



Recommendations for Sensible Drug Policy

The Maine Coalition for Sensible Drug Policy

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1. Executive Summary and Recommendations

This report represents a collaborative effort on behalf of the Maine Coalition for Sensible Drug Policy. It endeavors to explore the ongoing opioid crisis in all of its depth and breadth, painting a comprehensive picture of this public health crisis, its sociocultural moorings, and the impact of public policy on the crisis, by:

- highlighting the extent to which drug use exists along a continuum from benign through chaotic use patterns;
- exploring the strong connection between experiences of trauma and severe mental illness and the development of problematic relationships with drugs;
- adopting a broad definition of recovery, that encompasses any positive step towards improving ones health and wellbeing;
- documenting escalating rates of accidental drug poisonings, hepatitis C and other related conditions;
- exploring the failings and inappropriateness of the criminal justice system in addressing drug use;
- recognizing and calling out the racially motivated foundations and racialized consequences of punitive approaches to addressing drug use;
- elaborating on barriers to treatment and care and the contributions of the previous administration in exacerbating these issues; and
- highlighting the discrimination and stigma faced by people with a history of drug use in housing, employment, health care and other sectors.

The Coalition created this report to provide information and recommendations that, if accepted, will have a far-reaching and positive impact on Maine's addiction crisis. This report is a summary of the Coalition's in-depth report, which includes sources for background information and recommendations. The original report is available at the Health Equity Alliance.

The Coalition asserts specific recommendations to address the opioid crisis and advance sensible drug policy with the goals of reducing the prevalence of problematic drug use, reducing drug-related harms and facilitating recovery for people with problematic relationships with drugs. Recommendations fall into six domains:

- Primary prevention – reducing the prevalence of problematic drug use;
- Harm reduction – reducing drug-related harms associated with problematic drug use;
- Treatment and Care – increasing access to treatment for people with problematic drug use;
- Recovery Supports – advancing and sustaining health and wellbeing for people with a history of drug use;
- Criminal Justice – advancing criminal justice reform to align with public health evidence and a compassionate approach to drug use and reduce the impact of structural racism in public policy;
- Anti-Discrimination – reducing stigma and discrimination experienced by people who use drugs.

Recommendations:

These recommendations are grounded in public health science and advocates for a compassionate approach to drug use and the suspension of punitive programs that amount to efforts to ‘punish people into recovery.’ The evidence and/or arguments surrounding these recommendations is explored in-depth.

1. Improve and expand social safety net programs to reduce poverty, deprivation and social marginalization that drive rates of adverse childhood experiences.
2. Increase resiliency among youth and mitigate the effects of childhood trauma by fostering and funding evidence-based, age appropriate programs.
3. Support and fund harm reduction programming to establish well-resourced, fully-staffed syringe exchange and naloxone distribution centers in every county and foster outreach programs that conduct community and street-level outreach to people who use drugs, with a focus on those populations disproportionately impacted by substance use.
4. Fund and sanction the establishment of safer drug consumption facilities in major metropolitan areas throughout Maine.
5. Expand access to case management services for people who consume drugs, people engaged in treatment and people in short-term recovery including support with employment, housing and other needs.
6. Reduce reluctance to seek care by supporting and funding educational programs for healthcare providers about stigma surrounding people who consume drugs, harm reduction in health care, substance use treatment and compassionate care for people who consume drugs.
7. Reduce barriers to accessing treatment to ensure that all people who need substance use treatment can access it, including low-barrier and flexible treatment programs and additional supports for parents of young children.
8. Establish methadone and buprenorphine maintenance therapy, including comprehensive trauma-informed counseling services, in every county in Maine.
9. Cultivate low-barrier access to medical detox services by supporting and funding the establishment of medical detox services in every county in Maine.
10. Foster, support and fund programming offered through local recovery community centers established and maintained by people in long-term recovery including employment supports and job readiness programs, housing supports, recovery coaching services and other peer recovery support services.
11. Increase access to housing for people in all stages of recovery, including people who are actively using drugs, people in short-term recovery and people who are pregnant or parenting.

- 12.** Decriminalize possession of all drugs. Possession of illicit drugs and/or materials used to administer drugs becomes an administrative offense on all counts, regardless of the quantity of the substance within the possession of the accused. Eliminate the permissible inference of trafficking or furnishing based solely on the weight or amount of a substance possessed by the accused and add intent as an element of the crimes of trafficking and furnishing.
- 13.** Mandate the provision of a full range of treatment, including medication assisted treatment, and assertive post-release supports to cultivate seamless access to treatment upon release for people with substance use disorders in correctional facilities, for all correctional settings throughout Maine.
- 14.** Divert people out of the criminal justice system for crimes driven by substance use by supporting and funding the development of pre-arrest diversion programs, modeled on and adapting the Law Enforcement Assisted Diversion program in every county throughout Maine.
- 15.** Require the collection of data related to race, ethnicity and socioeconomic status for all stops, arrests, charges, convictions, sentences and other events at all levels of the criminal justice system. Establish a community panel to review data annually with the authority to require further review and action to address disparities. Require racial impact statements for all new policies considered by the Maine State Legislature.
- 16.** Support employment for people with a history of drug use and reduce employment discrimination by funding programs to engage employers around the importance of purpose for people in recovery and offering protections and incentives to hire people with substance use disorders as well as passing broad 'Fair Chance' policies that restrict the consideration of criminal history for all employment, housing, licensing and other relevant application processes. These should be supplemented by policies that address racial bias in hiring practices.
- 17.** Establish and/or amend non-discrimination policies to encompass people with substance use disorders, affording them protections against discrimination in housing.
- 18.** Support and fund a coordinated public education campaign and other efforts to reduce stigma around substance use and shift the cultural perception of people who consume drugs.

2. Introduction

After three years of struggle, multiple planning processes and ongoing efforts to address the opioid epidemic, Maine continues to be swallowed by the crisis, drowning in the tide of death and disease that define it. Maine has the unfortunate distinction of having the sixth highest increase in overdose deaths in the nation between 2017 and 2018.

The opioid crisis is the latest in a series of progressively more dangerous overdose epidemics that the US has seen since the last 1970s. After years of applying the same solutions to an escalating problem, it is clear that the prevailing drug policy has not been effective in addressing the harms associated with drug use. Efforts to address the latest opioid crisis must focus not just on surface-level reforms, but on upsetting and meaningfully altering the foundations of our understanding and approach to substance use.

Recommendations for Sensible Drug Policy

Drug policy in Maine and the US finds its origins in racially-motivated public policy dating back to the early 1900's, emerging initially as endeavors to control the 'racialized other' in the wake of abolition and growing immigration. Policy tends to lean heavily on an understanding of substance use as a personal choice and moral failing, deserving of and responsive to punitive consequences. These punitive efforts to deter and reduce drug use were ramped up significantly over the 1970's and 1980's in reaction to desegregation and the specter of the 'counterculture'. The intensifying policing of drug use, with especial emphasis on drug use among African Americans, created an epidemic of mass incarceration that effectively maintained racial segregation and deepened the disadvantage of already marginalized communities.

Drug policy in Maine and the US leans heavily on an understanding of substance use as a personal choice and moral failing, deserving of and responsive to punitive consequences. This fails to take into consideration the substantial advances in research from the medical, sociological, psychological and public health sectors. Reforms have thus far failed to meaningfully alter these foundations. This has led to a significant disconnect in the public policy domain, where substance use is treated simultaneously as a public health and a criminal justice issue. **As a nation, we seek both to support people with substance issues and to punish them.**

The Maine Coalition for Sensible Drug Policy (the Coalition) was established in 2017 in response to the recommendations of the Opioid Task Force convened by the State of Maine. The Coalition believes that the recommendations of the Task Force, while important, were not sufficient to stem the tide of the opioid epidemic. The Coalition supports a change in drug policy that advances evidence based practices, emerging promising approaches and innovative new solutions that will meaningfully address the current opioid crisis and the failings of Maine's drug policy.

The Coalition believes that it is unrealistic to fully eradicate drug use, and that a policy of reducing and mitigating risks and harms is the preferred approach. We propose a drug policy that advances the prevention of problematic drug use; the reduction of drug-related harms, including drug overdose deaths, infectious diseases and other potential issues; and the facilitation of recovery, defined as a process by which people realize "any positive change, as a person defines it."

The core of the Coalition was comprised of 10-15 members, including people with a history of drug use, professionals from health, public health, and social justice organizations, and legislators from both major political parties. Over the course of the last six months of 2018 the Coalition collected input and developed this report and recommendations.

3. Understanding the issues

3.1. Understanding Drug Use

Prevalence

Estimates of the prevalence of drug use and problematic drug use vary widely. According to the National Survey of Drug Use and Health, in 2016 29,000 Mainers reported using illicit drugs other than cannabis during the past year, of which 5,000 people reported using heroin, and 43,000 Mainers reported misusing prescription pain relievers. A 2018 report that utilized data from the health insurance sector found that 12.56 per 1,000 insured persons had been diagnosed with an opioid use disorder, placing Maine substantially higher than the U.S. rate of 4.6 per 1,000 people. Because this Maine figure does not include people who do not have insurance coverage (including MaineCare), we conclude that the actual rate of problematic drug use is even greater than 12.56 per 1,000 people.

Continuum of Drug Use

People use drugs along a continuum, ranging from social and recreational use to “chaotic” use. At the chaotic end of the spectrum, people’s lives are heavily focused on drugs and have been significantly negatively impacted by their drug use. Punitive approaches to drug use lead to lifelong social consequences such as incarceration, family rejection, and job loss, often leading to a downward spiral of negative financial, health and safety outcomes.

According to researchers, only 15% of people who report extramedical use of drugs other than tobacco and alcohol develop a physiological dependence for that drug, one of the diagnostic characteristics of a severe substance use disorder or addiction. While the 15% who develop a dependence on drugs may require long-term substance use treatment, most people will cease using drugs without treatment or with minimal help.

Trauma and Adverse Childhood Experiences

Researchers recognize the impact of co-occurring mental health conditions and childhood trauma on a person’s potential to develop a problematic relationship with drugs and to other adverse health outcomes. Often, substance use and psychiatric disorders occur together. Similarly, the Adverse Childhood Experiences (ACEs) study found a strong relationship between adverse childhood experiences such as physical, emotional, and sexual abuse and drug use. The more ACEs a person had, the more likely they were to have used illicit drugs.

By reducing the incidence of ACEs and childhood trauma, we can largely prevent the development of chaotic substance use and the negative consequences that often accompany it.

Research has shown that:

- 50% of participants at a community-based syringe exchange program had at least one comorbid (co-occurring) psychiatric disorder
- A male child who had experienced 6 of the catalogued adverse childhood experiences was 46 times more likely to use intravenous drugs
- Between 50% and 90% of people with a reported substance use disorder also had complex trauma histories
- People seeking treatment for opioid use disorder with more ACEs started using opioids earlier and were more likely to experience an accidental opioid overdose

Research findings validate the theory that problem drug use predominantly arises from the desire to escape psychic discomfort. While this does not discount the role of physical dependence and withdrawal avoidance in inhibiting recovery, physical dependence is secondary to psychic pain.

This research casts some doubt on the assumption that over-prescribing is primarily responsible for escalating rates of problem opioid use and fatal opioid poisonings. National surveys find that over 75% of people who misuse prescription medications obtain them from a non-medical source, and one research report found that fewer than 1% of patients prescribed opioids became addicted. Over-prescribing is undoubtedly a contributing factor insofar as overprescribing contributes to increased exposure to opioids.

Societal Conditions and Intergenerational Trauma

Emerging research suggests that ACEs are both caused by and cause adverse social conditions including poverty, discrimination, and other forms of inequality and social rejection. Deprivation, food insecurity, housing insecurity and other conditions intimately related to poverty can easily be considered traumatic in their own right, leading to elevated chronic stress levels among adolescents and adults. A growing body of research on historical trauma suggests that trauma can have intergenerational consequences, particularly among marginalized communities. Far from ‘being in the past’ historical trauma and oppression have ramifications that extend to today and into the future.

These findings validate the ‘dislocation theory of addiction’ popularized by theorist Bruce Alexander, who argued, “addiction of all forms (substances or otherwise) is a way of adapting to the social fragmentation and individual dislocation inherent in modern society.” Drugs and alcohol use are just one of many addictive tendencies that characterize modern life, expanding our perspective from problematic use of drugs to excessive and chaotic use of any behavior to escape. **The Coalition believes that social inequality is directly and indirectly responsible for problematic substance use and associated morbidity and mortality. In directing our efforts towards addressing social inequality, we address not only opioids, but other substances and other excessive behaviors as well.**

Recovery from Substance Use

The Coalition recognizes that while there is no single definition of recovery, the most commonly agreed upon definition was released in 2012 by the Substance Abuse and Mental Health Services Administration (SAMHSA). SAMHSA’s working definition of recovery is “a process of change through which individuals improve their health and wellness, live a self-directed life and strive to reach their full potential.” This definition does not include abstinence from substances as a feature or requirement of recovery. Recovery is defined as a process, rather than a status, and a person who is actively using illicit drugs can be in recovery. SAMHSA identified four major dimensions that support a life in recovery. These dimensions allow any person - recovering from substance use disorder or not - to lead a happy, healthy and productive life. They are:

1. **Health:** overcoming or managing one’s disease(s) or symptom, and making informed, healthy choices that support physical and emotional wellbeing.
2. **Home:** having a stable and safe place to live.
3. **Purpose:** conducting meaningful daily activities, such as employment or education and having the independence, income and resources to participate in society.
4. **Community:** having relationships and social networks that provide support, friendship, love and hope.

People in all stages of recovery require support in these areas. People who have an active substance use disorder have disconnected from themselves, their feelings, their families, and the community in which they live. Recovery is about connections and relationships. The process of recovery is highly personal, happens on a continuum, and occurs via many pathways. It can include - but is not limited to - clinical treatment, medication assisted recovery, 12-step programs, faith-based approaches, peer support, family support, harm reduction techniques, self-care, safe housing, peer-run recovery centers, employment and job-readiness trainings. Recovery should be customized to fit the individual. **Helping to support individuals by creating and maintaining connections must be the focus of policy.**

3.2. Understanding Drug-Related Harm

Accidental Drug Poisoning Deaths

During 2017, accidental drug poisoning deaths (overdoses) continued their steady climb. With 418 deaths, 2017 was the fifth consecutive year of increases in overdose mortality in Maine. Between 2012 and 2015 overdose mortality grew over 178%. The drug poisoning death crisis is driven by a combination of factors, including the extent to which fentanyl, a synthetic opioid, has come to permeate the supply of illicit opioids, and the combination of opioids with other substances. Table A provides Maine overdose death data.

Maine overdose death data show that:

- The average cause of death involved the combination of three drugs.
- Accidental drug poisoning deaths involving stimulants, such as cocaine, are also on the rise.
- The average age of people dying from accidental drug poisoning was 40, with a range of 18 to 75 years.
- This crisis is felt intensely in rural areas throughout Maine, although metropolitan areas experienced substantially more drug poisoning deaths in absolute numbers.

Table A: 2017 Maine Overdose Mortality, by substance(s) involved and geography		
Substance(s) involved	Number of Deaths	Percentage of Deaths
All Drug Overdose Deaths	418	100%
All opioids, licit and illicit	354	85%
Fentanyl	247	58%
Heroin	88	21%
Pharmaceutical opioids	124	30%
Cocaine	91	22%
Any benzodiazepine	98	23%
Methamphetamine	16	4%
Geographic Area	Number of Deaths	Rate per 100,000 people
Androscoggin	25	23.22
Lewiston	17	
Cumberland	109	37.26
Portland	57	
Kennebec	47	38.58
Augusta	14	
Knox	11	27.65
Penobscot	65	42.78
Bangor	30	
Somerset	18	35.56
Washington	13	41.15
York	82	40.16
Biddeford	23	
Sanford	12	

Source: Sorg, M. (2018). Expanded Maine Drug Death Report for 2017. *Margaret Chase Smith Policy Center, University of Maine*. Retrieved December, 18(2018).

Hepatitis C

Maine is in the midst of a hepatitis C crisis. Between 2013 and 2016 cases of acute hepatitis C rose 366%, with a rate of roughly 2.8 per 100,000 people in 2017. This rate is 180% higher than rate for the US as a whole. In 2017 62.5% of people diagnosed with acute hepatitis C in Maine reported a history of intravenous drug use. Reflecting overdose mortality, the hepatitis C crisis is felt both in rural and metropolitan areas, with some of the highest rates of acute hepatitis C in Washington and Waldo Counties.

Lack of access to hepatitis C testing services and the delayed onset of symptoms contribute to later diagnoses and higher rates of transmission. It is almost certain that the rate of people with hepatitis C is considerably higher than what has been documented here.

Hepatitis C is an infectious disease spread through exposure to blood, including through contaminated materials such as syringes and other injection supplies. Left untreated, the hepatitis C virus can lead to serious scarring, cirrhosis of the liver, and liver cancer. While hepatitis C is considered curable, effective treatment for the conditions is perceived to be immensely expensive. Since 2015, the State of Maine had spent \$18m-\$24m per year treating hepatitis C.

Human Immunodeficiency Virus (HIV)

HIV is a virus that is spread through exposure to contaminated blood, seminal fluid, vaginal fluid or breast milk. HIV has been found to live for up to 6 weeks in the barrel of a syringe, allowing it to be transmitted between drug users who share injection equipment. While the number of new cases of HIV attributed to injection drug use is relatively insignificant compared to other modes of transmission, a study from the U.S. Centers for Disease Control identified four of Maine's sixteen counties as being at-risk for an HIV outbreak.

Unlike hepatitis C, HIV is an incurable disease. Using anti-retroviral medications, people living with HIV can contain and reduce the presence of the virus in their systems to undetectable levels, making the virus untransmissible. However, like hepatitis C, HIV medications are expensive. The most recent study of costs found that the lifetime treatment cost for HIV was roughly \$379,668 per person.

Substance Use During Pregnancy & Infant Exposure

More women in Maine are using substances during pregnancy, resulting in an increase in the number of infants born exposed to substances. Currently, one in 12 infants in Maine is born exposed to a substance, including illicit drugs like heroin and fentanyl, as well as legal substances like tobacco and alcohol. Rates of unintended pregnancy among women using opioids are 86%, nearly 40% higher than the general population.

Many women who use substances during pregnancy are also survivors of complex trauma, including experiences of sexual and domestic violence, sex trafficking, poverty, homelessness, incarceration, and reproductive coercion—all of which contribute to psychic pain that drives chaotic substance use, and too often results in inadequate access to healthcare, treatment options, and other forms of support. The stigma of drug use is compounded for pregnant people, who legitimately fear judgment by providers and the potential loss of custody immediately postpartum, which can lead to avoidance of prenatal care. Maine's mandatory reporting statute is open to interpretation by health care providers, which leaves room for bias in reporting. Despite the reality that many people are highly motivated during pregnancy to enter treatment and recovery, wraparound services that promote the best health outcomes for adult and infant are scarce and largely inaccessible.

3.3. Understanding the Systems Surrounding Drug Use

The Criminal Justice System

According to the US Surgeon General, the misuse of drugs is a public health, not criminal justice, issue. However, since at least the early 1970s, when President Richard Nixon announced an “all-out, global war on the drug menace,” we as a country have centered our public narrative—and our solutions—almost exclusively on the criminal legal system.

The reliance on courts to address drug use has, in part, led to a swollen penal system: the US is home to 5% of the world’s population, but 25% of its incarcerated population. We also have poured an ever-increasing amount of money into our criminal legal system: from 1993 to 2012, the amount of criminal justice spending in the United States increased by 74%, going from \$158 billion to \$274 billion.

The consequences of the ‘drug war’ have affected people of low income, women, and people of color the most. The number of incarcerated women has risen 834% during the nation’s 40-plus year war on drugs, and the problem has been particularly problematic in small, rural counties. Nearly 80% of women in jails are parents, often primary caretakers for their minor children. One nationwide study found that among women incarcerated in jails, 82% had experienced drug dependence or problematic use in their lifetimes.

When we explore the history of the war on drugs, it is difficult not to recognize its foundation in racially-motivated public policy. Prior to the Harrison Narcotics Act of 1914, what are referred to today as ‘drugs’ were often used as ingredients in tonics, remedies and other medications utilized by the general populace to address their everyday maladies. In the wake of abolition drug policy was seized as a useful mechanism through which the establishment could maintain the subjugation of people of color. The progressive prohibition of these substances was pushed forward through the use of fear tactics that explicitly linked drug use with the racialized ‘other’ made wild and uncontrollable through drugs, conflating drug use with racial and ethnic minorities. In a post-slavery society this message found a willing audience. Most notably, African Americans, recently freed from slavery, were converted from slaves into free but unequal people, and quickly into criminals and deviants. Branded as morally deficient, it was easy work to strip away the rights and privileges afforded to the ‘ordinary citizen’ thereby maintaining systems of racial inequality and second-class citizenship.

Any analysis of our nation and our state’s drug policy cannot be adequately addressed without confronting the racial disparities in who we criminalize: despite the fact that people of all races engage in drug use at the same rates, people of color are disproportionately punished by the criminal justice system. For example, while only 3.4% of the Maine’s population identify as non-white, non-white people represent 19.46% of the state’s male prison population. Throughout the US one in three black men are expected to have spent time in incarceration, compared to one in 17 white men.

The criminal legal system is not equipped to address substance use disorder. Police, who are not social workers or doctors but who have instead been trained to use force to resolve conflicts, are usually a person’s first contact with the legal system. Once in jail, people are not offered treatment. Maine jails and prisons force mandatory detoxification without medical oversight. Because of the lack of access to supports, associated instability, and the decrease in tolerance to drugs after a period of abstinence, drug overdoses upon release from prison are high. One study showed that the likelihood of fatal overdose is between three and eight times more likely during the first two weeks after release from incarceration as compared to three to 12 weeks after release.

Recommendations for Sensible Drug Policy

Incarceration is often the beginning of what may amount to a lifetime of social exclusion and discrimination. After people serve time in jail or prison, they are released back into society with little to no support and significantly increased barriers to accessing healthcare, jobs, or housing. People convicted of felonies related to the possession and sale of drugs may not be eligible for federal financial aid, may be denied public housing, and can be declined employment on the basis of a criminal conviction.

The criminal justice system may re-traumatize a population already plagued by trauma. When drugs have become the primary coping mechanism for people in chaotic use, the harsh conditions facing them during incarceration and after release add both stress and trauma and blocks access to the supports needed in recovery, in essence pushing them back towards drugs. According to one study, 76.9% of drug offenders are likely to be rearrested within a year of release.

Despite the increase in spending and capacity in the criminal justice system, drug use has not been curbed in the past half century. Opponents of substantive criminal justice reform suggest that incarceration enables access to treatment, however effectiveness of compulsory treatment is weak, and some studies suggest may actually be harmful. Further studies suggest that there is no reduction in the likelihood of rearrest when somebody is incarcerated as compared to receiving probation, and the length of time in a corrections setting or on probation made no difference in the likelihood of rearrest.

The Coalition feels strongly that, as the system stands presently, the harm caused by the criminal justice system, both to the individual and the broader community, substantially outweighs any potential benefit of the system in terms of deterrence. We will only see a change when we address drug use as a public health emergency as opposed to a criminal justice emergency.

Treatment and Access to Care

According to the National Survey of Drug Use and Health in 2016, roughly 25,000 people living in Maine needed but did not receive treatment for illicit drug use. Reasons for not accessing treatment are complex and include an individual's readiness to change. However, there are a number of structural barriers that significantly constrain access to care:

- Lack of insurance: Over the past eight years the State of Maine has progressively curbed Medicaid enrollment, reducing the number of people with public insurance, and failed to expand Medicaid up to 138% of the federal poverty level. (This leaves a substantial gap in coverage between current Medicaid eligible populations and people above 138% of the federal poverty level who are eligible for tax incentives and cost reductions related for health insurance under the Affordable Care Act.) According to some analysts, this left approximately 77,000 people without health insurance, making treatment and basic health care cost prohibitive.
- Cost of care: 40% of people who use drugs live in households with annual household incomes below \$11,000 per year. Most opioid treatment programs (methadone maintenance treatment) throughout Maine charge roughly \$80/week per self-pay patient. With annual treatment costs for methadone maintenance therapy running around \$4,160 per year, this amounts to more than 37% of their annual income.
- Geography: Medical detox services are particularly constrained. Currently, there are a handful of medical detox centers in Maine, leaving vast areas of the state uncovered. There are currently seven opioid treatment programs (formerly called methadone clinics) throughout the entire state of Maine. These are largely oriented around the I-95 corridor, with two in more distant settings (Rockland and Calais).

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- Federal law: The Controlled Substances Act of 1970 maintains a strict set of expectations for methadone services that make it challenging to operate sustainably. The State of Maine lowered the Medicaid reimbursement rate for methadone maintenance treatment in 2010, capped the number of years that Medicaid will pay for treatment, and shrunk overall Medicaid rolls, leaving many would-be patients without insurance.
- Prescriber reluctance: Buprenorphine treatment is more widely accessible through primary care providers. Currently, Maine has 742 X-waivered buprenorphine prescribers, or one per 1,800 people. There are fewer federal regulations surrounding buprenorphine when compared to methadone, and recent federal policy further increased access to buprenorphine by increasing the number of patients a provider can prescribe to, and allowing Nurse Practitioners and Physicians' Assistants to prescribe as well. Currently, considerably fewer providers are actively prescribing buprenorphine than are certified to do so. Interviews with providers suggest that reluctance to prescribe is related to concerns over a 'difficult patient panel' and the complexities of working with people who use drugs.
- Provider stigma: Health care provider stigma impacts access to preventive and basic health services for people who use drugs. Research shows that negative attitudes toward PWUD contribute to suboptimal care and reduced patient empowerment. In one study, 25% of participants interviewed indicated that they had been prevented from obtaining medical care because of their drug use. This leads to increased reluctance to engage with healthcare professionals that prevent PWUD from receiving routine healthcare and may lead to increased acute care visits and reliance on emergency rooms.
- Self-stigma: Over time, stigma is internalized, reducing the likelihood that a person using drugs will seek help as a result of low self-worth. Based on results from a 2016 survey of Maine syringe exchange participants, 33% of constituents reported they were reluctant to seek medical help for injection or drug related issues.

Housing and Employment

Prevalence of housing insecurity and homelessness among people with a history of drug use is challenging to isolate, with few relevant recent studies to build from. One study of people with a history of injection drug use found that 38% of subjects reported experiencing homelessness during the study period. A 2016 survey of Maine syringe exchange participants found that 24% of respondents had experienced homelessness within the past year and 66% indicated experiencing homelessness at least once in their lifetime.

Homelessness among PWUD is associated with an increased risk of adverse health outcomes, including contracting HIV and hepatitis C and increased risk of fatal accidental drug poisoning. Studies have found that homeless people that use drugs are more likely to rush injection, share injection equipment, engage in sex work for drugs and other risk behaviors related to a combination of policy interventions (e.g., confiscation of materials or fear of persecution), and lack of sufficient income. A 2015 study found that housing insecurity was independently associated with death from any cause among people who inject drugs. Studies have suggested that homelessness can contribute to initiation of injection, as well as re-initiation of injection after a period of cessation.

Unemployment among people with a history of drug use poses significant challenges for the recovery process. One recent literature review found that economic recessions drove substance use because unemployment contributed to psychological distress that in turn increased drug use. Another review

found that unemployment was a significant risk factor for substance use and the development of substance use disorders, as well as increasing the risk of relapse after alcohol and/or drug treatment.

Stigma and Discrimination

Attitudes that shame, discredit and dehumanize people with a history of drug use run deep in our culture and are the product of more than 100 years of public policy and messaging that frame drug use as a character defect and people who use drugs as immoral. According to research, people frequently perceived individuals with a history of drug use as more dangerous and more responsible for their condition than other populations with mental health conditions. Similarly, family members were likely to report shame surrounding their loved one's drug history. These attitudes extend long into the recovery process. It is no surprise that people with a history of drug use, both actively using and having ceased use, report high levels of stigma and discrimination and related avoidance and shame.

Manifestations of stigma include:

- Language: Language plays a significant role in stigma; junkies, dope fiends, crack-heads, crack babies, drug users, drug use, drug abuse, drug misuse, “dirty” (as opposed to “clean”) are common negative names we apply to people who use drugs. Our language surrounding drug use frequently collapses a person into a behavior - parents, children, spouses, employees, all become ‘drug users.’ This language is internalized, leading to lower self-worth and self-efficacy.
The Coalition recognizes the preferences of people adversely affected by stigmatization and uses people first language: “people who use drugs.”
- Individual discrimination: Common examples of prejudice and discrimination include rejection by friends, rejection by family, being prevented from obtaining medical care, and being denied housing.
- Systemic discrimination. Unemployment and housing discrimination are unintended but devastating by-products of criminal stigma. Criminal convictions may exclude applicants from being hired, accessing affordable housing, and obtaining student loans and business loans among other things. Many people with a history of drug use have arrest records relating to drug possession, sales, or illegal activities to gain money for drugs. Due to the near universal use of criminal background checks as part of the employment process, this population faces great difficulty securing employment and housing. Many employers and landlords are reluctant to consider a person with a history of drug use. Add the stigma of criminal history, and reluctance turns to refusal. Criminal history reduces the likelihood of an employer considering an applicant by 50%. Further, there is no legal protection from discrimination or exclusion for people with a history of drug use or people with criminal convictions.
- Racism: Roughly one-in-four black men have found their lives colliding with the criminal justice system and subjected to incarceration, which means this same proportion of black men have had their rights stripped away. Viewed through this lens, US drug policy emerges as a system of legal discrimination. It replaces the Jim Crow laws of a bygone era, created to govern and control black bodies, with drug policy and the penal system, created to govern and control criminals, defined as such by the very system that exists to control them.
- Required reporting: Mandated reporter requirements frequently equate drug use in the family setting as concrete evidence of neglect. A person with children who openly admits to using drugs risks losing their children. This increases reluctance to engage with healthcare providers, effectively keeping people out of health care relationships and away from treatment.

4. Recommendations

4.1. Primary Prevention

1. *Improve and expand social safety net programs to reduce poverty, deprivation and social marginalization that drive rates of adverse childhood experiences.*

Specific suggestions to accomplish this include:

- a. *Ensure universal access to early childhood education.*
- b. *Align minimum wage with the 'living wage'.*
- c. *Promote housing security as a universal right - expand access to low-income and income-sensitive housing throughout Maine.*
- d. *Promote health care as a universal right, including for people who use drugs and people with the capacity for pregnancy - moving towards universal health care systems beginning with Medicaid expansion.*
- e. *Expand access to reproductive health care and family planning services, including abortion care.*
- f. *Expand access to mental health care services.*

The Coalition recognizes the extreme complexity surrounding the initiation of substance use and the development of problematic relationships with substances. The Coalition recommends the improvement and expansion of a broad set of social safety net programs that are expected to broadly reduce incidence of trauma and adverse childhood experiences, thus contributing to the prevention of the development of substance use disorders.

2. *Increase resiliency among youth and mitigate the effects of childhood trauma by fostering and funding evidence-based, age appropriate programs that:*

- a. *Identify and intervene with youth that have experienced trauma and/or with high ACE scores or at risk of having high ACE scores.*
- b. *Increase resiliency among all youth through school-wide and community-level programming.*

The Coalition recognizes that it is impossible to completely eliminate childhood trauma and adverse childhood experiences and recommends evidence-based programs to increase resiliency among youth and mitigate the effects of trauma, thus contributing to the prevention of the development of substance use disorders.

4.2. Harm Reduction Recommendations

3. *Support and fund harm reduction programming to establish well-resourced, fully-staffed syringe exchange and naloxone distribution centers in every county embedded and/or closely allied with treatment services. Foster outreach programs that conduct community and street-level outreach to people who use drugs, with a focus on those populations disproportionately impacted by substance use, including but not limited to the LGBTQ+ community, tribal communities, and people at high risk of unintended pregnancies. Distribute safer injection supplies, naloxone, HIV/HCV testing, safer sex supplies, and connect people who use drugs to resources including treatment, basic health services, customized sex education and contraceptive services.*

Recommendations for Sensible Drug Policy

The Coalition strongly recommends harm reduction programming, including syringe exchange and naloxone distribution programs, which is supported by a substantial body of evidence that these programs decrease morbidity and mortality related to drug use and lead to improved health outcomes among PWUD.

Syringe exchange programs have been closely studied for well over three decades and have been shown to dramatically reduce incidence of HIV among people who inject drugs and may reduce the transmission of hepatitis C when they are implemented at a ‘structural level’ (able to reach roughly 50% of the injecting population). Syringe exchange models that originated in urban areas for rural districts must be adapted to reduce geographic barriers by increasing the number of exchanges in rural areas to decrease travel distances, as well as modifying outreach models to reflect the needs of people in rural communities.

Naloxone distribution programs that equip and train PWUD to administer naloxone, a temporary opioid overdose reversal medication, have been shown to decrease fatal drug poisonings. Research shows that take-home naloxone programs reduce overdose mortality among program participants and the broader community, and that there is a dose-response relationship between the quantities of naloxone distributed and effect size (distributing more naloxone could have a greater impact on accidental drug poisoning deaths).

Beyond the impacts of harm reduction programming on morbidity and mortality, these resources have been shown to increase referrals and admission to substance use treatment. One analysis showed that treatment referrals originating from syringe exchange programs were more effective than general referrals, and another showed that individuals participating in naloxone distribution programs were more likely to access treatment over the long term.

4. Fund and sanction the establishment of overdose prevention sites in major metropolitan areas throughout Maine

A growing body of evidence supports the establishment of overdose prevention sites (OPS), also known as safer drug use facilities (SDUF) or supervised injection sites (SIS), in metropolitan areas with high rates of injection drug use. SISs provide medically supervised spaces for people to consume pre-obtained illicit substances in a sterile environment. In most cases, medical staff are on hand to provide medical advice, dispense safer drug use supplies, and administer naloxone in the event of an accidental drug poisoning.

Originating in Europe, SISs have been in existence for nearly as long as syringe access programs. The first and only legal SIS in North America is InSite, located in Vancouver. Studies of OPSs suggest that they are effective ways to reduce the transmission of HIV and viral hepatitis as well as reducing fatal drug poisonings. One 2004 systematic literature review of 75 articles found that OPSs have the potential to reduce unintentional fatal opioid poisonings and HIV and hepatitis C transmission, and increase access to primary care and drug treatment for participants. Further, OPSs were not found to increase crime or drug use, and actually decreased public drug consumption and syringe litter.

5. Expand access to case management services for people who consume drugs, people engaged in treatment and people in short-term recovery, including support with employment, housing and other needs by amending section 13.03-4 of the MaineCare Benefits Manual to include people with a severe substance use disorder who are not currently engaged in treatment, and removing the requirement that the individual be pregnant, living with his or her minor children, and/or an “intravenous drug user” (a person who consumes drugs intravenously).

6. *Reduce reluctance to seek care by supporting and funding educational programs for health care providers and students in all relevant specialties, including but not limited to primary care, infectious disease care, gastroenterology, hepatology, women's health and pre-natal care, concerning stigma surrounding people who consume drugs, harm reduction in health care, substance use treatment and compassionate care for people who consume drugs.*

A significant body of evidence suggests that case management services significantly improve outcomes for people engaged in or seeking substance use treatment services compared to treatment alone. While few studies exist examining outcomes related to the provision of case management services for persons not engaged in or seeking treatment, the Coalition strongly believes that the coordination of care provided by case management services would reduce morbidity and mortality related to substance use and increase initiation of substance use treatment.

Studies suggest that education on substance use and strategies to support people who consume drugs can improve attitudes of caregivers, including health care providers, towards people who consume drugs. Continuing medical education programs should include education about the nature of addiction and addiction as a disease-state, effective treatment for addiction, motivational interviewing, and disease conditions that people who consume drugs may be susceptible to. Education should also include guidance about providing harm reduction information to people who consume drugs.

4.3 Treatment Recommendations

7. *Reduce barriers to accessing treatment to ensure that all people who need substance use treatment can access it, including low-barrier and flexible treatment programs and additional supports for parents of young children.*

Specific suggestions to accomplish this include:

- a. *Expand MaineCare and explore and implementing gap coverage for people without insurance to ensure that all people who need substance use treatment can access it.*
- b. *Reduce requirements beholden upon people seeking treatment.*

One of the most significant barriers to accessing effective substance use treatment in Maine is lack of insurance. The Coalition highly recommends the expansion of MaineCare. Experts throughout the state agree that expanding MaineCare up to 138% of the federal poverty level would decrease the proportion of PWUD that are currently lacking insurance. This would dramatically increase access to medication assisted treatment, behavioral health and case management services, and basic healthcare.

In addition to expanding MaineCare up to 138% of the federal poverty level, the Coalition recommends exploring options and implementing gap coverage for people who are uninsured or underinsured. Gap coverage should support the overall health of recipients and emphasize access to recovery-oriented services, including medication assisted treatment services, behavioral health services and case management services.

Beyond people's ability to reasonably afford treatment services, recent research in the domain of addiction science lends itself strongly to decreasing non-financial barriers to accessing treatment, contradicting common practice in many clinics. Specifically this growing body of research recommends:

Recommendations for Sensible Drug Policy

- Continued buprenorphine treatment in the wake of relapse over discontinuance of treatment on the basis that the patient is unfit;
- Behavioral treatment as desired by the patient over mandated counseling;
- Drug testing as a tool to support recovery over punitive consequences resulting from drug testing;
- Buprenorphine treatment provided regardless of other drug use, over use of other substances as grounds for discharge;
- Buprenorphine prescribed for as long as necessary.

8. *Establish methadone and buprenorphine maintenance therapy, including comprehensive trauma-informed counseling services, in every county in Maine.*

Specific suggestions to accomplish this include:

- a. Expanding MaineCare to increase access to treatment.*
- b. Increasing the reimbursement rate for affiliated services to support business viability.*
- c. Decreasing barriers and burdens on methadone services to increase access through primary care and/or other avenues.*
- d. Increase the availability of and access to treatment during the perinatal period.*

Methadone maintenance therapy and buprenorphine maintenance therapy (also called medication assisted treatment or medication assisted recovery) are evidence-based practices to treat opioid use disorder. Methadone maintenance therapy has been intensively studied during the course of the last 50 years. Buprenorphine later joined this class of treatment in the 1980s and has likewise proven effective in treating opioid use disorders. Studies show that some patients respond best to methadone, and others to buprenorphine. Buprenorphine is more widely available due to fewer restrictions on prescribers and carries a lower risk of overdose due to a natural ceiling on its agonist effects and its frequent combination with naloxone. The Coalition strongly recommends increasing access to both medications.

By expanding MaineCare up to 138% of the federal poverty level, policy-makers would dramatically lower rates of un/underinsurance among people who use drugs, which would increase access to substance use treatment (including buprenorphine, methadone), and recovery services. This effort would be further supported by increasing reimbursement rates for treatment services, including medication assisted treatment.

The burdens and barriers confronted by opioid treatment programs as a result of the Controlled Substances Act and other legislation contribute to lower access to methadone compared to buprenorphine and/or other treatment modalities. The Coalition strongly recommends that policy-makers examine and address federal regulations regarding opioid treatment programs that reduce barriers and burdens on providers and/or balances these barriers and burdens with incentives that will increase business viability in an effort to extend methadone maintenance therapy into every county in Maine.

9. *Cultivate low-barrier access to medical detox services by supporting and funding the establishment of medical detox services in every county in Maine.*

While the evidence suggests that rapid cessation of opioid use may be less effective and more dangerous than medication-assisted treatment, detox is one of the few options available. The Coalition advocates for a pragmatic approach to recovery, encouraging people to pursue recovery in whatever form they feel will

work best for them. For people who opt for rapid cessation from opioids followed by abstinence, which remains the primary modality of recovery in the U.S. today, the Coalition recommends the allocation of State funds towards the development and funding of medical detox services in every county in Maine. Research suggests that detox from opioids without successive linkage to medication assisted treatment is less effective and associated with higher rates of opioid poisoning fatalities. The Coalition strongly recommends that people seeking opioid treatment be encouraged to utilize and be linked to medication assisted treatment when they seek treatment.

4.4. Recovery Recommendations

10. *Foster, support and fund programming offered through local recovery community centers established and maintained by people in longterm recovery including employment supports and job readiness programs, housing supports, recovery coaching services and other peer recovery support services.*

A robust network of friends, loved ones and associates (community), productive employment, educational avenues and volunteer opportunities (purpose) and stable housing (home) are key recovery supports. Recovery community organizations, peer supported centers that serve as locatable resources of community-based recovery support, play an important role in creating a supportive community. They provide resources, including advocacy training, resource mobilization, mutual support, networking, social activities and other services to individuals in recovery to help build and sustain their recovery over time. These centers serve as a unique opportunity to engage people in recovery in programming and services.

Recovery coaches are individuals, often in recovery themselves, who support people in their recovery process. Most recovery coaches are peers that have completed an intensive recovery coach training. Recovery coaches provide support, connect people to resources and encourage them along the way, with a focus on non-clinical issues, such as housing, employment, and legal issues.

Career Centers and other programs that are intended to connect people to meaningful employment are specifically intended to work with people who are “work ready,” i.e. they adhere to traditional codes of professionalism. Training programs to increase work readiness for the recovery community are of vital importance to connecting people to meaningful employment opportunities.

A wealth of evidence supports the effectiveness of ‘supported employment’ in helping people build recovery. According to researchers, the most effective supported employment programs encourage employment, understand substance abuse as part of the vocational profile, find a job that supports recovery, help with money management, and use a team approach to integrate mental health, substance abuse, and vocational services.”

11. *Increase access to housing for people in all stages of recovery, including people who are actively using drugs, people in short-term recovery and people who are pregnant or parenting. Support Maine’s recovery housing movement.*

Specific suggestions to accomplish this include:

- a. Funding ‘Housing First’ programs for people who use drugs living in extreme poverty in major metropolitan areas throughout Maine, including case management supports, housing and rapid treatment access.*
- b. Creating a funding mechanism to support certified recovery residences using a voucher system.*
- c. Establishing/endorsing a statewide network of recovery houses, including voluntary certification to ensure safety and quality.*

- d. Incentivizing state funded recovery houses from discriminating against people in medication assisted recovery by providing increased financial support for houses that accept people in medication assisted recovery.*
- e. Clarifying that recovery houses are exempt from federal regulations regarding maximum occupancy of unrelated people for recovery housing and ensuring the alignment of state and municipal fire codes with federal policy.*

The Coalition believes that recovery is unique to each person, and a range of housing options for all types of people - whether they are currently using substances, practicing abstinence, participating in medication assisted recovery or all of the above - should be available, including:

- Supported housing. “Housing First” is a housing model for people with histories of chronic homelessness which emphasizes client-centered services, immediate housing and does not require treatment for mental illness or substance use as a condition.” Studies of Housing First have found reduced governmental costs and improved personal well-being among participants.
- Certification of recovery residences. Recovery housing in Maine is extremely limited at present. The vast majority of recovery homes are abstinence based with only 21 houses known to accept residents currently using medication assisted treatment. The Coalition recommends the establishment of a voluntary certification system that recognizes recovery residences that meet quality and safety standards and do not discriminate against people on medication assisted treatment. State recognition could also offer guidance to cities and towns. Certified recovery residences would be listed in a statewide inventory to facilitate referrals to housing. Further, stipends should be made available to certified recovery residences via a foster care type system that would provide a stipend to community members for hosting people in recovery in their residential home. Owner-operators would be required to pass certification standards prior to applying for a stipend.
- State guidance. The Federal Housing Act prohibits discrimination by direct providers of housing (such as landlords, public housing authorities) because of race, religion, sex, national origin, familial status or disability. Substance use disorder and recovery from it is protected as a disability, provided that illicit substances are not being used. The Fair Housing Act also makes it unlawful to refuse to make reasonable accommodations in land use and zoning policies and procedures where such accommodations may be necessary to afford persons or groups of persons with disabilities an equal opportunity to use and enjoy housing. At present, Maine municipalities are operating without direction from the State government on rules and guidelines regarding recovery residences and federal law, including fire code requirements. The Coalition recommends that the State of Maine amend State fire codes regarding maximum occupancy of unrelated people to exempt recovery residences. Further, the Coalition recommends that the State provide guidance to municipalities around compliance with State policy and the Fair Housing Act and takes administrative action to mandate compliance with these laws in order to increase access to recovery residences.

4.5. Criminal Justice Reform Recommendations

- 12.** *Decriminalize possession of all drugs. Possession of illicit drugs and/or materials used to administer drugs becomes an administrative offense on all counts, regardless of the quantity of the substance within the possession of the accused. Eliminate the permissible inference of trafficking or furnishing based solely on the weight or amount of a substance possessed by the accused and add intent as an element of the crimes of trafficking and furnishing.*

Recommendations for Sensible Drug Policy

The Coalition believes that drug misuse is best addressed through public health rather than criminal legal means, and it recommends the decriminalization of the possession of all drugs. This will allow us to effectively treat substance use disorder, remove the collateral consequences of criminal convictions for many who suffer from substance use disorder, and will free up money we spend on criminalization to put towards treatment and healthcare.

In 2016, the Maine legislature took an important step in addressing the criminalization of people with substance use disorder when it de-felonized the possession of less than 200 milligrams heroin and fentanyl, among other drugs. Now, under Maine law, possession of less than 200 milligrams of heroin or fentanyl is a Class D crime, a misdemeanor. This is an important step, because felony records are, generally speaking, much tougher barriers for employment, housing, and other forms of public assistance. However, even misdemeanor convictions can derail a person from fully engaging in civil life: it may prevent a person from accessing federal student aid, receiving federally subsidized housing, being employed in certain fields, and obtaining certain professional licenses, among other things.

In order to decriminalize possession, we recommend the repeal of 17-A Maine Revised Statutes. §1107-A in its entirety, and the replacement of that section with a provision making possession of drugs in any amount an administrative penalty.

This proposal is not without precedent: in 2001, while in the midst of its own opioid crisis, Portugal decriminalized all drugs, including heroin, making possession of drugs an administrative violation that is dealt with outside of the country's criminal legal system. (Drug trafficking is still criminalized under Portuguese law.) When police encounter someone using or possessing drugs, they are required to issue a citation but may not arrest the person. A person with a citation must appear before a local board that is staffed by a doctor, lawyer and social worker that determine the appropriate response. This generally includes referrals to local resources, including harm reduction programs. As part of this new public health model, Portugal dramatically ramped up outreach services, including syringe exchange, to people who use drugs, and treatment access. In a 2012 review of the program found a decrease in recent and current drug use among people aged 15-24 and a dramatic decrease in drug-induced deaths.

Escalating the punishment for drug sales has done nothing to stem the tide of overdose deaths in the US and Maine, and we are skeptical that targeting drug dealers through criminalization does much more than continue to ensnare those with substance use disorder in the criminal justice system. However, to the extent that public officials insist on criminalizing drug selling or "trafficking," they must establish safeguards to protect those with serious substance use disorder from being criminalized for their disorder.

Current Maine law allows juries and judges to convict people for trafficking of drugs based solely on the amount of drugs in a person's possession. The threshold amount of drugs possessed for trafficking is lower than some people use in one week. This means that long-term drug users with higher tolerance are vulnerable to being incarcerated simply because they are heavy users, not because they are drug kingpins.

Instead of establishing trafficking solely by the amount of a drug in a person's possession, the Coalition recommends that the law should require as an element of the crime that a person has intent to traffic. This way, the legislature can ensure that prosecutors are not prosecuting those with very heavy habits, or those who are dealing solely to pay for their own drug dependence, but are going after those with more power who are higher up on the distribution chain.

13. *Mandate the provision of a full range of treatment, including medication assisted treatment, and assertive post-release supports to cultivate seamless access to treatment upon release for people with substance use disorders in correctional facilities, for all correctional settings throughout Maine.*

Recommendations for Sensible Drug Policy

The Coalition believes that people should never have to go to jail in order to receive treatment for substance use disorders, and jails and prisons should never be our state's default drug treatment facilities. Funding for treatment for drug addiction must be centered in communities, where people can live with their families, earn a living, and recover in a normal setting. However, to the extent that it will take time to shift our state's culture from one of criminalizing drug use to treating substance use disorder, Maine must provide treatment for those who are suffering in jails and prisons now. We believe that to deny people health care, including medication assisted treatment, violates the principles of the Eighth Amendment's prohibition on cruel and unusual punishment.

Maine's jails and prisons must end any prohibition on medication assisted treatment for substance use disorders. They must provide medication assisted treatment to any incarcerated person with a substance use disorder who wishes to receive it. Jails and prisons must also provide transitional support to those who leave incarceration, so that the factors that often lead to relapse – especially lack of stable housing and employment - are less likely to occur.

14. Divert people out of the criminal justice system for crimes driven by substance use by supporting and funding the development of pre-arrest diversion programs, modeled on and adapting the Law Enforcement Assisted Diversion program in every county throughout Maine.

Law Enforcement Assisted Diversion (LEAD) is a pre-arrest diversion program originating in King County, Washington to address low-level drug and prostitution crimes in select areas of Seattle. Officers exercise discretionary authority to divert people to a community-based, harm reduction intervention for law violations driven by unmet behavioral health needs, effectively diverting them out of the criminal justice system cycle. Evaluations of the LEAD program have found that participants were 58% less likely to be arrested and were significantly more likely to have housing, employment and legitimate income after receiving services than prior to the referral. Between jail bookings, jail days, prison incarceration, and other costs associated with criminal justice and legal system utilization, LEAD participants showed considerable cost reductions (-\$2,100), where their counterparts showed cost increases (+\$5,961).

Since 2016, two such programs have emerged in Maine, LEAAP (Law Enforcement Addiction Advocacy Program) in Portland and the Greater Bangor Area LEAD program in Bangor. The Coalition recommends implementing LEAD-type programs, rather than variants of Project Hope (started by the Scarborough Police Department). LEAD is founded in harm reduction that recognizes and celebrates incremental change towards an end goal of recovery, with a focus on improved stability and functioning. Project Hope has generally tended toward a treatment centered approach (frequently abstinence-based treatment) with an end goal of abstinence-based recovery. Further, most Project Hope variants in other parts of the state offer little support outside of the initial linkage to treatment and often don't follow-up with constituents. This contributes to concerns over the potential for unintentional adverse outcomes, including increased accidental drug poisoning fatalities.

The Coalition also recommends LEAD rather than Adult Treatment Court (i.e. "Drug Court"), which has often been advanced as an effort to soften the criminal justice system and better treat substance use as a public health issue. Drug Courts view substance use as a problem that the criminal justice system can solve and offer help with substance use disorder that a person might not otherwise be able to access, but at a price: the defendant must come to court weekly, must waive their rights to due process and plead guilty to participate.

- 15.** *Require the collection of data related to race, ethnicity and socioeconomic status for all stops, arrests, charges, convictions, sentences and other events at all levels of the criminal justice system. Establish a community panel to review data annually with the authority to require further review and action to address disparities. Require racial impact statements for all new policies considered by the Maine State Legislature.*
- a. Collect and report Information on race and socioeconomic status in the criminal justice system.*
 - b. Require racial impact statements for all legislation.*

The war on drugs has disproportionately affected poor people and people of color, especially Black people. In Maine, Black people are 46% of drug defendants even though they are only 1.6% of the population, and do not engage in illegal substance use more than any other race. Defendants in drug cases who are Black are 20% more likely to be sentenced to prison than defendants in drug cases who are white.

Despite the general information on disparities mentioned above, more specific information regarding racial disparities in the criminal legal system in its component parts is hard to come by in Maine, as criminal justice agencies do not use uniform systems of data collection or storage, nor do they collect the same categories of information. In order to know how to address the racial and money inequities, we must first know exactly where the problem is.

The recommendation that Maine require a centralized reporting structure for data on race and socioeconomic status is not novel: at a hearing before the Maine Advisory Committee to the U.S. Commission on Civil Rights in 2014, experts testified that Maine should inquire of law enforcement officials what data is kept on racial disparities in the criminal legal system. That Commission itself officially recommended that Maine require the reporting, at minimum of a quarterly basis, of relevant information regarding race in sentencing and incarceration.

Other states have begun requiring racial justice analyses before passing legislation (New Jersey, Connecticut, Iowa, Minnesota and Oregon), some with solely criminal justice focuses and some with focuses on other areas like child welfare. In Maine, where opioid use is addressed in so many legislative committees, we must have racial impact statements for all legislation. Since 1966, the Maine legislature has required fiscal notes for legislation, describing the impact of the bill on the finances of State government. Currently, the Office of Fiscal and Program Review (OFPR), a non-partisan staff office of the legislature, already creates preliminary fiscal impact statements for original printed bills. The legislature should require this office to not only forecast the economic impact of legislation, but also the projected impact on people of color in Maine. Much in the way that a given bill may not seem to require expenditures until OFPR adds a fiscal note, many bills may appear—and be intended to be—race neutral, until a deeper analysis is done.

4.6. Recommendations to Combat Stigma and Dehumanization

- 16.** *Support employment for people with a history of drug use and reduce employment discrimination by funding programs to engage employers around the importance of purpose for people in recovery and offering protections and incentives to hire people with substance use disorders as well as passing broad 'Fair Chance' policies that restrict the consideration of criminal history for all employment, housing, licensing and other relevant application processes. These should be supplemented by policies that address racial bias in hiring practices.*

Recommendations for Sensible Drug Policy

According to researchers, one in three American adults have a criminal record, and having a criminal record is a barrier to employment. The treatment of people who use drugs in the criminal justice system makes it difficult for them to find work after they have been sentenced, and employment has been shown to play an important part in reducing recidivism. The evidence demonstrates the best chance of success for people in recovery is to keep them employed.

Ban the Box (otherwise known as Fair Chance) policies seek to eliminate questions regarding criminal background on employment and other applications. These policies have been demonstrated to almost eliminate the barrier of having a criminal record on receiving a callback. In addition, hiring rates increased for people with criminal records where this policy was in practice. Once backgrounds are checked, individualized assessments that consider the time lapse from the last offense and its relevance to the job result in improved outcomes. Allowing the candidate an opportunity to review background-check results is also important due to a plethora of inaccurate and misleading information contained in many reports.

Ban the Box policies may reduce some of the stigma attached to having a criminal record, as well as have positive social and psychological outcomes. A potential downside to Ban the Box is a noted increase in employment discrimination against people of color. Recent studies indicate a reduced callback rate and reduced employment rate for people of color due to inherent bias with an assumption of criminal history. In a report produced by the Urban Institute, authors recommended potential remedies to this including increased regulation against equal employment violators, training for employers and stakeholders around ‘ban-the-box policies, expungement, expanded job training for justice involved individuals, and a requirement that job applications be name and address blind.

17. *Establish and/or amend non-discrimination policies to encompass people with substance use disorders, affording them protections against discrimination around housing, employment and other rights.*

Laws that protect people with disabilities pertain to people in recovery from alcohol and drug use as well. However, there has not been consistent enforcement of these laws. Informing people in recovery of their rights and resources that are available could improve outcomes. In addition, educating and helping employers is recommended.

18. *Support and fund a coordinated public education campaign and other efforts to reduce stigma around substance use and shift the cultural perception of people who consume drugs. This should emphasize the impact of trauma and adverse childhood experiences on substance use and break stereotypes related to people who consume drugs by exploring the extent to which they are our neighbors, loved ones, family and friends.*

Stigma research indicates the importance of educational initiatives including interaction between the public, the police, and medical students with people who use substances. In addition, leaflets with positive depictions of people with substance use disorders reduced stigmatized perceptions of heroin and alcohol dependency.

5. Conclusion

5.1 Summary and Concluding Statements

This report represents a collaborative effort on behalf of the Maine Coalition for Sensible Drug Policy. It explores the ongoing opioid epidemic, painting a comprehensive picture of this public health crisis, its sociocultural moorings and the impact of public policy on the crisis. In so doing, the Coalition asserts specific recommendations to address the opioid crisis and advance sensible drug policy with the goals of reducing the prevalence of problematic drug use, reducing drug-related harms and facilitating recovery for people with problematic relationships to drugs. The report's recommendations are grounded in public health science and advocate for a compassionate approach to drug use and the suspension of punitive programs that amount to efforts to 'punish people into recovery.'

5.2 How to Pay for This Agenda

No doubt, many features of this agenda require additional expenditures. To put those expenditures in context, however, we must remember the findings of Maine's Substance Use and Mental Health Office's 2013 Report, *The Cost of Alcohol and Drug Abuse in Maine, 2010*, and the Maine Center for Economic Policy's updated analysis in 2015, documenting the enormous costs of the status quo. The 2015 analysis found that Maine's substance abuse crisis cost the state at least \$750 million a year, with \$449 million born by the private sector, and \$300 million born directly by the public through government expenditures. Furthermore, while Maine spent about \$67 million in treatment, our state spent over \$230 million in enforcement—with over 78% of all drug arrests simply for possession. Clearly, our priorities are inverted. We ought to invest far more in the prevention, harm reduction, treatment, recovery, and public education strategies outlined in these recommendations, and far less in criminalizing people suffering from a public health crisis. Not only are these evidence-based strategies more effective, they are far more fiscally responsible.

The Office of Substance Use and Mental Health Services put it in their 2013 report, in 2010, only 14,996 individuals were reported to have received treatment, which is 20.9% of the total number of individuals who needed treatment. Because the cuts to MaineCare that resulted in over 50,000 Mainers losing access to Medicaid (and therefore treatment for substance use disorder), occurred *after* 2010, it is likely that fewer than one in five people who need treatment can access it today.

We estimate the cost of our prevention, harm reduction, treatment, recovery, and public education strategies to be about \$130 million for the next biennial budget (\$61 million/year), about half of which is Medicaid expansion. **In other words, our agenda constitutes only about a quarter of the resources already dedicated to drug enforcement strategies, well within range of the resources made available by decriminalizing drug possession.**

Thus, the decriminalization of drug possession, while important from a public health policy perspective, also has the potential to fund all (or nearly all) the costs of the strategies necessary to tackle the epidemic. By re-centering our response from the criminal justice system to the health care system, we can save lives and money. Furthermore, thanks to a healthy economy, Maine also has surplus revenue to direct to fight this epidemic, including:

- Over \$270 million in the “rainy day” fund.
- Over \$140 million in a projected revenue surplus for the next biennium.
- Over \$30 million in an accumulating fund that would otherwise automatically lower Maine's income tax rate.

Recommendations for Sensible Drug Policy

Many investments, particularly those involving Medicaid and Head Start, come with generous federal matching funds. These additional resources, in combination with a healthier, more productive workforce, will strengthen Maine's economy and the State's fiscal position through stronger revenues over time. Lawmakers should provide greater oversight to the federal funds made available through the recently enacted "SUPPORT for Patients and Communities Act" and the reauthorization of the "21st Century Cures Act." We should leave no stone unturned, and do our best to draw down any federal or other resources that can help move us forward.

Maine lawmakers should restore oversight and public accountability to the assets and forfeitures seized during drug enforcement operations, using them to fuel public health—not further criminalization. Increasing the marijuana excise tax, increasing and equalizing tobacco taxes, the Opioid Manufacturer Windfall Profits Tax, and the portions of "tax conformity" that benefit only high net-worth individuals and corporations, are all worthy of consideration as the legislature debates how to identify resources for these strategies. Previous legislative efforts, like using already-available TANF resources (Temporary Assistance to Needy Families) to create a housing voucher program, could easily be adopted, with a tremendous impact on the crisis.

Money isn't the issue. Within the criminal justice system alone—excluding revenue surpluses and popular, appropriate revenue increases—we can find more than enough to address this crisis. **Even without the savings from decriminalization, the total non-Medicaid expansion cost of these reforms is less than the projected revenue surplus for the next biennium.** In fact, the far greater fiscal danger are the compounding costs of inaction, driving up the costs to families, the public, and private businesses, with each passing day that this crisis continues.

5.3 Supporting Organizations:

American Civil Liberties Union (ACLU) of Maine
Amistad
Church of Safe Injection
Coastal Recovery Community Center
Frannie Peabody Center
Health Equity Alliance
James' Place
Journey House Recovery
Maine Association of Criminal Defense Lawyers
Maine Equal Justice Partners
Maine Family Planning
Maine HIV Advisory Committee

Maine People's Alliance
Maine Prisoners Advocacy Coalition
Maine Prisoners Reentry Network
Midcoast Recovery Coalition
National Association for the Advancement of Colored People (NAACP), Maine Prison Branch
National Association of Pregnant Women
Penobscot Community Health Center
Portland Overdose Prevention Site
Wabanaki Health and Wellness
Young People in Recovery, Maine

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