Executive Summary

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

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

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

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

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

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

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

Note to members: these general recommendations have **not** been voted on or otherwise approved by committee members and are subject to further discussion and voting at the final meeting

1. The Legislature should work towards changing how addiction is viewed in the State and should adopt statewide policies that destigmatize substance use disorder and increase compassion towards individuals with substance use disorder, including alcohol use disorder.

2. The Legislature should increase and fund access to services at every level of treatment for individuals with substance use disorder, including alcohol use disorder.

3. The Legislature should ensure or set an expectation that each of Maine's 33 hospitals adopt policies and practices that address substance use disorder, including alcohol use

disorder, as a medical condition that should not be discriminated against and ensure that individuals with substance use disorder, including alcohol use disorder, are treated appropriately at every hospital. Hospital policies and procedures should ensure that individuals with substance use disorder are not denied treatment due to stigma or lack of training regarding treatment of the condition.

4. The Legislature should explore options for ensuring the availability in Maine of multiple treatment modalities to provide more effective treatment for substance use disorder, including alcohol use disorder, including, but not limited to, motivational interviewing, home health services and recommendations for discharge planning that provide treatment outside of the hospital setting.

5. The Legislature should ensure that the State, at a policy level, recognizes that the emergency room is not the place to provide long-term care for substance use disorder, including alcohol use disorder. The Legislature should explore options for effective alternatives to treatment outside of the emergency room and hospital setting for substance use disorder to create a more effective system of care in the State.

6. The Legislature should explore options for encouraging education around the elements of the definition of "likelihood of serious harm" as it may apply to individuals with cooccurring disorders, including substance use disorder, as evaluated under the State's involuntary hospitalization and involuntary civil commitment processes.

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I. Introduction

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

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

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

The resolve set forth the following duties for the committee:

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

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

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

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

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

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

II. Background Information[2]

A. Substance Use Disorder Nationally and in Maine

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

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

The COVID-19 pandemic has impacted almost every aspect of our healthcare system resulting in both staffing and resource shortages and an increase in those seeking services. Alcohol misuse

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[1] Written public comment submitted to the committee are available here: https://legislature.maine.gov/doc/9236.

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

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increased as well during the COVID-19 pandemic. Despite the conservative nature of the alcohol statistics, the data is alarming: nationally, one study found that deaths due to alcohol increased 25% between 2019 and 2020. In Maine, alcohol-related deaths increased more than 27% between 2019 (455 deaths) and 2020 (579 deaths). It is projected that approximately 8,000 additional deaths will occur nationally due to increased alcohol consumption during the pandemic; however, the full impact both nationally and in Maine is unknown.

B. Voluntary Treatment Resources in Maine

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

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

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

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

C. Involuntary Treatment Resources in Maine

i. Emergency Hospitalization and Involuntary Commitment

Involuntary hospitalization is provided by psychiatric hospitals, which are defined in statute[3]. Maine's Department of Health and Human Services currently has contracts with eight "designated nonstate mental health institutions" to deliver involuntary hospitalization services, which include Southern Maine Health Care, Spring Harbor Hospital, Maine Medical Center, Mid

[3] *See* 34-B MRS §3801(7-B).

Coast-Parkview Health, Pen Bay Medical Center, MaineGeneral Medical Center, St. Mary’s Regional Medical Center and Northern Light Acadia Hospital. There are also two “state mental health institutes” – Riverview and Dorothea Dix Psychiatric Centers.

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

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

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

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[4] *See* 34-B MRS §3863.

[5] Mentally ill is a defined term, see 34-B MRS §3801(5), but includes individuals suffering effects from the use of drugs, narcotics, hallucinogens or intoxicants, including alcohol.

[6] *See* 34-B MRS §3801(4-A).

[7] *See* 34-B MRS §3863(3).

[8] *See* 34-B MRS §3864.

[9] For a commitment proceeding after the first hearing, the time period may not exceed one year. *See* 34-B MRS §3864(7).

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

ii. Maine's Progressive Treatment Program

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

D. Involuntary Commitment: Other States and Efficacy

As of 2018, 37 states including Maine, as described above, and the District of Columbia have adopted statutory provisions for the civil commitment of individuals because of substance use disorder. Massachusetts[11] and Florida[12] are often cited as examples of state involuntary commitment programs due to their high utilization rates. In 2018, the Commonwealth of Massachusetts involuntarily committed 6,048 individuals for substance use disorder. Florida involuntarily committed approximately 3,000 individuals in 2019. Additional information and other state data, including information on Kentucky's "Casey's Law" which was the model for LD 2008 as printed, may be found in Appendix D.

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

- A Florida study found that "successful completion" was similar between 100 involuntary and 219 voluntary participants.
- In one Massachusetts study, positive treatment experience and post-commitment medication treatment were correlated with longer post-commitment abstinence in persons who experienced civil commitment for opioid use disorder.

[10] *See* 34-B MRS §3801(8-A).

[11] *See* Massachusetts General Law Chapter 123, Section 35.

[12] *See* Florida Statutes section 397.6811, the Marchman Act.

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

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

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

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

III. Committee Process

The committee held four meetings on September 16, October 3, October 24, and November 30, 2022. All meetings were open to the public and held using a hybrid format where committee members were able to participate either in person or by video using a remote meetings platform. Notice of each meeting was distributed to the committee's interested parties through a dedicated email distribution list available to the public. Each meeting of the committee was also livestreamed through the Legislature's webpage and materials from the meetings were posted to the committee's webpage[13] for public access. In accordance with the committee's authorizing legislation, below is a summary of the activities of the committee.

A. First Meeting, September 16, 2022 [14]

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

[13] The committee's webpage is available here: https://legislature.maine.gov/court-ordered-treatment-for-substance-use-disorder-study.

[14] The archived video of the meeting is available at the following link: https://legislature.maine.gov/Audio/#228?event=86478&startDate=2022-09-16T09:00:00-04:00.

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

The presenters and committee members focused their conversations on the applicability of the existing programs to individuals with substance use disorder, including alcohol use disorder. It was during this initial presentation that the committee began discussing the challenge that capacity represents in compelling treatment for substance use disorder, including alcohol use disorder. Dr. Potenza explained that each individual is evaluated on a case by case basis. While it is possible for an individual to continue to have reduced capacity even while receiving treatment, the committee learned that individuals with substance use disorder that initially qualify for emergency hospitalization due to their impairment often have restored capacity as the intoxicant leaves their system. When capacity is restored, there is an obligation to look for voluntary treatment options. Attorney Moynihan then provided an overview of the relevant statutes for Maine's Progressive Treatment Program (PTP) and the committee discussed how the PTP could be used by individuals with substance use disorder. For admission to the PTP, an individual must have a severe and persistent mental illness[15]. Although the statute identifies qualifying mental illnesses and does not specifically mention substance use disorder, the committee learned that the statute also provides that an individual with a combination of mental disorders sufficiently disabling to meet the criteria of functional disability may be considered to have a severe and persistent mental illness, and it is possible that this could apply to an individual with substance use disorder and a cooccurring mental health disorder depending upon their level of impairment.

The committee next received a presentation from Kevin Voyvodich, a managing attorney with Disability Rights Maine's MH Advocacy Program. Attorney Voyvodich discussed the constitutional issues that arise when an individual's civil liberties are taken away and directed the committee to several relevant Supreme Court cases[16] and a Maine Law Court case, *Doe v. Graham*, 2009 ME 88, 977 A.2d 391 (Me. 2009). Attorney Voyvodich noted that Disability Rights Maine has made available on its website an advanced health care directive for planning mental health care that, while not designed for substance use disorder, allows an individual to document their wishes in the event that they lose capacity. Materials referenced in Attorney Voyvodich's presentation are available on the committee's webpage[17].

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[15] *See* 34-B MRS §3801(8-A).

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

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

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

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

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

- Currently available resources in the State at various levels of care, including facilities and providers;
- New programs or initiatives that may be happening in Maine, including plans for the opioid settlement funds;
- Funding for programs in other states;
- Current Judicial Branch resource challenges and the potential effect of increasing numbers of involuntarily hospitalizations; and
- Statistics and information specific to alcohol use disorder.

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

- Conversations about substance use disorder should include alcohol use disorder and drugs other than opioids;
- Incapacity due to substance use disorder, including alcohol use disorder, often is more limited in time which can present challenges when trying to compel treatment; and

- Current emergency hospitalization and involuntary commitment statutes are written in such a way that they could include substance use disorder.

B. Second Meeting, October 3, 2022[18]

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

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

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

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

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

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§3801(4-A) includes a criterion[19] which seems to be used with much less frequency but which may have broader applicability in the substance use disorder context.

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

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

Committee member Dr. Chris Racine built on the presentation he provided at the first meeting and provided the committee with additional information on the efficacy of involuntary commitment for substance use disorder. The members learned that various factors make answering the question of "does it work?" very difficult. Variability in state laws, small study sizes and the differing treatment approaches for various substance use disorders all make an "apples to apples" comparison challenging. Dr. Racine noted that many of the studies comparing voluntary and involuntary treatment have similar outcome data and it appears that some individuals with substance use disorder are well-served by involuntary treatment while others are not. As detailed in three studies cited by Dr. Racine, mental health providers themselves are of divided opinions regarding the use of involuntary civil commitment for substance use disorder. Committee member Dr. Kispert added that addiction medicine providers may not have the same experience as psychiatrists with working with patients that are involuntarily committed and that may inform some of their opinions. Dr. Racine commented that, in his experience, involuntary hospitalization is being used for individuals who present with substance use disorder as well as a cooccurring mental illness; however, there is no place to send individuals with only substance use disorder. The committee discussed barriers to treatment including lack of transportation services in rural areas of the state; lack of adequate telecommunications access; limited capacity for existing residential and detoxification facilities; varying abilities of facilities to provide treatments (e.g., not all treatment facilities accept medications for opioid use disorder); lack of supportive housing; limitations imposed by Federal law or private insurance; social barriers (e.g., stigma); and practice issues with implementing the existing laws in the context of substance use disorder. Members of the committee expressed frustration with the apparent inability of the

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

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current system to properly treat and support individuals and their families dealing with substance use disorder and a desire to understand gaps in the current process and recommend meaningful change.

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

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

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

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

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

[20] A copy of the disbursement information is available on the committee's website, here: https://legislature.maine.gov/doc/9235.

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

After the October 3, 2022, meeting, committee members were asked by email to provide suggested recommendations to be distributed to members for discussion at the third meeting. The members were also provided with background information[21] for review including:

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

C. Third Meeting, October 24, 2022[22]

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

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

[21] The committee member recommendations that were submitted prior to the third meeting and copies of the background materials are available here: https://legislature.maine.gov/substance-use-disorder-102422-meeting.

[22] The archived video of the meeting is available at the following link: https://legislature.maine.gov/audio/#126?event=86525&startDate=2022-10-24T09:00:00-04:00.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The committee then discussed syringe service programs and the benefits of those programs, including the reduction in the spread of multiple viruses, such as HIV and Hepatitis C, and bacterial infections. The cost of these diseases to the individual and the healthcare system is

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significant. Dr. Kispert added that some individuals still have difficulty obtaining clean needles from pharmacies because of stigmatization.

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

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

The committee chairs then posed several options to the members regarding possible next steps and polled the members in attendance. The questions and the straw poll results[23] are as follows:

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

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

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

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

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

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

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

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

  Straw poll results: seven members voted yes, two voted no and two members abstained[24].

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

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

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

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

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

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

- General needs: more opportunities for family involvement in the recovery process; ensuring that alcohol use disorder is considered in all process changes, not just opioid use disorder; reduction in stigma and increase in compassion for those experiencing substance use disorder; ensuring that hospitals are treating individuals experiencing substance use withdrawal; inability to address root cause of substance use disorder in emergency room setting yet this is where many of these individuals are presenting.

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

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

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

- Increase services at every level of treatment.

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

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

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

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

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

D. Fourth Meeting, November 30, 2022[25]

The fourth meeting of the committee was held on November 30, 2022.

IV. Recommendations

The committee was charged with studying services and processes currently available in Maine and in other states for individuals with substance use disorder and was required to submit a

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[25] The archived video of the meeting is available at the following link: INCLUDE LINK WHEN AVAILABLE

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report with a summary of its activities and recommendations, including any suggested legislation, to the Joint Standing Committee on Health and Human Services and the Joint Standing Committee on Judiciary for presentation to the First Regular Session of the 131st Legislature.

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

Below are the general recommendations of the committee.

Note to members: these general recommendations have **not** been voted on or otherwise approved by committee members and are subject to further discussion and voting at the final meeting

Recommendation #1: the Legislature should work towards changing how addiction is viewed in the State and should adopt statewide policies that destigmatize substance use disorder and increase compassion towards individuals with substance use disorder, including alcohol use disorder.

- The issue of stigma was raised repeatedly during the committee's discussions as a barrier to seeking treatment and as a barrier to the provision of treatment. Prior authorization requirements, federal prescription waiver requirements ("X waivers") and the language used to describe substance use disorder (i.e., substance *abuse* disorder) can further stigmatize those struggling with addiction.

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

- A lack of services was identified at each committee meeting as a problem that needs to be addressed. Not only are the individuals who are currently receiving services struggling to access what is available, a lack of services makes providers less likely to utilize existing emergency hospitalization and involuntary commitment processes for their patients with substance use disorder. While the state is undertaking many initiatives to increase available resources for substance use disorder, the problem is large enough that all aspects of treatment should be given greater attention.

Recommendation #3: the Legislature should ensure or set an expectation that each of Maine's 33 hospitals adopt policies and practices that address substance use disorder, including alcohol use disorder, as a medical condition that should not be discriminated against and ensure that individuals with substance use disorder, including alcohol use disorder, are treated appropriately at every hospital. Hospital policies and procedures should ensure that individuals with substance use disorder are not denied treatment due to stigma or lack of training regarding treatment of the condition.

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- The committee heard stories of individuals having to drive across the State to find a hospital that would provide withdrawal assistance. While some hospitals are treating substance use disorder properly, others may not be, and the provision of consistent treatment is necessary to ensure that those who seek help are supported.

Recommendation #4: the Legislature should explore options for ensuring the availability in Maine of multiple treatment modalities to provide more effective treatment for substance use disorder, including alcohol use disorder, including, but not limited to, motivational interviewing, home health services and recommendations for discharge planning that provide treatment outside of the hospital setting.

- The recovery process and needs of each individual with substance use disorder are different; however, there is a consistent need for support services outside of the hospital setting. As one member noted, for individuals leaving the hospital, it is important to establish supports to give them a life to return to.

Recommendation #5: the Legislature should ensure that the State, at a policy level, recognizes that the emergency room is not the place to provide long-term care for substance use disorder, including alcohol use disorder. The Legislature should explore options for effective alternatives to treatment outside of the emergency room and hospital setting for substance use disorder to create a more effective system of care in the State.

- In practice, emergency rooms are the "catch all" for many individuals suffering from substance use disorder and mental illness. Emergency rooms are busy, often crowded, and may not represent the most therapeutic environment for an individual who is going through a crisis. For an individual with a cooccurring mental health disorder presenting primarily with substance use disorder, identifying the root cause of the substance use disorder is likely beyond the scope of services that can be provided in a facility focused on triage.

Recommendation #6: the Legislature should explore options for encouraging education around the elements of the definition of "likelihood of serious harm" as it may apply to individuals with cooccurring disorders, including substance use disorder, as evaluated under the State's involuntary hospitalization and involuntary civil commitment processes.

- As discussed at several committee meetings, this definition of "likelihood of serious harm" includes multiple elements going beyond harm to self or others. Individuals with cooccurring disorders may present different risks than those that present solely with a physical disorder or substance use disorder. Medical practitioners seeking to utilize current law and judicial officers reviewing these cases should be trained on each element of the statutory definition to ensure that those who may need emergency hospitalization or involuntary commitment can receive it.

V. Conclusion

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

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

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