Recommendations for Sensible Drug Policy

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Prepared by The Maine Coalition for Sensible Drug Policy

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1. Preamble, Recommendations, and Supporting Organizations

Preamble

Whereas, the opioid crisis continues to escalate, claiming more and more lives and shattering more and more families, including over 418 accidental drug poisoning deaths in 2017 alone;

Whereas, the state of Maine suffers from a disproportionate share of adverse health outcomes related to opioid use, including a rate of acute hepatitis C that is four times the national average;

Whereas, the undersigned desire to advance the health and wellbeing of pregnant people and infants, and Maine continues to have a high rate of substance exposed infants, with roughly eight percent of children born in 2017 exhibiting some degree of neonatal abstinence syndrome;

Whereas, preventing substance use requires us to challenge and change the systems and structures that are complicit in traumatizing our youth and perpetuating the escapism inherent in problematic drug use;

Whereas, the continuum of care for people who use drugs is broken, characterized by a lack of access to critical services and an over-reliance on punitive approaches to addressing substance use that are of incredibly limited use;

Whereas, existing punitive drug policy was founded in racialized public policy and a misunderstanding of substance use, contributing to an epidemic of mass incarceration that perpetuates the effects of segregation;

Whereas, people of color continue to be penalized at a rate far exceeding whites in spite of statistically similar use patterns, leading to ongoing community-level trauma;

Whereas, addressing this complex crisis requires a complex array of tools including primary prevention, harm reduction, treatment and care, recovery supports, criminal justice reform and efforts to combat discrimination against people who use drugs;

Whereas, existing policy and strategies to address the adverse consequences of drug use and the prevailing culture around drug use have proven limited and at times more harmful than helpful;

We, the undersigned, also known as the Coalition for Sensible Drug Policy, do hereby recognize and promote these Recommendations for Sensible Drug Policy as a broad road map for addressing the opioid crisis and the failings of our existing drug policy. These Recommendations represent evidence-based approaches, promising practices and innovative new models. They build upon prior policy recommendations, including the report of the legislatively formed Opioid Task Force (2018) and the work of the Opioid Collaborative (2016). In particular, the Coalition advances previously unconsidered strategies, supported by a significant body of evidence, and radically reframes our approach to substance use, recognizing that the continuing crisis requires swift and serious action to reduce the loss of life, health and wellbeing.

Recommendations:

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-booking 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.

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

2. Executive Summary

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 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 several domains including:

- 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; and
- Anti-Discrimination – reducing stigma and discrimination experienced by people who use drugs

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.

3. Introduction

After three years of struggle, multiple planning processes and ongoing efforts to address the opioid crisis 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 between 2017 and 2018.[1] Further, recent research suggests that the opioid crisis is but the latest, incrementally more fatal, crisis in a series of progressively more dangerous overdose crises that the US has seen since the last 1970s.[2] After years of attempting to apply the same stale 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. It is becoming increasingly clear that 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 nation's and state's understanding and approach to addressing substance use.

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 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 understanding and addressing substance use drawing from more recent research from the medical, sociological, psychological and public health sectors. Reforms have thus far failed to meaningfully alter these foundations. This has lead 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 2018 in response to the recommendations of the Opioid Task Force convened by the State of Maine. While the Coalition feels that the Task Force's report was a valiant effort to impact the opioid crisis, it believes that the Task Force was fundamentally limited by process, preventing members from more significantly engaging and altering Maine's drug policy. Task Force recommendations tended toward the least objectionable suggestions, neglecting more controversial ideas. In response, the Coalition formed explicitly to produce and advance evidence-based practices, emerging promising approaches and innovative new solutions that will meaningfully address the opioid crisis and the failings of Maine's drug policy.

The Coalition was guided by a small Leadership Committee that included people with a history of drug use. The core of the Coalition was comprised of roughly 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. During the course of this process the Coalition consulted over 30 people, programs, and organizations directly involved in or affected by the opioid crisis and Maine drug policy, and over 100 people with a history of drug use.

The report is founded on the following principles: Human beings have consumed psychoactive substances for as long as we have existed. Recognizing that it is unrealistic that we will ever fully eradicate drug use, we seek instead to reduce and mitigate the risks and harms sometimes associated with drug use. As such, 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.
- The facilitation of recovery, defined herein as a process by which people realize "any positive change, as a person defines it for [themselves]" as intoned by Dan Bigg and John Szyler, founders of the Chicago Recovery Alliance.[3]

4. Understanding the issues

4.1. Understanding Drug Use

Prevalence

Estimates of the prevalence of drug use and problematic drug use vary widely from source to source. According to the National Survey of Drug Use and Health (NSDUH), in 2016 roughly 29,000 Mainers reported using illicit drugs other than cannabis during the past year, of which roughly 5,000 people reported using heroin. Beyond heroin, problematic use of prescription opioids continue to present as an issue that is not captured in the NSDUH's account of illicit drugs. According to the same source, roughly 43,000 Mainers reported misusing prescription pain relievers in 2016.[4] A 2018 report that utilized data from the health insurance sector found that roughly 12.56 per 1,000 insured persons (16,705 people if extended to the entire population) had been diagnosed with an opioid use disorder, placing Maine substantially higher than the U.S. rate of 4.6 per 1,000 people.[5] Assuming that not everybody experiencing problematic use has been diagnosed with an opioid use disorder and that problematic use is at least as high among people without health insurance as it is among people covered by private insurance and MaineCare, we conclude that the actual rate of problematic drug use is likely substantially higher than these sources reflect.

Continuum of Drug Use

Contrary to popular misconceptions of drug use, not all drug use is problematic. People use drugs (both legal and illegal) along a continuum, ranging from relatively benign social and recreational use to the more frequent or "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. 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.[6] Others will fall elsewhere within the spectrum, including a significant cohort of functional people who use drugs but otherwise have relatively successful, healthy lives, careers and families. 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.[7]

While all drug use carries inherent risk (including drug adulteration, accidental poisoning, and legal sanctions), these risks and consequences are most acute on the chaotic end of the spectrum. Further, the Coalition recognizes that punitive approaches to drug use lead to significant, lifelong social consequences such as incarceration, family rejection, and job loss, which only compound the risks and heighten the stakes, often leading to a downward spiral of increasingly negative financial, health and safety outcomes.

Trauma and Adverse Childhood Experiences

Increasingly, researchers are recognizing the impact of comorbid mental health conditions and childhood trauma on a person's potential to develop a problematic relationship with drugs and other adverse health outcomes.

Researchers have long established a high frequency of comorbid substance use and psychiatric disorders. One study found that 47% of methadone seeking study participants had comorbid psychiatric disorders, with anti-social personality disorder and major depressive among the most common.[8] A similar study conducted through a community-based syringe exchange program found that 50% of participants had at least one comorbid psychiatric disorder.[9]

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. According to the study, a male child who had experienced 6 of the catalogued adverse childhood experiences was 46 times more likely to use intravenous drugs.[10] Additionally, studies of comorbidity between substance use disorders and complex trauma suggest that between 50% and 90% of people with a reported substance use disorder also had complex trauma histories.[11] A 2017 study among people seeking treatment for opioid use found that people with more ACEs started using opioids earlier and were more likely to experience an accidental opioid poisoning.[12]

In explaining the connections between psychiatric disorder, ACEs, trauma and adverse health outcomes (including drug use), researchers have pointed to the neurological effects of chronic stress. The above findings validate the theory that problem drug use predominantly arises from the desire to escape psychic discomfort.[13] [14] While this does not discount the role of physical dependence and withdrawal avoidance in inhibiting recovery, physical dependence is secondary to psychic pain. Absent psychic pain, persons that have developed physical dependence may much more readily decrease and/or cease use.

The above casts some doubt on the assumption that over-prescribing is primarily responsible for escalating rates of problem opioid use and fatal opioid poisonings. According to the NSDUH, over 75% of people who misuse prescription medications obtain them from a non-medical source.[15] This is further supported by a 2010 review of opioid pain management that concluded that less than 1% of participants in the collective studies became addicted.[16] That said, over-prescribing is undoubtedly a contributing factor insofar as overprescribing contributes to increased exposure to opioids.

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

Societal Conditions and Intergenerational Trauma

While the ACEs studies are fantastic tools for understanding the development of problematic substance use, they are also fundamentally individualizing and lack sufficient context to understand the social origins of substance use. Where physical and emotional abuse and neglect have a demonstrated causative association with problem substance use, it is important to recognize that these behaviors do not happen in a vacuum. The emerging academic literature suggests that ACEs are both caused by and cause adverse social contexts including poverty, discrimination, and other forms of inequality and social rejection.[17] [18] Further, 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. Akin to this, a growing body of research on historical trauma suggests that trauma can have intergenerational consequences, particularly among marginalized communities. Researchers have suggested that trauma can be reproduced intergenerationally through parental behaviors as well as directly through a person's DNA.[19] [20] This suggests that 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 that "addiction of all forms (substances or otherwise) is a way of adapting to the social fragmentation and individual dislocation inherent in modern society."[21] Alexander's work considers drugs and alcohol to be but 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. This perspective is supported by recent research that suggests that opioid overdose deaths are but the most recent manifestation of an ongoing process. When taken in consideration with other drugs, overdose deaths have not spiked dramatically as might be imagined, but appear as an exponential growth curve.[22] As some drugs become more difficult to access, people turn to other drugs to facilitate their escape from psychic pain. Following this, 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."[23] Notably, 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 delineated four major dimensions that support a life in recovery. These dimensions allow any person 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

Where we adopt a broad understanding of recovery, to facilitate recovery it stands to reason that 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. Helping to support individuals by creating and maintaining connections must be the focus of policy.

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.

4.2. Understanding Drug-Related Harm

Accidental Drug Poisoning Deaths

During 2017, accidental drug poisoning deaths continued their steady climb upwards. With 418 deaths in that year, 2017 was the fifth consecutive year of increases in overdose mortality in Maine. With each year more deadly than the last, between 2012 and 2015 overdose mortality grew over 178%. Digging deeper, 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. The average cause of death involved the combination of three drugs. Meanwhile, accidental drug poisoning deaths involving stimulants, such as cocaine, are also on the rise. This is captured in Table A below.

The average age of people dying from accidental drug poisoning was 40, with a range of 18 to 75 years. Meanwhile, the geographic distribution of overdose deaths suggests that 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

Although it has received significantly less attention, in addition to accidental drug poisoning deaths, 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.[24]

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 actual seropositivity 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. Researchers have found that roughly 80% of people who contract hepatitis C develop a chronic infection. 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.[25]

Human Immunodeficiency Virus (HIV)

HIV is a chronic, incurable virus that is spread through exposure to contaminated blood, seminal fluid, vaginal fluid or breast milk. Most directly relevant to the Coalition's report, HIV has been found to live for up to 6 weeks in the barrel of a syringe, allowing it to be transmitted between people who use drugs who share injection equipment.[26]

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 similar to those recently in Indiana and Massachusetts.[27] Prior to 2015, Scott County, Indiana saw an average of roughly five new cases of HIV per year. Over the course of 6 months starting in March of 2015 this skyrocketed to 215 new cases of HIV, driven predominantly by injection drug use.[28] Likewise, Massachusetts has recently called attention to a significant surge in new cases of HIV related to injection drug use, with 129 new cases of HIV identified since 2015.[29]

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.[30]

Substance Use During Pregnancy & Infant Exposure

Maine is experiencing a rise in substance use during pregnancy, resulting in a dramatic 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.[31] Rates of unintended pregnancy among women using opioids are 86%, nearly 40% higher than the general population.[32]

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. Additionally, 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 and operationalization by individual hospital systems and providers, which leaves far too much 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.

Effective policy-making in this area is further hindered by misinformation about effects of substance use during pregnancy. As the organization National Advocates for Pregnant Women explains, "Carefully constructed, unbiased, scientific research has not found that prenatal exposure to any of the illegal drugs causes unique or inevitable harm (to a fetus of infant)."[33] The American College of Obstetricians and Gynecologists released a statement in 2011 decrying the use of criminal justice measures to address the issue of substance exposed infants, stating plainly that "incarceration and the threat of incarceration have proved to be ineffective in reducing the incidence of alcohol or drug abuse" and "the use of the legal system to address perinatal alcohol and substance abuse is inappropriate."[34]

4.3. 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.[35] However, since at least the early 1970s, when President Richard Nixon announced an "all-out, global war on the drug menace,"[36] we as a country have centered our public narrative—and our solutions—almost exclusively around 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.[37] 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.[38]

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,[39] 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.[40]

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.
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Indeed, 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,[43] 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,[44] non-white people represent 19.46% of the state’s male prison population.[45] Throughout the US one in three black men are expected to have spent time in incarceration, compared to one in 17 white men.[46]

The criminal legal system is an imperfect and ill-equipped tool 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. Instead, Maine jails and prisons force one way of resolving drug use: 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 exceptionally 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.[47]

Further, formal incarceration is merely the beginning of what often amounts to a lifetime of social exclusion and discrimination. According to the Prison Policy Initiative, there are seven million people living in the US who are currently under correctional control. 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, built around the dehumanization of incarcerated people, likely has the effect of retraumatizing a population already plagued by trauma. Where drugs have often become the primary coping mechanism for people in chaotic use, a retreat from a world full of stressors and trauma, the harsh conditions facing them during incarceration and after they are

released adds both stress and trauma and blocks access to the supports discussed in section 3.1 above, 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.[48]

Despite the increase in spending and capacity in the criminal justice system, drug use has not been curbed in the past half century as revealed by data from the National Institute of Drug Abuse dating back to 1978. Meanwhile studies in criminology have found serious fault with deterrence theory, the theory that harsh criminal consequences will deter criminal activities, particularly with regards to drug use.[49] [50] [51]

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.[52] Further studies suggest that there is no reduction in the likelihood of rearrest when somebody is incarcerated as compared to receiving probation,[53] and the length of time in a corrections setting or on probation made no difference in the likelihood of rearrest.[54]

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.[55] While this figure presents some challenges (including what constitutes "needing" treatment, and inclusion of cannabis as an illicit drug) it is the only available dataset on the topic. Reasons for not accessing treatment are complex and include constituents' individual readiness level (i.e., some people simply didn't want treatment). However, they also include a number of structural barriers that significantly constrain access to care.

Foremost among these barriers is cost and lack of insurance. Over the past eight years the State of Maine has progressively curbed Medicaid enrollment, effectively reducing the number of people with public insurance. Additionally, as of October 2018, the State of Maine has thus far 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 leaves approximately 77,000 people without health insurance. Based on results from a 2016 survey of syringe exchange consumers, roughly 48% of people who inject drugs lack any insurance whatsoever. This makes both treatment and basic health care cost prohibitive.[56]

Further constraining access, 40% of people who use drugs live in households with annual household incomes below $11,000 per year. Most methadone clinics throughout Maine charge roughly $80/wk. per patient self-pay. With annual treatment costs for methadone maintenance therapy running around $4,160 per year, this amounts to more than 37% of their annual income.

In addition to cost, treatment access is severely limited by geographic availability. 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). As a result, many people living in Maine's rural areas face an hour or longer drive to access methadone maintenance treatment services, and people from Northern and Western Maine may encounter travel times of two to three hours. Where methadone usually requires daily dosing, this quickly becomes unsustainable.

Existing federal law presents a major barrier to establishing more opioid treatment programs. The Controlled Substances Act of 1970 maintains a strict set of expectations for methadone services that make it challenging to operate sustainably. This adds costs, making it unsustainable for and discouraging many would-be providers. Meanwhile, 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.

Buprenorphine treatment is more widely accessible through primary care providers. Currently, Maine has 742 X-waivered buprenorphine prescribers, or one per 1,800 people.[57] This is directly related to the fact that there are fewer federal regulations surrounding buprenorphine when compared to methadone. Additionally, 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 and accounts of 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.[58]

Ultimately, healthcare providers are people too, and are impacted by broader social attitudes surrounding drug use and people who use drugs (PWUD). Beyond treatment, provider stigma is felt to substantially impact receipt of preventive and basic health services for people who use drugs. Stigma among doctors treating patients with substance use disorder is ubiquitous. A meta-analysis of healthcare professionals in 2013 demonstrated largely negative attitudes toward PWUD, contributing to suboptimal care and reduced patient empowerment.[59] Over time, stigma becomes internalized, reducing the likelihood that a person using drugs will seek help as a result of low self-worth. In one study, 25% of participants interviewed indicated that they had been prevented from obtaining medical care because of their drug use.[60] 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. 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.[61]

Where health is considered one of the four pillars of recovery, constricted access to treatment and basic healthcare services, whether due to lack of insurance, inability to pay, distance or provider stigma, emerges as a major impediment to recovery.

Housing and Employment

As stated above, housing (home) and employment (purpose) are two of the four pillars of recovery. 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 longitudinal study of people with a history of injection drug use found that 38% of subjects reported experiencing homelessness in during the study period.[62] A 2016 survey of Maine syringe exchange participants demonstrated that roughly 24% of respondents had experienced homelessness within the past year and 66% indicated experiencing homelessness at least once in their lifetime.[63]

Homelessness among PWUD is associated with dramatically 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 persons 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 all-cause mortality among people who inject drugs, substantially increasing the likelihood of death from any number of causes.[64] Studies have suggested that homelessness can contribute to initiation of injection,[65] as well as re-initiation of injection after a period of cessation.[66] Accordingly, the Coalition finds that homelessness and housing insecurity severely compromise recovery, and contribute to relapse among people who have been abstinent from drugs.

Likewise, unemployment among people with a history of drug use poses significant challenges for PWUD and the recovery process. Indeed, one recent literature review concluded that economic recessions drove substance use because unemployment contributed to psychological distress that in turn increased drug use.[67] A 2011 literature review explored the complex relationship between unemployment, substance use and relapse. According to the author, problematic drug use contributed to unemployment as might be expected. However, the author also 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.[68]

Stigma and Discrimination

Meanwhile the pillar of ‘community’ identified in section 3.1 above is severely challenged by stigma and discrimination against PWUD and others affected by drug policy.

Stigmatizing attitudes that shame, discredit and dehumanize people with a history of drug use run deep within our culture, the product of more than 100 years of public policy and messaging that frames drug use as a character defect and people who use drugs as immoral. Studies of social perceptions found that stigmatization of problem drug users was commonplace.[69] According to one review, people frequently perceived people with a history of drug use as more dangerous and more responsible for their condition than other populations with psychiatric issues.[70] Similarly, family members were likely to report shame surrounding their loved one’s drug history.[71] Furthermore, this stain extended long into the recovery process, and touched the reputations and

experiences of one's friends and family. It is no surprise then 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.[72]

This stigma surfaces in the language we use surrounding PWUD. 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 monikers. Our language surrounding drug use frequently collapses a person into a behavior - parents, children, spouses, employees, all become 'drug users.' Further, the language we use surrounding drugs sends a clear message that drug use is bad and the people who use drugs are immoral. This is subtly internalized, leading to lower self-worth and self-efficacy. Input from people adversely affected by stigmatization, in regards to drug use, resulted in the people first nomenclature: "people who use drugs."

Common examples of prejudice and discrimination found in Ahern, Stuber and Galea's (2006) study of stigma and discrimination of people who use drugs included rejection by friends (65.8% of study participants), rejection by family (75.2%), being prevented from obtaining medical care (24%), and being denied housing (34%).[73] Personal experiences lead people with a history of drug use to fear exposure to further stigma and discrimination, contributing to reluctance to seek treatment and basic healthcare, apply for jobs, pursue an education and seek out other activities important to their recovery.

Beyond interpersonal discrimination, people with a history of drug use and others directly impacted by US drug policy often suffer from systemic discrimination as well, further undermining their ability to avail themselves of health, home, community and purpose. 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.

Employment is not only important as a means of financial support, but also of self-worth. Because a great number of people with a history of drug use have arrest records relating to drug possession, sales, or illegal activities to gain money for drugs, and the almost 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%.[74] Further, there is no legal protection from discrimination or exclusion for people with a history of drug use or people with criminal convictions.

This emerges as a whole system of 'otherness,' breaking a certain segment of society out from the general population, considering them undeserving of and thusly exempted from its support and benefits. This takes on a whole other dimension when we consider the extent to which communities of color continue to be disproportionately arrested, charged and sentenced with drug crimes in comparison with their white counterparts in spite of similar rates of substance use. 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.[75]

Furthermore, mandated reporter requirements frequently equate drug use in the family setting as concrete evidence of neglect. As such, 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.

As vital as health, home community and purpose are to recovery, our current system, with its over reliance on a punitive approach to drug use, is actively eroding these pillars, contributing to high rates of relapse and recidivism. But beyond this, US and Maine drug policy is complicit in perpetuating systemic inequality against people of color and people with a history of drug use, effectively consigning members of these populations to second-class citizenship, wherein they are not afforded the same rights and privileges as the general population.

5. Recommendations

5.1. 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. As indicated in section 3.1 above, a growing body of evidence has affirmed that there is a causative connection between adverse childhood experiences, cumulative stress and trauma on the one hand, and problematic relationships with substances on the other. Examples of traumatic experiences that lead to cumulative stress include extreme deprivation, homelessness, loss of a parent, abuse and neglect, and imprisonment of a parent.

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.*

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

Following the 'asset-building model,' resilience leads to positive youth development. Resilience emerges as an internal asset, frequently accompanied by optimism, conflict resolution and problem-solving. However, positive youth development also relies on external protective factors that provide opportunities and challenges for realizing resilience.[76]

Numerous studies demonstrate a negative association between resilience measures and problematic substance use.[77] Likewise, the public health literature base is rife with studies demonstrating the impacts of specific evidence-based practices (EBPs) on resilience among at-risk youth (specific prevention) and youth at large (universal prevention) leading to reduced problematic substance use. The Coalition has elected to refrain from identifying specific EBPs for implementation. However, the Coalition strongly recommends committing resources sufficient to fund implementation of locally selected EBPs throughout the state.

5.2. 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.*

Harm reduction programming, including syringe exchange and naloxone distribution programs, is supported by a substantial body of evidence suggesting 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. These findings have been validated in a multitude of studies and meta analyses.[78] While less clear cut than HIV,

the evidence indicates that syringe exchange programs can reduce the transmission of hepatitis C when they are implemented at a 'structural level' (able to reach roughly 50% of the injecting population).[79] This suggests the need for widely accessible syringe exchange services in order to have a lasting impact on rates of hepatitis C. Along these lines, in order to adapt syringe exchange models that originated in urban areas for rural districts, analysts have suggested reducing 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.

Similarly, 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. One systematic review that evaluated 22 studies found that take-home naloxone programs reduced overdose mortality among program participants and the broader community.[80] Additionally, some researchers found a dose-response relationship between quantity of naloxone distributed and effect size, suggesting that distributing more naloxone programs could have a greater impact on accidental drug poisoning deaths.[81]

Beyond the impacts of harm reduction programming on morbidity and mortality, these resources have been shown to increase uptake of substance use treatment. Analyses of syringe service programs suggest that they are highly effect sources of treatment referrals.[82] One analysis showed that treatment referrals originating from syringe exchange programs were more effective than general referrals.[83] Additionally, one study showed that individuals participating in naloxone distribution programs were more likely to access treatment over the long term.[84]

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.[85] 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).*

Case management is a client-centered strategy to improve coordination and continuity of care. 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. Studies identify improvements over treatment alone in outcomes ranging from retention in care, reduced substance use, global functioning and reduced re-occurrence of symptoms (relapse).[86]

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.

By expanding targeted case management to people with severe substance use disorders who are not engaged in treatment and do not have a history of injection drug use, providers will be better able to coordinate services and care among people who use drugs, empowering them to develop the aforementioned pillars of recovery. This is expected to lead to increased functioning and stability among participants, as well as increasing the initiation of treatment and retention in care.

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.*

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.[87] [88]Accordingly, continuing medical education programs should include education surrounding the nature of addiction and addiction as a disease-state, education regarding effective treatment for addiction, education regarding disease conditions that people who consume drugs may be susceptible to, guidance around providing harm reduction information to people who consume drugs, and education around motivational interviewing.

5.3 Treatment Recommendations

7. *Reduce barriers to 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 afford 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. As stated above, most people experiencing substance use issues have no insurance whatsoever. Lacking insurance, the costs of medication assisted treatment regimens tend to be prohibitive, posing an insurmountable obstacle for people with low incomes. The Coalition highly recommends the express 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 services, behavioral health services, case management services and basic healthcare services, helping to improve the overall health of people who use drugs in alignment with the pillars of recovery as identified by SAMHSA.

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 to ensure that all people who need substance use treatment can afford it. Gap coverage should support the overall health of recipients but may 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.[89] Specifically this growing body of research recommends:

- 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 make up the vast majority of medication assisted treatment regimens (MAT). First introduced in the 1960s, 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.

Both medications function by staving off withdrawal symptoms and reducing drug-seeking behavior accordingly. The maximal efficacy of buprenorphine is lower than the proscribed optimal daily methadone dose, suggesting that buprenorphine may not be the best fit for persons using high-dose opioids. Additionally, some studies have found that the structure that frequently

accompanies methadone treatment through federally certified programs works better for some types of patients. However, buprenorphine tends to be 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, an opioid antagonist. As such, 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. As indicated following recommendation 7 above, this would dramatically increase access to substance use treatment and recovery services, including medication assisted treatment.

During the last 8 years, many clinics and addiction practices have been severely challenged by progressive reductions to MaineCare. With increasing reductions to addiction coverage, practices have hemorrhaged patients who could no longer afford their services, compromising their business viability and leading many to close down altogether. MaineCare expansion would boost the business viability for addiction practices throughout Maine, facilitating growth and expansion of these vital services and helping to establish practices in areas outside of the metropolitan core. This effort would be further supported by increasing reimbursement rates for behavioral health and addiction services, including medication assisted treatment. By increasing the reimbursement rate for these vital services, policy-makers would help boost the business viability of addiction practices, thereby increasing the availability of substance use treatment throughout the state.

Lastly, opioid treatment programs are more tightly regulated by the federal government than other addiction practices including buprenorphine prescribing. The burdens and barriers confronted by opioid treatment programs as a result of the Controlled Substances Act and other legislation contributes to lower access to methadone compared to buprenorphine and/or other treatment modalities, leaving methadone in the hands of a few organizations and largely confined to more metropolitan areas.

As such, 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.*

Research suggests that detox from opioids without successive linkage to medication assisted treatment in the form of buprenorphine or methadone is significantly less effective and associated with higher rates of opioid poisoning fatalities.[90] The Coalition strongly recommends that people seeking opioid treatment be encouraged to utilize and be linked firmly to medication assisted treatment as possible.

However, the Coalition is dedicated to individual self-direction and recognizes that there is no wrong way to pursue recovery. As such, the Coalition advocates for a pragmatic approach to recovery, encouraging people to pursue recovery in whatever form they feel will work best for them.

Additionally, in spite of the above referenced findings, rapid cessation from opioids followed by abstinence remains the primary modality of recovery in the U.S. today.[91] To this end, the Coalition recommends the allocation of State funds towards the development and funding of medical detox services in every county in Maine.

For many people seeking to cease drug use, withdrawal symptoms are an initial challenge faced in attaining abstinence. Medical detox facilities are medically supervised practices that assist people who are physically dependent on substances to cease use and weather the short-term effects of withdrawal and connect them with other services to facilitate long-term recovery. 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 for many other drugs.

5.4. Recovery Recommendations

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.*

According to SAMHSA, 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. Taken together, these supports amount to integration in the community, a task made acutely difficult by stigma and in many cases criminal history.

According to the Recovery Research Institute, "Recovery Community Centers are peer-operated centers that serve as locatable resources of community-based recovery support."[92] 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.

Where many communities have Career Centers and other programs that are intended to connect people to meaningful employment, these centers 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.[93] [94]

One meta-analysis found that among four types of employment supports programs, supported employment and augmented supported employment were most effective in helping people obtain and maintain employment. Another study found that engagement in supported employment programming significantly increased overall empowerment of the individual and decreased internalized stigma. Accordingly, where self-worth and self-efficacy are crucial components of recovery, supported employment increases both. According to researchers, the most effective supported employment programs: 1) encourage employment, 2) understand substance abuse as part of the vocational profile, 3) find a job that supports recovery, 4) help with money management, and 5) 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 thee alignment of state and municipal fire codes with federal policy.*

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

Housing First is a "supportive housing model for persons 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."[95] Previous studies of Housing First have found reduced governmental costs and improved personal well-being among participants By 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, we could have a significant impact for people living with substance use disorders.

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 Federal Housing Act, 42 U.S.C 3601 et seq., prohibits discrimination by direct providers of housing, such as landlords and real estate companies as well as other entities, such as municipalities, banks or other lending institutions and homeowners insurance companies whose discriminatory practices make housing unavailable to persons 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 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."[96]

At present, Maine municipalities are operating in silos, without direction from the State government on rules and guidelines. Often houses outside Cumberland County find it difficult to work within the fire codes regarding maximum occupancy of unrelated people. As such, the Coalition strongly recommends that the State of Maine amend State fire codes regarding maximum occupancy of unrelated people to exempt recovery residences (RR). 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 RRs.

In a 2018 article published in the Bangor Daily News, Troy Bennett "reached out to more than 90 homes believed to be recovery residences in [Maine]." Bennet's survey found that currently there are 76 homes operating within state lines, with more than 77% of those in the Portland area, suggesting that only 17 houses exist outside the confines of Cumberland County.[97] As a result, people with a history of substance use are most often forced to choose between living in Cumberland County or struggling with housing.

Beyond availability, across the country, RR operators have been charged for allegedly offering drugs to residences, sexually assaulting guests, and keeping them in an the deadly cycle of addiction to keep money flowing into the business. Though Maine has been spared of any of these heinous accusations, the Coalition believes that we must take a proactive approach to ensure the safety and quality of RRs.

In response to the above, the Coalition recommends the establishment of a voluntary certification system that recognizes and extols RRs that meet certain quality and safety standards and do not discriminate against people on medication assisted treatment. Through oversight, houses would receive guidance and support in offering this critical service. "State recognition could also offer guidance to cities and towns, which can be leery of [RRs] and have rules that make it hard for them to open despite federal law protecting … residents."[98] Certified RRs would be listed in a statewide inventory to facilitate referrals to housing. Further, stipends should be made available to certified recovery residences (RR) 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.

5.5. 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.*

The Coalition believes that drug misuse is best addressed through public health rather than criminal legal means. As such, it recommends the decriminalization of the possession of all drugs. Doing this will allow us to effectively treat substance use disorder, remove the devastating 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.[99] Now, under Maine law, possession of less than 200 milligrams of heroin or fentanyl is a Class D crime, a misdemeanor.[100] 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,[101] receiving federally subsidized housing,[102] being employed in certain fields,[103] and obtaining certain professional licenses,[104] 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.[105]

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.[106] 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.[107] This generally includes referrals to local resources, including harm reduction programs, and rarely includes any fines or fees for the first instance. 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.[108]

In the years that followed, competing public health narratives have emerged, endeavoring to shape and influence the perception and reception of this dramatic new approach to substance use. In a 2012 review and comparison of these competing narratives, CE Hughes and A Stevens dissect the claims of the proponents and opponents and compare their accounts against the available evidence. Hughes and Stevens observe a notable decrease in recent and current drug use among people aged 15-24 between 2001 and 2007, and a dramatic decrease in drug-induced

deaths between 2000 and 2008. Additionally, they note that in comparison to peer countries in Europe, following its reforms, Portugal was the only nation to exhibit declines in problematic drug use, and declines in drug-related deaths were more pronounced in Portugal than its peer countries.[109]

Meanwhile, according to the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) new HIV diagnoses attributable to drug injecting continues to decline, from 1,408 in 2000[110] to 30 in 2016, where it has remained relatively flat among people who do not use drugs.[111]

The 2008 EMCDDA report for Portugal indicates a dramatic increase in clients in medication assisted treatment programs (methadone or buprenorphine) between 2000 and 2007. While this peaked in 2010 and later declined somewhat before plateauing in 2013, this may be interpreted as market saturation. Participation in medication assisted treatment programs remained at nearly double the 2000 level in 2016.

Put simply, when Portugal started treating drug use as a public health issue and diverted its limited money away from criminalizing drugs and into public health, it saw positive results.

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.[112] 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.[113] The threshold amount of drugs possessed for trafficking is lower than some people use in one week.[114] 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.*

As an initial matter, we wish to stress that (1) people should never have to go to jail in order to receive treatment for substance use disorders, and (2) 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.

Most jails in Maine, and the Maine Department of Corrections, do not allow the use of medication-assisted treatment for opioid use disorder. Instead, those who enter jail or prison already using medication assisted treatment must stop that treatment, and those who were actively using drugs up until the time of incarceration are forced into detoxification without medical supervision. Detoxing can be dangerous and is, for most opioid users, almost unbearably painful. Upon release from incarceration, people who have been abstinent without medical care are released back into our communities without ready access to healthcare, jobs, or housing. Because of the lack of stability and the decrease in tolerance to drugs after a period of abstinence, drug overdoses upon release from prison are exceptionally high.

Maine's jails and prisons must immediately 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-booking 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-booking diversion program originating in King County, Washington to address low-level drug and prostitution crimes in select areas of Seattle. "In a LEAD program, officers exercise discretionary authority at point of contact to divert individuals to a community-based, harm reduction intervention for law violations driven by unmet behavioral health needs,"[115] effectively diverting them out of the criminal justice system cycle. 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.

Since it's launch in Seattle in 2011, LEAD has been rigorously evaluated. A 2017 peer-reviewed evaluation found that LEAD participants were 58% less likely to be arrested. Additional studies of client outcomes found that LEAD participants were significantly more likely to have housing, employment and legitimate income after receiving services than prior to the referral. Further, evaluations of system utilization and associated costs found that 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).

The Coalition recommends LEAD (and variants thereof) specifically due to some concerns the Coalition has over Project Hope variants and Adult Treatment Court (i.e. "Drug Court"). 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, started by the Scarborough Police Department, has generally tended towards 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. That said, there is an opportunity to integrate and adapt both models (LEAD and Project Hope) to address the aforementioned concerns and better adapt LEAD to Maine's rural environs.

Major concerns also emerge over Adult Treatment Court (also known as "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, while well-intentioned, contain serious flaws that make them unsuitable for comprehensively addressing Maine's drug use problems. First, by their very nature, drug courts still view substance use as a problem that the criminal justice system can solve. Drug courts 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,[116] even though they are only 1.6% of the population,[117] and do not engage in illegal substance use more than any other race.[118] Defendants in drug cases who are Black are 20% more likely to be sentenced to prison than defendants in drug cases who are white.[119]

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.[120] That Commission itself officially recommended that Maine "require the reporting, at minimum of a quarterly basis, of relevant information"[121] regarding race in sentencing and incarceration. Though the recommendation is not novel, we join the chorus of experts in the criminal justice field calling for the collection of information on race and socioeconomic status by criminal justice actors.

Acknowledging that our criminal justice system disproportionately targets and punishes people of color, including a recognition that the war on drugs and our response to people with substance use disorder have historically disproportionately harmed people of color, other states have begun requiring racial justice analyses before passing legislation. For example, earlier this year New Jersey Republican Governor Chris Christie signed into law legislation that will provide legislators with statistical analyses and projections of how criminal justice policies are likely to affect people of color, before any final votes are taken. Several other states—Connecticut, Iowa, Minnesota and Oregon—have also enacted similar legislation, 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. We cannot fully address the harm our drug policy has had until we are confident that we are no longer creating legislation that disproportionately harms one group of people.

5.6. 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.*

According to researchers, one in three American adults have a criminal record.[122] As indicated above studies clearly indicate that 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.[123] The evidence demonstrates the best chance of success for people in recovery is to keep them employed. The Path Forward initiative in Ohio is geared to do just that. This is part of the Ohio Bureau of Worker's Compensation pilot project; The Opioid Workplace Safety Program will provide $5 million to employers over two years to hire and manage people in recovery. Implementation will be based on successful programs partnering with treatment providers and employers.[124]

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.[125] In addition, hiring rates increased for people with criminal records where this policy was in practice.[126] [127] 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.[128] [129] 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[130]

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.*

While there is no strong evidence to support the social, economic or health benefits of anti-discrimination policies, this recommendation emerges from a desire to send a strong message that it is unacceptable to discriminate against people with substance use disorders. Where the evidence strongly shows that the majority of people with substance use disorders are survivors of complex trauma and/or severe mental illness, it is easy to understand why it is important to protect this class. The war on drugs and the associated social exclusion of people who use drugs, when viewed through this lens, becomes a war on some of our most vulnerable citizens – survivors of childhood abuse, sexual assault, people with severe mental illnesses, and others. While existing federal law posits some protections for 'people in recovery' (i.e. people with a history of drug use who are currently abstinent from drugs) by encompassing them within the federal definition of 'disabled' persons, this definition is inconsistently applied and poorly enforced. Further, the authors can think of no other example in which differently abled people who are engaged in treatment are considered to have different rights than people who are not engaged in treatment. As such, this facet of law merely reinforces drug user stigma.

18. *Beyond sending a strong message of social inclusion, establishing/expanding non-discrimination policies to include people with substance use disorders provides a legal mechanism through which rampant institutional, cultural and statutory discrimination might be challenged. 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 (medical professionals) 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.[131]

The "Time to Change" campaign in England has had success in improving public opinion and reaction to people with mental health issues.[132] This has important implications for people who use substances as well. A similar campaign organized to reduce stigma around drug use is underway in the UK called; "Nice people take drugs". The nonprofit, Release, has conducted an educational initiative and billboards on buses with their slogan to get the message out.[133]

6. Conclusion

6.1 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 crisis in all of its depth and breadth, painting a comprehensive picture of this public health crisis, it's 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, reducing the disparate racial impacts of existing drug policy and facilitating recovery for people with problematic relationships to drugs. The above 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.' The evidence and/or arguments surrounding these recommendations is explored in-depth.

6.2 How we pay for this agenda

No doubt, many features of this agenda require additional expenditures. To put those expenditures in context, however, we ought to 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," documenting the enormous costs of the status quo.[134]

When the Maine Center for Economic Policy updated the analysis in 2015, they found that Maine's substance abuse crisis costs 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.[135]

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"(14). Remember, 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, meaning today, it is likely that fewer than one in five people who need treatment can access it.

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 plenty of 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.

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. Furthermore, 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.

Finally, 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,[136] increasing and equalizing tobacco taxes, the Opioid Manufacturer Windfall Profits Tax,[137] and the portions of "tax conformity" that benefit only high net-worth individuals and corporations,[138] 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,[139] could easily be adopted, with a tremendous impact on the crisis.

In other words, money isn't the issue. Just within the criminal justice system—excluding revenue surpluses and popular, appropriate revenue increases—we can we easily 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.

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[103] *See, e.g.*, 32 M.R.S. § 9410-A(1)(F) (person with three or more misdemeanors in the past five years is ineligible to be employed as private security guard license); CMR 10-144-101 § 12.07(J) (person with any misdemeanors in the past 10 years ineligible to provide consumer directed attendant services under MaineCare).

[104] *See, e.g.*, 32 M.R.S. § 8105 (person with three or more misdemeanors in the past 5 years ineligible for private investigator license); 38 M.R.S. § 1310-N (person who has been found in violation of any law may be denied license to operate solid waste facility); 8 M.R.S. § 231 (person with three or more misdemeanors in last five years ineligible for fireworks technician license); CMR 16-222-001 (person must submit to criminal background check in order to be eligible for motor vehicle inspection technician license).

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[114] The law provides a person who possesses 6 grams or more of heroin is trafficking in heroin. 17-A M.R.S. 1105(1)(H). A heavy user could use up to 1 gram of heroin per day, and could therefore be prosecuted for trafficking for possessing less than one week's worth of heroin.

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The Opioid Manufacturer Windfall profit tax is modeled after the federal Crude Oil Windfall Profit Tax Act (PL 96-223) passed in the 1980s. The "purpose of the tax was to recoup for the federal government much of the revenue that would have otherwise gone to the oil industry as a result of the decontrol of oil prices. Supporters of the tax viewed this revenue as an unearned and anticipated windfall caused by high oil prices, which were determined by the OPEC (Organization of Petroleum Exporting Countries) cartel." Essentially, the profits of pharmaceutical companies that benefited from an epidemic caused by their products should be similarly deemed worthy of a windfall profit tax. Like the tax on excess oil profits, a baseline of opioid consumption could be set at, say, 1999, prior to the spike in use precipitated by the deceptive and misleading practices of manufacturers. Then, profits above that baseline should be taxed at similar levels to the excess crude oil profits, anywhere from 22.5-70%. The tax should be applied retroactively, and for future years.

[138] For more information on the tax conformity package passed by the legislature in 2018, see the Maine Center for Economic "Policy Brief: Legislature splits the difference in final tax compromise." August 2018. It outlines the provisions that benefited a broad base of Maine families, as well as tax breaks with little evidence of efficacy, targeted at a very small subset of upper-income individuals and corporations. https://www.mecep.org/wp-content/uploads/2018/08/2018-Tax-Conformity-Final-Deal.pdf Accessed December 31, 2018.

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