compatible with this treatment modality, Dr. Kispert explained that many of the treatment strategies that involuntary commitment would utilize are founded in harm reduction (e.g., motivational interviewing). He noted that a delineation is not made within harm reduction for those who have co-occurring disorders and those that do not. A copy of the presentation is available on the committee's webpage and is included as Appendix K.

Committee members then discussed accounts of those who have said that their recovery was initiated through involuntary mechanisms such as incarceration. While some individuals with substance use disorder report that an interaction with the criminal justice system and abstinence brought on by incarceration is what brought them into recovery, others have reported that programs relying on detention resulted in additional trauma from the experience. A member responded that this highlights that each person's recovery is unique. Another member noted that relying on these anecdotal reports may not present the full picture as it is likely only the individuals who were successfully released from the criminal justice system who are providing their accounts. At the September 16th meeting, the committee learned about the success of Maine's treatment courts, which rely on the threat of incarceration as leverage for participants' compliance. One committee member pointed out that while Maine's treatment courts show positive outcomes, they are resource intensive and still involve an affirmative choice by the individual (i.e., applying for the program).

The committee chairs then posed several options to the members regarding possible next steps and polled the members in attendance. The questions and the straw poll results[24] are as follows:

- Is the committee interested in creating a new court process for involuntary commitment for substance use disorder treatment?

  Straw poll results: ten members voted no, one member abstained;

- Is the committee interested in amending the emergency hospitalization statutes ("blue paper" process) so that it applies more effectively to substance use disorder?

  Straw poll results: seven members voted no, three voted yes and one member abstained;

[24] Committee member Hon. Jed French, participating on behalf of the Judicial Branch, opted to abstain from taking a position on any of the proposed recommendations.

- Is the committee interested looking at recommendations related to additional resources for treatment of substance use disorder?

  Straw poll results: ten members voted yes, one member abstained; and

- Is the committee interested in looking at recommendations that would focus on the education of healthcare providers in hospitals, primary care or other settings?

  Straw poll results: seven members voted yes, two voted no and two members abstained.[25]

Based on the members' interests, the committee then focused on considering recommendations related to additional resources for treatment of substance use disorder, the discussion of which included:

- The challenge of evaluating gaps in the current system for individuals with co-occurring disorders as the necessary level of care appears to be unique to each individual and resource needs for the treatment for alcohol use disorder may differ from those for opioid use disorder; and

- That the gaps themselves may be evolving based on recent investments and changing public health restrictions. As the committee learned at the October 3rd meeting, significant resources are being invested into the State's substance use disorder programs and new initiatives are already in process which means that some gaps are being addressed. Additionally, due to the COVID-19 pandemic, treatment beds were even more limited, as a room that held two beds would now only hold one. This issue may be resolved, however, as the State comes out of the pandemic-related limitations.

The committee discussed the following as issues or perceived gaps in Maine's current treatment programs and resources:

- acute phase needs: greater capacity for withdrawal and detoxification beds outside of a hospital setting;

- longer-term needs: additional lower level treatment options; community-based care and home health care for individuals who are at the greatest risk of harm; and recovery residences or other housing options that provide an alternative environment for individuals going through treatment; and

- general needs: more opportunities for family involvement in the recovery process; ensuring that alcohol use disorder is considered in all process changes, not just opioid use disorder; reduction in stigma and increase in compassion for those experiencing substance use disorder; ensuring that hospitals are treating individuals experiencing

[25] In addition to committee member Hon. Jed French, committee member Gordon Smith abstained from taking a position on this proposed recommendation citing a need for additional information.

substance use withdrawal; inability to address root cause of substance use disorder in emergency room setting yet this is where many of these individuals are presenting.

Following this discussion and to facilitate the development by committee staff of a draft report for consideration at the fourth meeting, the committee chairs proposed the following general recommendations based on the members' discussions over the course of the three meetings.

1. On a statewide basis, work towards changing how we look at addiction and adopt policies that destigmatize substance use disorder and increase compassion towards people with substance use disorder (including alcohol use disorder).

2. Increase services at every level of treatment.

3. Ensure that or set an expectation that each of Maine's 33 hospitals adopt policies and practices that address substance use disorder (including alcohol use disorder) as a medical condition that should not be discriminated against and ensure that substance use disorder (including alcohol use disorder) is treated appropriately at each of those hospitals. Policies and procedures should ensure that people are not denied treatment due to stigma or lack of training regarding treatment of the condition.

4. Use a number of treatment modalities to provide more effective treatment for substance use disorder (including alcohol use disorder) to include motivational interviewing, home health services, and recommendations for discharge planning that provide treatment outside of the hospital setting.

5. That the state, at a policy level, recognize that the emergency room is not the place to provide long-term care for substance use disorder (including alcohol use disorder) and we need to look at effective alternatives to treatment outside of the emergency room and hospital setting and create a system of care in our state.

6. Encourage education around the elements of the definition of "likelihood of serious harm" as it may apply to individuals with co-occurring disorders including substance use disorder.

As it became clear that many committee members were not prepared to formally vote on these proposed recommendations without additional time for consideration and review, the committee instead directed staff to prepare a draft report that includes those general recommendations for review, discussion and voting at the fourth meeting.

D. Fourth Meeting, November 30, 2022[26]

The fourth meeting of the committee was held on November 30, 2022. The committee had previously been provided with a copy of this draft report for discussion, and the focus of the

[26] The archived video of the meeting is available at the following link: https://legislature.maine.gov/audio/#228?event=86577&startDate=2022-11-30T09:00:00-05:00.

fourth meeting was on discussing and voting on the general recommendations put forward at the third meeting. As a result of the committee's discussions, the fifth proposed general recommendation was eliminated because the committee believed it was redundant and the remaining five recommendations were refined and presented for a vote. The committee's final recommendations, as voted on and unanimously accepted by those members present for the respective votes at the fourth meeting,[27] are listed in Part IV.

IV. RECOMMENDATIONS

The committee was charged with studying services and processes currently available in Maine and in other states for individuals with substance use disorder and was required to submit a report with a summary of its activities and recommendations, including any suggested legislation, to the Joint Standing Committee on Health and Human Services and the Joint Standing Committee on Judiciary for presentation to the First Regular Session of the 131st Legislature.

As summarized in Part III of this report, the committee met four times in the development of these recommendations, engaged in robust discussions on the impact of and the numerous issues related to substance use disorder and heard from experts, state agencies and other stakeholders in relation to the duties set forth in the committee's enabling legislation.

Below are the recommendations of the committee.

Recommendation #1: the Legislature should build on existing efforts to change how addiction is viewed in the State and should adopt statewide policies that destigmatize substance use disorder and increase compassion towards individuals with substance use disorder, including alcohol use disorder, and individuals with co-occurring disorders.[28]

- The issue of stigma was raised repeatedly during the committee's discussions as a barrier to seeking treatment and as a barrier to the provision of treatment. The committee noted that there are ongoing efforts in the State to destigmatize substance use disorder and that many medical professionals and the institutions for which they work have gone to great lengths to treat individuals with substance use disorder effectively and with compassion.

- The committee discussed, however, that continued attention is needed across all systems in the State, not just in health care settings, as substance use disorder is an issue that touches many in our communities. Prior authorization requirements, federal prescription waiver requirements ("X waivers") and the language used to describe substance use

[27] Although the committee members present and voting at the fourth meeting voted unanimously in support of the recommendations, one member subsequently requested to change their vote. See footnote 32 for additional information.

[28] Senator Anne Carney, Representative Colleen Madigan, Representative Stephen Moriarty, Representative Jennifer Poirier, Dr. Chris Racine, Mikki Rice, Malory Shaughnessy, Gordon Smith and Meagan Sway voted in support of this recommendation. Senator Lisa Keim, Senator Heather Sanborn, Hon. Jed French, Constance Jordan, Dr. David Kispert, Dr. Tim Pieh and Karen Walsh were absent.

disorder (i.e., substance *abuse* disorder) can further stigmatize those struggling with addiction. The committee also discussed the importance of including individuals with co-occurring disorders in this recommendation as there is a need for a better understanding of the interaction between substance use disorder and other disorders.

Recommendation #2: the Legislature should increase funding and continue to fund access to services at every level of treatment for individuals with substance use disorder, including alcohol use disorder, and individuals with co-occurring disorders.[29]

- Difficulty in obtaining necessary services was identified at each committee meeting as a problem that needs to be addressed, both with increased resources and with greater accessibility for available resources. While the efforts to increase capacity are ongoing, members expressed concern that current resource limitations can result in emergency rooms serving as the "catch all" for many individuals suffering from substance use disorder and mental illness. Emergency rooms are busy, often crowded and may not provide a therapeutic environment for an individual who is going through a crisis.

- For an individual with a co-occurring mental health disorder presenting primarily with substance use disorder, identifying the root cause of the substance use disorder is likely beyond the scope of services that can be provided in a facility focused on triage. A member noted the committee had learned there are no treatment facilities in Maine specializing in acute care for individuals with co-occurring substance use and mental health disorders, and some providers are less likely to utilize existing emergency hospitalization and involuntary commitment processes for their patients with substance use disorder if there are no appropriate treatment facilities to which to send them.

- In discussing this recommendation, the committee acknowledged the State's ongoing efforts to expand bed capacity and services and the importance of developing new tools such as the Maine Treatment Connection that can provide the public with information regarding access to services at each level of care. The committee also highlighted the need for patients, families, providers, public safety officers and other community members to be able to identify available services in real-time along the full continuum of care as new treatment resources become available. While the State is undertaking many initiatives to increase available resources for substance use disorder, the problem is large enough that members felt that all aspects of treatment should continue to receive funding and attention. The committee also expressed the importance of evaluating additional resource needs for newly established programs, such as hiring and training staff, and determining the impact of these initiatives on residential treatment capacity and waitlists.

[29] Senator Anne Carney, Representative Colleen Madigan, Representative Stephen Moriarty, Representative Jennifer Poirier, Constance Jordan, Dr. Chris Racine, Mikki Rice, Malory Shaughnessy, Gordon Smith and Meagan Sway voted in support of this recommendation. Senator Lisa Keim, Senator Heather Sanborn, Hon. Jed French, Dr. David Kispert, Dr. Tim Pieh and Karen Walsh were absent.

- Given the anticipated increase in services available in the State, the committee additionally recommends that Joint Standing Committee on Health and Human Services and the Joint Standing Committee on Judiciary request that the Department of Health and Human Services provide a report to the 131st Legislature in 2024 regarding the impact of its initiatives. This report should detail the increase treatment capacity, including specific data regarding the number of beds that have been added and changes in waitlist times, as well as forecasts of future capacity needs.

Recommendation #3: the Legislature should set an expectation that each of Maine's health care facilities has an important role in treating individuals with substance use disorder, including alcohol use disorder, and individuals with co-occurring disorders and that each of Maine's health care facilities has the capacity and training to treat substance use disorder as a medical condition within available resources.[30]

- Over the course of its meetings, the committee heard stories of individuals needing to drive across the State to find a hospital that would provide withdrawal assistance. In discussing the general recommendation articulated at the third meeting, however, the members noted that substance use disorder treatment is not limited to a hospital setting and that hospitals likely already have antidiscrimination policies and procedures in place. Because treatment for substance use disorder is provided in a number of health care contexts and the committee's work did not delve into hospital policies, the committee determined that this recommendation should encompass all health care facilities and focus on capacity and training. The committee discussed specific needs such as capacity for medically-monitored withdrawal and training options such as clinical supervision for providers of substance use disorder treatment, but acknowledged that health care facilities across the State have varying levels of resources and have faced challenges with staffing and issues related to the COVID-19 pandemic.

- The committee struggled with how to frame a recommendation to best address their original concern of individuals with substance use disorder, including those with co-occurring disorders, seeking treatment and receiving a response from a healthcare facility of "we don't do that here." While some health care facilities are treating substance use disorder properly, committee members expressed frustration that others do not appear to be treating it as the medical condition that it is, and the provision of consistent treatment is necessary to ensure that those who seek help are supported.

Recommendation #4: the Legislature should explore options for expanding the availability in Maine of multiple treatment modalities to provide evidence-based treatment for substance use disorder, including alcohol use disorder, and individuals with co-occurring disorders, including, but not limited to, motivational interviewing, contingency management, medication assisted treatment for all substance use disorders, home health

[30] Senator Anne Carney, Representative Colleen Madigan, Representative Stephen Moriarty, Representative Jennifer Poirier, Constance Jordan, Dr. Chris Racine, Mikki Rice, Malory Shaughnessy, Gordon Smith and Meagan Sway voted in support of this recommendation. Senator Lisa Keim, Senator Heather Sanborn, Hon. Jed French, Dr. David Kispert, Dr. Tim Pieh and Karen Walsh were absent.

and community-based services and recommendations for discharge planning that provide treatment outside of the hospital setting.[31]

- The recovery process and needs of each individual with substance use disorder are different; however, the committee consistently noted a need for support services outside of the hospital setting. As one member commented, for individuals leaving the hospital, it is important to establish supports to give them a life to return to. The committee discussed that many providers are currently using multiple treatment modalities to help patients with substances use disorder; however, the goal is to expand these services and provide support across the continuum of care, including services to address complications that may arise after the acute phase of treatment.

Recommendation #5: the Legislature should support education around the elements of the definition of "likelihood of serious harm" as it may apply to individuals with co-occurring disorders, including substance use disorder, as evaluated under the State's involuntary hospitalization and involuntary civil commitment processes.[32]

- As discussed at several committee meetings, this definition of "likelihood of serious harm" includes multiple elements going beyond harm to self or others. Individuals with co-occurring disorders may present different risks than those that present solely with a physical disorder or substance use disorder. In considering this recommendation, the committee discussed several diagnoses that are associated with changes in cognitive function resulting from substance use disorder and whether to include more detail regarding what evidence should be considered in clinical determinations of likelihood of serious harm. Similar to the committee's discussions at the second and third meetings, the conversation touched on the tension that exists when trying to protect an individual from harm while also making a clinical assessment that is consistent with the statutory framework and preserving the individual's civil liberties.

- Several committee members commented that protective custody is a related and important area of the law that warrants additional education and questioned whether that should be included in the recommendation; however, this topic was not previously explored during the committee's discussions. Senator Carney suggested that a letter to the Joint Standing Committee on Judiciary might be a more appropriate mechanism to have that education issue addressed. The committee determined that the final recommendation

[31] Senator Anne Carney, Representative Colleen Madigan, Representative Stephen Moriarty, Representative Jennifer Poirier, Constance Jordan, Dr. Chris Racine, Mikki Rice, Malory Shaughnessy, Gordon Smith and Meagan Sway voted in support of this recommendation. Senator Lisa Keim, Senator Heather Sanborn, Hon. Jed French, Dr. David Kispert, Dr. Tim Pieh and Karen Walsh were absent.

[32] Senator Anne Carney, Representative Colleen Madigan, Representative Stephen Moriarty, Representative Jennifer Poirier, Constance Jordan, Dr. Chris Racine, Mikki Rice, Malory Shaughnessy, Gordon Smith and Meagan Sway voted in support of this recommendation. Senator Lisa Keim, Senator Heather Sanborn, Hon. Jed French, Dr. David Kispert, Dr. Tim Pieh and Karen Walsh were absent. Subsequent to the fourth meeting, Representative Colleen Madigan requested to be recorded for the purposes of the final report as opposed to Recommendation #5. She explained: "All co-occurring physical and behavioral health disorders must be considered along with substance use disorders when considering whether someone has capacity and whether there is a likelihood of serious harm. This includes both acute and chronic physical conditions whether caused by substance use disorder or not."

would focus on the existing legal standard, as medical practitioners seeking to utilize current law and judicial officers reviewing these cases should be trained on each element of the statutory definition to ensure that those who may need emergency hospitalization or involuntary commitment can receive it.

V. CONCLUSION

Throughout the committee process, members expressed a strong desire to do something meaningful to help save the lives of those struggling with substance use disorder in the face of seemingly innumerable challenges. Each member brought their unique perspective to the issue and shared valuable information that helped to provide a clearer picture of the obstacles faced by these individuals at each stage of their recovery process. The committee recognizes that better addressing substance use disorder in Maine will require the participation of stakeholders and a continued commitment to provide necessary treatment resources at each level of care. Members repeatedly commented that there are many paths to recovery and the important part is getting individuals into recovery. The recommendations put forth in this report represent only the beginning of the work towards addressing this growing problem and committee urges the Legislature to continue the work that this committee has begun, as continued investment and discussion of these issues is critical.

Finally, the committee would like to thank all of the presenters and members of the public for generously offering their time, expertise and advice on the complicated issues involved in providing treatment to those with substance use disorder in this State. Their knowledge and perspectives were invaluable to the committee as it endeavored to develop recommendations on these challenging and complex but also critical issues. The committee also would like to thank staff for their time and dedication to the committee's work.

APPENDIX A

Authorizing Legislation: Resolve 2021, c. 183

LAW WITHOUT GOVERNOR'S SIGNATURE

MAY 8, 2022

CHAPTER

183

RESOLVES

STATE OF MAINE

IN THE YEAR OF OUR LORD

TWO THOUSAND TWENTY-TWO

H.P. 1496 - L.D. 2008

Resolve, To Establish the Committee To Study Court-ordered Treatment for Substance Use Disorder

Emergency preamble. Whereas, acts and resolves of the Legislature do not become effective until 90 days after adjournment unless enacted as emergencies; and

Whereas, the Committee To Study Court-ordered Treatment for Substance Use Disorder is needed to explore the legal issues and best medical practices and related issues concerning substance use disorder treatment that is involuntary or includes some form of leverage to ensure adherence to treatment; and

Whereas, the study must be initiated before the 90-day period expires in order that the study may be completed and a report submitted in time for submission to the next legislative session; and

Whereas, in the judgment of the Legislature, these facts create an emergency within the meaning of the Constitution of Maine and require the following legislation as immediately necessary for the preservation of the public peace, health and safety; now, therefore, be it

Sec. 1. Study committee established. Resolved: That the Committee To Study Court-ordered Treatment for Substance Use Disorder, referred to in this resolve as "the study committee," is established.

Sec. 2. Study committee membership. Resolved: That, notwithstanding Joint Rule 353, the study committee consists of 16 members appointed as follows:

1. Three members of the Senate appointed by the President of the Senate, including members from each of the 2 parties holding the largest number of seats in the Legislature;

2. Three members of the House of Representatives appointed by the Speaker of the House, including members from each of the 2 parties holding the largest number of seats in the Legislature;

3. One member appointed by the Governor;

4. One member representing hospitals, appointed by the President of the Senate;

5. One member representing substance use disorder treatment providers, appointed by the Speaker of the House;

6. One member representing families affected by substance use disorder, appointed by the President of the Senate;

7. One member with lived experience with substance use disorder, appointed by the Speaker of the House;

8. One member representing primary health care providers, appointed by the President of the Senate;

9. One member representing hospital emergency department providers, appointed by the Speaker of the House;

10. One member representing an organization whose primary mission is the protection of civil liberties, appointed by the President of the Senate;

11. One member representing a statewide organization representing physicians, appointed by the Speaker of the House; and

12. One member representing the Judicial Department, appointed by the Chief Justice of the Supreme Judicial Court.

Sec. 3. Chairs. Resolved: That the first-named Senate member is the Senate chair and the first-named House of Representatives member is the House chair of the study committee.

Sec. 4. Appointments; convening of study committee. Resolved: That all appointments must be made no later than 30 days following the effective date of this resolve. The appointing authorities shall notify the Executive Director of the Legislative Council once all appointments have been completed. After appointment of all members, the chairs shall call and convene the first meeting of the study committee. If 30 days or more after the effective date of this resolve a majority of but not all appointments have been made, the chairs may request authority and the Legislative Council may grant authority for the study committee to meet and conduct its business.

Sec. 5. Duties. Resolved: That the study committee shall:

1. Review services and processes currently available in this State for persons with substance use disorder;

2. Review options offered in other jurisdictions for persons with substance use disorder, including but not limited to judicial orders for involuntary treatment as well as other treatment options that include some form of leverage to ensure adherence to treatment, and review outcomes;

3. Review the constitutional and other rights of persons with substance use disorder and how other jurisdictions protect those rights; and

4. Develop recommendations for treatment options for persons with substance use disorder, including implementation plans.

Sec. 6. Staff assistance. Resolved: That the Legislative Council shall provide necessary staffing services to the study committee, except that the Legislative Council staff support is not authorized when the Legislature is in regular or special session.

Sec. 7. Report. Resolved: That, no later than November 2, 2022, the study committee shall submit a report that includes a summary of its activities and recommendations, including suggested legislation, to the Joint Standing Committee on Health and Human Services and the Joint Standing Committee on Judiciary for presentation to the First Regular Session of the 131st Legislature.

Sec. 8. Outside funding. Resolved: That the study committee shall seek funding contributions to fully fund the costs of the study. All funding is subject to approval by the Legislative Council in accordance with its policies. If sufficient contributions to fund the study have not been received within 30 days after the effective date of this resolve, no meetings are authorized and no expenses of any kind may be incurred or reimbursed.

Sec. 9. Appropriations and allocations. Resolved: That the following appropriations and allocations are made.

LEGISLATURE

Study Commissions - Funding 0444

Initiative: Allocates funds from outside sources for the costs to the Legislature of the Committee To Study Court-ordered Treatment for Substance Use Disorder.

OTHER SPECIAL REVENUE FUNDS	**2021-22**	**2022-23**
Personal Services	$660	$660
All Other	$840	$1,090
OTHER SPECIAL REVENUE FUNDS TOTAL	$1,500	$1,750

Emergency clause. In view of the emergency cited in the preamble, this legislation takes effect when approved.

APPENDIX B

Membership List, Committee To Study Court-ordered Treatment for Substance Use Disorder

Committee to Study Court-ordered Treatment for Substance Use Disorder

Resolve 2021, ch. 183

Membership List

Name	Representation
Sen. Anne Carney - Chair	Member of the Senate
Rep. Colleen Madigan - Chair	Member of the House
Sen. Lisa Keim	Member of the Senate
Sen. Heather Sanborn	Member of the Senate
Rep. Stephen Moriarty	Member of the House[1]
Rep. Jennifer Poirier	Member of the House
Dr. Tim Pieh	Member representing hospitals
Malory Shaughnessy	Member representing substance use disorder treatment providers
Karen Walsh	Member representing families affected by substance use disorder
Mikki Rice	Member with lived experience with substance use disorder
Constance Jordan	Member representing primary health care providers
Dr. Chris Racine	Member representing hospital emergency department providers
Meagan Sway	Member representing an organization whose primary mission is the protection of civil liberties
Dr. David Kispert	Member representing a statewide organization representing physicians
Hon. Jed French	Member representing the Judicial Department
Gordon Smith, Esq.	Member appointed by the Governor

[1] By letter dated May 20, 2022, Representative Barbara Cardone was appointed to the committee as a member of the House of Representatives. By letter dated July 11, 2022, Representative Stephen Moriarty was appointed to the committee to replace Representative Cardone as a member of the House of Representatives. Representative Cardone resigned from the Legislature on August 15, 2022.

APPENDIX C

Memorandum dated October 3, 2022, Department of Health and Human Services, Office of Behavioral Health

Janet T. Mills
Governor

Jeanne M. Lambrew, Ph.D.
Commissioner

Maine Department of Health and Human Services
Office of Behavioral Health
11 State House Station
41 Anthony Avenue
Augusta, Maine 04333-0011
Tel.: (207) 287-2595; Fax: (207) 287-9152
TTY: Dial 711 (Maine Relay)

MEMORANDUM

TO: The Committee to Study Court-Ordered Treatment for Substance Use
FROM: Department of Health and Human Services
DATE: October 3, 2022
RE: Responding to Questions from the Committee

DHHS is committed to continuing to advance and strengthen our behavioral health continuum of care to support individuals who may be experiencing substance use disorders. Our strategic efforts are outlined within the Maine Opioid Response Strategic Action plan Maine Opioid Response Strategic Action Plan. This plan is designed to confront the epidemic of substance use disorder (SUD) and opioid use disorder (OUD) with evidence-based strategies that are targeted and tailored for maximum impact in Maine.

Please find below an overview of substance use disorder treatment resources available in Maine across each level of care inclusive of community resources, the availability of resources across the state, and the number of SUD treatment providers. Newly funded initiatives and services to expand capacity and services for individuals across the state have been highlighted.

Four Pillars of the Maine Opioid Response Strategic Plan			
PREVENTION	HARM REDUCTION	TREATMENT	RECOVERY

I. PROMOTION, PREVENTION AND EARLY INTERVENTION RESOURCES

Sources of Strength- The Sources of Strength is a peer (student) led school culture change program that brings together trained Adult Advisors and Peer Leaders to create campaigns for the school community that focus on positive, uplifting, and hopeful messaging. A Sources of Strength School develops improved peer culture and a more positive attitude among students related to mental health and help-seeking behavior. CDC provides oversight to this program and is funded through Federal SOR grant funds and by the Garrett Lee Smith Youth Suicide Prevention Grant.

Student Intervention Reintegration Program- SIRP a 12-hour educational program for youth ages 13-18 who have experimented with alcohol and/or other drugs. The program is offered state-wide, and students are referred by school staff or caregivers. There are three components of the program— student, parent, and community engagement—that work together to achieve attitude and behavior changes, resulting in lower risk choices by participants. CDC provides oversight of this program and is funded through Federal SOR grant funds. https://sirpmaine.com/

Community-based Primary Prevention – Currently Maine CDC funds 19 community-based organizations/coalitions throughout the state to implement a variety of programs and interventions at the local level with the goal of preventing substance use and/or misuse. These interventions range from working with schools on restorative policies, or directly with students on social emotional learning or other youth engagement activities; drug take back days and other safe storage/disposal initiatives and education; supporting business owners and their employees by offering Responsible Beverage Seller trainings to liquor licenses or assistance in creating/enhancing workplace substance use prevention policies and programs.

Maine Youth and Young Adult Screening, Brief Intervention and Referral to Treatment (MY-SBIRT) - SBIRT is a clinically effective public health approach for identifying individuals who engage in risky substance use behaviors and intervening to prevent more severe use consequences. Maine CDC, in collaboration with several other state departments, is currently assessing the implementation of SBIRT throughout the state in schools and primary care practices. Upon completion of the assessment, Maine CDC will be developing an SBIRT implementation plan with the goal of universal screening in School Based Health Centers, college and university health centers, and primary care practices.

Community Overdose Prevention Coalitions – Supported by a federal Prevent Prescription Drug/Opioid-related Overdose Deaths grant, Maine CDC will be funding five coalitions (one each in Oxford, Androscoggin, Penobscot, Washington, and Somerset counties) to enhance overdose prevention and response initiatives in a high need area of the county. The goal is to mobilize all sectors of a community to provide a local response to decrease stigma, substance misuse and overdose in their area.

Prescription Drug Misuse Prevention - Supported by a federal Strategic Prevention Framework for Prescription Drugs grant, Maine CDC is offering 20 community-level mini-grants annually to support prevention initiatives such as drug take back days, dissemination of Deterra drug disposal pouches and lock boxes, and the creation of educational materials and messaging focused on the New Mainer community.

II. CLINICAL OUTPATIENT RESOURCES

Outpatient treatment- Outpatient Treatment offers a variety of non-residential services and programs to meet the client's treatment needs. Services may involve case management, treatment planning, individual and group counseling, family therapy, patient education, crisis intervention, recovery services, MAT, medication management, and discharge planning. Services may be provided in person, by telephone, or by telehealth in any appropriate setting in the community. These services are provided by Licensed SUD agencies across the state inclusive of FQHC's or by licensed clinicians who practice independently across the state. Services are primarily billed through MaineCare and the Office of Behavioral Health (OBH) provides funding through contracts to support services for uninsured and underinsured.

Intensive outpatient (IOP) programs- Provide treatment for substance use disorders (SUDs) which offer services to clients seeking primary treatment; step-down care from inpatient, residential, and withdrawal management settings; or step-up treatment from individual or group

outpatient treatment. IOP treatment includes a prearranged schedule of core services, e.g., individual counseling, group therapy, family psychoeducation, and case management. IOP services are provided 3-5 days a week, at least 3 hours per day.

III. HARM REDUCTION RESOURCES

Syringe Service Providers (SSP)- CDC oversees the Syringe service programs (SSPs); which are statewide community-based prevention programs that can provide a range of services, including linkage to substance use disorder treatment, access to and disposal of sterile syringes and injection equipment, vaccination, testing, and linkage to care and treatment for infection diseases.

Narcan/Naloxone Tier Distribution- To comply with Governor Mills' executive order dated February 6, 2019; An Order to Implement Immediate Responses to Maine's Opioid Epidemic; Section III. OVERDOSE AND DEATH PREVENTION; Section C. directing the Office of Behavioral Health (OBH) to purchase doses of intranasal naloxone and intramuscular naloxone for distribution. In July of 2019, the Maine Naloxone Distribution Initiative began ordering and distributing state-purchased naloxone to community organizations, clinical sites, and end-users throughout the State of Maine to distribute free of charge. These organizations, known as Tier Two Distributors, order their naloxone kits from one of four Tier One Distributors who disseminate naloxone to Maine's sixteen counties. These Tier One organizations are Bangor Public Health, MaineGeneral, Portland Public Health, and Maine Access Points. Tier Two organizations can either keep their naloxone on hand in case of emergencies at their facility, as is the case with schools, some community organizations, and businesses, or *if they are engaged with high-risk individuals* as part of their community work, they can work as redistributors, dispensing their naloxone kits to end-users to facilitate the reversal of private overdoses in the community

Narcan/Naloxone Distribution Department of Corrections- DOC provides naloxone to releasing prisoners from state correctional facilities.

Fentanyl Test Strips- Fentanyl test strips are a harm reduction strategy aimed toward reducing fatal overdoses from drug supplies that contain fentanyl. Fentanyl test strips are not 100% accurate in detecting fentanyl due to the binding properties of the chemical compound but are a proven effective strategy. When used and interpreted correctly, and in combination with other harm reduction strategies, fentanyl test strips reduce the occurrence of fatal overdose due to fentanyl contamination. Fentanyl test strips are distributed at the community level through the Options program or SSP's.

Options Program- The OPTIONS co-responder initiative embeds licensed behavioral health clinicians within local emergency medical services (EMS) and law enforcement agencies in every county across Maine. Liaisons work alongside their first responder counterparts to:

1. Provide short-term counseling interventions when appropriate.
2. Conduct proactive outreach with at-risk communities.
3. De-escalate behavioral health crises when possible.

4. Engage in post-overdose follow up and help with referrals.

Each OPTIONS liaison serves the entire county in which they are located. Currently there are 16 Options Liaisons working in every county in Maine. As part of the OPTIONS liaison initiative, OBH and the Maine CDC are working to better integrate the varying levels of support services in each county. These services may include Syringe Service Programs (SSPs), Tier 1 and Tier 2 naloxone distributors, Recovery Centers, MAT treatment providers, food and housing supports among others. The Options Program is overseen by OBH and funded with federal grant dollars.

IV. RESIDENTIONAL, PARTIAL HOSPITALIZATION AND INPATIENT RESOURCES

SUD Residential Programs- Services are provided in a residential facility setting. Residential rehabilitation programs are designed to treat persons who have significant social and psychological impairment. These are currently 20 licensed residential programs operating across the state.

Inpatient Detoxification Services- A medical intervention process aimed at helping a substance user through the experience of acute withdrawal. Additionally, inpatient detox is necessary in that it offers a safe and secure environment in which clients work closely alongside case managers and develop a plan for immediately transitioning to the next appropriate level of clinical care. Inpatient Detox Services are typically offered in hospitals across the state.

Non-Hospital Based Detoxification Services- For those experiencing acute physical problems related to substance use. Withdrawal management services monitored by medical professionals (e.g., physicians, nurses) in a residential setting. These services are offered by community-based providers. There are currently 2 non-hospital-based detoxification programs, Wellspring and Milestone. These services are typically reimbursed through MaineCare and OBH provides funding for uninsured and underinsured. Referrals are typically made through community providers.

Partial Hospitalization Program (PHP)- This program is a comprehensive option for substance use treatment. It generally consists of days full of a variety of treatments, therapies, and activities. However, unlike inpatient programs, you can go home or to a recovery residence at night. A partial hospitalization program (PHP) bridges the gap between residential treatment and intensive outpatient treatment (IOP). A recent rate study was conducted for PHP programs in Maine to support the expansion of PHP programs across the state.

V. MAT & MOUD RESOURCES

Office Based MOUD Resources- Provide FDA approved medication utilized for the treatment of Opioid Use Disorders and Alcohol Use Disorder who meets the general eligibility requirements. Medications include Buprenorphine, Buprenorphine/Naloxone, Vivitrol, Sublocade, and Oral Naltrexone. Provides medications prescribed by a qualifying physician in an outpatient medical or behavioral health center and includes counseling and behavioral therapies.

These services are offered through primary care providers, emergency departments and licensed SUD providers. This service is offered statewide. This service is reimbursed through MaineCare and OBH provides funding for uninsured and underinsured individuals.

Certified Opioid Treatment Programs (Methadone)- Provide MAT-Methadone to individuals who meet the general eligibility requirements. The Provider shall provide services that include medication (Methadone), counseling services, drug screening, required laboratory testing, and medical services. These are the only providers who can provide Methadone to treat an opioid use disorder. We currently have 12 OTP programs across the state in York County, 3 in Cumberland County, Androscoggin County, Kennebec County, 3 Penobscot County, Aroostook County, Knox County and Washington County

Department of Corrections MAT Services- Registered Professional Nurses to dispense medication approved for Opioid Use Disorder, Buprenorphine or Naltrexone, to individuals who suffer from OUD. MAT is to cover the cost of FDA approved medication utilized for the treatment of individuals with OUD. Vendors will help provide transitional care to incarcerated individuals release back into the community which includes comprehensive reentry planning with access to evidence-based MAT providers upon release. These services will include group therapy, peer recovery coach services, nurse case manager services, patient navigator services and any additional case management services deemed necessary.

Jail MAT Services- OBH currently works with and provide funding to 8 county jails across the state to provide Medication Assisted Treatment Services (MAT) to uninsured individuals diagnosed with an Opioid Use Disorder (OUD) who were incarcerated and released through the community-based MAT program. The Provider shall concurrently provide MAT utilizing Buprenorphine, Buprenorphine/Naloxone, Methadone, Sublocade, and evidence-based counseling services. This Agreement covers the cost of the following: medications, drug screen testing, behavioral therapies, as well as community medical provider related cost.

Opioid Health Home- The OHH model uses a team-based approach to support both the individual in treatment as well as the providers delivering care. The team includes Clinical team lead, MOUD prescriber, nurse care manager, clinician licensed to deliver OUD counseling, peer recovery coach, and patient navigator. The OHH model is covered by MaineCare and DHHS also provides funding for uninsured individuals – there are 110 OHH locations statewide serving 3,200 individuals a month.

VI. RECOVERY RESOURCES

Recovery Coaches- Recovery coaches serve as personal guides and mentors for people on their journey of recovery, suggesting strategies and resources to aid in managing the transformative nature of recovery, and empower the recoveree to sustain a productive and fulfilling life.

Recovery Coaches are available at each Recovery Community Center as well as through Opioid Health Home services.

Healthy Acadia provides Recovery Coaching services across 10 northern Maine Counties and served 449 Recoverees between July 1, 2021, and June 30, 2022. OBH has used SUD General Funds, Federal SOR grant funds, and Prevention and Treatment funds to support this work.

Healthy Acadia also provides Recovery Coaching and Workforce Development though the Recovery CORE program. Each year, Healthy Acadia recruits, trains, and supports 25-30 Recovery Coaches, and places these RCs at various service locations in Northern Maine. The host agency contributes funds for each member, with Healthy Acadia providing the remaining funds. At the end of their term of service, roughly half of the Recovery CORE members are hired directly by their host agency or go on to earn a professional licensure or certification in the Behavioral Health field including CADC, MHRT-C, or enrolling in a post-secondary program for social services. OBH has used SUG General funds and Prevention and Treatment Funds to support this work.

Maine Behavioral Health provides Recovery Coaching services in 8 Maine Health Emergency Departments across the State, and served 170 individuals between July 1, 2021, and June 30, 2022. OBH has used SUD General Funds and federal SOR grant funds to support this work.

Milestone's detox facility in Portland employs two Peer Navigators, trained as Recovery Coaches to provide peer support at their facility and to help facilitate patient's transition to the next step in their recovery. OBH has used SUD General funds to support these positions.

The Maine Prisoner Reentry Network provides Peer Recovery Support services to justice involved individuals in Kennebec County. These peers, trained in Recovery Coaching, support individuals referred by the District Attorney's Office, Specialty Alternative Courts, local law enforcement, and Maine Pretrial Services. OBH has used SUD General Funds and federal SOR grant funds to support this work.

Recovery Coach Training

The Office of Behavioral Health provides funding for two providers, Healthy Acadia, and the Portland Recovery Community Center, to deliver Recovery Coach training using the Connecticut Community for Addiction Recovery model. Since OBH began funding these trainings in 2018, these providers have trained more than 1,000 Recovery Coaches. CCAR trainings include:

- Recovery Coaching Basics (6 hours)
- Recovery Coach Academy (30 hours)
- RCA Train the Trainer (12 hours)
- Ethical Considerations (16 hours)
- Coacher vision (12-hour group supervision model)
- RC in the Emergency Department (16 hours)

OBH has used SUD General Funds, Federal SABG, and Federal SOR grant funds to support this work.

Recovery Community Centers- Recovery Community Center's provide peer recovery support services, educate the community about addiction and recovery, and promote the positive benefits of recovery to reduce stigma. They serve as community centers for people in recovery—providing a safe, stigma-free place for people to gather and create a community that includes everything from support groups for people in recovery and their families, to advocacy activities and recreational and social events.

OBH Supports the following Recovery Community Centers:

Provider	Center Name and Town	County
Amistad (2)	(1) Bath Recovery Community Center (2) Boothbay Harbor Peer and Wellness Center	(1) Sagadahoc (2) Lincoln
AMHC (4)	(1) Aroostook Recovery Center of Hope, Houlton (2) Down East Recovery Support Center, Calais (3) Down East Recovery Support Center, Machias (4) Roads to Recovery Community Center, Caribou	(1) Aroostook (2) Washington (3) Washington (4) Aroostook
Bangor Area Recovery Network	The BARN, Brewer	Penobscot
Coastal Recovery Community Center	Coastal Recovery Community Center, Rockland	Knox
Crooked River Counseling	Lake's Region Recovery Center, Bridgeton	Cumberland
Healthy Acadia	INSPIRE Center, Ellsworth	
Larry Labonte Recovery Center	Larry Labonte Recovery Center, Rumford	Oxford
Maine Prisoner Reentry Network	Augusta Reentry and Recovery Center, Augusta	Kennebec
*Portland Recovery Community Center	Portland	Cumberland
Pir2Peer Recovery Community Center	Pir2Peer, Millinocket	Penobscot
Recovery. Employment. Support. Training. Center	R.E.S.T. Center, Lewiston	Androscoggin
Save a Life, Inc	Save a Life, Inc, Lincoln	Penobscot

Recovery Community Centers across the state employ more than 35 Recovery Coaches and more 100 volunteer Recovery Coaches. For the past 2 years, Recovery Community Centers have reported an average of more than 750 unique individuals served monthly, with more than 111 unique daily visitors. OBH has used SUD General funds, federal SABG and federal SOR grant funds to support these efforts.

Recovery Community Center Coordination and Technical Assistance
OBH provides funds for training and technical assistance to ensure that Recovery Community Center staff and volunteers have access to best practices, emerging trends, and the development of the organizational infrastructure necessary to providing Peer Recovery Services. Portland Recovery Community Center has delivered these HUB coordinating services since 2017. In this role, PRCC also supports local community coalitions to develop the capacity to open their own Recovery Community Centers, assists with data collection, marketing and community engagement, and volunteer recruitment and training. OBH has used SUD General funds, federal SABG and federal SOR grant funds to support this work.

Recovery Residences- Recovery Residences offer peer-to-peer recovery support aimed at promoting abstinence-based, long-term recovery. These residences follow the social model of recovery which emphasizes experiential knowledge gained through one's recovery experience.

OBH provides funding for the Maine Association of Recovery Residences (MARR), the State affiliate of the National Association of Recovery Residences, to provide certification, training, and technical assistance of Recovery Residences. There are currently 67 MARR certified Residences offering 689 recovery beds in 11 Maine counties. OBH has used SUD general funds, Federal SABG, and Federal SOR grant funds to support this work.

In partnership with Maine Housing, OBH provides funds to offer an operational subsidy to 17 MARR Certified Recovery Residences. This funding helps offset the costs for more than 130 Recovery beds.

VII. OTHER RESOURCES

Driver Education and Evaluation Program (DEEP)- DEEP is a legislatively mandated (5 MRSA c.521, Sub-c. V) operating-under-the-influence (OUI) countermeasure program. The goal of the programs is to reduce the incidences of injury, disability and fatality that result from alcohol and other drug related motor vehicle crashes, and to reduce the risk of re-offense for OUI. DEEP provides effective, efficient, and meaningful interventions such as education, treatment, and counseling services.

Drug Court Program - Maine's Treatment and Recovery Courts (TRCs) offer treatment services to participants whose criminogenic risks and treatment needs are high, producing a likelihood of recidivism under standard supervision. Treatment and Recovery Courts employ a non-adversarial courtroom atmosphere in which a dedicated multi-disciplinary team works toward a common goal of breaking the cycle of recidivism caused by underlying substance use disorder or mental health issues. Participants remain in the community while being supervised by a case manager and, if on probation, a probation officer. TRCs are located statewide with 7 operating with the District Court System.

Knowyouroptions.me - The Overdose Prevention Through Intensive Outreach Naloxone and Safety (OPTIONS) initiative is a coordinated effort of the Maine Office of Behavioral Health (OBH) and other state agencies to improve the health of Mainers using substances through harm reduction strategies, helping them on the road to recovery, and dramatically reducing the number

of fatal and non-fatal drug overdoses. Specifically, the knowyouroption.me website has searchable SUD resource list https://knowyouroptions.me/resources/
that can be filter by county or service, and provides information to be connected directly a local OPTIONS liaison https://knowyouroptions.me/about-options/

VIII. NEW SUD INITIATIVES AND RESOURCES

MaineMOM Program –
This program focuses on improving care for pregnant and postpartum Mainers with SUD, along with their infants. As of the end of July, MaineMOM had served 84 parents and families and trained 125 clinicians and staff statewide to provide evidence-based and recovery-focused health care through a Statewide learning community. MaineMOM delivers services based on a "no wrong door" system of screening, welcoming, and engaging people in care through partnerships with 19 health care sites across Maine. MaineMOM also includes MaineMOM.org, a website with information on available services. MaineMOM is supported by a federal award through the Centers for Medicare and Medicaid Innovation and is a MaineCare covered service.

Maine Treatment Connection- DHHS is rolling out a behavioral health service locator tool called Maine Treatment Connection. This tool facilitates rapid digital referrals and transfers, and fosters collaboration among medical and mental health providers, criminal justice organizations, homeless services, crisis lines, 2-1-1, social services, and substance use disorder (SUD) treatment programs—closing the loop on care. For Mainers seeking assistance, there is a public facing online portal that will be launching later this year. The platform will enable people to anonymously self-screen and seek mental health and addiction treatment for themselves or others from nearby providers. This secure platform will provide real-time treatment availability, thereby reducing time required to manually contact multiple providers in the hopes of finding necessary, available services. It will also provide valuable analytics back to DHHS regarding the BH care continuum. This effort is funded through multiple state and federal resources.

Maine CDC Youth Primary Prevention Project -
As part of the Maine CDC's substance use prevention efforts, through the Opioid Prevention and Treatment Fund the Mills Administration has provided an additional $1 million to be distributed to community partners across the State for targeted work with middle school aged youth. This initiative will kick off in January of 2023. Implementing partners will choose evidence-based substance use prevention programming based on the needs of their local communities. This investment in our communities and specifically, our middle school aged youth, has the goal of preventing substance use while teaching youth resiliency and fostering a feeling of mattering. Community partners would be required to choose an evidence-based program from an approved list. Two examples of evidence-based programs are Life Skills Training and Prime for Life. This project is funded under the Opioid Prevention and Treatment fund.

SUD Capital Request for Applications (RFA)
DHHS is advancing an initiative to provide up to $4.5 million in funding to eligible behavioral health providers for capital projects that will increase residential treatment beds for substance sse Disorder (SUD) capacity in Maine. This expansion grant is federally funded.

SUD Catalyst Request for Applications (RFA)

DHHS is advancing an initiative to provide up to $1.9 million in funding expand treatment of substance use disorder (SUD) in rural Maine. The funding can be used by behavioral health providers to invest in start-up costs, such as staff training and development, that will allow them to increase the number of patients they serve in rural areas of the state. This new initiative complements State funding for renovation and capital costs increase the number of available beds for residential SUD treatment and medically supervised withdrawal in Maine. These expansion grants are federally funded and offered by the Maine Department of Health and Human Services' Office of Behavioral Health. This expansion grant is federally funded.

Rate Increases
In state fiscal years 2022 and 2023, the budget invests an historic $230 million in behavioral health to support the workforce, capacity, and resilience of substance use and mental health providers as well as sustainable MaineCare rates into the future. MaineCare significantly increased reimbursement rates for residential SUD treatment, averaging a 37.5 percent increase to SUD IOP services. Additional rate determinations are underway.

Medicaid SUD 1115 Waiver on December 22, 2020, Maine received approval for a five-year SUD 1115 demonstration waiver that allows MaineCare to draw down federal funding for sites with more than 16 beds (previously not permitted under the "Institution of Mental Disease exclusion"). The waiver supports the expansion of residential facilities within the state. Recently the Office of MaineCare Services has received further federal approval of several pilots under the waiver to expand services for MaineCare-enrolled parents with SUD who are at-risk of or are involved with Child Protective Services (CPS). T The pilots are intended to address current gaps in coverage for services fundamental to parents' successful recovery and relationships with their children, such as home-based skill development, parenting support services, and, as directed by the Legislature (PDF), maintenance of MaineCare coverage during the CPS assessment process. With this waiver, Maine is the first state in the nation approved to offer continued Medicaid coverage for members who might otherwise lose access during the CPS process due to changes in household size.

Assessment of SUD delivery system- In recent years, DHHS has completed numerous analyses to better understand the sociodemographic and geographic distribution of SUD prevalence in Maine, learn more about the provider and consumer experiences in delivery and accessing care, and assess service access and utilization. The Office of MaineCare Services is planning for a second stage of this work focusing on the determining barriers to receipt of SUD treatment and recovery services across the continuum and identifying opportunities for collaboration with state and local partners.

IX. LICENSED SUD TREATMENT PROVIDERS

SUD SERVICE	LICENSCED PROVIDERS	BEDS
Medication Management Agencies (MAT)	66	
Outpatient Agencies and Sites	357	
Residential Facilities	19	332 beds
Intensive Outpatient Providers	121	
Withdrawal/Detox Providers	14	
Methadone Treatment Providers	119	

APPENDIX D

Civil (Involuntary) Commitment for Substance Use Disorders: Data, Presentation by Dr. Christopher Racine

Civil (Involuntary) Commitment for Substance Use Disorders: Data

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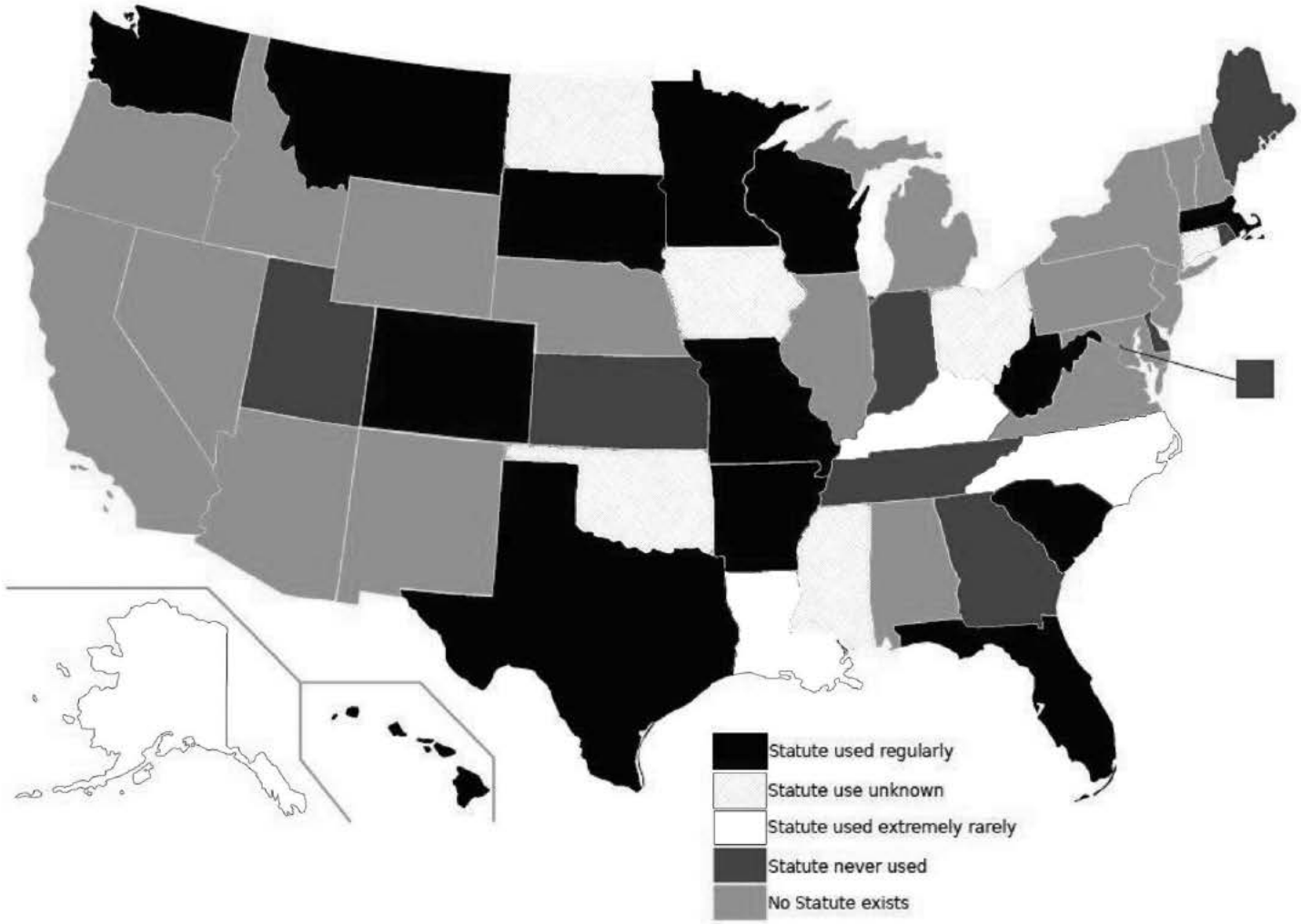
Nature and Utilization of Civil Commitments for Substance Use

37 States and District of Columbia as of 2018

29 States Explicitly Authorize



Nature and Utilization of Civil Commitment for Substance Abuse in the United States
Paul P. Christopher, Debra A. Pinals, Taylor Stayton, Kellie Sanders and Lester Blumberg
Journal of the American Academy of Psychiatry and the Law September 2015, 43 (3) 313-320

Does it work?

- "Outcome data has been limited, difficult to generalize, and complicated by variability in state laws . . . . Although useful in providing some insights, these studies are difficult to apply broadly and are often compromised by vague or absent outcome measures, small sample sizes, subjectivity in assessment, and insufficient detail regarding specific treatments provided during the commitment period. "

Civil Commitment for Opioid and Other **Substance Use Disorders**: Does It Work?Jain A, Christopher P, Appelbaum PS.Psychiatr Serv. 2018 Apr 1;69(4):374-376.

Some mixed evidence

- Florida: “Successful Completion” was similar between 100 involuntary and 219 voluntary participants
  - Sweeney TJ, Strolla MP, Myers DP: Civil commitment for substance use disorder patients under the Florida Marchman Act: demographics and outcomes in the private clinical setting. Journal of Addictive Diseases 32:108–115, 2013
- Minnesota: 6 of 7 patients who were committed for substance use relapsed almost immediately after discharge
  - Lamoureux IC, Schutt PE, Rasmussen KG: Petitioning for involuntary commitment for chemical dependency by medical services. Journal of the American Academy of Psychiatry and the Law 45:332–338, 2017
- MASS: Positive treatment experience and post-commitment medication treatment were correlated with longer post-commitment abstinence in persons who experienced civil commitment for opioid use disorder
  - Commitment Treatment Period Average 21-30 days
  - Median Days to relapse: 14, Median Days to relapse 72
    - Civil Commitment Experience Among Opioid Users. Christopher, P. 2018

Comparison Study: Alcohol in Veterans

Findings suggest that, at least in veterans with substance use problems who receive residential treatment, **there did not appear to be any difference in length of sobriety and reason for admission**. Specifically, no differences were found between those veterans who sought residential treatment voluntarily when compared with veterans who were admitted for treatment subsequent to legal charges with recommendation for treatment due to problems with alcohol use.

	Voluntary (n = 60)	Involuntary (n = 60)		
	M (SD)	M (SD)	Statistics, p	Confidence Intervals
Mean days	100.48 (93.21)	117.30 (117.90)	$t(118) = -0.867$, $p = .39$	[−55.24, 21.61]

A Comparison Between the Involuntary and Voluntary Treatment of Patients With Alcohol Use Disorder in a Residential Rehabilitation Treatment Program.
Boit H, Palmer GA, Olson SA.
J Addict Nurs. 2019 Jan/Mar;30(1):57-60.

Australia: Alcohol use

- A total of 231 patients who were involuntarily treated for alcohol dependence and 231 matched controls who received treatment as usual within the period May 2012 to April 2018.
- There were no significant differences between Involuntary and voluntary group. Both the IDAT and control groups had a reduced number of emergency department presentations and unplanned hospital admissions in the year after index treatment had been completed.

Relapse in involuntary substance treatment: a transversal study

- Brazilian Study
  - No significant differences between individuals who were admitted involuntarily (64%) and voluntarily (54%) were observed (P=0.683) in terms of relapses.
  - Small study
  - No demographics on severity of illness
  - Mixes of substances

Relapse in **involuntary substance treatment**: a transversal study.Sant'Anna WT, Mitsuhiro SS, Figlie NB, Diehl A, Pillon SC, Laranjeira R.Rev Colomb Psiquiatr (Engl Ed). 2020 Oct-Dec;49(4):255-261. doi: 10.1016/j.rcp.2019.02.004. Epub 2019 Apr 20.

Increased Fatal Overdoses in Mexico

- Tijuana, Mexico
  - Involuntary substance treatment significantly increased the odds of reporting a non-fatal overdose event [adjusted odds ratio (aOR) = 1.76; 95% confidence interval (CI) = 1.04-2.96].
  - Many Caveats:
    - Involuntary substance abuse treatment in Mexico notorious for lack of evidence based treatment
    - No discussion of severity of substance use

Increased non-fatal overdose risk associated with **involuntary** drug **treatment** in a longitudinal study with people who inject drugs.Rafful C, Orozco R, Rangel G, Davidson P, Werb D, Beletsky L, Strathdee SA.Addiction. 2018 Jun;113(6):1056-1063.

Nature and Utilization of Civil Commitments for Substance Use Disorders

1. Massachusetts: 6048 (2018)
2. Florida: approx. 3000 (2019)
3. South Carolina 1400 (2019)
4. Minnesota: 350 (2019)
5. Wisconsin: 260 (2011)
6. Colorado: 150-200 yearly

Missouri, Hawaii, and Texas all with less than 100 reported annual cases

No data from 13 states who regularly use substance abuse civil commitment statutes

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KENTUCKY: Casey's Law

- Obtain a copy of the petition from the District Court clerk's office
- A spouse, relative, friend or guardian of the substance abuse-impaired person completes the petition and files it with the District Court clerk.
- The court reviews the allegations in the petition and examines the petitioner under oath.
- The court determines whether there is probable cause to order treatment for the person named in the petition (the respondent).
- If probable cause is established a judge appoints an attorney to represent the respondent, order the respondent to be evaluated, and schedule a hearing within 14 days.
- The respondent is notified of the date and purpose of the hearing.
- The respondent is evaluated by two qualified health professionals, at least one of whom is a physician, to determine if the respondent could benefit from treatment.
- If the judge finds the respondent should undergo treatment, the court shall order treatment from 60 days up to 360 days, depending upon the request in the petition and the result of the evaluation. Treatment options vary depending upon each individual's circumstances and can range from detoxification to intensive treatment through recovery.
- **As the law is currently written, the petitioner is obligated to pay all costs incurred in the process as well as for treatment and must sign a guarantee for payment. The petitioner is also responsible for locating a treatment program**
- **Refusal of treatment = Contempt of Court and possible jail time**

Florida: The Marchman Act

"There is good faith reason to believe the person is substance abuse impaired and, because of such impairment:

- Has lost the power of self-control with respect to substance use; AND EITHER
- Has inflicted, or threatened or attempted to inflict, or unless admitted is likely to inflict, physical harm on himself or herself or another; OR
- Is in need of substance abuse services and, by reason of substance abuse impairment, his or her judgment has been so impaired that the person is incapable of appreciating his or her need for such services and of making a rational decision in regard thereto; however, mere refusal to receive such services does not constitute evidence of lack of judgment with respect to his or her need for such services. "

STEWART-MARCHMAN-ACT Foundation

Florida: The Marchman Act

1.A sworn affidavit is signed at the local county courthouse or clerk's office.

2.A hearing is set before the court after a Petition for Involuntary Assessment and Stabilization is filed.

3.Following the hearing, the individual is held for up to five days for medical stabilization and assessment in a designated treatment and assessment center.

4.A Petition for Treatment must be filed with the court and a second hearing is held for the court to review the assessment.

5.Based on the assessment and the recommendation that the individual needs extended help, the judge can then order a 60-day treatment period with a possible 90-day extension, if necessary.

6.If the individual exits treatment in violation of the judge's order, the individual must return to court and answer to the court as to why they did not comply with treatment. Then the individual is returned immediately for involuntary care.

7.If the individual refuses, they are held in civil contempt of court for not following treatment order and are ordered to either return to treatment or be incarcerated.

8. The respondent (person with substance use disorder) is responsible for payment of treatment

Massachusetts: Section 35

According to MGL chapter 123 Section 35, only a qualified petitioner may request the court to commit someone to treatment under Section 35. They are: a spouse, blood relative, guardian, a police officer, physician, or court official. They must go to the local court and file a written petition or affidavit for an order of commitment

- The court reviews the facts and decides whether or not to issue either a summons or a warrant of apprehension
  - **Right to a forensic evaluation**
- The court will hear the testimony and evidence from the exam and other evidence that relates to the case and then make a decision to grant or deny the petition for commitment. Based on the following criteria:
  - The individual has an alcohol or substance use disorder; AND
  - There is a likelihood of serious harm to self or others as a result of their substance use disorder.
- Commitment is for "up to" 90 days

"Getting Sectioned"

Massachusetts: Section 35

- If the judge grants the petition and orders the commitment, the individual will be returned to a holding cell to await transportation by the local Sheriff's Department to the commitment facility. Transportation typically does not occur until after the courts close so the individual may wait several hours depending on what time their hearing was held.
- The forensic evaluator, after conferring with Central Intake, will make a recommendation to the judge as to which facility will provide the most appropriate level of services. The following programs are approved to treat civil commitments.
- Publicly funded program
  - No choice in treatment facilities
  - Some insurances will pay, some will refuse

Mental Health Providers' Opinion

"Psychiatrists' Opinions About Involuntary Civil Commitment: Results of a National Survey"

Survey sent to 1500 members of the APA, 739 responses

- 22% supported commitment for alcohol use disorders
- 22.3% supported commitment for substance use disoders
- 62.9% supported commitment for psychosis

Mental health professionals' attitudes towards legal compulsion: report of a National Survey (UK)

- 10% of psychiatric professionals favored use of involuntary commitment for substance abuse

Addiction Medicine Providers

- addiction medicine providers supported the application of civil commitment for SUD—60.7% reported being in favor of its use whereas only 21.5% reported being opposed

Psychiatrists' Opinions About Involuntary Civil Commitment: Results of a National Survey. Robert A. Brooks. Journal of the American Academy of Psychiatry and the Law Online June 2007, 35 (2) 219-228;

Roberts C, Peay J, Eastman N, et al: Mental health professionals' attitudes towards legal compulsion: report of a National Survey. Int J Forensic Ment Health 1:71–81, 2002

Jain A, Christopher PP, Fisher CE, Choi CJ, Appelbaum PS. Civil commitment for substance use disorders: a national survey of addiction medicine physicians. J Addict Med. 2021;15:285–291.

THANK YOU!

APPENDIX E

Overview of Involuntary Hospitalization and Progressive Treatment Program Laws, Presentation by Daniel Potenza, MD and Molly Moynihan, Assistant Attorney General

Overview of Involuntary Hospitalization and Progressive Treatment Program Laws

COMMITTEE TO STUDY COURT-ORDERED TREATMENT FOR SUBSTANCE USE DISORDER

SEPTEMBER 16, 2022

Daniel Potenza, MD, Clinical Director
Dorothea Dix Psychiatric Center

Molly Moynihan, AAG
Office of the Attorney General

Agenda

- Overview of Involuntary Hospitalization Process
  - Key Statutory Provisions
  - Protective Custody
  - Emergency Hospitalization Procedures (“Blue Paper”)
  - Judicial Procedure and Commitment (“White Paper”)
- Overview of Progressive Treatment Program Process
  - Key Statutory Provisions
  - Judicial Procedure
  - “Green Paper” Admission to Hospital

Involuntary Hospitalization Statutes

- Title 34-B, Ch. 3, Subch. 4 "Hospitalization"
  - Definitions (§ 3801)
  - Protective custody (§ 3862)
  - Emergency "blue paper" hospitalization (§ 3863)
  - Post-admission judicial procedures and commitment (§ 3664)
  - Discharge (§ 3871)

  - Other sections, including powers of the DHHS Commissioner (§ 3802), patient rights (§ 3802), habeas corpus (§ 3804), voluntary admission to a psychiatric hospital (§ 3831), freedom to leave (§ 3832), etc.

Involuntary Hospitalization: Definitions

- Mentally ill person § 3801(5)
  - A person having a psychiatric or other disease that substantially impairs that person's mental health or creates a substantial risk of suicide
  - Includes persons suffering effects from the use of drugs, narcotics, hallucinogens or intoxicants, including alcohol
  - A person with developmental disabilities or a person diagnosed as a sociopath is not for those reasons alone a mentally ill person

Involuntary Hospitalization: Definitions

- Likelihood of Serious Harm (hospitalization) § 3801(4-A)
  - (A) A substantial risk of harm to the person as manifested by recent threats of, or attempts at, suicide or serious self-inflicted harm
  - (B) A substantial risk of physical harm to other persons as manifested by recent homicidal or violent behavior or by recent conduct placing others in reasonable fear of serious physical harm
  - (C) A reasonable certainty that the person will suffer severe physical or mental harm as manifested by recent behavior demonstrating an inability to avoid risk or to protect the person adequately from impairment or injury

Protective Custody § 3862

- When may a law enforcement officer take a person into protective custody?
  - If a law enforcement officer has probable cause to believe that a person may be **mentally ill** and due to that condition the person poses a **likelihood of serious harm** as defined in section 3801, subsection 4-A, paragraph A, B or C, or if a law enforcement officer knows that a person has an advance health care directive authorizing mental health treatment and the officer has probable cause to believe that the person lacks capacity
- What happens once the law enforcement officer decides to take the person into protective custody?
  - Law enforcement officer shall deliver the person immediately for examination by a medical practitioner

Emergency Involuntary Hospitalization (§ 3863)

- What steps must occur for a person to be admitted to a psychiatric hospital on an emergency basis?
  - Application
  - Certifying Examination
  - Judicial Endorsement

  } "Blue Paper" sections

  - Admission to a Psychiatric Hospital
- What standards apply?
  - Person is mentally ill, and because of that illness, poses a likelihood of serious harm
  - Adequate community resources are unavailable for care and treatment of the person's mental illness

Emergency Involuntary Hospitalization (§ 3863)

- What happens following the person's emergency admission to a psychiatric hospital? Discharge, voluntary stay, or continued involuntary admission?
  - *Within 24 hours*: staff medical practitioner must examine patient to certify in a second opinion the findings under Section 2 of the "blue paper;" otherwise, the person must be immediately discharged (§ 3863(7))
  - *Within 3 days*: hospital CAO determines if further hospitalization needed, and if so, whether patient can be admitted on a voluntary basis; if not, CAO (or Commissioner for non-state hospitals) initiates "white paper" application with the District Court (§ 3863(5-A))

Judicial Procedure & Commitment (§ 3864)

- "White paper" application filed in District Court
- Hospital CAO provides notice to the person and guardian or next of kin
  - Copy of application
  - Right to retain attorney or have one appointed
  - Right to select independent examiner
- District Court issues Notice of Hearing
  - Attorney and independent examiner appointed
  - Hearing set within 14 days of date of application
- Independent examiner meets with person and prepares report to the court

Judicial Procedure & Commitment (§ 3864)

- Hearing: § 3864(5)
  - Held at hospital
  - Confidential
  - Participants include patient, counsel, court, examiner, expert psychiatric witness, others
- Required Findings: § 3864(6)
  - Clear and convincing evidence that the person is **mentally ill** and that the person's recent actions and behavior demonstrate that the person's illness poses a **likelihood of serious harm**;
  - Adequate community resources for care and treatment of the person's mental illness are unavailable;
  - Inpatient hospitalization is the best available means for treatment of the patient; and
  - Court is satisfied with individualized treatment plan offered by the hospital
- Maximum Length of Commitment: § 3864(7)
  - Initial hearing: Court may order commitment for a period not to exceed 4 months
  - Subsequent hearings: for a period not to exceed one year

Post-Commitment Considerations

- Discharge (§ 3871)
  - Examination of patient required "as often as practicable, but no less often than every 30 days" to determine patient's mental status and need for continuing hospitalization
  - Mandatory conditions for discharge include when "conditions justifying hospitalization no longer obtain"
- Continued Involuntary Hospitalization (§ 3864(8))
  - If deemed necessary, new "white paper" application submitted and same judicial process triggered

Progressive Treatment Program (§ 3873-A)

- What is the Progressive Treatment Program (PTP)?
  - The PTP is a form of court-ordered outpatient services for patients with severe and persistent mental illness who would benefit from an individualized treatment plan in the community.

Progressive Treatment Program: Definitions

- Likelihood of serious harm (§ 3801(4-A)(D))
  - In view of the person's treatment history, current behavior and inability to make an informed decision, a reasonable likelihood that the person's mental health will deteriorate and that the person will in the foreseeable future pose a likelihood of serious harm as defined in paragraphs A, B or C

- Severe and persistent mental illness (§ 3801(8-A))
  - Diagnosis of one or more qualifying mental illness or disorders plus a listed disability or functional impairment that has persisted continuously or intermittently or is expected to persist for at least one year as a result of that disease or disorder
    - Qualifying mental illnesses or disorders:
      - schizophrenia, schizoaffective disorder or other psychotic disorder major depressive disorder, bipolar disorder or a combination of mental disorders sufficiently disabling to meet the criteria of functional disability
    - Listed disabilities or functional impairments which must result from the diagnosed qualifying mental illness or disorder include:
      - inability to adequately manage one's own finances, inability to perform activities of daily living and inability to behave in ways that do not bring the attention of law enforcement for dangerous acts or for acts that manifest the person's inability to protect the person from harm.

Progressive Treatment Program: Judicial Process

- Criteria for PTP admission (§ 3873-A(1))
  - Patient suffers from severe and persistent mental illness
  - Patient poses a likelihood of serious harm
  - Benefit of a suitable individualized treatment plan
  - Available licensed and qualified community providers to support the treatment plan
  - Patient unlikely to follow the plan voluntarily
  - Court-ordered compliance will help protect the patient from interruptions in treatment, relapses or deterioration of mental health
  - Compliance will enable the patient to survive more safely in a community setting without posing a likelihood of serious harm

Progressive Treatment Program: Judicial Process

- Application to District Court
  - Certificate of a medical practitioner that criteria for PTP satisfied
  - Proposed individualized treatment plan
  - Identification of one or more licensed and qualified community providers willing to support the plan
- Applicant provides notice to the person and guardian or next of kin
  - Copy of application
  - Right to retain attorney or have one appointed
  - Right to select independent examiner
- District Court issues Notice of Hearing
  - Attorney and independent examiner appointed
  - Hearing set within 14 days of date of application
- Independent examiner meets with person and prepares report to the court
- Hearing

Progressive Treatment Program

- PTP Order
  - Following hearing, District Court may enter patient's admission to the PTP for a period of up to 12 months directing patient to follow plan and identifying incentives for compliance and potential consequences for non-compliance
- Post-Order
  - "Green Paper" (§ 3873-A(7)(B))
    - Court may endorse an application for the patient's admission to a psychiatric hospital under the emergency hospitalization procedures set forth in § 3863 conditioned upon a certificate from a medical practitioner that the patient has failed to comply with an essential requirement of the treatment plan
  - Motion for Enforcement (§ 3873-A(8))
  - Motion to dissolve, modify, or to extend the term of the treatment plan for an additional term of one year (§ 3873-A(9))

Conclusion

- Questions

APPENDIX F

Civil (Involuntary) Commitment for Substance Use Disorders, Presentation by Dr. Christopher Racine

Civil (Involuntary) Commitment for Substance Use Disorders

CHRISTOPHER RACINE, MD, MPH

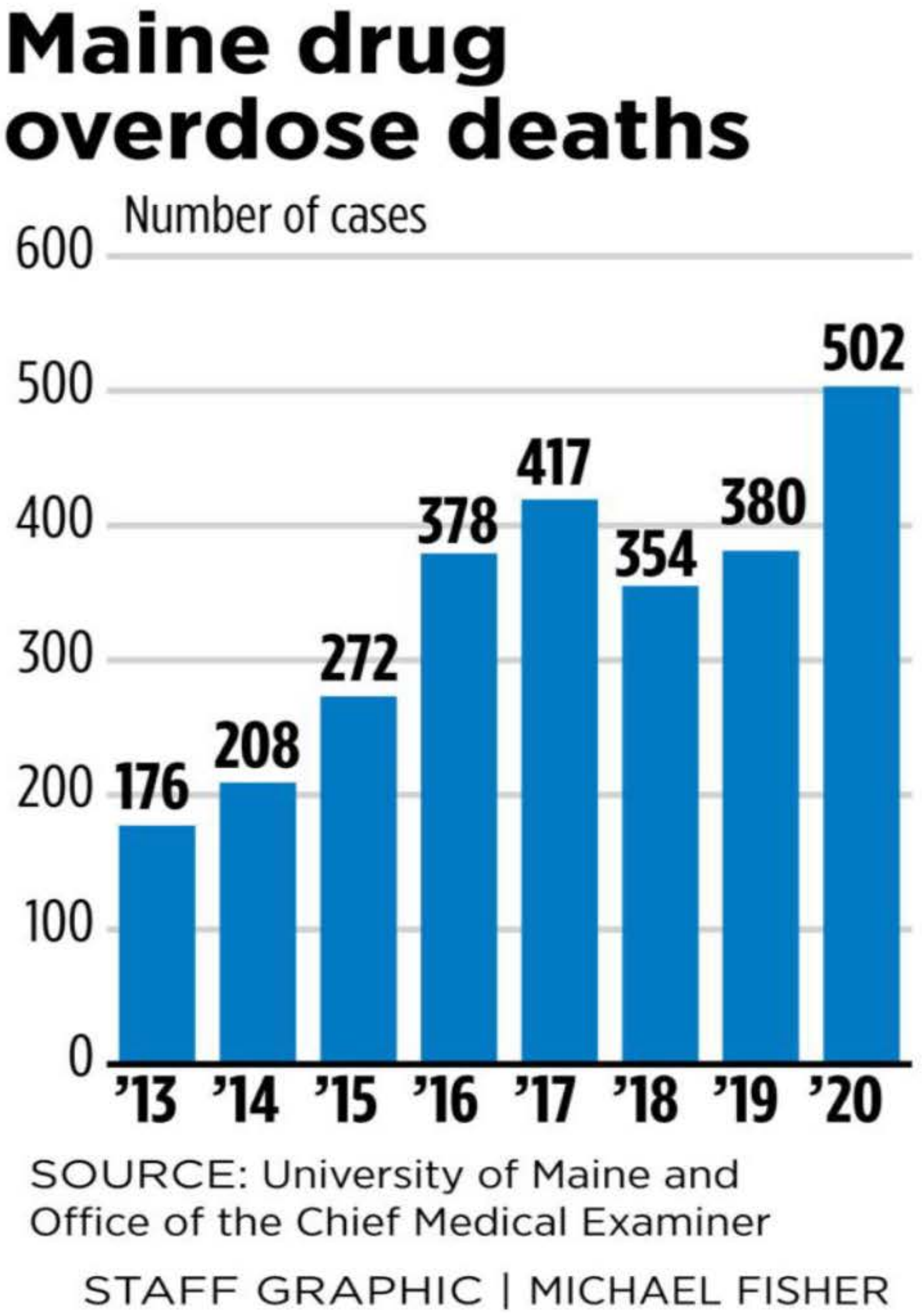
DIVISION DIRECTOR, EMERGENCY PSYCHIATRY

MAINE MEDICAL CENTER DEPARTMENT OF PSYCHIATRY

ASSISTANT PROFESSOR, TUFTS UNIVERSITY SCHOOL OF MEDICINE

Overdose Deaths in Maine

9th Highest Rate in the Country of Overdose Deaths according to CDC statistics



esshеald.com

2021: 621!

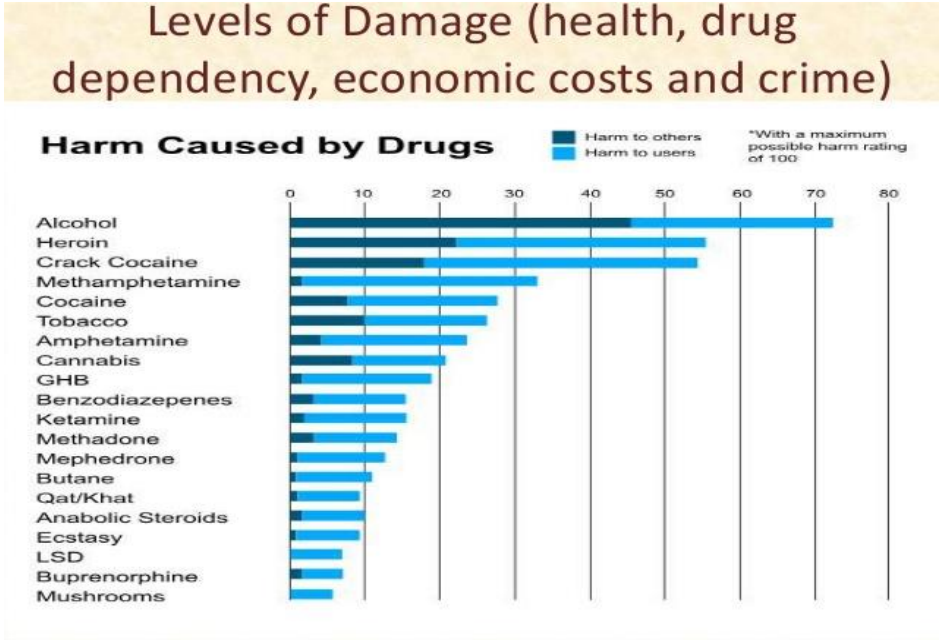
Substance Use Disorders: Economic Costs

- In 2010, Alcohol misuse cost the United States $249 Billion
- The cost of the opioid epidemic may be over $500 Billion

Table 1: Estimated Cost of Opioid-involved Overdose Deaths in 2015 (2015 $)

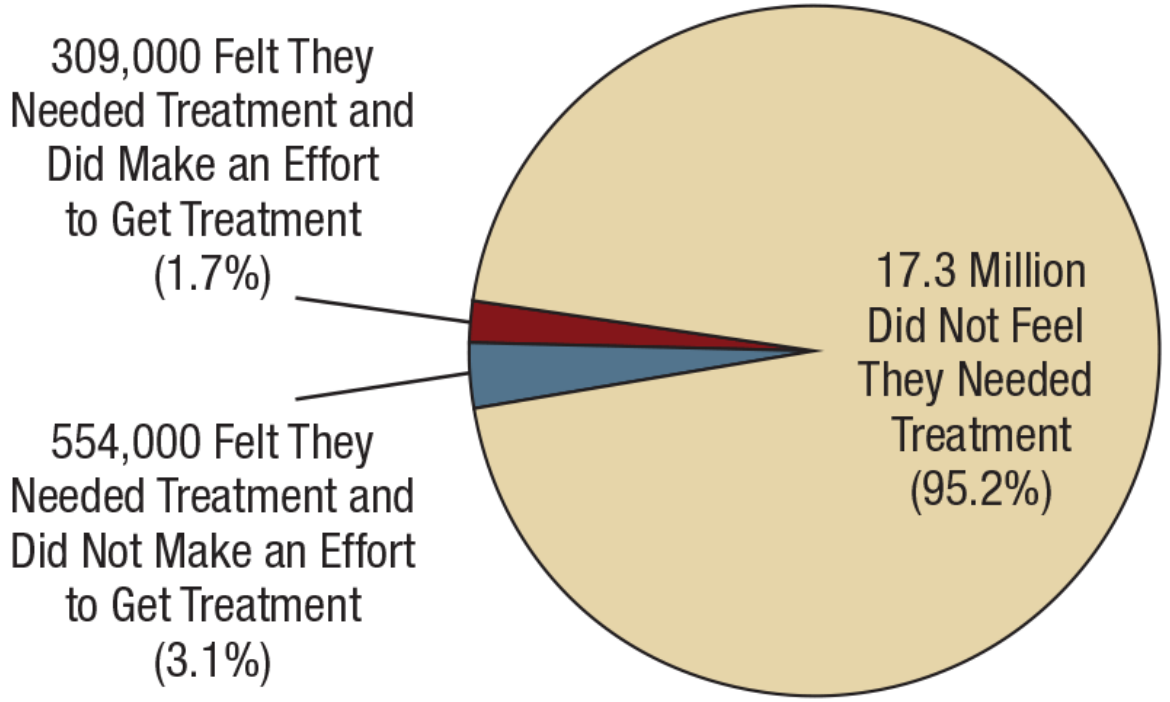
VSL Assumption	Estimated Cost of Fatalities
Age-dependent	$431.7 billion
Low	$221.6 billion
Middle	$393.9 billion
High	$549.8 billion

Note: We assign the VSL of 18 to 24 year-olds for fatalities in the 0 to 17 year-old group, and we assign the VSL of 55 to 62 year-olds for fatalities in the over-62 year-old group. Two fatalities had no reported age; they were assigned the average VSL over all other fatalities. We also adjust Aldy and Viscusi's figures for the effects of inflation and real income growth, following the procedure described in the U.S. DOT (2016), p. 8.
Source: Aldy and Viscusi (2008); U.S. Department of Transportation (2016); CDC WONDER database, multiple cause of death files; Ruhm (2017); CEA calculations.



Sacks, J.J.; Gonzales, K.R.; Bouchery, E.E.; et al. 2010 national and state costs of excessive alcohol consumption. *American Journal of Preventive Medicine* 49(5):e73–e79, 2015.
Aldy and Viscusi (2008); U.S. Department of Transportation (2016); CDCWONDER database, multiple cause of death files; Ruhm (2017); CEA calculations.

Most Persons with Substance Use Disorders Do Not Seek Treatment



18.1 Million Adults Needed but Did Not Receive Substance Use Treatment

https://www.samhsa.gov/data/sites/default/files/NSDUH-ServiceUseAdult-2015/NSDUH-ServiceUseAdult-2015/NSDUH-ServiceUseAdult-2015.htm#fig14

Substance Misuse in America

1. Tens of thousands of people are dying in the United States each year due to substance abuse
2. Substance abuse is costing American society billions of dollars a year
3. There are evidence-based medication and psychosocial treatments available
4. A very small percentage of people with substance use disorders think they need treatment. An even smaller percentage of people actually seek out treatment.

Involuntary Commitment Laws

Review of Commitment Law Development

- *Parens Patriae* = "Parent of the Country"
  - The idea that the government can intervene on behalf of individuals who cannot act in their own self interest
  - Based in English Common Law
  - Beneficence supersedes autonomy

Maine Civil Commitment Statute

- Three Pronged
- "Blue Paper"
  - Substantial risk of physical harm to the person shown by
    - recent threats of suicide or serious bodily harm to self or
    - recent attempts at suicide or serious bodily harm to self
  - Substantial risk of physical harm to others as shown by
    - recent homicidal or other violent behavior or
    - recent conduct placing others in reasonable fear of serious physical harm
  - Inability to care for self
    - reasonable certainty that severe physical or mental impairment or injury will result to the person as shown by recent behavior demonstrating person's inability to avoid risk or to protect himself or herself adequately from impairment or injury

34-B M.R.S.A. §3801(4-A)(C)

Review of Civil Commitment Laws

1. The “state” has an established right to hospitalize persons who have mental illness for their own benefit and that of society

2. The standard for such confinement is generally dangerousness to self or others

3. It has to be the “Least Restrictive” alternative

4. Treatment should be offered to those confined

5. “Due Process” and procedural safeguards exist to prevent abuse

6. The burden of proof for keeping someone confined is “Clear and Convincing” evidence

7. Based on the idea that mental illness is “treatable”

Involuntary Treatment for Substance Use Disorders

Civil Commitment for Substance Use: The Argument in Favor

- Society has accepted involuntary confinement for a class of persons who might be dangerous to themselves or others
- This is based on the accepted theory that mental illness is treatable
- Untreated substance use disorders are causing at least as much, if not more, harm to individuals and society than mental illness
- Emerging scientific consensus accepts the “disease” model of addiction
- Evidence is that most persons with addictive disorders do not think they need treatment
- Persons with substance use disorders are disproportionately incarcerated and/or homeless
- Could serve as a viable alternative to unnecessary incarceration
- WHY CANT SOMEONE BE COMMITTED FOR THEIR SUBSTANCE USE DISORDER?????

Opposition and Arguments Against Civil Commitment for Addictive Disorders

- Deprivation of liberty
- Capacity
- It's a choice
- Inadequate availability of treatment
- One issue that is of particular concern is that many institutions have refused to integrate empirically validated treatments into their protocols
  - Abstinence based programs
- Time for treatment (months to years)

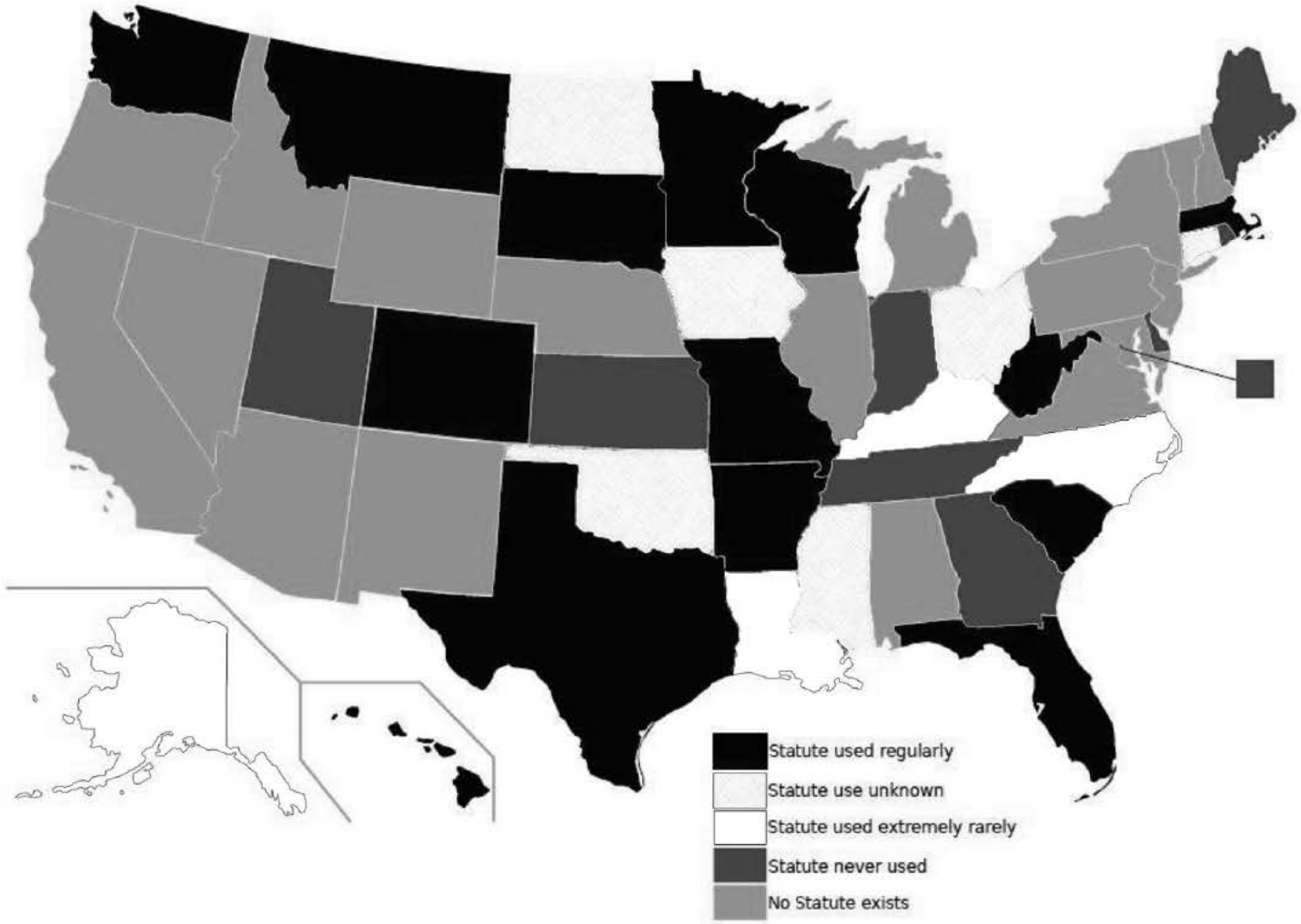
Opposition and Arguments Against Civil Commitment for Addictive Disorders

- Persons placed in inappropriate settings
- Slippery slope arguments
- Enforcement is not possible
- Scope of the problem is too big
- Can actually be dangerous!

Nature and Utilization of Civil Commitments for Substance Use

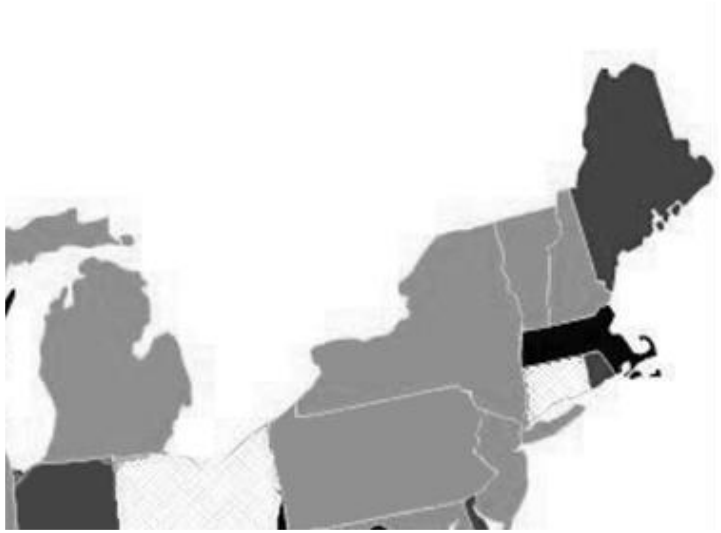
37 States and District of Columbia as of 2018

29 States Explicitly Authorize



Nature and Utilization of Civil Commitment for Substance Abuse in the United States
Paul P. Christopher, Debra A. Pinals, Taylor Stayton, Kellie Sanders and Lester Blumberg
Journal of the American Academy of Psychiatry and the Law September 2015, 43 (3) 313-320

Maine Civil Commitment Statute



34-B 3801

Mentally ill person. "Mentally ill person" means a person having a psychiatric or other disease that substantially impairs that person's mental health or creates a substantial risk of suicide. "Mentally ill person" includes persons suffering effects from the use of drugs, narcotics, hallucinogens or intoxicants, including alcohol. A person with developmental disabilities or a person diagnosed as a sociopath is not for those reasons alone a mentally ill person.
[2009, c. 651, §6 (AMD) .]

Nature and Utilization of Civil Commitments for Substance Use Disorders

1. Massachusetts: 6048 (2018)
2. Florida: approx. 3000 (2019)
3. South Carolina 1400 (2019)
4. Minnesota: 350 (2019)
5. Wisconsin: 260 (2011)
6. Colorado: 150-200 yearly

Missouri, Hawaii, and Texas all with less than 100 reported annual cases

No data from 13 states who regularly use substance abuse civil commitment statutes

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Nature and Utilization of Civil Commitments for Substance Use Disorders

- Treatment settings vary
  - Hospitalization/confinement
  - Mandatory community treatment
- Length of Treatment varies
  - Days is some places
  - >1 year in certain circumstances
- Which substances?
  - Most provide for treatment of alcohol and illicit substances
  - Washington state senate Bill 5811-targeting heroin
    - "Three of more visible track marks" as evidence of "grave disability"

Case Studies: Florida and Massachusetts

Florida: The Marchman Act

"There is good faith reason to believe the person is substance abuse impaired and, because of such impairment:

- Has lost the power of self-control with respect to substance use; AND EITHER
- Has inflicted, or threatened or attempted to inflict, or unless admitted is likely to inflict, physical harm on himself or herself or another; OR
- Is in need of substance abuse services and, by reason of substance abuse impairment, his or her judgment has been so impaired that the person is incapable of appreciating his or her need for such services and of making a rational decision in regard thereto; however, mere refusal to receive such services does not constitute evidence of lack of judgment with respect to his or her need for such services. "

STEWART-MARCHMAN-ACT Foundation

Florida: The Marchman Act

1.A sworn affidavit is signed at the local county courthouse or clerk's office.

2.A hearing is set before the court after a Petition for Involuntary Assessment and Stabilization is filed.

3.Following the hearing, the individual is held for up to five days for medical stabilization and assessment in a designated treatment and assessment center.

4.A Petition for Treatment must be filed with the court and a second hearing is held for the court to review the assessment.

5.Based on the assessment and the recommendation that the individual needs extended help, the judge can then order a 60-day treatment period with a possible 90-day extension, if necessary.

6.If the individual exits treatment in violation of the judge's order, the individual must return to court and answer to the court as to why they did not comply with treatment. Then the individual is returned immediately for involuntary care.

7.If the individual refuses, they are held in civil contempt of court for not following treatment order and are ordered to either return to treatment or be incarcerated.

Florida: The Marchman Act

- Support
  - Has survived since 1993
  - Many family testimonials
  - Perception from law enforcement and advocates that it gives an option to incarceration
  - Some believe ER volumes have gone down
  - Treatment and assessment centers have grown
- Criticisms
  - Not accessible in many rural areas
  - Many counties do not have the money to support it
  - Many for-profit treatment centers and lawyers have started advertising
  - Lack of data to support
  - Planning and implementation has been haphazard

Massachusetts: Section 35

According to MGL chapter 123 Section 35, only a qualified petitioner may request the court to commit someone to treatment under Section 35. They are: a spouse, blood relative, guardian, a police officer, physician, or court official. They must go to the local court and file a written petition or affidavit for an order of commitment

- The court reviews the facts and decides whether or not to issue either a summons or a warrant of apprehension
  - **Right to a forensic evaluation**
- The court will hear the testimony and evidence from the exam and other evidence that relates to the case and then make a decision to grant or deny the petition for commitment. Based on the following criteria:
  - The individual has an alcohol or substance use disorder; AND
  - There is a likelihood of serious harm to self or others as a result of their substance use disorder.
- Commitment is for "up to" 90 days

"Getting Sectioned"

Massachusetts: Section 35

If the judge grants the petition and orders the commitment, the individual will be returned to a holding cell to await transportation by the local Sheriff's Department to the commitment facility. Transportation typically does not occur until after the courts close so the individual may wait several hours depending on what time their hearing was held.

The forensic evaluator, after conferring with Central Intake, will make a recommendation to the judge as to which facility will provide the most appropriate level of services. The following programs are approved to treat civil commitments.

Oversight	Facility Name	Location	Population	Capacity
DPH	High Point Women's Addiction Treatment Center (WATC)	New Bedford, MA	Female	102 beds (30 ATS and 72 CSS)[4]
	High Point Treatment Center at Shattuck Hospital (HPTC)	Jamaica Plain, MA	Female	32 beds (16 ATS and 16 CSS)
	High Point Men's Addiction Treatment Center (MATC)	Brockton, MA	Male	108 beds (32 ATS and 76 CSS)
DMH	DMH Women's Recovery from Addiction Program (WRAP)	Taunton, MA	Female	45 beds (15 ATS and 30 CSS)[5]
DOC[1]	Massachusetts Alcohol and Substance Abuse Center (MASAC)	Plymouth, MA	Male	251 beds (42 ATS and 209 CSS)
	MCI – Framingham First Step Program[3]	Framingham, MA	Female	N/A; dual status must have bail (ATS and CSS)
HCSD[2]	Stonybrook Stabilization and Treatment Center – Ludlow	Ludlow, MA	Male	85 beds (ATS and CSS)
	Stonybrook Stabilization and Treatment Center – Springfield	Springfield, MA	Male	32 beds (CSS)

Massachusetts: Section 35

Between 2010 and 2016, Massachusetts saw an 83 percent increase in the number of Section 35 commitments.

20% are “self-commitments”

MASAC

Massachusetts: Section 35

- Support
  - Allowances for MAT (including Vivitrol) at most facilities
  - Opioid-related death rate is declining in Massachusetts as opposed to most New England states
  - Alternative to incarceration for drug related crimes
  - Entitled to at least 20 hours of therapy per week
  - Section 35 commission established in August 2018
- Criticism
  - Prison-like settings (including some that are actual former prisons)
  - Inadequate legal protections such as cursory hearings
  - People who have been civilly committed may have a higher risk of death by overdose (2016 Section 55 report)
  - Overuse of the court system

Does it work?

- "Outcome data has been limited, difficult to generalize, and complicated by variability in state laws "
  - Civil Commitment for Opioid and Other Substance Use Disorders: Does It Work? Psychiatric services (Washington, D.C.) 69(4):374-376 · April 2018
- Florida: "Successful Completion" was similar between 100 involuntary and 219 voluntary participants
  - Sweeney TJ, Strolla MP, Myers DP: Civil commitment for substance use disorder patients under the Florida Marchman Act: demographics and outcomes in the private clinical setting. Journal of Addictive Diseases 32:108–115, 2013
- Minnesota: 6 of 7 patients who were committed for substance use relapsed almost immediately after discharge
  - Lamoureux IC, Schutt PE, Rasmussen KG: Petitioning for involuntary commitment for chemical dependency by medical services. Journal of the American Academy of Psychiatry and the Law 45:332–338, 2017
- MASS: Positive treatment experience and post-commitment medication treatment were correlated with longer post-commitment abstinence in persons who experienced civil commitment for opioid use disorder
  - Commitment Treatment Period Average 21-30 days
  - Median Days to relapse: 14, Median Days to relapse 72
    - Civil Commitment Experience Among Opioid Users. Christopher, P. 2018

Mental Health Providers' Opinion

"Psychiatrists' Opinions About Involuntary Civil Commitment: Results of a National Survey"

Survey sent to 1500 members of the APA, 739 responses

- 22% supported commitment for alcohol use disorders
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Jain A, Christopher PP, Fisher CE, Choi CJ, Appelbaum PS. Civil commitment for substance use disorders: a national survey of addiction medicine physicians. J Addict Med. 2021;15:285–291.

Future Directions

- Need for well-crafted research into utilization and success rates for guidance
  - Setting for treatment
  - Length of treatment
  - Type of substance (opioids vs. others)
  - Enforcement mechanisms
- Systemic evaluation of practical considerations
  - Availability of treatment settings and providers
  - Potential to overwhelm the health system
  - How does this intersect with treatment for mental illness
- A re-examining of whether such a mechanism is needed and/or wanted

Summary/Conclusions

- Substance use disorders in the United States are responsible for tens of thousands of deaths and with substantial economic burden
- Commitment statutes in most states, including Maine, generally allow for the civil commitment of persons with substance use disorders who are “dangerous”
- However, very few states regularly utilize these statutes.
- In states who civilly commit persons with dangerous substance use disorders, there data is mixed regarding efficacy of utilizing civil commitment for substance use disorder treatment
- Lack of available substance use treatment facilities is a significant barrier to implementing a pathway for involuntary substance abuse treatment
  - Highly recommend against the widespread implementation of such a policy without significant investment in bolstering and/or creating a treatment infrastructure for those who are committed
- Treatment programs should use evidence-based treatments including psychotherapeutic and psychopharmacologic treatments to maximize benefits and minimize potential harms of violating personal autonomy

THANK YOU!

APPENDIX G

Maine's Treatment and Recovery Courts, Presentation by Richard Gordon

Maine's Treatment and Recovery Courts

MAINE'S TREATMENT AND RECOVERY COURTS

- Veterans Treatment Courts

  Kennebec (Augusta, Justice Cashman, Mon)

  Cumberland (Portland, Judge French, Wed)

- Co-Occurring Disorders Court

  Kennebec (Augusta, Justice Cashman, Mon)

MAINE'S TREATMENT AND RECOVERY COURTS

- Family Recovery Courts

  Androscoggin (Lewiston, Judge Archer, alternating Mon)

  Kennebec (Augusta, Judge Walker, alternating Fri)

  Penobscot (Bangor, Judge Larson, alternating Wed)

MAINE'S TREATMENT AND RECOVERY COURTS

- Treatment and Recovery Courts (formerly Adult Drug Treatment Courts)
  - York (Alfred, Justice Douglas, Fri)
  - Cumberland (Portland, Judge French, Wed)
  - Androscoggin (Auburn, Justice Stewart, alternating Fri)
  - Oxford (South Paris, Judge Ham-Thompson, alternating Fri)
  - Midcoast (Belfast/Rockland, Judge Walker, alternating Fri)
  - Penobscot (Bangor, Judge Larson, alternating Wed)
  - Hancock (Ellsworth, Judge Larson, alternating Fri)
  - Washington (Calais/Machias, Judge Mitchell, Fri)

Oversight of the Treatment and Recovery Courts

- Treatment and Recovery Courts, Veterans Treatment Courts, CODC
  - Statewide Steering Committee chaired by Judge David Mitchell (Washington TRC)
  - Composed of all TRC/VTC/CODC judges, Statewide Coordinator, and representatives of all disciplines involved with the TRC/VTC/CODC programs.
- Family Recovery Courts
  - Statewide Steering Committee chaired by Judge Eric Walker (Kennebec FRC)
  - Composed of all FRC judges, Statewide Coordinator, and representatives of all disciplines involved with the FRC's.

Entry Criteria

- Treatment and Recovery Courts
  - High Risk – risk of failing to thrive under standard supervision- NOT risk of violence
  - High Need
  - Legally Eligible Charge
- Family Recovery Courts
  - High Risk/High Need
  - Jeopardy

Treatment and Recovery Court Team Members

Judge	Prosecutor	Defense Attorney	Treatment Provider	Case Manager	Probation Officer
Coordinator	Law Enforcement Officer	Veterans Justice Outreach (VJO)	Mentor/Peer Support	Case Manager Supervisor	Evaluator

TEAM MEMBER IMPACT

- Judge: When the judge spends an average of 3 or more minutes in court per participant, costs savings go up 36% and recidivism goes down by 153%; When assigned voluntarily, recidivism goes down 84%; When term is indefinite, recidivism goes down 35%

- Prosecutor: When the prosecutor attends Staffing, cost savings go up 171%; attends court sessions, recidivism goes down 35%

- Defense Attorney: When the defense attorney attends Staffing, cost savings go up 93%; attends court sessions, recidivism goes down 35%

- Treatment: When the treatment provider communicates with the team by email recidivism goes down 119%

- Treatment: When treatment attends the court sessions recidivism goes down by 100%; When offers concurrent mental health treatment, recidivism goes down 80%

- When all team members attend Staffing recidivism goes down by 35%

- LEO: When a LEO is on a team, recidivism goes down 88%; When LEO attends court session, recidivism goes down 83%.

Recidivism reduction and cost saving are relative to courts that do not follow these practices,

NPC Research Key Component Study, 2008

10 KEY COMPONENTS

Treatment and Recovery Courts

- Key Component 1 — Drug Courts integrate alcohol and other drug treatment services with justice system case processing.
- Key Component 2 — Using a non-adversarial approach, prosecution and defense counsel promote public safety while protecting participants' due process rights.
- Key Component 3 — Eligible participants are identified early and promptly placed in the drug court program.
- Key Component 4 — Drug Courts provide access to a continuum of alcohol, drug, and other related treatment and rehabilitation services.
- Key Component 5 — Abstinence is monitored by frequent alcohol and other drug testing.

- Key Component 6 — A coordinated strategy governs drug court responses to participants' compliance.
- Key Component 7 — Ongoing judicial interaction with each drug court participant is essential.
- Key Component 8 — Monitoring and evaluation measure the achievement of program goals and gauge effectiveness
- Key Component 9 — Continuing interdisciplinary education promotes effective drug court planning, implementation, and operations.
- Key Component 10 — Forging partnerships among drug courts, public agencies, and community-based organizations generates local support and enhances drug court program effectiveness.

https://www.ndci.org/resources/defining-drug-courts-the-key-components/

BEST PRACTICE STANDARDS

- I. Target Population
- II. Equity and Inclusion
- III. Roles and Responsibilities of the Judge
- IV. Incentives, Sanctions, and Therapeutic Responses
- V. Substance Use Disorder Treatment

- VI. Complementary Treatment and Social Services.
- VII. Drug and Alcohol Testing.
- VIII. Multidisciplinary Team.
- IX. Census and Caseloads.
- X. Monitoring and Evaluation.

https://www.ndci.org/standards/

5 PHASE PROCESS

Phase 1: Orientation, Engagement, and Stabilization

- 30 days (minimum)
- Court: weekly or as directed
- Show up!
- Be honest!
- Treatment and case management plans developed and implemented
- Attend pro-social activities
- 14 days with no missed, positive, or diluted tests
- 7 days with no court-imposed sanctions

Phase 2: Sobriety and Abstinence

- 90 days (minimum)
- Court weekly or as directed
- Engage in treatment and case management plans
- Demonstrate changes to people, places and things
- Attend pro-social activities
- 30 days with no missed, positive, or diluted tests
- 7 days with no court-imposed sanctions

Phase 3: Maintenance and Relapse Prevention

- 90 days (minimum)
- Court every other week or as directed
- Continued engagement with treatment
- Develop a relapse prevention plan
- Return to work or education
- Strengthen community involvement
- 60 days with no missed, positive, or diluted test
- 14 days with no court-imposed sanctions

Phase 4: Maintenance and Community Involvement

- 90 days (minimum)
- Court monthly or as directed
- Continued engagement in treatment
- Increased return to the community with lower supervision
- 60 days with no missed, positive, or diluted test
- 14 days with no court-imposed sanctions

Phase 5: Early Recovery and Alumni

- 90 days (minimum)
- Court monthly or as directed
- Continued engagement in treatment
- Develop a continuing plan of care for after completion of court
- 90 days with no missed, positive, or diluted test
- 14 days with no court-imposed sanctions

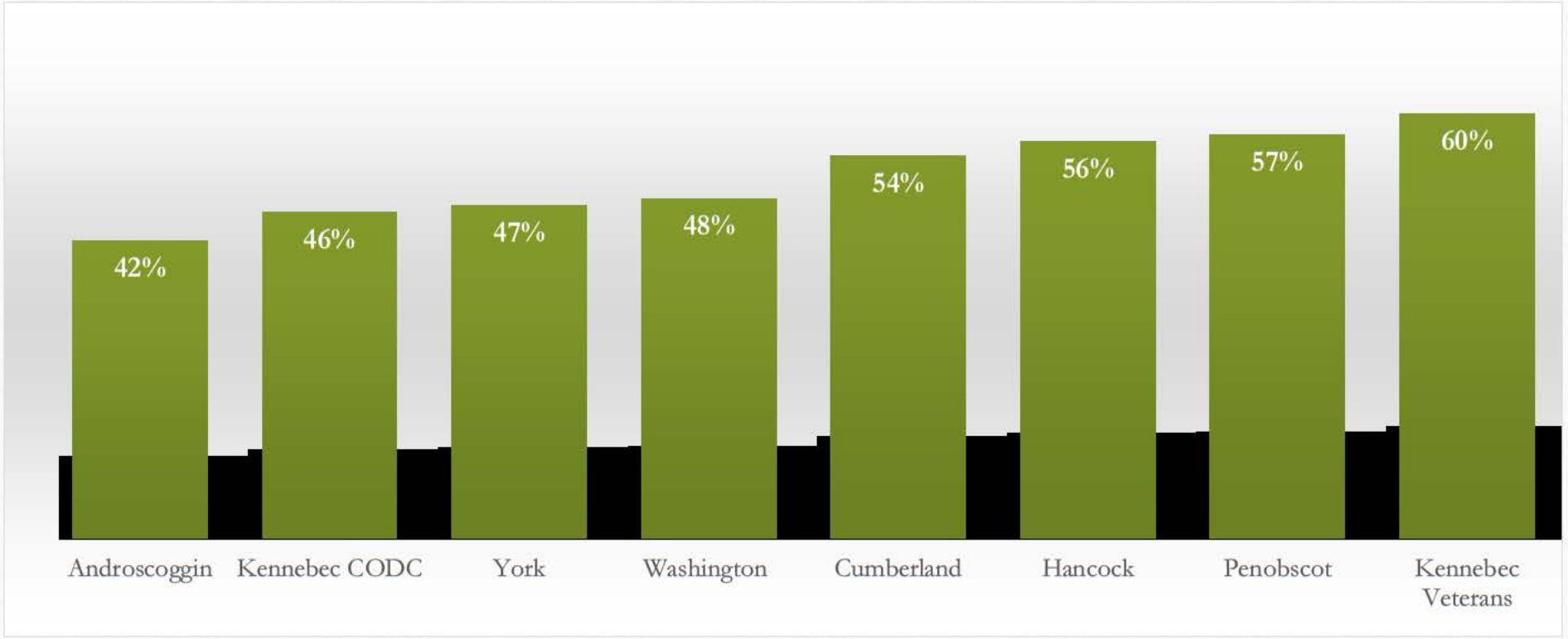
Treatment Courts Work

How do we know?

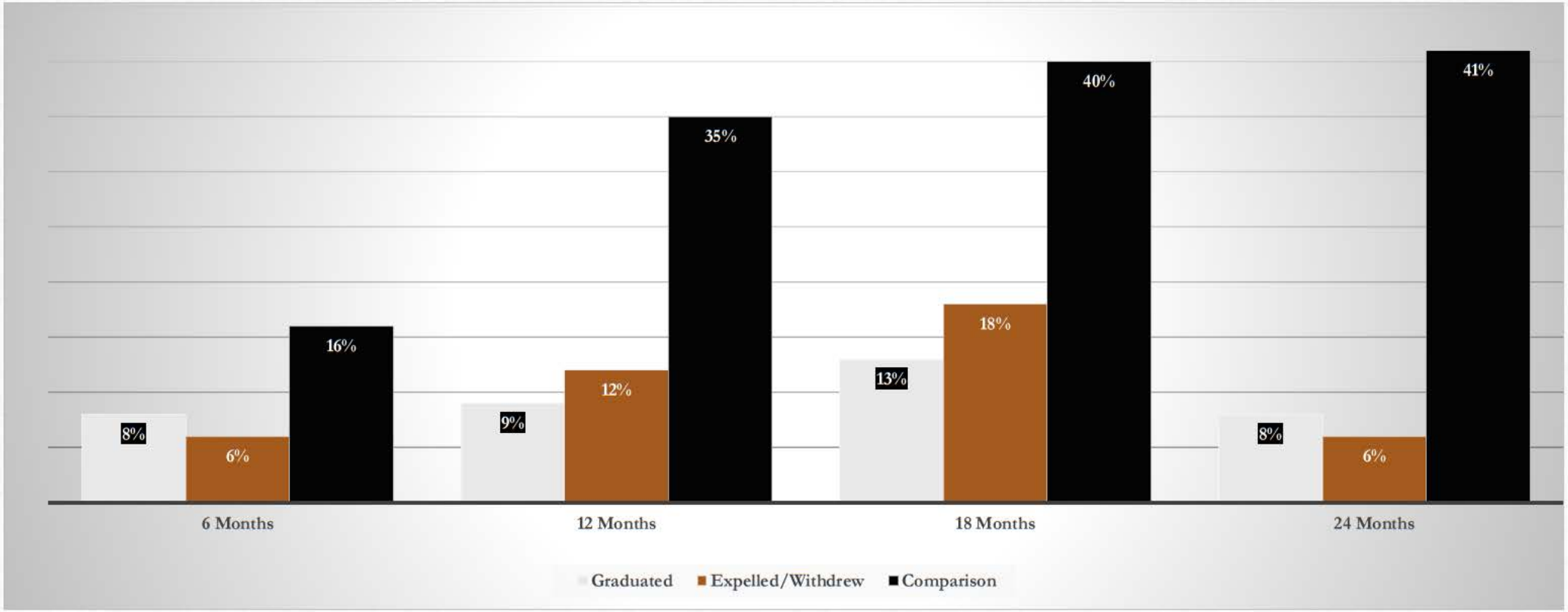
Recent year long evaluation of the Treatment Courts by Public Consulting Group

What does the data show?

Graduation Rates of the Treatment and Recovery Courts



Conviction Recidivism of Treatment and Comparison Groups After Release: 2016-2019



Conviction rates fairly comparable regardless of exit type; both superior to comparison group.

Treatment Courts have Cost Benefits

Time	Treatment Group Cost Per Person	Comparison Group Cost Per Person	Treatment Savings Percent Per Person	Treatment Savings Dollars Per Person
Exit	$ 38,193	$ 43,461	12%	$ 5,268
6 months	$ 41,235	$ 50,414	18%	$ 9,179
12 months	$ 42,974	$ 58,672	27%	$ 15,699
18 months	$ 44,712	$ 60,845	28%	$ 16,133

Lower cost at exit and even greater savings taking reduced recidivism into account.

TREATMENT AND RECOVERY COURTS WORK!

Kim S.

Adult Drug Treatment Court Grad

I just enjoy so many things these days that I'm not willing to give up.

Courtney A.

Family Recovery Court Graduate

This opportunity saved my life and gave me the ability to be a mother again.

TRANSFORMATION

WHY TREATMENT AND RECOVERY COURTS WORK

- More than just an alternative
- Unite public health with public safety
- Meet accountability with compassion
- Ensure evidence-based treatment and recovery solutions instead of incarceration
- Transform courtrooms into places of hope, safety, and health

Treatment Court Referral Form

https://mjbportal.courts.maine.gov/CourtForms/FormsLists/DownloadForm?strFormNumber=CR-234

MAINE JUDICIAL BRANCH

TREATMENT AND RECOVERY COURT REFERRAL FORM

ADULT DRUG TREATMENT AND RECOVERY COURT

- ☐ ANDROSCOGGIN COUNTY
- ☐ CUMBERLAND COUNTY
- ☐ HANCOCK COUNTY
- ☐ OXFORD/FRANKLIN COUNTY
- ☐ PENOBSCOT COUNTY
- ☐ REGION VI (LINCOLN/KNOX/SAGADAHOC/WALDO)
- ☐ WASHINGTON COUNTY
- ☐ YORK COUNTY

CO-OCCURING DISORDERS COURT

- ☐ KENNEBEC COUNTY

VETERANS TREATMENT COURT

- ☐ KENNEBEC COUNTY
- ☐ CUMBERLAND COUNTY

☐ Veteran (Check if applicable and attach DD-214, if available)

Defendant: _____

Date of Birth (mm/dd/yyyy): ____/____/____

Current Mailing Address: _____

Current Residential Address: _____

County: _____

In Custody: ☐ Yes ☐ No If yes, location: _____

If no, phone number: _____

Email: _____

Docket Number and Charge: _____

_____

An interpreter for the _____ language is requested.

Country, region, or dialect: _____

Accommodations requested: _____

Referred by: _____

Phone and Email address: _____

ADTC: Return completed form to the clerk of the court where your charges are pending.
CODC and Kennebec County VTC: Return completed form to Kennebec County Clerk's Office.
Cumberland County VTC: Return completed form to Cumberland County Clerk's Office.

ADA Notice: The Maine Judicial Branch complies with the Americans with Disabilities Act (ADA). If you need a reasonable accommodation, contact the Court Access Coordinator, accessibility@courts.maine.gov, or a court clerk.
Language Services: For language assistance and interpreters, contact a court clerk or interpreters@courts.maine.gov.

CV-234, Rev. 04/22 Page 1 of 1 www.courts.maine.gov
Treatment and Recovery Court Referral Form

INCENTIVES & SANCTIONS

Positive Behavior

Incentive Matrix: "What do we want the participant to learn from this?"

Step 1. Identify the ***Behavior***

Easier/Positive	Moderate	Difficult/Distal
• Attendance at treatment • Attendance at other appointments • Home for home visits • Report to UA • Timeliness • Payment	• Honesty • Testing Negative • Participating in Prosocial Activities • Employment • Progress toward Tx Goals • Progress in Tx	• Complete Tx LOC • Extended Abstinence/Neg. Tests • Treatment Goals Completed • Phase Goals Completed • Program Goals Completed

Step 2. Determine the ***Response Level***

		Easier/Positive	Moderate	Difficult/Distal
Distal	Phase 1	Small	Medium	Large
	Phase 2	Small	Medium	Large
	Phase 3		Small	Large
	Phase 4		Small	Large
Prox	Phase 5		Small	Medium

Step 3. Choose the ***Responses*** *(Paired with Judicial Approval/Verbal Praise)*

3a. Incentive Response

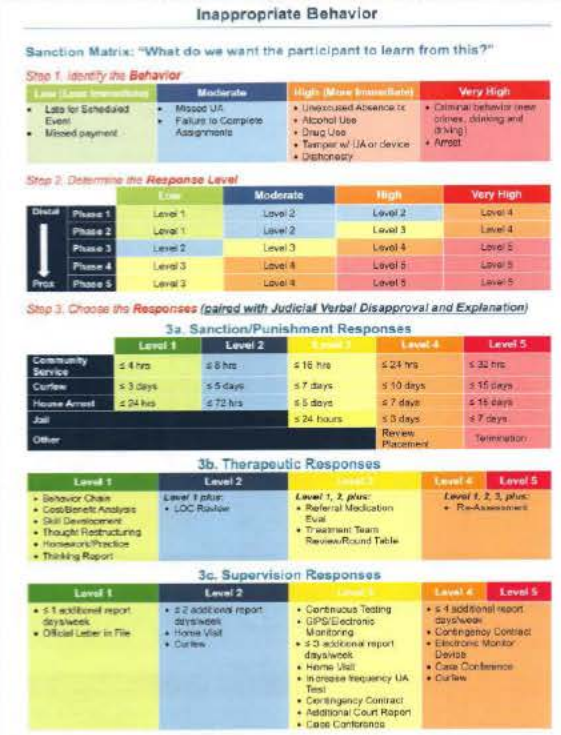
Small	Medium	Large
• Fish Bowl • Decision Dollars • Example for other participants in court • Handshake • Candy • ≤ 1 day reduction of curfew	*Any small and/or:* • ≤ 3 day reduction of curfew • Choice of Gift Certificate • Supervisor Praise • Written Praise • Positive Peer Board • Certificate • Reduction in CS hours • Reduction in program fees	*Any small, medium or:* • Framed Certificate • Travel Pass • Larger Gift Certificate • Position as Mentor to New Participants • Reduction of Curfew

3b. Therapeutic Response

	Phase 1	Phase 2	Phase 3	Phase 4
Single Event	• Behavior Chain • Cost/Benefit Analysis	• Behavior Chain • Cost/Benefit Analysis • Change in LOC	• Behavior Chain • Aftercare Fqcy • Re-evaluate Pharmacological Interventions	• Behavior Chain • Aftercare Fqcy • Re-evaluate Pharmacological Interventions
Continued Progress				

3c. Supervision Responses

Phase 1	Phase 2	Phase 3	Phase 4
• Change in Curfew Status	• Reduced Contacts • Reduction in Home Visits	• Reduced Contacts • Reduce Home Visits • Reduce in External Monitoring Devices	• Reduced Contacts • Decreased Drug Testing



Inappropriate Behavior

Sanction Matrix: "What do we want the participant to learn from this?"

Step 1. Identify the ***Behavior***

Low (Less Immediate)	Moderate	High (More Immediate)	Very High
• Late for Scheduled Event • Missed payment	• Missed UA • Failure to Complete Assignments	• Unexcused Absence to • Alcohol Use • Drug Use • Tamper w/ UA or device • Dishonesty	• Criminal behavior (new crimes, drinking and driving) • Arrest

Step 2. Determine the ***Response Level***

		Low	Moderate	High	Very High
Distal	Phase 1	Level 1	Level 2	Level 2	Level 4
	Phase 2	Level 1	Level 2	Level 3	Level 4
	Phase 3	Level 2	Level 3	Level 4	Level 5
	Phase 4	Level 3	Level 4	Level 5	Level 5
Prox	Phase 5	Level 3	Level 4	Level 5	Level 5

Step 3. Choose the ***Responses*** *(paired with Judicial Verbal Disapproval and Explanation)*

3a. Sanction/Punishment Responses

	Level 1	Level 2	Level 3	Level 4	Level 5
Community Service	≤ 4 hrs	≤ 8 hrs	≤ 16 hrs	≤ 24 hrs	≤ 32 hrs
Curfew	≤ 3 days	≤ 5 days	≤ 7 days	≤ 10 days	≤ 15 days
House Arrest	≤ 24 hrs	≤ 72 hrs	≤ 5 days	≤ 7 days	≤ 15 days
Jail			≤ 24 hours	≤ 3 days	≤ 7 days
Other				Review Placement	Termination

3b. Therapeutic Responses

Level 1	Level 2	Level 3	Level 4	Level 5
• Behavior Chain • Cost/Benefit Analysis • Skill Development • Thought Restructuring • Homework/Practice • Thinking Report	*Level 1 plus:* • LOC Review	*Level 1, 2 plus:* • Referral Medication Eval • Treatment Team Review/Round Table	*Level 1, 2, 3, plus:* • Re-Assessment	

3c. Supervision Responses

Level 1	Level 2	Level 3	Level 4	Level 5
• ≤ 1 additional report days/week • Official Letter in File	• ≤ 2 additional report days/week • Home Visit • Curfew	• Continuous Testing • GPS/Electronic Monitoring • ≤ 3 additional report days/week • Home Visit • Increase frequency UA Test • Contingency Contract • Additional Court Report • Case Conference	• ≤ 4 additional report days/week • Contingency Contract • Electronic Monitor Device • Case Conference • Curfew	

LINKS AND RESOURCES

- Maine Treatment Courts: https://www.courts.maine.gov/courts/treatment/index.html
- Maine Treatment Court Handbook: https://mjbportal.courts.maine.gov/CourtForms/FormsLists/DownloadForm?strFormNumber=CR-249
- National Association of Drug Court Professionals (NADCP): https://www.nadcp.org/
- Justice for Vets: https://justiceforvets.org
- New England Association of Recovery Court Professionals: https://nearcp.org
- 2020 Annual Report on Maine's Drug Treatment Courts: https://www.courts.maine.gov/about/reports/adtc-report-2020.pdf
- Maine Adult Drug Treatment Courts Evaluation Report 2015-2020: https://www.courts.maine.gov/about/reports/adtc-evaluation-report-2020.pdf
- National Drug Court Institute: Home - National Drug Court Institute - NDCI.org

APPENDIX H

Alcohol and COVID-19 Pandemic in Maine and the Nation, Presentation by Tim Diomede, MPPM

Alcohol and COVID-19 Pandemic in Maine and the Nation

Tim Diomede, MPPM
October 3rd, 2022

State Epidemiological Outcomes Workgroup www.MaineSEOW.com

Purpose/Background

The State Epidemiological Outcomes Workgroup (SEOW) serves as a clearing house for substance use and mental health related data indicators. Established in 2005.

The SEOW was funded under the federal Substance Abuse and Mental Health Services Administration (SAMHSA) Partnership for Success grant, focused on the prevention of substance use among 12- to 25-year-olds.

Currently funded by a combination of funding streams under the Maine CDC

SEOW Objectives

- ✓ Identify, organize, analyze and share key substance use prevention and related behavioral health indicators data;
- ✓ Create data-guided products that inform prevention planning/policies;
- ✓ Assist communities in understanding, using and presenting data in an effective manner;
- ✓ Build state and local level monitoring and surveillance systems;
- ✓ Help secure funds and measure progress; and
- ✓ Provide an opportunity for networking and collaboration.

ALCOHOL AND COVID-19 PANDEMIC IN MAINE AND THE NATION

August 2022

STATEMENT OF NEED

Alcohol misuse is a public health concern that became worse during the COVID-19 pandemic. Data show that access to alcohol in Maine has steadily increased along with associated death, injuries, and diseases. This brief provides information and context for alcohol use in Maine during the pandemic and beyond.

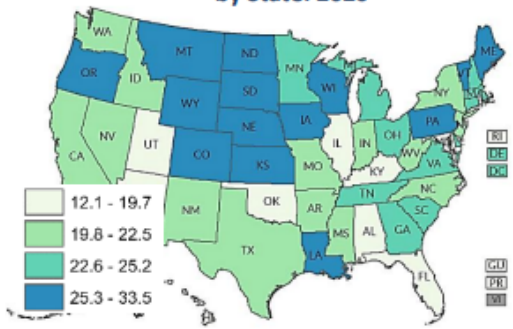
NEW RESEARCH

A study by the National Institute on Alcohol Abuse and Alcoholism found that deaths due to alcohol increased 25% between 2019 and 2020.[1] It is projected that around 8,000 additional deaths will occur nationally due to increased alcohol consumption during the pandemic, however the full impact of increased alcohol consumption during the pandemic is currently unknown. Projected deaths are attributed to 18,700 more cases of liver failure and 1,000 more cases of liver cancer by 2040.[2]

ALCOHOL USE IN MAINE

Alcohol is the most widely used substance in Maine and can have harmful impacts on society, including motor vehicle crashes, crime, chronic disease, straining health/medical resources, and lowering work productivity. It is the manner and frequency with which people use alcohol and/or other substances that are often linked to substance-related consequences.[3]

Binge drinking among 18 to 24-year-olds, by State: 2020



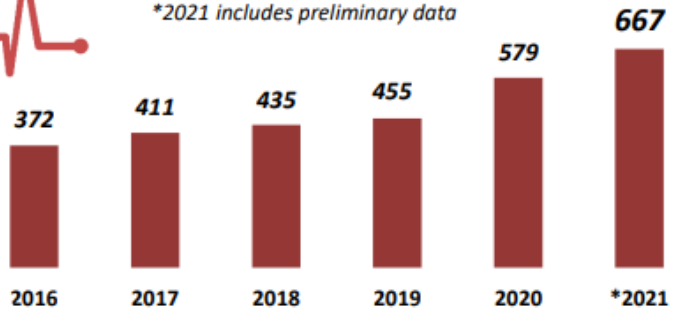
Maine has continued to observe some of the highest rates of binge drinking among young adults 18-24 in the nation. In 2020, more than one in four (27.1%) young adults in Maine reported binge drinking in the past month. [4]

MORTALITY

Preliminary data from 2021 show that 667 Mainers died due to an alcohol related cause (disease or poisoning); this is a 47% increase since 2019. There were 88 more alcohol related deaths in 2021 than reported in 2020, and 295 more deaths than in 2016; a 79% increase.[5]

Alcohol Related Deaths in Maine

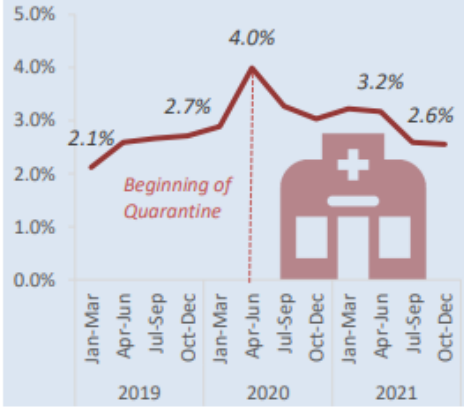
**2021 includes preliminary data*



Increased alcohol consumption during the COVID-19 pandemic is projected to cause short and long-term public health consequences.

EMERGENCY DEPARTMENT VISITS

Percentage of ED Visits for Alcohol in Maine



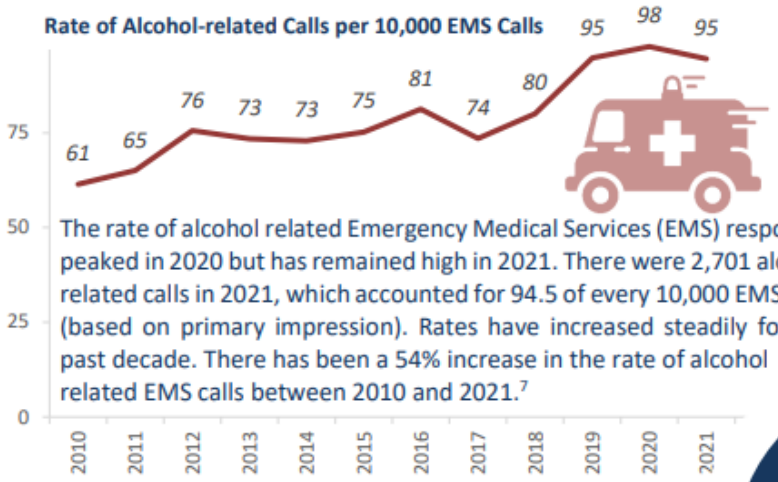
The proportion of emergency department (ED) visits related to alcohol steeply increased at the start of the pandemic and peaked between April and June of 2020 (4.0%). The overall number of alcohol related ED visits remains high with 19,602 in 2020 and 19,480 in 2021; this equates to more than two alcohol-related ED visits every hour.[6]

This fact sheet is a product of the Maine State Epidemiological Outcomes Workgroup (SEOW). For more info, visit www.maineseow.com

ALCOHOL AND COVID-19 PANDEMIC IN MAINE AND THE NATION

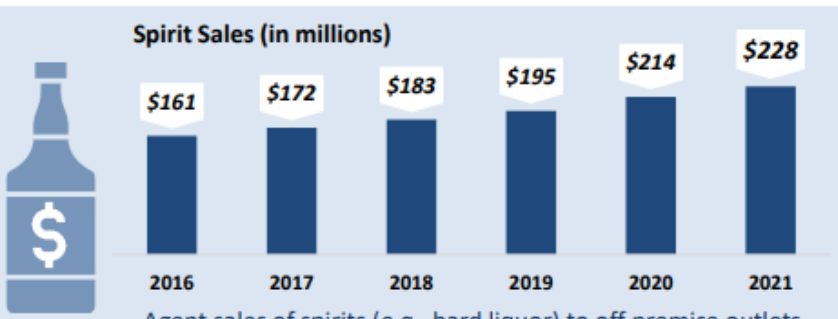
August 2022

AMBULANCE RESPONSES



The rate of alcohol related Emergency Medical Services (EMS) responses peaked in 2020 but has remained high in 2021. There were 2,701 alcohol related calls in 2021, which accounted for 94.5 of every 10,000 EMS calls (based on primary impression). Rates have increased steadily for the past decade. There has been a 54% increase in the rate of alcohol related EMS calls between 2010 and 2021.[7]

SALES

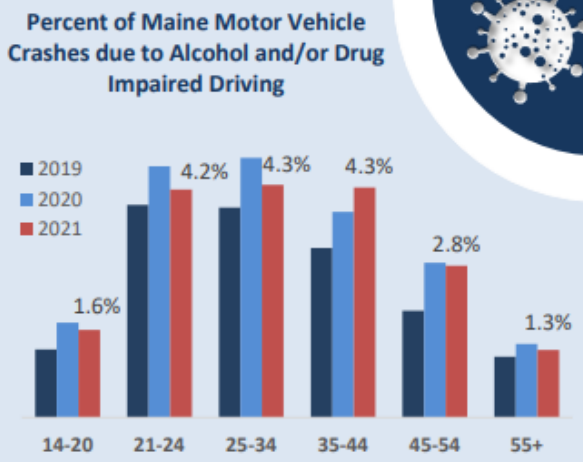


Agent sales of spirits (*e.g.*, hard liquor) to off premise outlets (*e.g.*, liquor stores) in Maine increased through the pandemic. Sales increased 17% from 2019 to 2021 and 42% since 2016.[9] In contrast, the estimated economic burden of excess alcohol use in Maine was nearly $1 billion dollars in 2010.[10]

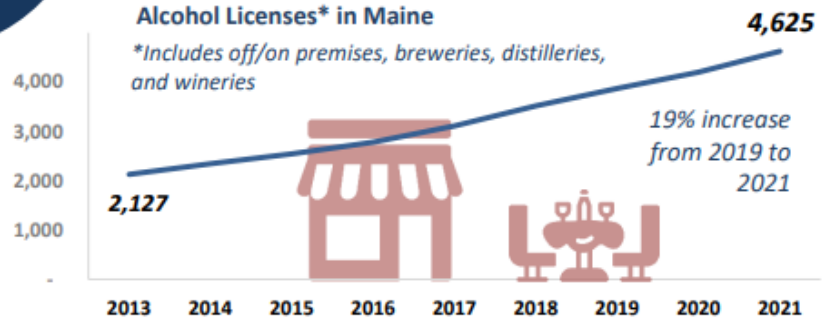
Public health concerns and long-term impacts must be considered when making decisions on alcohol policy, availability, and consumption.

IMPAIRED DRIVING

During the Covid-19 pandemic, there has been an increase in the proportion of impaired driving crashes due to alcohol and/or drugs. All age groups observed increases from 2019 to 2021; the highest rates were among Mainers 21 to 44.[8]



ACCESSIBILITY



Maine establishments selling alcohol more than doubled between 2013 and 2021 (+117%).[9] From 2019 to 2021, off premise alcohol outlets (*e.g.*, grocery stores, convenience stores) increased by 18% while restaurants/lounges serving alcohol increased by 24%. The cocktails-to-go program started at the beginning of the pandemic has been continued by legislation through March 2025 extending Mainers heightened access to alcohol.

1. National Institute on Alcohol Abuse and Alcoholism
2. Massachusetts General Hospital
3. 2020 SEOW State Profile
4. Behavioral Risk Factor Surveillance System*
5. Maine Data, Research, and Vital Statistics
6. Rapid Health Information for Maine
7. Maine Emergency Medical Services
8. Maine Dept. of Transportation.
9. Bureau of Alcohol Beverages and Lottery
10. CDC

*Self-reported data

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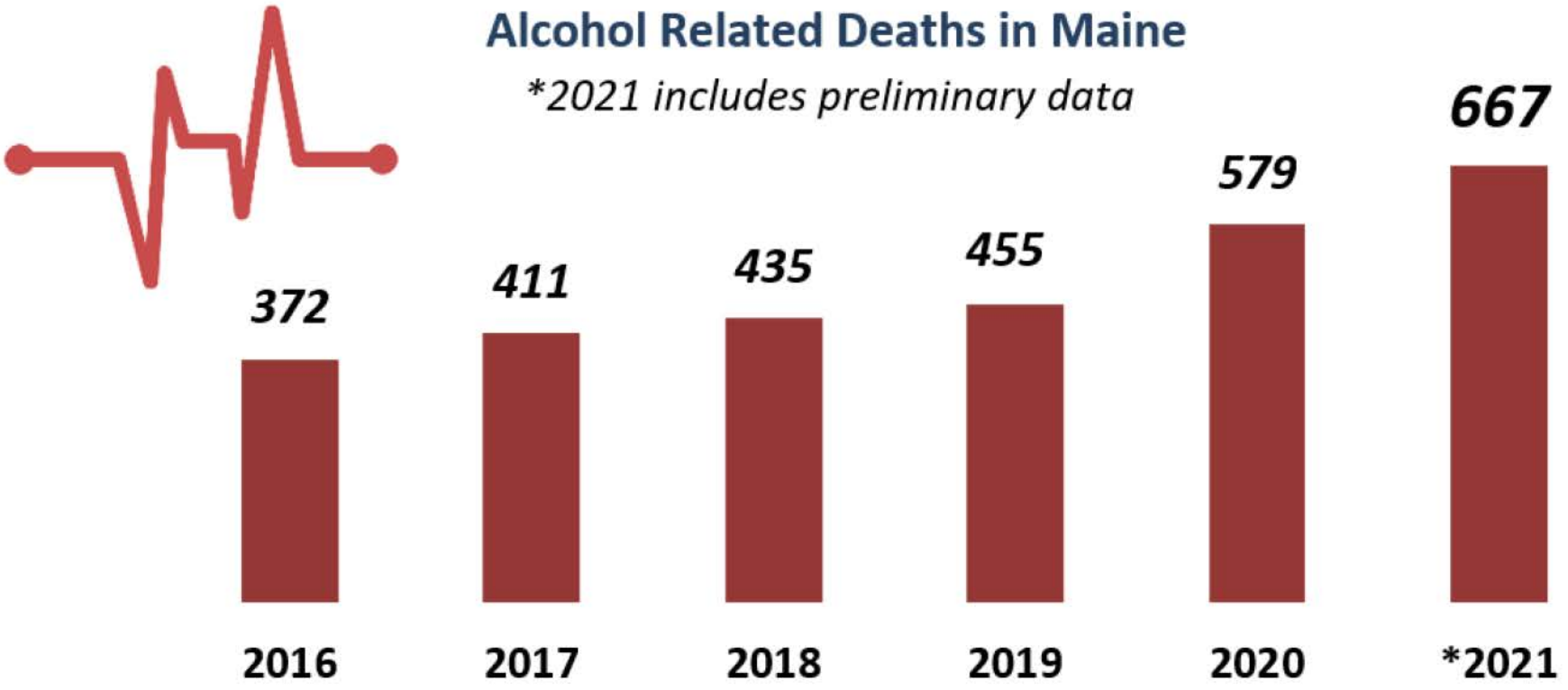

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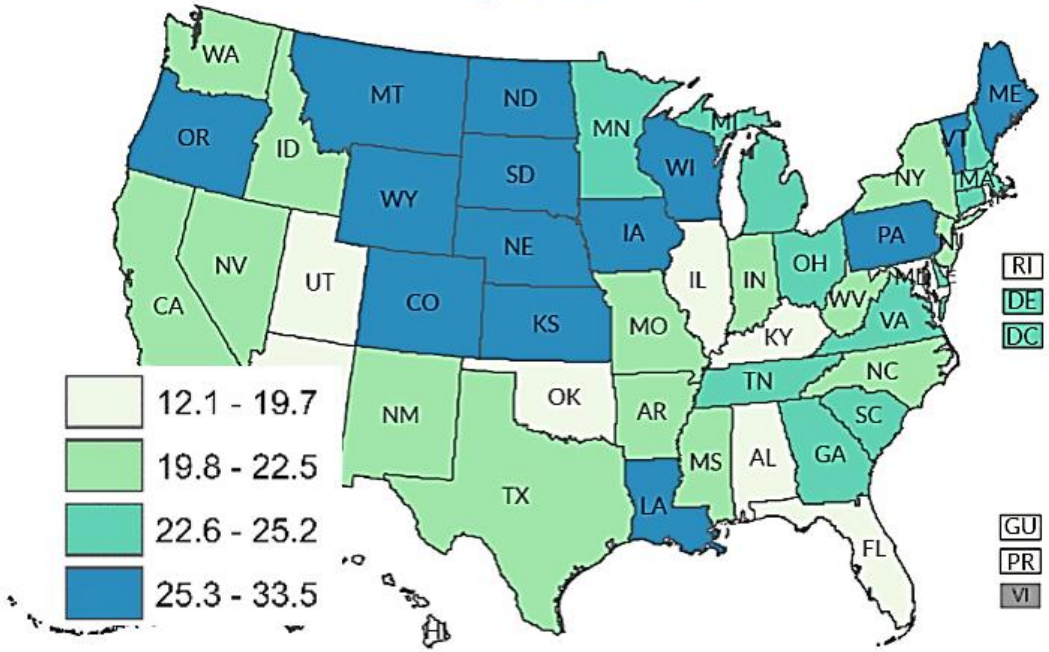

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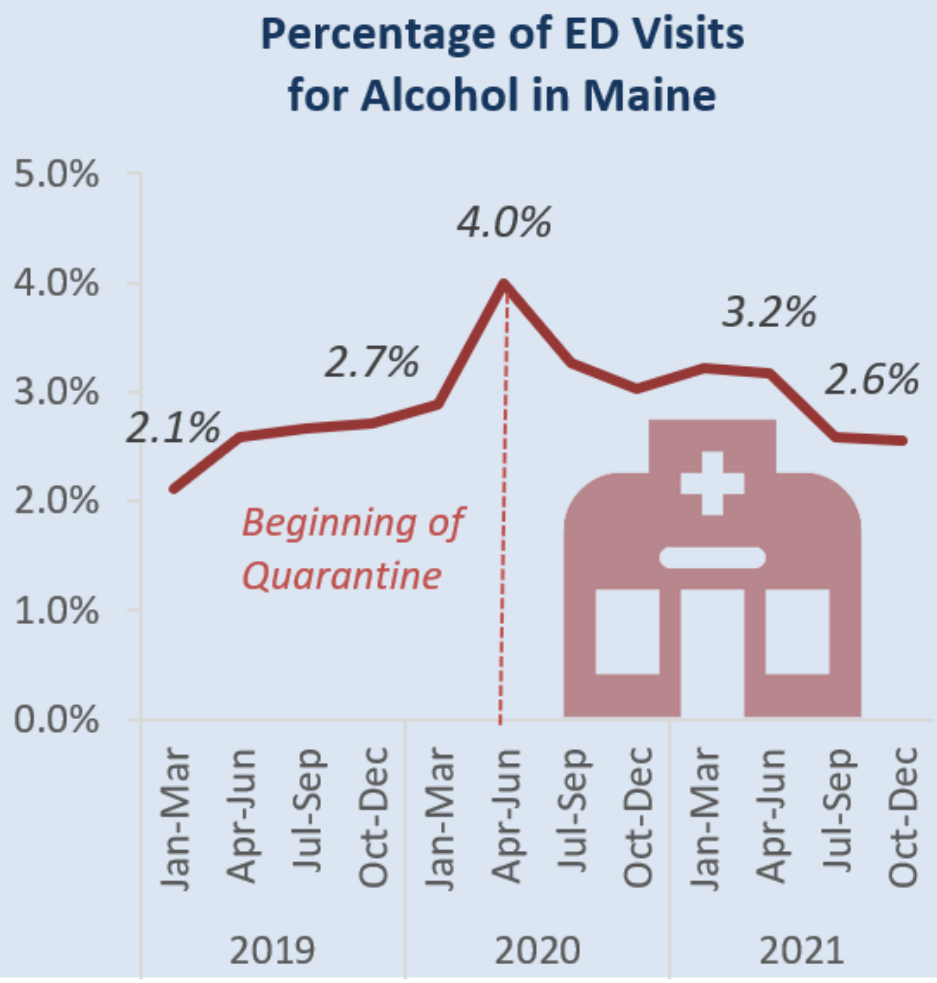

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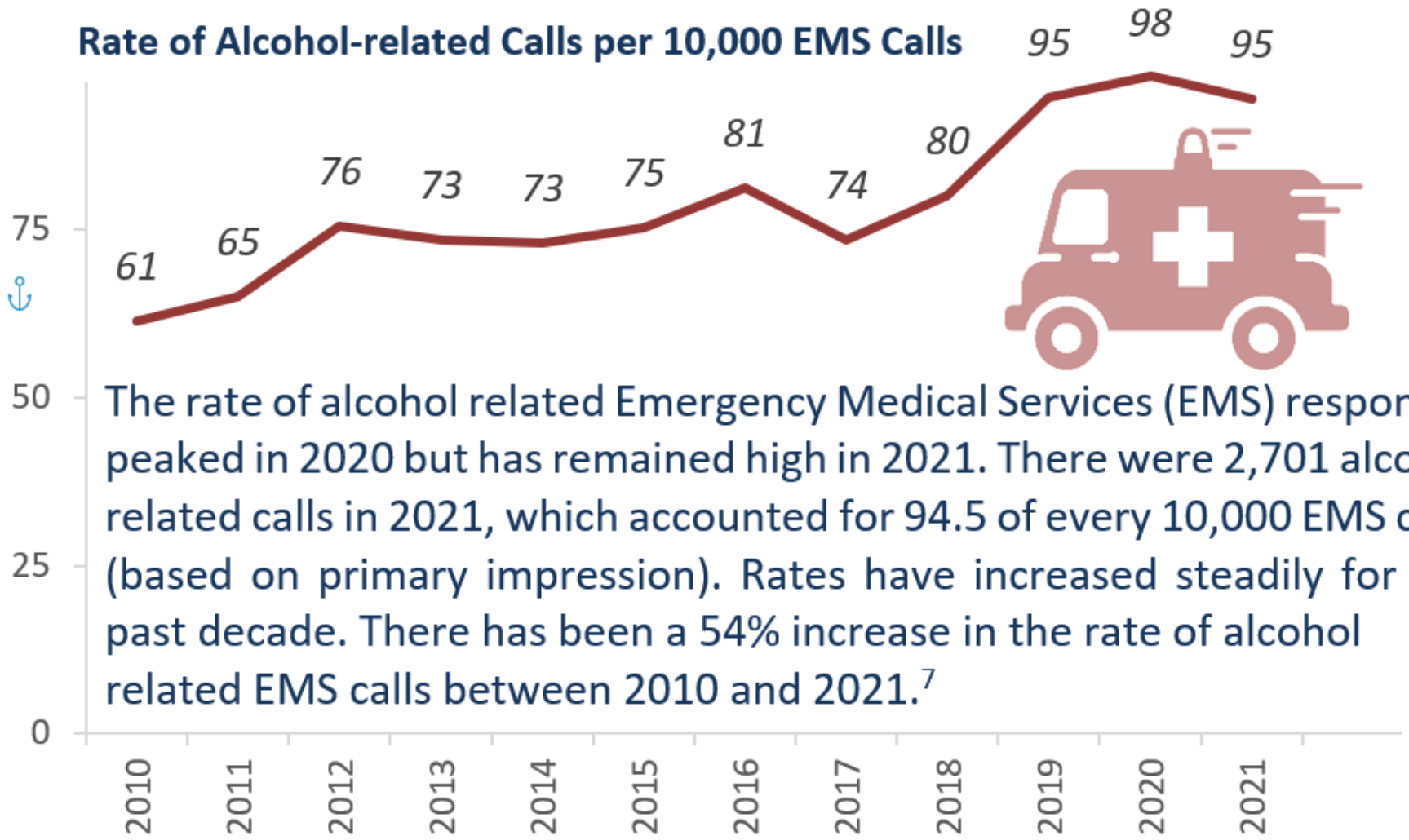

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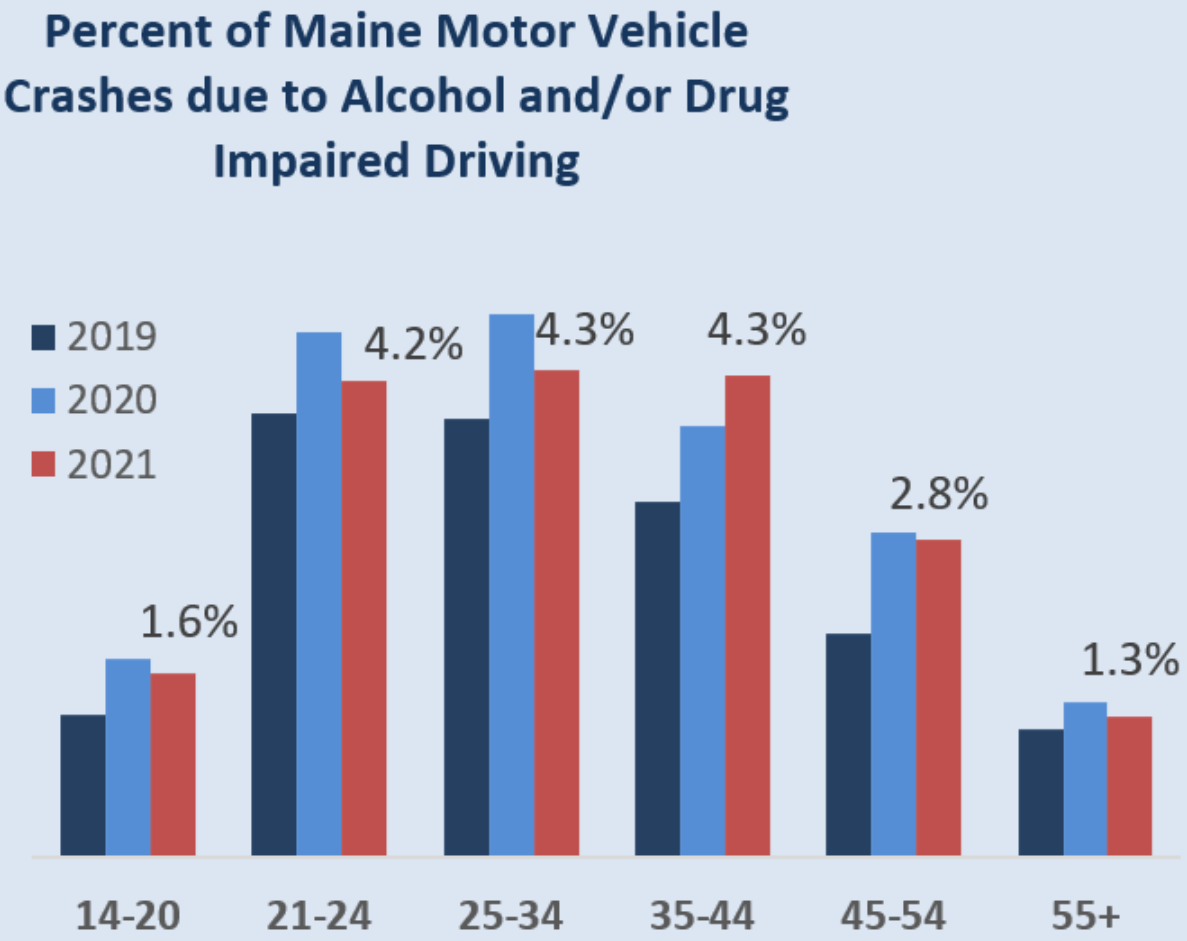
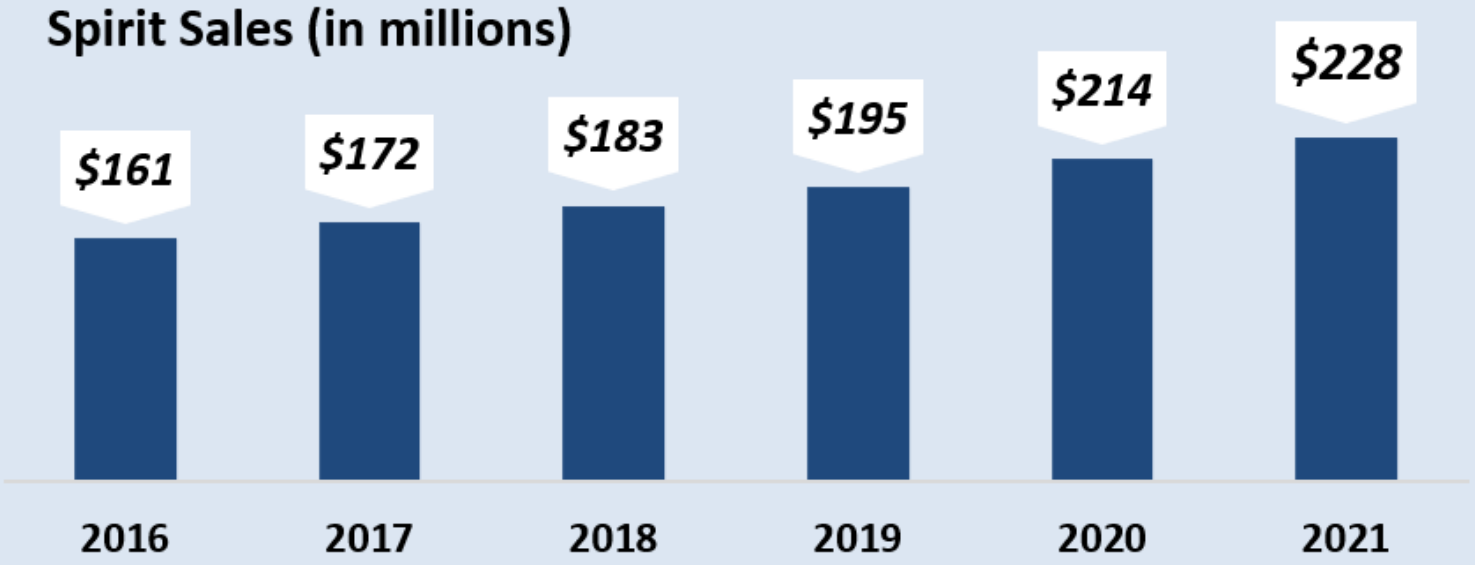


SALES



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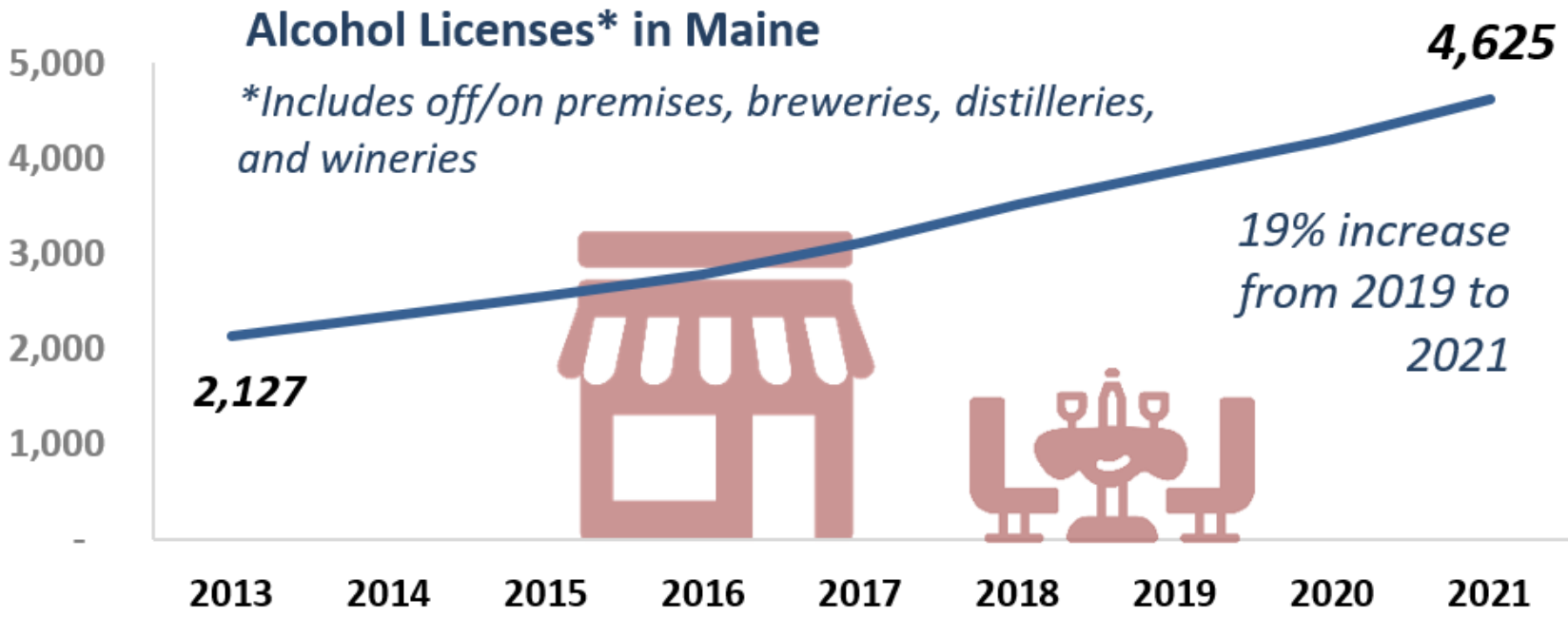

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Contact

Timothy Diomede, MPPM
SEOW Chair
Timothy.Diomede@maine.gov
www.maineseow.com

APPENDIX I

Maine Monthly Overdose Report for August 2022

MAINE MONTHLY OVERDOSE REPORT

For August 2022

Marcella H. Sorg, Abby Leidenfrost
Margaret Chase Smith Policy Center University of Maine

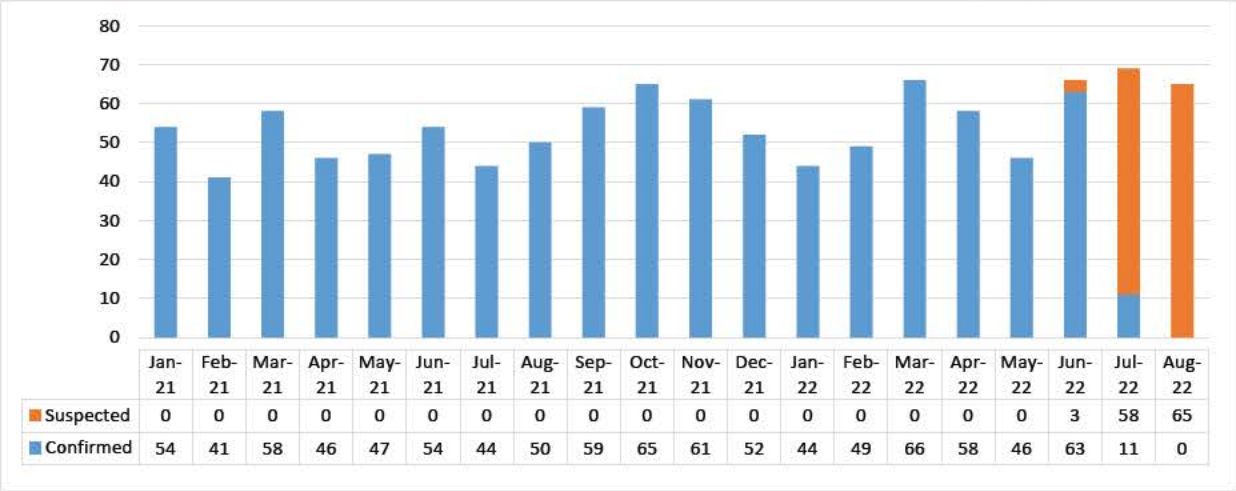
Overview

This report documents suspected and confirmed fatal and nonfatal drug overdoses in Maine during August 2022 as well as for the period January 2021–August 2022 (Table 1). During August, the proportion of fatal overdoses averaged 6.8% of total overdoses. Monthly proportions of 2022 fatalities have fluctuated from a low of 5.1% in May 2022 to a high of 8.0% in April. During the first eight months of 2022, the average number of overdoses per month was approximately 852 (58 fatal and 794 nonfatal incidents). This compares to the monthly average for January–August 2021 of 753 (49 fatal and 704 nonfatal cases). The 2022 number of fatal overdoses January–August is 18.4% higher than during the January–August 2021. During the period January–August 2022, fatal overdoses comprised 6.8% of all overdoses, about the same level as during the first eight months of 2021, 6.5%.

Data derived from multiple statewide sources were compiled and deduplicated to compute nonfatal overdose totals. These include nonfatal overdose incidents reported by hospital emergency departments (ED), nonfatal emergency medical service (EMS) responses without transport to the ED, overdose reversals reported by law enforcement in the absence of EMS, and overdose reversals reported by community members or agencies receiving state-supplied naloxone. There are also an unknown number of private overdose reversals that were not reported, and an unknown number of the community-reported reversals that may have overlapped with emergency response by EMS or law enforcement. The total number of fatal overdoses in this report includes those that have been confirmed, as well as those that are suspected but not yet confirmed for part of June, July, and August (see Figure 1).

The total number of reported fatal and nonfatal overdoses January through August 2022, 6818, is displayed in Table 1 in the bottom row: 463 (6.8%) confirmed and suspected fatal overdoses,

Figure 1. Suspected and confirmed fatal overdoses January 2021 through August 2022.



	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22
Suspected	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3	58	65
Confirmed	54	41	58	46	47	54	44	50	59	65	61	52	44	49	66	58	46	63	11	0

2983 (43.8%) nonfatal emergency department visits, 1826 (26.8%) nonfatal EMS responses not transported to the emergency department, 1496 (21.9%) reported community overdose reversals, and 50 (0.7%) law enforcement reversals in incidents that did not include EMS.

Table 1: Composite overdose totals by month, calendar months January 2021–August 2022, with updated community reversal and law enforcement totals for January–August 2022

	Nonfatal						
	Emergency dept.	EMS not transported to emergency	Community reversals with naloxone	Law enforcement reversals with naloxone and without EMS	Total nonfatal overdoses	Total confirmed and suspected fatal overdoses	Total overdoses
January 2021	270	164	127	0	561	54	615
February 2021	277	118	100	0	495	41	536
March 2021	329	172	156	2	659	58	717
April 2021	334	190	136	0	660	46	706
May 2021	409	163	100	1	673	47	720
June 2021	411	223	189	0	823	54	877
July 2021	482	225	167	0	874	44	918
August 2021	428	232	222	3	885	50	935
September 2021	473	234	276	2	985	59	1044
October 2021	383	246	208	2	839	65	904
November 2021	308	219	195	2	724	61	785
December 2021	344	198	176	11	729	52	781
2021 Total	4448 (46.6%)	2384 (25.0%)	2052 (21.5%)	23 (0.2%)	8907 (93.4%)	631 (6.6%)	9538 (100.0%)
January 2022	296	206	178	1	681	44	725
February 2022	333	185	153	4	675	49	724
March 2022	458	201	202	9	870	66	936
April 2022	290	177	189	7	663	58	721
May 2022	402	248	186	12	848	46	894
June 2022	482	250	177	11	920	66	986
July 2022	346	287	170	5	808	69	877
August 2022	376	272	241	1	890	65	955
2022 YTD total	2983 (43.8%)	1826 (26.8%)	1496 (21.9%)	50 (0.7%)	6355 (93.2%)	463 (6.8%)	6818 (100.0%)

County Distribution of Fatal Overdoses

Table 2 shows the frequency distribution of fatal overdoses at the county level. The August monthly totals can be compared either to the percentage of the census population on the far left column, the percentage of all Maine fatal overdoses for 2021, or year-to-date percentages for 2022. Caution must be exercised viewing single counties with small numbers for a single month. These may fluctuate randomly, without reflecting any significant statistical trend.

The year-to-date 2022 percentages for most counties fall within 0%–1% of the 2020 census distribution. Cumberland County is 3% lower and Hancock County 2% lower than the 2020 census proportion. Penobscot County is 4% higher and Androscoggin is 2% higher.

Table 2: County of death among suspected and confirmed fatal overdoses

	% 2020 Estimated Census Population	Jan–Dec 2021 Est. N=631		Jan–Aug 2022 Est. N=463		Aug 2022 Est. N=65	
Androscoggin	8%	69	(11%)	45	(10%)	8	(12%)
Aroostook	5%	39	(6%)	29	(6%)	4	(6%)
Cumberland	22%	114	(18%)	86	(19%)	11	(17%)
Franklin	2%	8	(1%)	9	(2%)	0	(0%)
Hancock	4%	22	(3%)	11	(2%)	1	(2%)
Kennebec	9%	64	(10%)	40	(9%)	8	(12%)
Knox	3%	11	(2%)	11	(2%)	2	(3%)
Lincoln	3%	16	(3%)	8	(2%)	2	(3%)
Oxford	4%	28	(4%)	19	(4%)	1	(2%)
Penobscot	11%	106	(17%)	71	(15%)	10	(15%)
Piscataquis	1%	11	(2%)	6	(1%)	2	(3%)
Sagadahoc	3%	7	(1%)	7	(2%)	1	(2%)
Somerset	4%	26	(4%)	22	(5%)	3	(5%)
Waldo	3%	15	(2%)	16	(4%)	2	(3%)
Washington	2%	25	(4%)	14	(3%)	5	(8%)
York	16%	70	(11%)	69	(15%)	5	(8%)

Table 3 displays the age and gender composition of the 2022 year-to-date fatal overdose population, the 2021 fatal overdose population, and the 2020 estimated census population. The overall age 2022 categories are within 2%–3% of 2021. The cumulative proportion of males has risen from 71% in 2021 to 72% in the 2022. The cumulative age distribution for 2022 compared to 2021 shows 2 deaths under 18 in 2021 and 1 death in 2022, an increase of 2% in the proportion of those aged 18–39, a 3% decrease in those aged 40–59, and a 2% increase in the proportion of those 60 and above.

Table 3: Decedent reported age and sex characteristics among suspected and confirmed fatal overdoses*

	% 2020 estimated Census population	Jan–Dec 2021 Est. N=631		Jan–Aug 2022 Est. N=464		Aug 2022 Est. N=65	
Males	49%	451	(71%)	332	(72%)	47	(72%)
Under 18	19%	2	(<1%)	1	(<1%)	0	(0%)
18–39	26%	247	(39%)	189	(41%)	25	(38%)
40–59	27%	316	(50%)	218	(47%)	32	(49%)
60+	29%	66	(10%)	55	(12%)	8	(12%)

* Percentages may not total 100 due to rounding.

Table 4 displays the reported race and ethnicity of confirmed and suspected fatal overdoses for whom race and ethnicity were reported in 2021 and 2022, compared to the 2020 census population. Note that race and ethnicity are not finalized until the full death certificate is entered into Vital Records. Race and ethnicity proportions in 2022 have remained relatively stable, within 1%–2%, compared to 2021. Out of 460 decedents for whom race was reported January through August 2022, 91% of the victims were identified as White, 3% as Black/African American, and 1% as American Indian/Alaska Native. Out of 449 decedents for whom Hispanic ethnicity status was reported, 2% were identified as Hispanic. As mentioned earlier, the drug death population includes some persons who were residents of other states, whereas the census population is restricted to residents only.

Table 4: Decedent race and ethnicity among suspected and confirmed fatal overdoses*

	% 2020 estimated Census population: Race & Hispanic/ Latinx ethnicity	Jan–Dec 2021 Est. N=627 Race† N=621 Ethnicity		Jan–Aug 2022 Race N=460 Ethnicity N=449		Aug 2022 Race N=64 Ethnicity N=63	
White alone, non-Hispanic	91%	585	(93%)	419	(91%)	58	(91%)
Black/African American alone, non-Hispanic	2%	21	(3%)	12	(3%)	2	(3%)
American Indian/Alaska Native, non-Hispanic	1%	14	(2%)	5	(1%)	1	(2%)
Other race and 2+ races combined, non-Hispanic	7%	7	(1%)	6	(1%)	1	(2%)
Hispanic/Latinx alone or in combination	2%	10	(2%)	7	(2%)	1	(2%)

*Race and ethnicity data are usually unavailable until drug deaths are confirmed.
†Percentages may not total 100 due to rounding.

Out of the 463 cases for which military background was reported January–August 2022, 32 (7%) were identified as having a military background. Undomiciled or transient housing status was reported for 52 (11%) of the victims. The largest totals of undomiciled persons were found in Cumberland County (22, 42%), and Penobscot County (12, 23%).

Table 5 reports some of the basic incident patterns for fatal overdoses. Both EMS and police responded to most fatal overdoses (75%) in the first eight months of 2022. Law enforcement was more likely to respond to a scene alone (19%) than EMS (5%). The overwhelming majority (98%) of confirmed drug overdoses were ruled as, or suspected of being, accidental manner of death. Of the 463 confirmed or suspected fatal overdoses in 2022, 170 (37%) had a history of prior overdose.

Although most cases had bystanders or witnesses present at the scene by the time first responders arrived, the details about who was present at the time of the overdose were frequently unclear. However, responding family and friends or bystanders administered naloxone for 56 (12%) of the 2022 fatal overdoses, an increase over the previous two years (4% in 2020 and 9% in 2021). Often, bystanders or witnesses administered naloxone in addition to EMS and/or law enforcement. During 2022, 26% of suspected and confirmed fatal overdose cases had naloxone administered at the scene by EMS, bystanders, and/or law enforcement. This rate is slightly lower

Table 5: Event characteristics among suspected and confirmed fatal overdoses

	Jan–Dec 2021 Est. N=631		Jan–Aug 2022 Est. N=463		Aug 2022 Est. N=65	
First Responder						
EMS response alone	26	(4%)	23	(5%)	4	(6%)
Law enforcement alone	108	(17%)	88	(19%)	12	(18%)
EMS and law enforcement	491	(78%)	349	(75%)	49	(75%)
Private transport to Emergency Dept.	8	(1%)	5	(1%)	1	(2%)
Naloxone administration reported at the scene	187	(30%)	122	(26%)	15	(23%)
Bystander only administered	36	(6%)	27	(6%)	2	(3%)
Law enforcement only administered	22	(3%)	19	(4%)	4	(6%)
EMS only administered	84	(13%)	34	(7%)	3	(5%)
EMS and law enforcement administered	20	(3%)	10	(2%)	2	(3%)
EMS and bystander administered	15	(2%)	20	(4%)	2	(3%)
Law enforcement and bystander administered	5	(1%)	5	(1%)	1	(2%)
EMS, bystander, and law enforcement administered	2	(<1%)	4	(1%)	0	(0%)
Naloxone administered by unspecified person	3	(<1%)	3	(<1%)	1	(2%)
History of prior overdose	216	(34%)	170	(37%)	26	(40%)

than in 2021 (30%). Of the 372 suspected or confirmed drug death cases with EMS involvement during 2022, 191 (51%) victims were already deceased when EMS arrived. In the remaining 181 (49%) cases, resuscitation was attempted either at the scene or presumably in the ambulance during transport to the emergency room. Of those 181 who were still alive when EMS arrived, 60 (33%) were transported, and 121 (67%) did n/463ot survive to be transported. Thus, out of 372 ultimately fatal cases with EMS response, only 60 (16%) remained alive long enough to be transported but died during transport or at the emergency room. This is likely due to the high number of cases with fentanyl as a cause of death. Fentanyl acts more quickly than other opioids and there is less time for bystanders to find an overdose victim alive and respond by administering naloxone and calling 911.

Table 6 displays the frequencies of the most prominent drug categories causing death among confirmed drug deaths. As expected, within the 338 confirmed drug death cases so far in 2022, nonpharmaceutical fentanyl was the most frequent cause of death mentioned on the death certificate at 265 (78%).

Fentanyl is nearly always found in combination with multiple other drugs. Heroin involvement, declining rapidly in recent years, was reported as a cause of death in only 2% of 2022 deaths, compared to 3% in 2021 and 11% in 2020. Xylazine and nonpharmaceutical tramadol were identified as co-intoxicants with fentanyl for the first time in 2021. Among 338 confirmed deaths in 2022, there were 18 cases (5%) with xylazine listed in addition to fentanyl as a cause of death, and 6 cases (2%) with tramadol listed along with fentanyl.

Stimulants continue to increase as a cause of death, usually in combination with other drugs, particularly fentanyl. Methamphetamine was cited as a cause of death in 117 (35%) of the confirmed fatal overdoses in 2022, an increase from 27% in 2021; 96 (82%) of the methamphetamine deaths also involved fentanyl as a co-intoxicant cause of death. Cocaine-involved fatalities constituted 89 (26%) of confirmed cases in 2022, a slight increase from 25% in 2021. Fentanyl is

mentioned as a cause in combination with cocaine in 71 (80%) of 2022 cocaine cases. Cocaine and methamphetamine are named together on 25 (7%) death certificates in 2022, in 21 (6%) cases as combined co-intoxicants with fentanyl.

Table 6: Key drug categories and combinations causing death among confirmed overdoses

Cause of death (alone or in combination with other drugs) Sample size for confirmed cases only	Jan–Dec 2021 Est. N = 631		Jan–Aug 2022 N = 338	
Fentanyl or fentanyl analogs	489	(77%)	265	(78%)
Heroin	22	(3%)	8	(2%)
Cocaine	156	(25%)	89	(26%)
Methamphetamine	172	(27%)	117	(35%)
Pharmaceutical opioids**	130	(21%)	68	(20%)
Fentanyl and heroin	20	(3%)	8	(2%)
Fentanyl and cocaine	127	(20%)	71	(21%)
Fentanyl and methamphetamine	133	(21%)	96	(28%)
Fentanyl and xylazine	53	(8%)	18	(5%)
Fentanyl and tramadol	24	(4%)	6	(2%)

**Nonpharmaceutical tramadol is now being combined with fentanyl in pills and powders for illicit drug use. When found in combination with fentanyl, and in the absence of a known prescription, tramadol is categorized as a nonpharmaceutical opioid.

Highlight of the Month

RECOVERY RESIDENCES

This month we highlight the work of the Maine Association of Recovery Residences (MARR) and the continuing increases in the number of beds available for Mainers seeking a safe and drug-free environment in their early stage of recovery from substance use disorders. As of the end of September 2022, there were 67 certified recovery residences in the state. Seventy-eight percent of these residences welcome residents on medication for opioid use disorders (MOUD). By the end of this calendar year, it is anticipated that over 70 certified houses will be open across the state. For the first time, two residences for men in Portland now offer housing to men on medication. The MARR website is updated on a daily basis and provides important information to those individuals seeking a bed. Financial assistance is available from the state through the Maine State Housing Authority in those instances where the residences are certified and accepting of individuals on medication. General Assistance is available through local communities for residences that are certified.

The MARR certification standards are consistent with the standards of the National Alliance of Recovery Residences, considered the gold standard for recovery residences. In addition to certified residences, there are approximately 60 additional recovery residences (sometimes referred to as sober homes) that are available in the state. While these facilities are not licensed or certified, they are required to meet local zoning requirements for any single family home.

In late September, MARR sponsored four workshops on stigma reduction presented by national consultant Tedra Cobb. These workshops were presented at recovery community centers in Portland, Bangor, Augusta, and Bath.

For more information, go to https://www.mainerecoveryresidences.com/.

Background Information about this Report

This report, funded jointly by the Maine Office of Attorney General and the Office of Behavioral Health,1 provides an overview of statistics regarding suspected and confirmed fatal and nonfatal drug overdoses each month. Data for the fatal overdoses were collected at the Office of Chief Medical Examiner and data regarding nonfatal overdoses were contributed by the Maine CDC, Maine Emergency Management Services, Maine ODMAP initiative, Maine Naloxone Distribution Initiative, and Office of Attorney General Naloxone Distribution. Year-to-date numbers are updated as medical examiner cases are finalized, and their overdose status is confirmed or ruled out. The totals are expected to shift as case completion occurs. In addition, due to the small sample size in each month, we expect totals to fluctuate from month to month due to the effects of random variation. The monthly reports will be posted on mainedrugdata.org. A "drug death" is confirmed when one or more drugs are mentioned on the death certificate as a cause or significant contributing factor for the death. Most drug-induced fatalities are accidents related primarily to drug lethality, the unique vulnerability of the drug user, such as underlying medical conditions, and the particular circumstances surrounding drug use during that moment.

A "suspected" drug fatality is identified by physiological signs of overdose as well as physical signs at the scene and witness information. In order to be confirmed as a drug death, the medical examiner must have issued a final death certificate which includes the names of the specific drugs. A forensic toxicology exam must also have been done, which includes a minimum of two toxicology tests, one to screen for drugs present, and another that will quantify the levels of drugs in the decedent's system. All cases receive a thorough external examination. In some cases a complete autopsy is also done. Additional data, such as medical records and police incident reports are also collected. Normally cases are completed within one month; however, due to recent problems being experienced by our national toxicology testing service, completion of cases was delayed.

By highlighting drug deaths at the monthly level, this report brings attention to the often dramatic shifts in totals that can occur from month to month. These fluctuations are common with small numbers and will tend toward an average over time. Whereas the overall number of overdose deaths are a critical indicator of individual and societal stress, this metric itself can be quite resistant to public policy interventions due to its complexity. Overdose fatalities occur because of multiple unique and interacting factors, as mentioned above. For that reason, these reports will seek to monitor components that can be directly affected by specific public health education and harm reduction interventions.

The statistics in this report reflect both suspected and confirmed "occurrent" deaths, that is, deaths that occur in the State of Maine, even though they may not be Maine residents. This will differ slightly from the statistics reported by the National Center for Health Statistics, which reports only confirmed "resident" deaths. In addition, due to recently reported updates of toxicology results and newly confirmed or eliminated drug death cases, both the 2021 and 2022 statistics have changed slightly from those reported in the previous monthly report.

Following a death, a toxicology report is needed to confirm that a case is an overdose, what substances are involved, and to determine cause and manner of death. Toxicology testing for Maine is done at a national reference laboratory located out-of-state. Prior to the pandemic, toxicology tests were customarily available to the Office of the Chief Medical Examiner within two to three weeks; in the pandemic period, turnaround times have extended to between eight and ten weeks. Emergent substances requiring out-of-scope toxicology testing have also caused additional delays. However, the national laboratory has informed the OCME that these issues are being addressed and turnaround is improving. We have resumed monthly reports. Any anticipated delays will be announced on mainedrugdata.org.

1 The Office of Attorney General supports ongoing regarding research on fatal overdoses by the University of Maine. Additionally, the Overdose Data to Action cooperative agreement from the U.S. Centers for Disease Control & Prevention also provides funding to the State of Maine's Office of Behavioral Health and Maine Center for Disease Control, which support University programs involving fatal and nonfatal overdoses surveillance and enable the collection of metrics included in this report. The conclusions in this report do not necessarily represent those of the U.S. CDC.

APPENDIX J

Maine Opioid Response: 2021 Strategic Action Plan

Maine Opioid Response: 2021 Strategic Action Plan

Introduction

Maine has been hit hard by the opioid epidemic. Between 2010 and 2019, almost 2,700 individuals died from an opioid-related overdose. These are our neighbors, our colleagues, our friends, and our family members. We owe it to each of them, and to the tens of thousands of Mainers currently living with the chronic illness of addiction, to do more to break this deadly cycle.

Too many Maine youth are experiencing traumatic events, and too many are experimenting with substances that increase their risk of addiction. For people with an opioid use disorder, finding treatment that is local, immediate, and affordable must improve. Many people in recovery face stigma, along with employment, housing, and transportation shortages faced by the general population – shortages that have been exacerbated by the pandemic. The pandemic has made recovery from substance use disorder much more difficult, and the number of overdoses and deaths has escalated. Our work is more critical than ever.

Accomplishments

Maine's annual Strategic Action Plan is designed to confront the epidemic of substance use disorder (SUD), emphasizing opioid use disorder (OUD), with evidence-based strategies that are targeted and tailored for maximum impact in Maine. Since Executive Order 2, issued two years ago, the Mills administration has taken the following steps:

- Purchased and distributed 55,788 doses of naloxone through public health and harm reduction organizations (through November 2020), resulting in 1,136 opioid overdose reversals during the period January – November 2020.
- Recruited and trained 534 recovery coaches (more than double the original objective), of whom 133 are actively coaching individuals in recovery.
- Provided Medication Assisted Treatment (MAT) to over 500 inmates within the Department of Corrections, while they were incarcerated or linked to community providers upon release, in addition to approximately 200 individuals in current treatment.
- Provided MAT to over 250 individuals with a diagnosis of SUD in county jails.
- Despite the challenges of the global pandemic, supported 22 emergency departments in standing up low-barrier MAT through which over 500 patients received their first dose of medication in the hospital.
- Increased the prescribing of buprenorphine for MAT by 43% in the past three years.
- Increased the number of recovery residences from 101 to 120 in two years, including certified residences growing from 23 to 51, with 42% of all residences currently welcoming individuals using MAT in their recovery.
- Increased Syringe Service Provider sites from 7 to 12, with 3 additional applications pending.
- Increased Recovery Community Centers from 9 to 13 locations, with an additional 2 centers planned for York County and the community of Lincoln.
- Enhanced prevention efforts, including the Department of Education making available to every school in the state a pre-K through grade 12 social and emotional learning (SEL) curriculum known as SEL4ME. In its first three months of use, SEL4ME has registered 3665 users and on-line modules have been accessed over 12,000 times.
- Served 295 individuals in Maine's Adult Drug Courts, Co-Occurring Court and Veterans Courts in 2019, an increase of 11.3% over the previous year.

2021 STRATEGIC ACTION PLAN

1 GOAL → 5 FOCUS AREAS → 10 PRIORITIES → 33 STRATEGIES

OUR GOAL Reduce the negative health and economic impacts of opioid and other substance use disorders (SUD/OUD) on individuals, families, and communities in Maine and, in so doing, give hope to all persons with a substance use disorder that recovery is not just possible, but probable.

OUR SHARED VALUES This plan includes five cross-cutting values that are foundational to each area of focus. All actions called for in this plan shall be undertaken through the lens of these shared values: 1) reducing the stigma associated with substance use disorder and identifying it as a chronic medical condition; 2) building resilience in individuals across the lifespan; 3) improving data collection, analysis, and timely communication; 4) building and maintaining a robust infrastructure capable of supporting the priority activities; 5) implementing all activities subject to available funding from federal, state, community, and philanthropic sources.

Focus Areas, Priorities, Strategies

LEADERSHIP

Priority A: Take decisive, evidence-based and community focused actions in response to Maine's opioid crisis

Strategy #1: *Provide strong state-level leadership and coordination among prevention, harm reduction, treatment, and recovery strategies*

CURRENTLY PLANNED/FUNDED ACTIVITIES (FY21)	PRIORITY FUTURE ACTIVITIES (FY22 - FY23)
a. Continue to make SUD/OUD response a top priority of the Mills administration with leadership from the Director of Opioid Response, the Prevention and Recovery Cabinet, the Opioid Coordinating Council, Clinical Advisory Committee, and the Opioid Data Sharing Committee **b.** Assess and update the SUD/OUD Strategic Action Plan **c.** Ensure dedicated staff to support the implementation of the Strategic Action Plan **d.** Enhance the Governor's Office of Policy Innovation and the Future (GOPIF) web page for SUD/OUD **e.** Inventory all SUD/OUD programs and, including state, federal (HRSA, SAMHSA, etc) and private philanthropy. **f.** Host an annual Opioid Response Summit, enhanced with monthly educational webinars **g.** Build collaborative relationships with local, state, and national stakeholders and philanthropic organizations **h.** Support, and implement if enacted, legislation establishing an overdose fatality review panel	**i.** Regularly review and enhance the Opioid Response Strategic Action Plan **j.** Secure and publicly promote leadership commitments from key stakeholders **k.** Expand the Opioid Response Summit to include an additional half-day of workshops and an evening reception **l.** Support additional recovery events in local communities **m.** Hold manufacturers and distributors accountable

Strategy #2: *Develop a treatment and prevention workforce sufficient to meet the needs of Maine's population*

CURRENTLY PLANNED/FUNDED ACTIVITIES (FY21)	PRIORITY FUTURE ACTIVITIES (FY22 - FY23)
a. Support the development and growth of new and emerging workforce models for addressing SUD/OUD, including Community Health Workers, Recovery Coaches, and Community Paramedicine **b.** Implement a Substance Use Disorders Learning Community **c.** Through the Support for ME initiative and MaineCare's Comprehensive Rate System Evaluation, examine rates to ensure adequate payment to support recruitment and retention of workforce	**d.** Support universities and community colleges in developing curriculum **e.** Assess workforce supply and demand, including a review of licensing categories **f.** Continue to evaluate and promote expansion of MAT prescriber capacity in geographic areas of need

Strategy #3: *Support local and regional community engagement efforts*

CURRENTLY PLANNED/FUNDED ACTIVITIES (FY21)	PRIORITY FUTURE ACTIVITIES (FY22 - FY23)
a. Support the growth and sustainability of Recovery Community Centers **b.** Engage and showcase communities in statewide events, including the annual Opioid Response Summit **c.** Support the use of film and storytelling to engage communities **d.** Promote Recovery Friendly Communities **e.** Support public, private, and philanthropic funding of communities implementing prevention initiatives	f. Evaluate and fund as resources allow, promising local community engagement efforts

Strategy #4: *Promote changes in public understanding, beliefs and behaviors regarding substance use disorder and opioid use disorder (SUD/OUD)*

CURRENTLY PLANNED/FUNDED ACTIVITIES (FY21)	PRIORITY FUTURE ACTIVITIES (FY22 - FY23)
a. Develop and implement evidence-based public messaging campaigns **b.** Conduct outreach and education opportunities for health care providers **c.** Implement an education module for law enforcement professionals and Maine Criminal Justice Academy recruits **d.** Host and participate in forums, presentations, and recovery events in local communities and key sectors **e.** Create more opportunities for individuals, families, and others affected by SUD/OUD to tell their personal stories of addiction or recovery **f.** Educate employers and support efforts that promote recovery-friendly workplaces, including the new Youth Employment Assistance Program (YEAP)	**g.** Disseminate a stigma and discrimination reduction curriculum, including continuing education credits, to all health care providers, first responders, and frontline support staff **h.** Continue to work with employers to promote treatment and recovery-friendly worksites **i.** Engage municipal governments, business associations, and community service organizations in taking supportive actions **j.** Evaluate stigma and discrimination reduction efforts for possible replication

Strategy #5: *Maximize the collection of actionable data and evaluate the impact of interventions*

CURRENTLY PLANNED/FUNDED ACTIVITIES (FY21)	PRIORITY FUTURE ACTIVITIES (FY22 - FY23)
a. Establish an Opioid Data Sharing Committee (ODSC), replacing the Statewide Epidemiology Outcomes Workgroup (SEOW) Opioid Sub-Committee **b.** Continue to support the SEOW in its prevention work, including the engagement and education of multi-sector partnerships **c.** Develop a strategic data plan, including clearly defined roles and purposes for the data currently available, including automation of population-based surveillance data **d.** Conduct an economic study and report on the cost of SUD/OUD to Maine families and businesses **e.** Create an online data hub to increase public transparency **f.** Share key data to inform policy and program design **g.** Conduct ongoing data analysis and interpretation to improve understanding of program performance **h.** Promote the use of ODMAP (overdose mapping tool) i. Share overdose spike data with clinicians and community partners, promoting appropriate response	**j.** Compile stories that add context and texture to communications of data and outcomes **k.** Communicate the results of data analysis and interpretation to policymakers and the public **l.** Support efforts to align state and federal guidelines on SUD data-sharing

PREVENTION

Priority B: Prevent the early use of addictive substances by children, youth, and young adults

Strategy #6: *Support healthy early childhood development*

CURRENTLY PLANNED/FUNDED ACTIVITIES (FY21)	PRIORITY FUTURE ACTIVITIES (FY22 - FY23)
a. Support the activities of the Children's Cabinet which benefit and improve early childhood development and prevent early use **b.** Support the implementation of early childhood education and social and emotional learning skills for children and youth **c.** Support access to contraception. **d.** Support efforts to thoroughly review infant and child mortality data **e.** Continue to implement the Safe Sleep campaign	**f.** Expand the availability of Home Visiting and Public Health Nurses **g.** Promote educational information and skill-building for parents and families, including evidence-based programs to develop effective parenting skills **h.** Provide education and training opportunities for child care providers **i.** Implement social and emotional learning curriculum in all schools **j.** Identify and implement out-of-school social and emotional learning programs **k.** Evaluate social and emotional learning programs for efficacy and potential expansion

Strategy #7: *Reduce adverse childhood experiences (ACEs)*

CURRENTLY PLANNED/FUNDED ACTIVITIES (FY21)	PRIORITY FUTURE ACTIVITIES (FY22 - FY23)
a. Promote awareness and education on the prevention of ACEs **b.** Support parents with SUD/OUD in maintaining custody or achieving reunification **c.** Provide parent education, coaching and case management **d.** Explore the evidence base and potential target audiences for trainings on childhood brain development, ACEs, and SUD prevention **e.** Promote ACEs education and training for high-risk communities and/or families	**f.** Explore the creation of ACEs Response Teams to support children exposed to violence **g.** Reduce arrests and incarceration through the OPTIONS program, pre-booking diversion and Drug Courts **h.** Participate in a comprehensive, cross-departmental plan to address ACE's and trauma informed interventions

Strategy #8: *Promote life skills and resilience-building for all youth*

CURRENTLY PLANNED/FUNDED ACTIVITIES (FY21)	PRIORITY FUTURE ACTIVITIES (FY22 - FY23)
a. Support and participate in the Maine Resilience Building Network's "Youth Matters" Initiative **b.** Support the Maine Youth Action Network's efforts to engage youth and create more resources to address students' mental health and emotional needs **c.** Support Positive Action Teams in Piscataquis County **d.** Support the Department of Education and Maine Center for Disease Control and Prevention, Office of Behavioral Health, Office of Child and Family Services, and others in promoting and disseminating social and emotional learning (SEL) curriculum and programs, including Sources of Strength, Primed for Life, Second Steps, and Maine Department of Education's curriculum developed in collaboration with EVOLUTION LAB **e.** Support the StrengthenME resilience and wellness initiative	**f.** Assess potential partnerships with School Based Health Centers **g.** Continue to support the promotion and dissemination of SEL curriculum, subject to ongoing evaluation of efficacy and successful outcomes

Strategy #9: *Identify and support youth and young adults at risk of developing a substance use disorder*

CURRENTLY PLANNED/FUNDED ACTIVITIES (FY21)	PRIORITY FUTURE ACTIVITIES (FY22 - FY23)
a. Provide trauma-informed, evidence-based education and trainings to high-risk youth **b.** Include information on SUD treatment for adolescents in online content **c.** Strengthen school and community-based approaches to SUD/OUD prevention **d.** Provide support for Teen Centers **e.** Support restorative justice practices **f.** Develop and distribute Maine-specific and trauma-informed programs and curricula at no cost to all public schools **g.** Continue to implement the Maine Youth Leadership Institute SEALFIT program **h.** Implement and increase referrals to the Student Intervention Reintegration Program (SIRP) **i.** Identify and assess for potential implementation evidence based practices for reaching the young adult population **j.** Support federally funded (HRSA) Pediatric and Behavioral Health Partnership (MPBHP)- tele consult line for providers to access child psychiatrists for behavioral health issues, including polysubstance issues	**k.** Increase the number of children's behavioral health counselors, especially in rural areas **l.** Increase the number of mental health/behavioral health (MH/BH) counselors and/or social workers in schools **m.** Increase restorative justice practices in schools **n.** Promote the use of SBIRT (Screening, Brief Intervention & Referral for Treatment) for early use of addictive substances in primary care, school-based health centers and other youth settings **o.** Expand SIRP through virtual offerings and outreach to primary care physicians and Department of Corrections as new referral resources **p.** Identify new partners and strategies to reach the young adult population through secondary education and workplaces.

Strategy #10: *Support and expand community partnerships to educate and engage youth, families, and communities*

CURRENTLY PLANNED/FUNDED ACTIVITIES (FY21)	PRIORITY FUTURE ACTIVITIES (FY22 - FY23)
a. Promote community-based efforts to educate and engage parents and youth on the risks of early use of addictive substances **b.** Promote opportunities to engage youth in healthy activities **c.** Support community youth organizations **d.** Provide interdepartmental support and participation in efforts among partners to understand and build upon evidence-informed rural community prevention models **e.** Promote education for parents and providers on the impact of the early use of addictive substances and how to reduce early use among children and youth **f.** Support the development and implementation of a networked campaign of messaging and materials to reduce early use of addictive substances and vaping devices **g.** Engage communities in efforts to address social norms and policies that increase protective factors, such as the Youth Matters initiative of the Maine Resilience Building Network	**h.** Promote healthy outdoor after-school programs/activities, such as the Icelandic Model **i.** Explore federal funding and private philanthropic opportunities to sustain local prevention efforts and build capacity.

Strategy #11: *Implement and sustain COVID response, recovery and resiliency strategies*

CURRENTLY PLANNED/FUNDED ACTIVITIES (FY21)	PRIORITY FUTURE ACTIVITIES (FY22 - FY23)
a. Adapt school and community based prevention strategies to virtual learning environments. **b.** Design and implement the StrengthenME Initiative to provide free tools, support, and connections to Community Health Workers to reduce stress and promote wellness, resilience, and recovery **c.** Continue to assess, learn, and sustain innovations that improve quality, access, and effectiveness of programs and services, including telemedicine enhancements	**d.** Assess and maintain the most effective COVID innovations to expand the access and reach of prevention strategies. **e.** Working with the Children's Cabinet and other aligned organizations, research and develop messaging and interventions that promote healthy coping skills to prevent increased substance use during times of stress.

Priority C: Reduce the number of prescribed and illicitly obtained opioids

Strategy #12: *Improve the safety of opioid prescribing*

CURRENTLY PLANNED/FUNDED ACTIVITIES (FY21)	PRIORITY FUTURE ACTIVITIES (FY22 - FY23)
a. Support clinician adherence to evidence-based guidelines for opioid prescribing through the SUD Learning Community and other online trainings **b.** Offer the Controlled Substances Stewardship Program to practices & providers to assist with tapering opioids **c.** Enhance reporting from the prescription monitoring program (PMP) **d.** Support drug take-back days **e.** Provide clinical training opportunities to address safe prescribing practices	**f.** Use PMP data to identify and engage high prescribing outliers **g.** Evaluate expansion of the Controlled Substances Stewardship Program **h.** Add additional academic detailing programs

Strategy #13: *Strengthen law enforcement efforts to intercept and reduce illicit opioid supply*

CURRENTLY PLANNED/FUNDED ACTIVITIES (FY21)	PRIORITY FUTURE ACTIVITIES (FY22 - FY23)
a. Continue to aggressively prosecute drug traffickers **b.** Continue to assist law enforcement in coordinating, cooperating, and collaboratively aligning data, programs, technology, and resources **c.** Explore alternative funding sources, systems, and technology, including statutory changes, so that drug testing is not a barrier to successful prosecution of drug traffickers	**d.** Implement alternative options to reduce barriers to drug testing, subject to available resources **e.** Maximize the use of seized assets to support enforcement efforts

HARM REDUCTION

Priority D: Reduce the number of fatal and non-fatal overdoses

Strategy #14: *Ensure the availability of naloxone for high-risk individuals via targeted distribution*

CURRENTLY PLANNED/FUNDED ACTIVITIES (FY21)	PRIORITY FUTURE ACTIVITIES (FY22 - FY23)
a. Deploy mobile response teams in every Maine county as part of the OPTIONS (Overdose Prevention Through Intensive Outreach, Naloxone and Safety) initiative to educate and engage high risk individuals in harm reduction strategies, including the distribution and use of naloxone and to offer treatment/recovery services, including MAT **b.** Support legislation permitting Emergency Medical Technicians (EMTs) to distribute as well as administer naloxone **c.** Support MeHAF funded pilot harm reduction education for pregnant patients, OB staff, and providers and naloxone distribution to post-partum patients	**d.** Continue to mobilize response teams in collaboration with local law enforcement, emergency responders, recovery coaches and harm reduction professionals as part of the OPTIONS Initiative **e.** Continue to support quality improvement initiatives for pregnant women

Strategy #15: *Ensure widespread distribution and ease of access to naloxone by the general public*

CURRENTLY PLANNED/FUNDED ACTIVITIES (FY21)	PRIORITY FUTURE ACTIVITIES (FY22 - FY23)
a. Continue to support the purchase and distribution of sufficient doses of naloxone to supply Tier 1 and Tier 2 distributors as designated by the Naloxone Steering Committee	**b.** Educate health care providers about the opportunities and importance of prescribing naloxone, including co-prescribing naloxone with opioids **c.** Collaborate with the State Board of Pharmacy and other health professional boards on stigma reduction, naloxone distribution, and co-prescribing initiatives

Strategy #16: *Increase public awareness of overdose prevention and the use of naloxone*

CURRENTLY PLANNED/FUNDED ACTIVITIES (FY21)	PRIORITY FUTURE ACTIVITIES (FY22 - FY23)
a. Update and resume the "Have it On Hand" and related public messaging campaigns as part of the OPTIONS campaign **b.** Update and launch Eyes Open overdose prevention campaign.	**c.** Evaluate the effectiveness of the public education campaigns **d.** Broaden public education efforts where found to be effective

Priority E: Engage active users and the recovery community in harm reduction

Strategy #17: *Increase awareness, understanding, and utilization of harm reduction strategies and resources*

CURRENTLY PLANNED/FUNDED ACTIVITIES (FY21)	PRIORITY FUTURE ACTIVITIES (FY22 - FY23)
a. Train and deploy "co-responders" –licensed behavioral health specialists embedded in emergency response units - in every Maine county as part of OPTIONS program **b.** Provide education on overdose prevention and treatment resources at naloxone distribution sites and syringe service programs through the OPTIONS program **c.** Educate and promote the "Good Samaritan" law through the OPTIONS program, and assess its current effectiveness **d.** Implement public health education and intervention campaign as part of the OPTIONS program **e.** Expand sterile syringe access **f.** Expand drug testing resources (e.g. fentanyl test strips)	g. Evaluate safe supply programs and consider implementation of effective harm reduction programs that meet the requirements of state and federal law

Strategy #18: *Provide resources and supports for people experiencing homelessness*

CURRENTLY PLANNED/FUNDED ACTIVITIES (FY21)	PRIORITY FUTURE ACTIVITIES (FY22 - FY23)
a. Engage and educate people experiencing homelessness in harm reduction strategies and options for treatment and recovery through the OPTIONS and StrengthenME initiatives **b.** Implement the Housing for Opioid Users Service Engagement (HOUSE) pilot to engage individuals experiencing homelessness in treatment and housing	

Priority F: Engage providers, law enforcement, and the public in harm reduction strategies

Strategy #19: *Support the design and statewide replication of promising practices to reduce public opposition to effective harm reduction strategies*

CURRENTLY PLANNED/FUNDED ACTIVITIES (FY21)	PRIORITY FUTURE ACTIVITIES (FY22 - FY23)
a. Convene community conversations to listen and share information and educational materials on harm reduction strategies	b. Contract with organizations with content expertise to provide education and training on harm reduction strategies

Strategy #20: *Promote a comprehensive system of care and referrals among health care and harm reduction services*

CURRENTLY PLANNED/FUNDED ACTIVITIES (FY21)	PRIORITY FUTURE ACTIVITIES (FY22 - FY23)
a. Promote bidirectional referrals between syringe exchange programs, primary care, MAT, and other health services, including the diagnosis and treatment of hepatitis C and HIV **b.** Decriminalize the possession of needles	c. Evaluate models of interconnected systems of care and referrals

TREATMENT

Priority G: Ensure the availability of treatment that is local, immediate, affordable, and best fit

Strategy #21: *Dedicate staff and funding to support the screening, treatment, and recovery of pregnant women with substance use disorder and support substance-exposed infants*

CURRENTLY PLANNED/FUNDED ACTIVITIES (FY21)	PRIORITY FUTURE ACTIVITIES (FY22 - FY23)
a. Support, enhance, and align all efforts to ensure high quality treatment for pregnant and parenting women among departments, offices, and programs, including working with the Perinatal Quality Collaborative to join the Alliance for Innovation on Maternal (AIM) Health **b.** Implement integrated models of care for pregnant and parenting women, such as the Maternal Opioid Misuse (MOM) initiative **c.** Maintain a Maternal SUD and Substance-Exposed Infant (SEI) Task Force **d.** Support the annual SEI conference **e.** Promote evidence-based approaches to supporting substance-affected infants during the newborn hospitalization, including use of Eat, Sleep, Console and Snuggle ME guidelines **f.** Ensure that all substance-exposed infants have a Plan of Safe Care (POSC)	**g.** Develop a statewide strategic workplan for addressing the prevention and treatment of substance exposed infants in Maine. **h.** Enhance the Cradle ME referral system to include Public Health Nursing, Home Visiting and WIC **i.** Implement the federal Medicaid 1115 Waiver for SUD services **j.** Increase access to SUD treatment for parents with children in foster care **k.** Support the development of systems to ensure SEI newborns get appropriate preventive services, developmental screening, and follow-up Hepatitis C screening **l.** Review and update the birth certificate worksheet to reduce stigmatizing language and collect surveillance data around SEI, POSC, and maternal SUD

Strategy #22: *Improve patient access to Medication Assisted Treatment (MAT), with special efforts to reach populations most at risk*

CURRENTLY PLANNED/FUNDED ACTIVITIES (FY21)	PRIORITY FUTURE ACTIVITIES (FY22 - FY23)
a. Strengthen Maine's system for treatment and recovery **b.** Implement the federal Medicaid 1115 IMD Waiver to enhance access to residential SUD treatment **c.** Continue supporting emergency departments in adding rapid induction MAT **d.** Continue supporting county jails and Department of Corrections in adding MAT **e.** Support the Wabanaki nations in creating a Maine-based treatment and recovery center	**f.** Work with the Department of Corrections and county jails to identify sustainable funding to provide MAT universally to all incarcerated individuals with a diagnosis of SUD **g.** Assess need and fill gaps in treatment capacity for adolescents, including medically supervised withdrawal **h.** Pilot and evaluate mobile MAT services **i.** Support expansion of MAT programs in county jails and DOC by including all forms of MAT **j.** Improve referrals with and within specialty courts

Strategy #23: *Increase MAT provider capacity for providing low barrier, rapid access to treatment*

CURRENTLY PLANNED/FUNDED ACTIVITIES (FY21)	PRIORITY FUTURE ACTIVITIES (FY22 - FY23)
a. Support Federally Qualified Health Centers (FQHCs) in piloting low barrier MAT, including rapid induction and bridging capacity, especially in rural areas **b.** Build upon existing MaineCare payment and benefits models, including the Opioid Health Homes (OHH) program **c.** Assess and update reimbursement systems, including commercial insurance, to maximize counseling capacity	**d.** Implement a statewide system for providing education and technical assistance support for MAT providers, including an SUD Learning Community **e.** Secure leadership commitments from health systems and provider groups to increase their number and capacity of MAT (X-waivered) clinicians **f.** Allocate resources to ensure adequate reimbursement to treatment providers across the range of services **g.** Assess transportation needs to ensure access to MAT appointments **h.** Support additional capacity for "bridging" from MAT induction to maintenance treatment and recovery **i.** Provide education and training on the Contingency Management & Community Reinforcement approach for stimulant use disorder

Strategy #24: *Implement innovative treatment strategies in response to the COVID-19 pandemic*

CURRENTLY PLANNED/FUNDED ACTIVITIES (FY21)	PRIORITY FUTURE ACTIVITIES (FY22 - FY23)
a. Expand the allowable credentials for preparation of take-home doses of methadone by Opioid Treatment Programs **b.** Implement the StrengthenME Initiative to provide proactive outreach from Recovery Community Centers and Recovery Coaches to reduce stress and improve connectivity and Community Health Workers to engage communities disproportionately affected by COVID- **c.** Maintain the use of digital technology, including telehealth, to deliver MAT and support patient monitoring **d.** Implement active outreach as part of "OPTIONS" program to increase referrals to treatment	e. Assess and maintain the most effective innovations to build resiliency and preparedness

Strategy #25: *Implement the most promising practices in response to increased use of stimulants and polysubstances*

CURRENTLY PLANNED/FUNDED ACTIVITIES (FY21)	PRIORITY FUTURE ACTIVITIES (FY22 - FY23)
a. Design a Contingency Management pilot	**b.** Assess and update reimbursement systems and insurance coverage for stimulants and polysubstance use disorders **c.** Implement the Contingency Management pilot

Priority H: Increase the proportion of persons with SUD/OUD who seek or are in treatment

Strategy #26: *Provide clear public information about real time availability of treatment options and how to access treatment and referrals, including telehealth options*

CURRENTLY PLANNED/FUNDED ACTIVITIES (FY21)	PRIORITY FUTURE ACTIVITIES (FY22 - FY23)
a. Implement the Map & Match initiative to identify gaps in the treatment service continuum and geographic access shortages with real time capacity data **b.** Implement the treatment and recovery services locator tool, including education of providers and the public **c.** Pilot an SUD telephonic helpline in Washington County **d.** Implement the Office of Medicaid Service's "Health Care Happens Here" campaign to provide a digital health option during the COVID-19 pandemic **e.** Improve the 211 database and maintain the 211 Opioid Helpline **f.** Use Opioid Data Sharing Committee results to determine gaps in treatment and recovery	g. Refine efforts to match people seeking treatment with options that offer the best fit for their needs

Strategy #27: *Reduce structural and systemic barriers to treatment*

CURRENTLY PLANNED/FUNDED ACTIVITIES (FY21)	PRIORITY FUTURE ACTIVITIES (FY22 - FY23)
a. Collaborate with Maine's CAP Agencies and other partners to provide transportation and child care for people seeking treatment **b.** Improve access to public and private health insurance coverage **c.** Examine compliance with federal and state parity laws by commercial health insurance companies	

RECOVERY SUPPORTS

Priority I: Support individuals in recovery

Strategy #28: *Support recovery for youth and adults with SUD/OUD*

CURRENTLY PLANNED/FUNDED ACTIVITIES (FY21)	PRIORITY FUTURE ACTIVITIES (FY22 - FY23)
a. Provide recovery supports for youth with SUD/OUD through support for Young People in Recovery and other youth-led and youth-serving organizations **b.** Provide employment support through the Department of Labor's "Connecting with Opportunities" and "Maine Works" initiatives **c.** Provide more supports, including case management and recovery support specialists, to assist individuals coming out of incarceration in maintaining their recovery	**d.** Continue supporting youth-led and youth-serving organizations and activities **e.** Support secondary prevention projects within Maine Center for Disease Control and Prevention and the Department of Education **f.** Identify and pilot new/innovative models of recovery

Strategy #29: *Support individuals involved in the criminal justice and juvenile justice systems*

CURRENTLY PLANNED/FUNDED ACTIVITIES (FY21)	PRIORITY FUTURE ACTIVITIES (FY22 - FY23)
a. Promote and expand pre-arrest diversion programs and treatment alternatives to incarceration, including Treatment and Recovery Courts for individuals with SUD or co- occurring mental health disorders **b.** Support the law enforcement Co-Responder and SUD Liaison/Navigator programs **c.** Support innovative pre-arrest and post arrest diversion programming pilots, such as law enforcement assisted diversion (LEAD) and the Sequential Intercept Model in order to provide care coordination, improve communication, reduce recidivism, and support recovery **d.** Support the peer-to-peer mentoring program for participants in Treatment and Recovery Courts	**e.** Review recommendations from the 2020 evaluation of Maine's Treatment and Recovery Courts for potential implementation **f.** Evaluate the Southern Kennebec County Diversion and Support Program for potential replication **g.** Evaluate the Waldo-Knox Drug Offense Diversion and Deflection Program **h.** Assess and support evidence-based re-entry programs, such as those operated by the Maine Prisoner Re-Entry Program **i.** Expand the training for prosecutors, defense attorneys, and participants in Treatment and Recovery Courts

Strategy #30: *Increase the availability of recovery coaching services*

CURRENTLY PLANNED/FUNDED ACTIVITIES (FY21)	PRIORITY FUTURE ACTIVITIES (FY22 - FY23)
a. Support peer recovery coach trainings **b.** Continue to expand peer recovery coaches in emergency departments initiating MAT **c.** Continue to expand peer recovery coach capacity through community recovery centers and improve the monitoring and supervision of recovery coaching **d.** Create a comprehensive list of all certified (CCAR) recovery coaches in the state, regardless of their source of training	**e.** Host an education and coordination conference for recovery coaches, including recovery coaches who are incarcerated **f.** Establish a second level, state certification for Recovery Coaches who meet the requirements **g.** Evaluate cost and establish payment codes for recovery coaching **h.** Connect recovery coaches who have graduated from a Treatment and Recovery Court to current and potential Court participants

Strategy #31: *Provide resilience-building programs and services for people in recovery*

CURRENTLY PLANNED/FUNDED ACTIVITIES (FY21)	PRIORITY FUTURE ACTIVITIES (FY22 - FY23)
a. Implement the StrengthenME Initiative to help people cope with the stress of the COVID pandemic	b. Assess resilience-building programs and strategies for adults, and make recommendations for potential implementation

Strategy #32: *Expand safe and secure housing options for people in recovery*

CURRENTLY PLANNED/FUNDED ACTIVITIES (FY21)	PRIORITY FUTURE ACTIVITIES (FY22 - FY23)
a. Partner with the Maine State Housing Authority (MSHA) to implement Public Law Chapter 524, "An Act to Ensure the Quality of and Increase Access to Recovery Residences" **b.** Partner with the Maine Association of Recovery Residences (MARR) to encourage certification of residences and reduce discrimination against residences allowing MAT **c.** Work with housing providers to support individuals with SUD in successfully maintaining permanent housing, including through a permanent supportive housing (PSH) initiative utilizing a Health Home model program to serve those who are at risk for, or are chronically homeless	d. Continue the MSHA pilot and increase the number of certified residences in the pilot

Priority J: Build and support recovery-ready communities

Strategy #33: *Increase community-based recovery supports*

CURRENTLY PLANNED/FUNDED ACTIVITIES (FY21)	PRIORITY FUTURE ACTIVITIES (FY22 - FY23)
a. Develop an initiative around recovery ready communities, including recovery ready campuses **b.** Fund and support additional SUD/OUD community coalitions/partnerships	**c.** Evaluate the Youth Employment Assistance Program for possible replication statewide **d.** Fund and support additional SUD/OUD community coalitions/partnerships **e.** Implement recovery ready initiative

APPENDIX K

Harm Reduction: Principles and Evidence, Presentation by David Kispert, MD

Harm Reduction: Principles and Evidence

David Kispert MD

Principles of Harm Reduction

"Harm reduction is a set of practical strategies and ideas aimed at reducing negative consequences associated with drug use. Harm reduction is also a movement for social justice built on a belief in, and respect for, the rights of people who use drugs."

NATIONAL HARM REDUCTION COALITION

8 Principles of Harm Reduction

- Accepts, for better or worse, that drug use is part of our world and works to minimize its harmful effects rather than simply ignore or condemn them.
- Understands drug use as a complex, multi-faceted phenomenon that encompasses a continuum of behaviors from severe use to total abstinence, and acknowledges that some ways of using drugs are clearly safer than others
- Establishes quality of individual and community life and well-being — not necessarily cessation of all drug use — as the criteria for successful interventions and policies

8 Principles (continued)

- Calls for the non-judgmental, non-coercive provision of services and resources to people who use drugs and the communities in which they live in order to assist them in reducing attendant harm
- Ensures that people who use drugs and those with a history of drug use routinely have a real voice in the creation of programs and policies designed to serve them
- Affirms people who use drugs (PWUD) themselves as the primary agents of reducing the harms of their drug use and seeks to empower PWUD to share information and support each other in strategies which meet their actual conditions of use

8 Principles (continued)

- Recognizes that the realities of poverty, class, racism, social isolation, past trauma, sex-based discrimination, and other social inequalities affect both people's vulnerability to and capacity for effectively dealing with drug-related harm.
- Does not attempt to minimize or ignore the real and tragic harm and danger that can be associated with illicit drug use

Examples of Harm Reduction

- Naloxone (Narcan) distribution
- Needle and Syringe Distribution Programs
- Supervised Injection Sites
- Medications for OUD Treatment
- Non-abstinence housing (Housing First)
- Decriminalization of the possession or use of drugs

Harm Reduction vs Abstinence Programs

- A client presents after 1 month of treatment and reports consuming five drinks on each of the past three nights.
  - **Abstinence-based program** would count that as a failure.
  - **Harm reduction** practitioner would ask how much the client drank at the beginning of therapy. If the client were drinking 10 drinks every day, then the consumption of five drinks a day would be a therapeutic success, or steps in the right direction.
    - If the client's goal were to abstain, then the therapist would continue to work with the client.
    - If the client's goal was to avoid blacking out, and five drinks would keep the blood alcohol level below the risk of blacking out, then treatment would be a success.

Motivational Interviewing

- Intervention with some evidence to support its effectiveness in reducing the abuse of substances (Livingston, Milne, Fang, & Amari, 2012)

- The focus is not on convincing the person to follow a particular course, but rather to examine the consequences of current behaviors and potential behavior changes (Smedslund et al., 2011).

- Motivational Interviewing entails:
  - Expressing empathy to build rapport with the client
  - Developing discrepancy between what the client wants and where he or she is currently
  - Rolling with client resistance to build the relationship and move toward change
  - Supporting self-efficacy in the client to take the necessary steps.

College Student Drinking

- Alcohol Skills Training Program (ASTP) combines cognitive-behavioral skills, norms clarification, and motivational enhancement techniques in a group setting

- Post-intervention weekly drinking decreased from 14.8 drinks at baseline to 6.6 drinks 12 months later
- Compared with an alcohol information group reduction of 19.4 drinks at baseline to 12.7 drinks at follow-up
- Assessment only condition increase of 15.6 drinks at baseline to 16.8 drinks at the same follow-up

Workplace Programs

- National surveys have estimated that over 70% of heavy drinkers and drug users are employed full-time (Substance Abuse and Mental Health Services Administration [SAMHSA], 1999)

- Adding a brief intervention to an employee assistance program's produced decreases in drinking and associated consequences at 3-month follow-up.
  - Intervention participants reported decreases of 7.56 peak drinks per occasion at baseline to 4.78 peak drinks at follow-up
  - Treatment-as-usual participants decreased from 6.27 drinks to 6.07 drinks

Medications for Opioid Use Disorder (MOUD)

- The therapies were identified to provide a less harmful opioid (e.g., methadone or buprenorphine) under medical supervision in both specialty and outpatient clinics.

- Several reviews have identified MOUD as effective in reducing:
  - Illicit opioid use
  - HIV risk behaviors
  - Criminal activity
  - Opioid-related death (Connock et al., 2007; WHO, 2004).

Needle and Syringe Distribution Programs

- Developed to reduce the spread of blood-borne diseases (e.g., HIV and hepatitis) among people who inject drugs. These programs have been around since the mid 1980s, often include drug treatment referrals, peer education, and HIV prevention

- Thorough review of 45 studies concluded that these programs are effective, safe, and cost effective (Wodak & Cooney, 2006) with no evidence of deleterious effects (Strathdee & Vlahov, 2001)

Supervised Injection Sites (SIS)

- People who inject drugs can use their own drugs using clean equipment in the presence of medically trained personnel

- Over 25 studies have been published documenting:
  - Significant reductions in needle sharing and reuse, overdoses, injecting/discarding needles in public places (Strathdee & Pollini, 2007)
  - Reduced fatalities due to overdose (Kerr, Tyndall, Lai, Montaner, & Wood, 2006)
  - Increased enrollment in detoxification and other addiction treatments (Wood, Tyndall, Zhang, Montaner, & Kerr, 2007).

- First government-authorized supervised injection site in the United States began operating in New York City in 11/2021

Advocacy on Federal Level

"Harm reduction is an important part of the comprehensive approach to addressing substance use disorders through prevention, treatment, and recovery where individuals who use substances set their own goals."

SAMHSA
Substance Abuse and Mental Health Services Administration

Bottom Line

Many of our most successful addiction treatment strategies are routed in the principles of harm reduction

Questions to the Group

Is involuntary commitment/compulsory treatment compatible with the principles of harm reduction?

AND

If not, is that a concern?

Additional Literature for Consideration

- “Why Forced Addiction Treatment Fails” by Maia Szalavitz
  - New York Times Opinion Guest Essay Piece
  - 4/30/22
  - Alternative narrative providing thorough review of evidence

https://www.nytimes.com/2022/04/30/opinion/forced-addiction-treatment.html

Citations

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