



Maine Adult Drug Treatment Court

EVALUATION REPORT

December 2020

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- Maine Office of Behavioral Health
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- York Adult Drug Treatment Court
- Cumberland Adult Drug Treatment Court
- Androscoggin Adult Drug Treatment Court
- Penobscot Adult Drug Treatment Court
- Hancock Adult Drug Treatment Court
- Washington Adult Drug Treatment Court
- Co-Occurring Disorders and Veterans Treatment Courts (Kennebec County)

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Evaluation Staff

Helaine Hornby, M.A., *Principal Investigator*

Travis Robinson, M.P.A., *Project Manager*

Christopher Newhard, Ph.D., *Data Analyst*

Kacie Schlegel, M.P.A., *Research Analyst*

Tina Marie Williams, M.Ed., M.P.A., *Research Analyst*

James Payne, J.D., *Subject Matter Expert*

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For further information contact:

Travis Robinson, Project Manager

trobenson@pcgus.com

(317) 829-6560

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Produced for Maine Pretrial Services, Inc.
By Public Consulting Group, Inc.

Corporate Headquarters: 148 State St., 10th Floor, Boston, MA 02109



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Farewell

Good-bye my love, my one and only
Or so I thought when I was lonely
My heart was empty
And you eased my mind
And I thought you were just being kind
You took everything and caused paranoia
And my love, you stole just for 'ya
I'm done with this mindset
You tricked me and I fell
This is good-bye and you will miss me
But my life is staying with me
In the end you made me strong
And you grow weaker as time goes on

Maine Adult Treatment Court Participant, 2020

I. Executive Summary



Some people have never gone into a courtroom [before] where they left *not* in handcuffs.



Treatment Court Participant

This quote embodies recognition among treatment court participants that there is something different about treatment courts. Scholars explain it as “the judicial adoption of the disease model for explaining drug using behavior.”¹ The disease model profoundly shapes the adjudication process and particularly how judges view and treat participants. Public Consulting Group, Inc. (PCG), who has been contracted to conduct this independent evaluation, has found this to be exemplified by treatment courts in Maine.

The **Maine Adult Drug Treatment Court Evaluation**, the first in five years, provides much for Maine’s treatment court system to celebrate. Most notably, Maine can demonstrate significant reductions in post-treatment criminal recidivism, savings in costs, and most importantly, the rescue of lives. To speak to people who have completed treatment court or who are still in the process is an inspiration and a privilege.

Working in this field is extremely difficult. Judges, case managers and the entire team on the front line in Maine experience both the joy and rewards as well as pains and frustration.

Yet to hear how participants’ lives literally are being rescued provides the succor for them to continue.

More than once PCG heard, “I gave up on myself, but they [the treatment team] did not give up on me.”

Treating substance use disorders alone is challenging but doing so in the context of criminal charges and, often times, a history of failure, is more so. As stated by the federal Substance Abuse and Mental Health Services Administration (SAMHSA),² “while many similarities exist between substance abuse treatment for those in the criminal justice system and for those in the general population, people in the criminal justice system have added stressors ... and characteristics that affect treatment ... criminal thinking and criminal values along with the more typical resistance and denial ... found in other substance abuse treatment populations.”

SAMHSA references the multiple unsuccessful attempts at abstinence that “reinforce a negative self-image.” Maine treatment courts now have a new tool to help with that, Medication Assisted Treatment (MAT), allowing participants to treat their withdrawal symptoms to opioids. “MAT

¹ Nolan Jr, J. L. (2002). Drug treatment courts and the disease paradigm. *Substance use & misuse*, 37(12–13), 1723–1750.

² Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration. (2005). Substance abuse treatment for adults in the criminal justice system. (Treatment Improvement Protocol (TIP) Series, No. 44.)

medications relieve the withdrawal symptoms and psychological cravings that cause chemical imbalances in the body. Medications used for MAT are evidence-based treatment options and do not just substitute one drug for another.”³

In PCG’s most recent round of treatment court interviews, the toll of the COVID-19 pandemic is becoming evident, not only on treatment court participants, due largely to isolation and the interruption of activities, but also on staff. Both judges and case managers report increased concern and observation of relapse and regression, including overdosing and people absconding. While these are factors which are already anticipated in the treatment and recovery process, it appears worse now and is creating “secondary trauma” among the staff; they report they are struggling and experiencing sleepless nights worrying about their clients. While this report addresses the current situation, the analyses encompass information dating back to 2015 since the last statewide evaluation was completed and provides a more comprehensive perspective.

Not everyone in treatment court succeeds, but Maine’s graduation rate now exceeds 50 percent and is consistent with national averages. The evaluation demonstrates, however, that graduation is not the only benchmark for success. Treatment court participants have lower recidivism rates than those in matched comparison groups. Even people who do not complete the program are engaged for an average of 12.6 months compared to 17.8 months for those who graduate. They have been afforded the ability to receive positive coping skills and recovery tools provided by the treatment courts, even without formal completion of the program. They too demonstrate far lower recidivism than those without treatment.

Adult Drug Treatment Courts (ADTCs) were initiated in the United States thirty years ago and were authorized by legislation in Maine nineteen years ago in 2001 through “An Act to Provide for the Establishment of Alcohol and Drug Treatment Programs in Maine Courts” (4 M.R.S.A. Sections 421–423).⁴ They serve individuals with serious substance use and Co-Occurring disorders who are involved with the criminal justice system who are high risk for recidivism and have high needs for treatment and services. Individuals who already have been convicted and sentenced can obtain mitigated charges and reduced sentences if they agree to treatment and follow the program to completion.

This final report emanates from a one-year study initiated on January 1, 2020, conducted by PCG. The evaluation is generally divided into three components: a **process study** which analyzes the courts’ operations adherence to best practice standards; an **outcome study** which compares what treatment court participants have achieved to similarly situated offenders in Maine who have not had access to the program; and a **cost benefit analysis**. It concludes with recommendations. The following courts are included:

- Washington County Adult Drug Treatment Court (Machias and Calais)
- Penobscot County Adult Drug Treatment Court (Bangor)
- Androscoggin County Adult Drug Treatment Court (Auburn)
- York County Adult Drug Treatment Court (Alfred)
- Hancock County Adult Drug Treatment Court (Ellsworth)

³ More information is available at <https://www.samhsa.gov/medication-assisted-treatment>.

⁴ Cumberland County operated a drug court from 1996 to 1998 before authorizing legislation.

- Cumberland County Adult Drug Treatment Court and Veterans Treatment Track (Portland)
- Maine Co-Occurring Disorders Court and Veterans Treatment Court [Kennebec County (Augusta)]

During calendar year 2019 these courts served 295 people, an increase of 11.3 percent over the previous year, with about 180 active participants at one time.⁵ The census is currently down, from 166 active participants in June to 138 in November 2020. The pandemic has stymied intake, in part due to reduced scheduled court admissions, jail use and access.

Findings: Court Practices

Excellent judicial demeanor and participant engagement: A critical and unique element of treatment courts is the relationship of the participant to the judge. Through observation and interviews PCG found all the judges to be fair, engaging, sympathetic and consistent. They attend all treatment team meetings, where the progress of participants is discussed in addition to the court procedures. A tangible measure of engagement is the amount of time spent with each participant; with the benchmark being three minutes per person, per session, Maine’s average is 5.5 minutes⁶.

Dedicated and highly supportive case management: Case management is provided by Maine Pretrial Services (MPS) and, for a period on a limited basis, Catholic Charities under contract with the Office of Behavioral Health (OBH). Case managers obtain high praise from all who interact with them, but particularly participants. They assess tangible needs such as housing, transportation, jobs and social support, leaving the therapeutic assessment to treatment providers. They also monitor participants and oversee drug testing. While turnover has been an issue for some treatment teams, MPS is constantly assessing how to resolve this, including employment contracts and retention bonuses. Their starting salaries are consistent with comparable positions in Maine.

Skilled treatment providers, yet questions about mental health/co-occurring capacity: Four agencies in Maine have contracts with the Office of Behavioral Health to provide therapies for substance misuse and mental health concerns: *Blue Willow*, *Wellspring*, *Catholic Charities* and *Aroostook Mental Health Services*. Maine consistently uses Intensive Outpatient Program (IOP) and Moral Reconciliation Therapy (MRT), both of which are evidence-based practices for substance use disorder treatment. Treatment providers are active participants on the treatment team. Several courts report concern about the lack of mental health services for those who need it, which national estimates put at 63 percent for this population⁷. Each of the providers’ contracts has a provision for offering mental health treatment and a stipulation that the agency be co-occurring capable. This report recommends further examination by the parties at the court level, including an OBH representative, of mental health capacity, fidelity and remedies.

⁵ State of Maine Judicial Branch. (2020). 2019 Annual Report on Maine’s Adult Drug Treatment Courts.

⁶ This study uses standards developed by the National Association of Drug Court Professionals available at <https://www.nadcp.org/standards/adult-drug-court-best-practice-standards/>.

⁷ <https://www.nadcp.org/wp-content/uploads/2018/12/Adult-Drug-Court-Best-Practice-Standards-Volume-2-Text-Revision-December-2018.pdf>, p. 18

Adherence to high risk and high need criteria but excessive “suitability” discussions:

Treatment courts and treatment providers consistently use evidence-based assessment tools to identify people with high risks for criminal recidivism and high need for treatment or therapeutic responses. PCG has documented, for example, 75 percent of those admitted had a felony charge (A, B or C) associated with the current admission. Those with misdemeanors may have had other factors, such as criminal history, to make them high risk. Interviews with participants have revealed each person had a long history of abusing alcohol and/or drugs, often with failed attempts at treatment. Concerns rest with the subjective suitability discussions which may take place in the treatment teams when referrals are being considered, contrary to best practice standards. Potential participants were called into question for the very factors which made them high-risk, and some were rejected. Yet the data show that former behavior, such as trafficking in drugs, does not prohibit a person from succeeding in treatment courts. The impulse to exclude people who otherwise fit within the high risk/high need guidelines should be suppressed.

Reduced referral to admission time, but many courts still exceed 30-day standard: Referral to admission time has decreased in several courts due to awareness of the issue and the institution of new practices, including enlisting the help of court clerks and providing dedicated case managers to the referral and assessment process. Courts who exceed 45 days on average are asked to review their processes to see what more could be done to streamline these efforts.

Prosecutorial time constraints and defense counsel availability limiting treatment court expansion: Some members of the treatment team, most notably the judge, case manager and treatment provider are paid to participate as part of their jobs. There is limited funding for defense counsel and no dedicated funding for prosecutors [district attorneys (DAs), assistant district attorneys (ADAs) or assistant attorneys general (AAGs)] to participate.⁸ Thus, even if case management staff are added, there are limits on the time these other critical parties can devote to treatment court and thus to the ability to expand. Ideally the legislature would provide funding to the Attorney General’s office to expand ADA or AAG time devoted to treatment court; alternatively, existing staff can be reassigned, as has been done in Penobscot, to carve out dedicated time for prosecutors to participate.

Adequate rewards and sanctions with room for creativity: Maine meets the ratio of rewards to sanctions recommended in the practice standards, which is 4 to 1. Praise and applause lead the list of rewards, while there is no plurality in sanctions. The ratio of positive to negative behaviors addressed in court is 5 to 1 and rewards to sanctions is 4 to 1, which is precisely the standard. Participants value rewards which mitigate drug court requirements and represent a freedom or easing of restrictions, such as moving to the front of the drug testing line, fewer court appearances, or reduced curfew. Especially since all of these are free, the treatment teams should more actively consider them as options. Courts have had to come up with more inventive sanctions due to COVID-19, with jail, and even community service, discouraged. Instead, they are using increased supervision (e.g., more check-ins) as well as additional therapeutic responses. Judges think these are working well and should be considered in all the courts.

Presence of racial disparities: White individuals are over-represented in treatment courts; comparing Black individuals to their numbers in the adjudicated population from which candidates are drawn, they are under-represented. The treatment teams report they are not getting referrals,

⁸ The distinction between ADAs and AAGs is based upon local jurisdictional organization and policies for each County providing Treatment Court services.

spurring the recommendation here that more be done to educate defense counsel as well as probation officers who are typical referral sources about the success of the program for all groups and the under-representation of people of color in Maine’s treatment courts. In addition, after the pandemic, perhaps more could be done by defense attorneys and MPS to alert jail officers and stir interest in jails for people of color to apply.

Need for additional recovery and peer supports: Based on interviews with treatment court participants and graduates, PCG has been persuaded of the need to enhance recovery and peer supports throughout the system. PCG was referred to the works of William White,⁹ who identifies three aspects of recovery capital: personal, family/social and community capital. While Maine’s ADTC program itself is constructed to address personal and family/social capital, the community element needs supplementation. This has already begun in some of the courts and more infrastructure is being developed in communities to support recovery. For example, a recovery representative began attending the Kennebec CODC in November 2020. PCG suggests the treatment team itself be supplemented with a recovery representative.

Veterans responding positively to treatment court: Veterans treatment tracks have been expanding across the state in the belief that serving veterans separately will honor the culture of veterans and produce better results. In fact, Veterans Treatment Court participants in Kennebec County have a higher graduation rate than others; however, their enrollment numbers are smaller, so the results are not statistically significant.

While they appear to be represented consistently with their numbers in the adjudicated population, more veterans could be identified through the expanded use of the Veterans Re-Entry Search Services (VRSS) system; the VRSS identifies people in jail who are veterans. Among the courts where expansion is being considered, Penobscot County should activate its VRSS account and York County should establish one. The Cumberland County Jail System appears to be the most active user of VRSS and can be used as a reference for how it is working.

Impact of COVID-19 pandemic: Almost all participants reportedly have struggled with isolation and lack of contact, which has contributed to a deterioration in their mental health. In addition, during the beginning of the pandemic, caseworkers experienced difficulty with adequate drug testing and meeting directly with clients. As a result, many participants reportedly have reverted into a mindset of criminal thinking, for example making excuses to try to get away with negative behaviors. In particular, team members noted a substantial number of participants would tamper with at-home drug tests and sweat patches or would lie about having symptoms mimicking COVID-19 so they would not have to make an in-person check-in. Most disconcerting is that multiple treatment court participants have experienced drug overdoses during the pandemic, a trend which has been documented nationally. The US CDC reports 81



⁹ White, W. & Cloud, W. (2008). Recovery capital: A primer for addictions professionals. *Counselor*, 9(5), 22–27.

thousand such deaths in the 12 months ending in May 2020, the highest number ever recorded in a 12-month period and “an acceleration of overdose deaths during the pandemic.”¹⁰

Findings: Structural and Management

Broad-based leadership managed through a statewide Steering Committee: Treatment courts are managed by a broad representative body, referred to as the Steering Committee, which has been meeting monthly since the start of the pandemic, as opposed to quarterly before. The chairman is a treatment court judge. All the disciplines on the treatment team are represented along with the OBH and other community leaders. This body provides the leadership and oversight structure of the system and is staffed by the Judicial Branch. The presence of such a steering committee is consistent with National Association of Drug Court Professionals (NADCP) best practices of guidance from a multidisciplinary group.

Need to acquire a new case management system: DTxC was decommissioned 18 months ago (from the start of this evaluation), being replaced by a module within the state’s Enterprise Information System, which is incomplete and insufficient to manage case information, and unable to generate standard reports. OBH has agreed to replace it and MPS has identified excellent, cost-effective systems used elsewhere. However, a replacement has not yet been made. As a result, there has been a significant loss in the ability to monitor and manage the entire system beyond a single court. Even within courts, case managers report a diminished ability to share information among team members.

Structural difficulties in ability to make changes: The organizational and management structure of Maine’s treatment courts is unusual in that the management falls under the jurisdiction of the Judicial Branch whereas the bulk of the financial resources required for case management and treatment itself comes from the Executive Branch, specifically the Department of Health and Human Services. In addition, significant decisions on who is referred and admitted come from the bar, namely defense counsel and prosecutors. The Judicial Branch itself does not have control over the human capital reflected in the diverse roles of the treatment team or the financial resources to move an agenda for change forward. Because the treatment courts have only one staff person, who is responsible for all the specialty courts including Family Recovery Courts, there is inadequate staffing for some maintenance functions such as updating the Policy and Procedures Manual which is now well underway, in addition to new initiatives. COVID-19 has put a strain on MPS, to respond to new forms of testing, monitoring and case management. Because it is difficult to add state staff through the legislature, this study recommends OBH fund a Special Project Manager at MPS who can work on an annual agenda developed by the Judicial Branch, OBH, and MPS in conjunction with the chair of the Steering Committee and the Specialty Docket and Grants Coordinator, to guide initiatives.

Need for uniform core training: When members join a treatment team from any of the disciplines other than case management, they are not required to engage in training. Yet there are basic online programs available that can orient any team member to the tenets of treatment court. One is **Essential Elements of Adult Drug Courts** produced by the National Drug Court Institute.¹¹

¹⁰ <https://www.cdc.gov/media/releases/2020/p1218-overdose-deaths-covid-19>.

¹¹ National Drug Court Institute. (2020). Essential Elements of Adult Drug Courts. Available at <https://www.ndci.org/resources/online-course-essential-elements-adult-drug-courts/>.

Another source is the Center for Court Innovation. All team members should start with a common understanding of treatment court principles and practices.

Two Regions lacking treatment courts: There are two judicial regions with no ADTC, Veterans Treatment or Co-Occurring Disorders Courts. In concurrence with the Governor’s Office of Opioid Response recommendations, treatment courts should be expanded, logically in the regions where none exist now, by adding courts in Regions VI and VIII (described in detail in the body of the report).

Findings: Community Relations

Treatment courts need enhanced public awareness: The public is largely uninformed about the presence of treatment courts and even the recovery community could benefit from increased knowledge and positive stories about what treatment courts achieve. Sometimes it is easier to see the people who have fallen down than those who have risen up. A concerted effort should be made to use the findings of this report and the testimony of those who experienced treatment court, perhaps forming a small speaker’s bureau, to address community groups about the program and to tout its accomplishments. A side element could be to raise money for an emergency fund that case managers could access to help with participant needs which cannot be met through other sources.

Findings: Treatment Court Outcomes

Maine’s Adult Drug Treatment Courts enhance public safety and improve lives at no additional cost to taxpayers. That is the conclusion from our analyses, including a comparison of treatment court participants to a matched group of non-participants. This section and the following one on cost-benefit demonstrate that participants in treatment court have lower post-program arrest and conviction recidivism rates at a statistically significant level. Slightly more than 50 percent, on average, graduate from treatment court; however, even those who do not have far lower recidivism rates, again including both arrests and convictions, than the comparison group. Those who withdraw or are expelled spend an average of 12.6 months in treatment court compared to an average of 17.8 months for those who graduate. Thus, the non-graduates have a strong dosage, more than a year of treatment, and succeed far better than those with no treatment at all. Further, there is a lower mortality rate resulting from alcohol and drugs in the treatment court group than the comparison group although the difference is not statistically significant. In addition, the cost of participating in treatment court is favorable. Treatment court generates a cost savings of 12 percent for each person who enters, rising to a savings of 28 percent at 18 months when lower recidivism rates are taken into account; this is in comparison to traditional adjudication for those who serve time in jail, in prison or on probation.

Admission Rates

- About half the people who are formally referred to treatment courts are ultimately admitted. However, nearly half of those who are not admitted are the result of the person ultimately declining to participate.
- Males and females are proportionally equally represented in admissions.
- There is a very wide variation in admission rates among courts, from 83 percent in Cumberland County to 36 percent in Penobscot and Androscoggin.

Graduation Rates

- The statewide average graduation rate is 52 percent, consistent with other states. *Veterans Treatment Court* is slightly higher at 60 percent and *Co-Occurring Disorders Courts* slightly lower at 46 percent, with *ADTC* at 53 percent. The differences are not statistically significant.
- Females graduate at a higher rate, 57 percent, than males, 51 percent; however, the difference is not statistically significant.
- Graduation rates vary from 42 percent in *Androscoggin* to 57 percent in *Penobscot*, exceeded by *Veterans Treatment Court* in *Kennebec* at 60 percent.

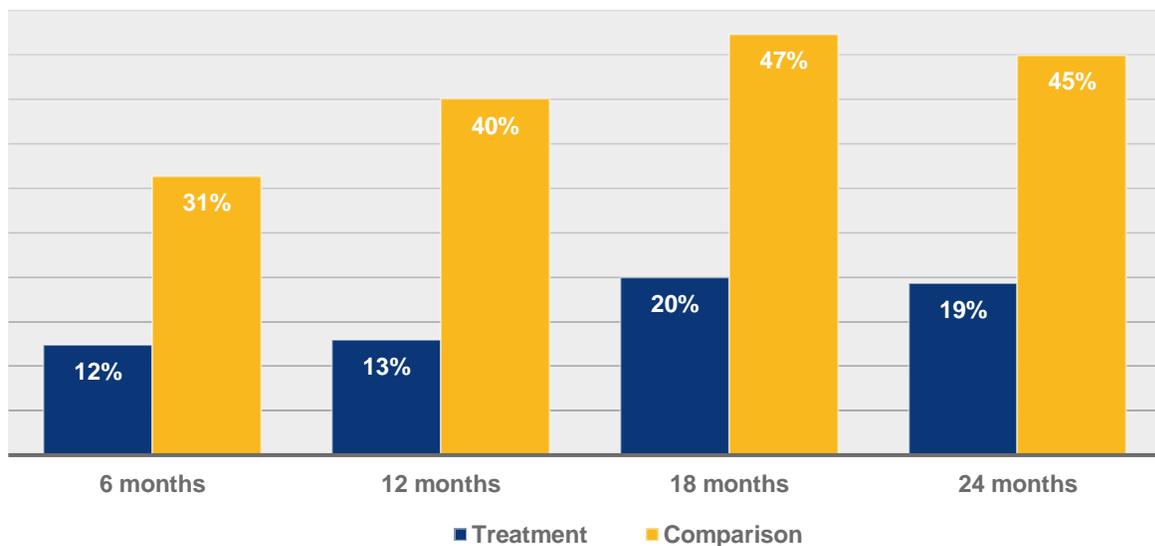
Relation between Admission and Graduation Rates

- There is a moderate positive correlation between admission rates and graduation rates. That is, high admission rates are slightly correlated with high graduation rates, but not at a significant level. Being more discriminating about who to admit generally does not increase graduation rates.

Arrest Recidivism

- After discharge or sentence completion, arrest recidivism is 12 percent at six months for the treatment court participants and 31 percent for the comparison group, a 258 percent difference.
- At 24 months, there is a 237 percent difference, with the comparison group having many more arrests.
- Arrest rates of treatment court participants are lower at a statistically significant level, meaning the differences would not have been derived from chance.

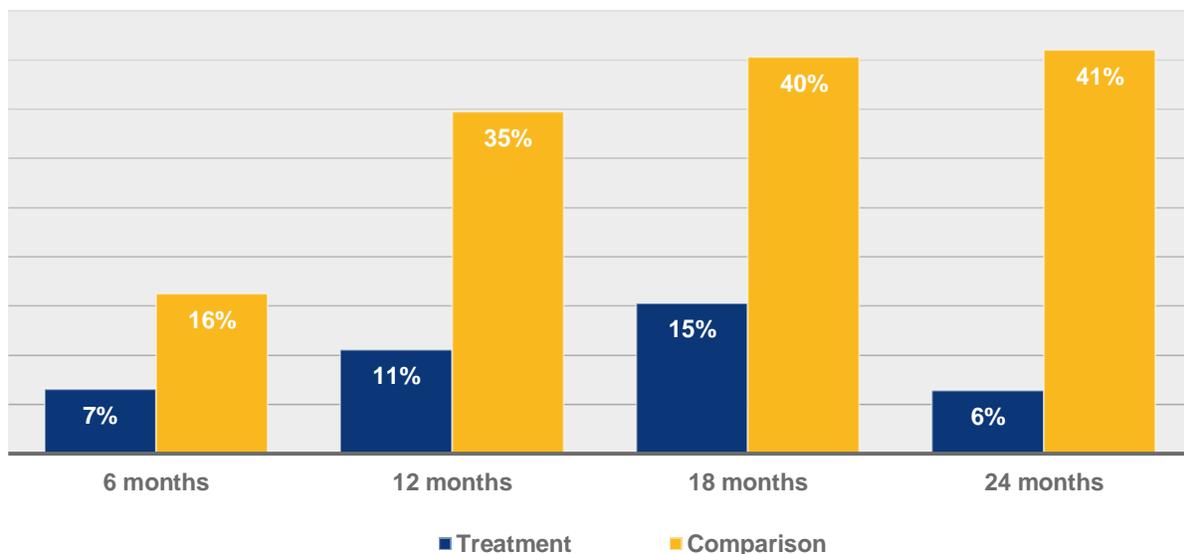
Arrest Recidivism Rates of Treatment and Comparison Groups



Conviction Recidivism

- After discharge or sentence completion, conviction recidivism is seven percent at six months for the treatment court participants and 16 percent for the comparison group, more than twice as high.
- The difference between treatment and comparison group conviction recidivism grows as time goes on, reaching 683 percent at 24 months, greatly magnifying the positive effect of treatment court.
- Convictions rates of the treatment court participants are lower at a statistically significant level, meaning the differences would not have been derived from chance.

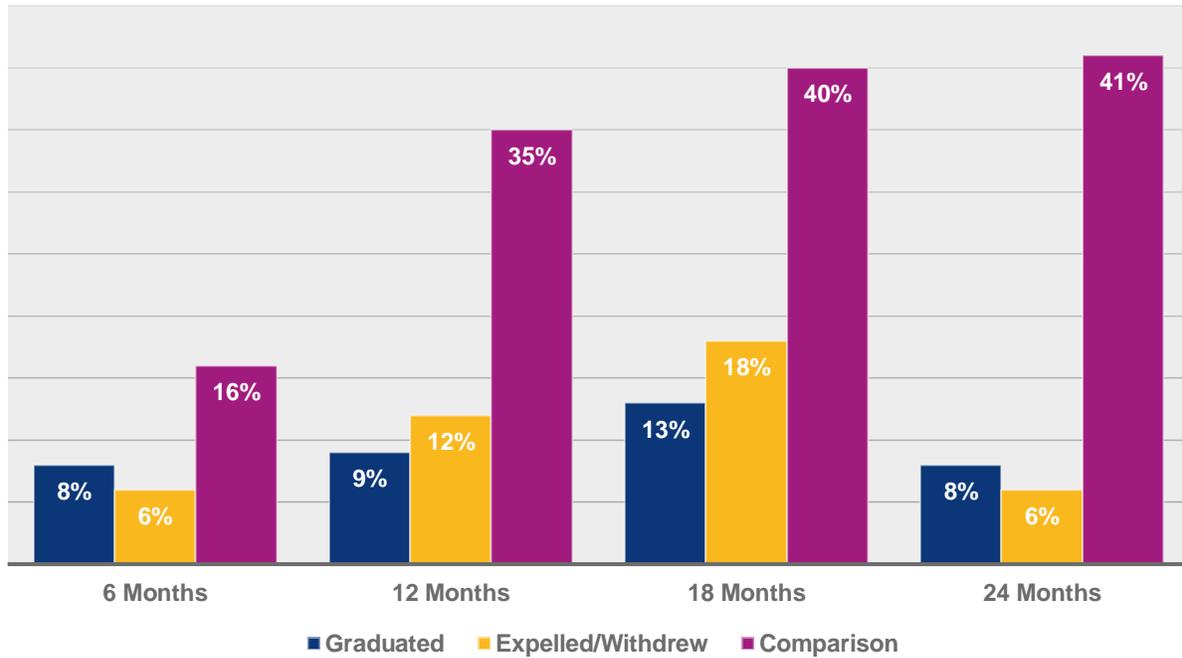
Conviction Recidivism Rates of Treatment and Comparison Groups



Conviction Recidivism by Treatment Court Graduation

- Average participation time for those who withdraw or are expelled before graduation is 12.6 months compared to 17.8 months for graduates.
- Those who do not graduate also have far lower conviction recidivism rates than the comparison group, showing participation has a large impact even absent graduation.

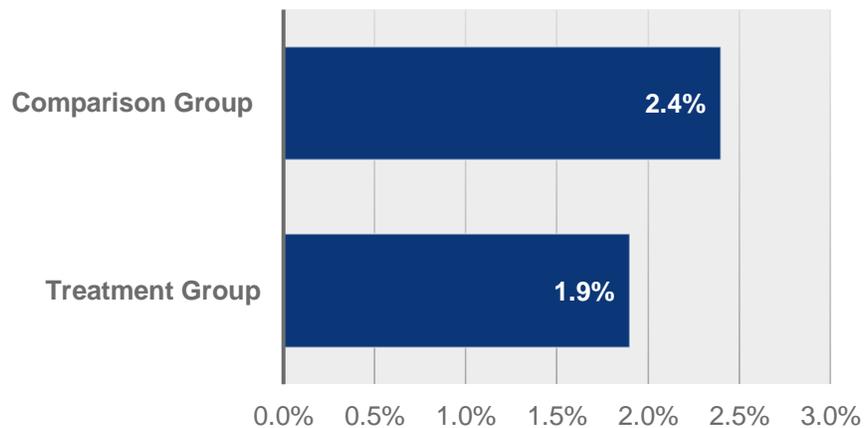
Conviction Recidivism Rates of Treatment and Comparison Groups, Separating Graduates from Non-Graduates



Mortality

- Over four years, 1.9 percent of the treatment court group and 2.4 percent of the comparison group died of a drug overdose.
- These rates suggest that over four years, two out of one hundred people will die for a reason related to overdose.
- While mortality rates are higher for the comparison group, the differences are not statistically significant (chi squared tests, $p < 0.05$ level).

Rates of Death Due to Drug Overdose over Four Years, Treatment and Comparison Groups



Treatment Court Costs and Benefits

- Average case management and treatment costs for each person enrolled in a treatment court is \$8,488 per year, or a total of \$10,964 for 15.5 months, which is the average duration of treatment court, counting both those who complete and those who do not.
- Average probation and incarceration costs for each person enrolled in treatment court is \$27,229 per person from entry to discharge, again counting both those who complete and those who do not, including prison, jail and probation costs.
- Average comparison group costs from entry to discharge is \$43,461 counting prison, jail and probation costs.
- Treatment court generates a cost savings of 12 percent for each person who enters, rising to a savings of 28 percent at 18 months when lower recidivism rates and costs are taken into account.

Treatment Court Savings from Exit to 18 Months

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

Maine's costs and benefits are consistent with those of other states.

Recommendations

The recommendations are organized by the following categories: structural and management; judicial proceedings and treatment team; and, community relations. The groups that would lead implementation of the recommendation are shown in parentheses.

Structural and Management

1. **Acquire a new case management system to replace DTxC and the current EIS system. (Office of Behavioral Health)**

MPS has reviewed several systems which are functioning in treatment court settings in other states and has provided recommendations to OBH for their suitability to Maine. These are not expensive but are sorely needed to fill the management information gap which is now 18 months long.

2. **Fund a Special Projects Manager at MPS to implement joint initiatives. (Office of Behavioral Health)**

Since OBH cannot fund another state agency (such as the Administrative Office of the Courts [AOC]), it should consider supporting a Special Projects Manager at MPS to work with the Judicial Branch on activities requiring extra staffing. If followed through, an annual agenda should be set by the Judicial Branch, OBH, and MPS, in conjunction with the chair of the Steering Committee, to guide initiatives inclusive of implementing priority activities in this report.

3. **In revising the Policy and Procedure Manual, currently in progress, address issues identified in the field and update the Participant Handbook accordingly. (Steering Committee, Judicial Branch)**

- a. provide guidance on when certain offenses (*e.g.*, drug trafficking, violent offenses) should result in exclusion from admission to treatment courts;
- b. provide guidance on when a jail sanction should precipitate a separate hearing and the acceptable timeframe, if required;
- c. provide guidance on when participants should be terminated, and any procedural due process required;
- d. reinforce that Maine policy does not permit “up front jail time” as part of the sentence; and
- e. reinforce that negotiated sentences cannot be stiffer for participants entering treatment court and failing than not entering at all.

4. **Require core training for all new treatment team members and revive training plans as soon as feasible focusing on co-occurring disorders as an expectation; role specific training; treatment and recovery; and use of community supports. (Steering Committee, Judicial Branch)**

All new members of treatment teams should be required to take the online **Essential Elements**

of Adult Drug Courts¹² within three months of joining the team. Current members with little or no treatment court training should do so as well. Training is needed on the relationship between substance use disorder and mental health treatment. While they are distinct conditions, almost two-thirds of those with a substance use disorder have a co-occurring mental health diagnosis. Treatment providers are required in their contracts to deliver co-occurring services and the treatment team should understand that as an expectation including during the process of deciding who to admit. In addition, while ongoing training plans have been stymied in the pandemic, there is a continued call in the field for role specific training to avoid “role bleeding” as well as treatment and recovery training and enhanced use of peer and community supports. These should be delivered as soon as feasible, including the use of online options.

5. Create new ADTCs in judicial Regions VI and VIII. (Judicial Branch)

There are two judicial regions with no ADTC, Veterans Treatment, or Co-Occurring Disorders Courts. In concurrence with the Governor’s Office of Opioid Response recommendations, treatment courts should be expanded, logically, in the regions where none exist now: Regions VI and VIII. As part of the expansion, the Judicial Branch should consider experimenting with the pre-plea model in the new jurisdictions to expand referrals and reduce referral times. In addition, MPS may wish to continue tracking out of county referrals as a measurement of counties that are not served but warrant future treatment court expansion.

6. Institute activities to support case managers in light of the pandemic. (Maine Pretrial Services)

Treatment team members report experiencing extreme stress and secondary trauma during the pandemic due to their concerns about participants. Treatment team members have reported that during the pandemic there have been increases in client overdoses, and more clients are absconding, as well. MPS should develop support activities for treatment team members to address and alleviate pandemic-related stress.

7. Allocate funds for transportation to treatment court if Medicaid cannot pay. (Office of Behavioral Health)

Participants report that their transportation can be paid to treatment but not to court itself; this is due to Medicaid reimbursement policy. Many walk from treatment to court. OBH should consider supplying funds from other sources or vouchers to cover the cost of transportation to treatment court for those who need it.

Judicial Proceedings and Treatment Team

8. In courts which exceed 45 days to admission, develop a streamlined referral process; ameliorate “suitability discussions” to be consistent with best practice standards. (Judicial Branch)

At a Steering Committee meeting, courts with shorter referral times should share their business processes for others to consider.

¹² National Drug Court Institute. (2020). Essential Elements of Adult Drug Courts. Available at <https://www.ndci.org/resources/online-course-essential-elements-adult-drug-courts/>.

Examples:

- a. Support staff, such as clerks, should be engaged in the treatment court process and be trained on the benefits of treatment courts. Penobscot has a 72-hour screening after referral policy (goal is 30 days) which was facilitated by assigning a clerk to the treatment court who moves the process and supports the treatment team.
- b. Treatment teams could use their additional case managers, if applicable, to handle screening and referrals to help support the timeliness between admission and referral.
- c. Case managers could interview people in jail to promote early referrals.

9. Enhance the availability of prosecutorial or Assistant District Attorney time. (Office of the Attorney General)

Either adopt Penobscot's model of moving prosecutorial resources to create a part-time post, focused exclusively on treatment court, or find other resources to attain a part-time prosecutor who will work under the auspices of the elected District Attorney.

10. Diversify rewards and sanctions. (Judicial Branch)

Most rewards given are verbal praise and applause; when participants request passes (e.g., for travel or extended curfew) they are generally provided but rarely initiated by the court. Participants value rewards which mitigate drug court requirements and represent a freedom, or easing of restrictions, such as fewer court appearances or a reduced curfew. Courts have had to develop more inventive sanctions due to COVID-19, with jail and even community service discouraged. Instead, they tend to be using increased supervision (e.g., more check-ins) as well as additional therapeutic responses. Judges think these are working well and have vocalized reconsidering the use of punitive sanctions and instead taking more therapeutic approaches.

One tool which is available to enhance supervision, which has been utilized in Kennebec County, is **ReConnect**. It helps keep track of participants' whereabouts by tagging participants' locations and faces during morning check-ins. While taking supervision to another level of intrusiveness, **ReConnect** can be particularly useful in the pandemic when face to face contact is constrained. Every court has access to the application.

11. Enhance mental health capacity both on the treatment team and in the provision of services; require mental health representation on Treatment Team. (Office of Behavioral Health, Judicial Branch)

Some courts are satisfied with available mental health treatment but at least half are not. If courts are not satisfied with mental health treatment the judge, case manager and other treatment team members should meet with OBH and the treatment provider under OBH contract for their court to discuss the adequacy of mental health assessment and treatment options, the way the provider is adhering to its OBH contract requirements (*below*), and steps needed to improve consistent access to mental health treatment, including how to expedite mental health screenings:

- a. *Ensure the following counseling is provided to all participants, when included in the Individualized Treatment Plan:*

- i. *Individual Counseling based on an individual need or the integrated individualized treatment plan;*
- ii. *Family Counseling;*
- iii. *Group Counseling which shall consist of Intensive Outpatient Services, substance use disorder group, or Dialectical Behavioral Therapy (DBT) depending on the level of care required of the Comprehensive Assessment; and*
- iv. *Aftercare Services, if clinically appropriate.*

In addition, due to the prevalence of mental health disorders within the population with substance use disorders, courts should have mental health overtly represented on the treatment team. If the current representative is dually licensed, he or she could fulfill the role. Otherwise, a person with mental health credentials should be added.

12. Add a peer representative (recovery coach) to the treatment team. (Steering Committee, Judicial Branch)

To emphasize the importance of peer support in recovery and to balance the oversight and supervision functions with the support functions, many are advocating for a peer voice on the treatment team. This person should help serve as a link to the recovery community for each person who wants it, which is most participants. Many peers are in recovery themselves and some have “lived experience” in the justice system, including imprisonment. Maine has 800 trained peer recovery coaches and more are planned through the Maine Alliance for Addiction Recovery and other organizations. There are programs to certify peers and groups such as Healthy Acadia¹³ do not require people to be in recovery to be certified, creating choice among models. The Steering Committee should support uniform implementation of peer recovery representatives for consistency across treatment courts. It could work with the peer recovery program to identify and enlist the help of properly trained recovery coaches.

13. Expand use of VRSS to identify veteran candidates for treatment court. (Judicial Branch)

VRSS is a free application which identifies people in jail who are veterans. Among the courts where expansion is being considered, Penobscot should activate its VRSS account and York should establish one. The Cumberland County Jail appears to be the most active user now and can be used as a reference for how it is working.

Community Relations

14. Address racial disparity in treatment courts particularly among Black individuals who are under-represented. (Maine Pretrial Services Special Projects Manager)

¹³ Healthy Acadia in Hancock County offers free 30-hour Recovery Coach Academy training through an Office of Behavioral Health grant.

Maine, as elsewhere in the US, has fewer Black participants in treatment court proportionally than in the adjudicated population from which candidates are drawn. Some say the problem is lack of referrals, which derive largely from defense counsel. This recommendation is classified under *community relations* because PCG accepts the reasoning for the problem and believes both defense attorneys, jail and probation officers, and other community members should be engaged in resolving it since they are primary referral sources. This starts with education about the issue and the benefits of treatment court, and then working together to create strategies for addressing it. Team members want to see training, public service announcements, and marketing to legal defenders, law enforcement, jail and probation across the state to raise awareness of treatment courts including their effectiveness and how they are an underutilized tool for fostering racial justice. One element of the training and public relations is treatment courts are underutilized yet effective with people of color.

15. Strengthen relations with the recovery community. (Maine Pretrial Services Special Projects Manager)

The recovery community provides mutual aid and has a unique culture; when people leave treatment court, they generally need the support of the community to sustain gains. There are burgeoning groups and supports for recovery in the community; examples are Portland Recovery Community Center, Healthy Acadia and the Maine Prisoner Re-Entry Network (MPRN) which recently received an OBH grant to foster relationships of trained people in recovery with those in jails and treatment court, initially in Kennebec. Some courts have stronger connections to recovery and support groups in the community than others; some work primarily with AA and NA while others have more expansive relations. All courts are encouraged to expand their relations both to foster formal peer supports and to enhance informal community supports. For some participants these relations are critical to successful aftercare.

16. Foster positive perceptions of specialty courts in the community. (Maine Pretrial Services Special Projects Manager)

Maine needs increased community awareness treatment courts exist and are effective. The findings of this report can be one tool to illustrate effectiveness. Others are the testimony of people who have succeeded in these programs, at least one of whom has exemplified herself at the national level. A speaker's bureau of graduates could be organized to address local groups. The community can provide tangible support by providing jobs, gift cards, recreational activities and friendship as well as referrals. The coordinator should work with the Court Communication division to design and launch a public information program.

17. Explore creating an emergency fund to support participants with basic needs such as cell phones, car insurance, gas, transportation and housing. (Maine Pretrial Services Special Projects Manager)

There are new resources to support participants such as the Eastern Maine Development Corporation (EMDC) grants to assist with employment, training and housing. Case managers should make the most of these resources. However, funds may be needed for other supports such as cell phones and car insurance. Working with community foundations, rotary clubs, chambers of commerce, a GoFundMe page, a small emergency fund could be created to assist treatment court participants with recovery and community integration.

Next Steps

The Steering Committee should develop a process for considering the recommendations and a plan for moving the most salient ones forward. PCG can assist with the process in the second year of its evaluation contract. This includes working with the Court Communication Division to prepare a draft press release and public presentation of the outcomes.

II. Introduction

Purpose

The mission of the Adult Drug Treatment Courts (ADTCs) is threefold: to stop criminal activity related to the abuse of alcohol and other drugs; to hold adult defendants accountable; and to increase the likelihood of successful rehabilitation of participants through intensive judicial supervision, case management, and specialized treatment for the abuse of substances and other disorders. Maine operates several types of specialty dockets based on the ADTC model. Maine Pretrial Services, Inc. (MPS), in coordination and collaboration with the Maine Department of Health and Human Services (DHHS), Office of Behavioral Health (OBH) and the Maine Judicial Branch is sponsoring this evaluation of Maine's six ADTC programs, the Co-Occurring Disorders Court and the Veterans Treatment Court, two other types of specialty dockets.

There has not been a comprehensive evaluation of Maine's specialty dockets including ADTCs since 2015. Public Consulting Group, Inc., (PCG) has been contracted to perform such a study. Its principal investigator also oversaw the 2015 study under the auspices of Hornby Zeller Associates, Inc., which has since been acquired by Public Consulting Group, Inc., a national and international public consulting firm whose headquarters are in Boston, Massachusetts.

Treatment Court Background

ADTCs in Maine are post-plea/post-adjudication specialty courts. Participants who abuse substances receive comprehensive supervision, drug testing, treatment services and immediate incentives and sanctions. ADTC programs bring the full weight of all interveners (judges, case managers, prosecutors, defense counsel, substance use treatment specialists, probation officers, law enforcement and correctional personnel, educational and vocational experts, mental health workers and many others) to bear, requiring participants to address their substance use disorder and to increase their capacity to function successfully in the community.

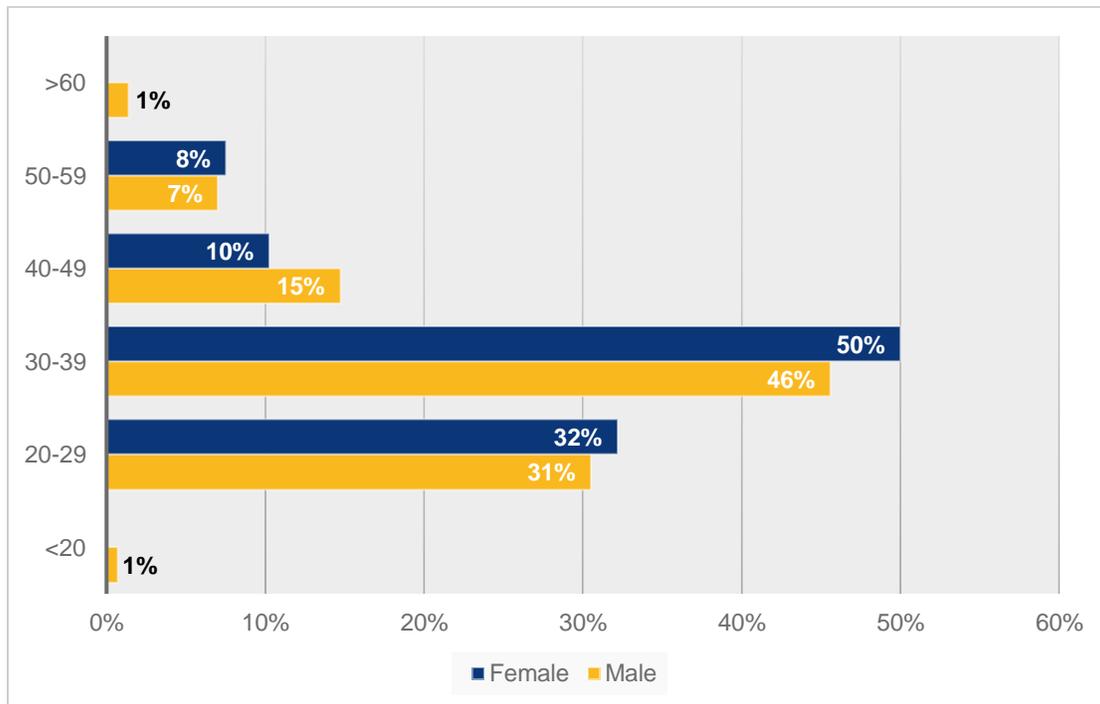
Treatment courts work similarly to court diversion programs in that, in exchange for a guilty plea, participants can expect a greatly reduced sentence upon graduation. Participants are allowed to remain in the community while being supervised by treatment court staff. A recent Maine Supreme Court ruling affirmed the use of treatment courts as a deferred disposition, defining deferred dispositions as encompassing all models which require an entry of a plea followed by a period of time measuring the success of a defendant's treatment.

ADTCs are available to people 18 years of age and older with serious criminal charges or probation violations who have a diagnosed moderate-to-severe substance use disorder and are at significant risk of future criminal conduct. Prior convictions or pending criminal charges for murder, elevated aggravated assault, kidnapping, or sexual assault are disqualifications. Participants must live in the county (or in some instances close driving distance) to a treatment court; if not, the District Attorney from the residing county must agree to transfer the case to the county with the treatment court. Application for admission may be made at any stage of the criminal proceedings.

During calendar year 2019 these courts served 295 people, an increase of 11.3 percent over the previous year, with about 180 active participants at one time.¹⁴ The census is currently down, from 166 active participants in June to 138 in November 2020. The COVID-19 pandemic has stymied intake in part due to reduced scheduled court admission, jail use and access.

The age of participants, by gender is shown in **Figure 1**. Roughly a third are in their twenties, half in their thirties, and a sixth are older. Females tend to be slightly younger.

Figure 1. Age of Treatment Court Participants by Gender



Each specialty docket (also referred to as court) has a unique focus on issues of substance use disorder, mental illness and criminal conduct. The focus of this final report is the following courts, operated in either a district or superior court:

- Washington County Adult Treatment Court (Machias and Calais)
- Penobscot County Adult Treatment Court (Bangor)
- Androscoggin County Adult Treatment Court (Auburn)
- York County Adult Treatment Court (Alfred)
- Hancock County Adult Treatment Court (Ellsworth)
- Cumberland County Adult Treatment Court and Veterans Treatment Track (Portland)
- Maine Co-Occurring Disorders Court and Veterans Treatment Court [Kennebec County (Augusta)]

¹⁴ State of Maine Judicial Branch. (2020). 2019 Annual Report on Maine's Adult Drug Treatment Courts.

In Augusta, the Maine Co-Occurring Disorders Court began admitting adults with significant substance use disorders and mental illnesses and serious criminal charges in 2005. Its goals include promoting recovery from substance abuse and mental illness, promoting the development of prosocial skills, and improving public safety by reducing future criminal behavior. Although located at the Capital Judicial Center in Augusta, as the only specialty docket of this kind, it accepts referrals from all counties. However, individuals need to relocate to Kennebec County to participate.

A separate track for veterans was added to the Kennebec docket in 2011 in recognition of the needs of veterans whose substance abuse and/or mental illness have contributed to criminal conduct but also the separate culture of veterans; this court accepts veterans from any branch of the United States military or National Guard. It works closely with the Veterans Administration and Medical Center at Togus as well as veterans' centers elsewhere in the state. Like the Co-Occurring Disorders Court, it accepts referrals from throughout the state. However, veteran participants are expected either to reside in Kennebec County or to have reliable transportation and the flexibility to travel to Augusta on a near-daily basis. Cumberland County also has a Veterans Treatment Track which began accepting participants on January 1, 2019¹⁵.



VETERANS
TREATMENT
TRACK

Report Organization

Following a discussion of the study's methodology, the report addresses management and administration of the ADTC program in Maine and then the *Adult Treatment Court Best Practice Standards Volume I and II* published by the National Association of Drug Court Professionals (NADCP). For each standard there is a brief description of the standard itself, followed by a discussion of strengths, variations and areas of concern. In several instances, other sources of information are cited to amplify the data collected through interviews and site visits.

Following the Standards discussions, the report provides descriptive statistics about the people treated in these courts. It then provides data on outcomes including arrest and conviction recidivism, comparing those in the treatment courts with a matched group of people adjudicated in Maine without the benefit of treatment court. The report follows with a cost benefit analysis, comparing the costs and outcomes of treatment court participants to those who are traditionally adjudicated. The report concludes with Recommendations for consideration.

¹⁵ Each of the ADTCs is supposed to be developing a Veterans Treatment Track. When a veterans population will allow for stand-alone funding, it can become a Veterans Treatment Court.

III. Methodology

PCG established three methods for keeping the client and stakeholders of this study informed:

- bi-weekly meetings with the leaders of MPS to review the study's progress, discuss issues, and gain feedback on findings;
- monthly meetings with an Evaluation Committee representing members of the treatment teams and other stakeholders including past treatment court participants; and,
- monthly report updates to the statewide Steering Committee for the entire specialty court docket which includes all of the treatment court judges.

Consistent with PCG's "action research" model, these meetings allowed for mid-course corrections to be made both to the evaluation methodology and to the treatment court practices themselves. PCG adapted its evaluation approach largely from the national evaluation of drug courts sponsored by the National Institute of Justice (NIJ)¹⁶ [referred to as Multi-site Adult Drug Court Evaluation (MADCE)] as well as past studies conducted in Maine and elsewhere.

Process Evaluation

For the first phase, PCG conducted a process evaluation which documented case flow, service delivery and resources in relation to the treatment courts' planned target population and established policies and procedures. An important element was to determine the degree to which Maine's treatment courts operate in conformance both with best practice standards at the national level and its own laws, policies and procedures. Thus, our process evaluation findings are categorized by the NADCP *Adult Drug Court Best Practice Standards Volume I and II*¹⁷. These standards were created in 2013, with the release of Volume I of the *Adult Drug Court Best Practice Standards, supplemented in 2015 with the release of Volume II which included scientific research on best practices in substance use disorder treatment and correctional rehabilitation and revised in 2018*. The other source document was the *Maine Adult Drug Court Policy and Procedure Manual, 2013*. For each standard PCG has determined the strengths, variations in consistency amongst the courts, and areas of concern regarding the implementation of these standards.

Data Collection Methods

PCG employed a mix of data collection methods including interviews, focus groups with treatment court participants and court observations. In February and March 2020, PCG staff completed its first round of site visits to each treatment court. Visits included interviews with each treatment court team member, observation of the treatment court team meeting, observation of the treatment court proceeding, and a treatment court participant focus group. During the observations PCG recorded who was present, behaviors discussed and each reward and sanction offered, among other information.

¹⁶ Rossman, S.B., Roman, J.K., Zweig, J.M., Rempel, M., & Lindquist, C.H. (2011). *Multi-site Adult Drug Court Evaluation (MADCE)*. U.S. Department of Justice, Washington, D.C.

¹⁷ National Association of Drug Court Professionals. (2013). Adult drug court best practice standards. Available at <https://www.nadcp.org/standards/adult-drug-court-best-practice-standards/>.

Between September and November 2020, PCG performed a second round of court observations to glean changes which have occurred with regard to: capacity and increasing referrals; the time from referral to admission; admission inequities, suitability discussions and “better deals;” mental health services, peer supports and social service supports; Co-Occurring Disorders and Veterans Tracks; and, EIS and computer software. PCG also sought to uncover how the COVID-19 pandemic affected treatment court teams and participants. The second visit included observation of the treatment court proceeding and treatment team meeting plus interviews with the judge and case manager.

Due to COVID-19 restrictions Androscoggin was not observed in the first round and was the only court observed in person in the second round; others were performed by Zoom. **Table 1** shows the site visits made while **Table 2** shows the qualitative data collection tools PCG utilized to gather information. **Table 3** and **Table 4** show the people interviewed; a total of 136 interviews were completed including 76 with members of the treatment teams, 42 with treatment court participants and 18 with others.

Table 1. Treatment Court Site Visits

Treatment Court	Location	Visit Date 1	Visit Date 2
Kennebec County	Augusta	February 18–19, 2020	October 5, 2020 (CODC); November 9, 2020 (VTC)
Penobscot County	Bangor	February 18–19, 2020	September 30, 2020
York County	Alfred	February 20–21, 2020	October 2, 2020
Hancock County	Ellsworth	February 20–21, 2020	October 16, 2020
Cumberland County	Portland	February 27–28, 2020	October 9, 2020
Washington County	Machias	March 5–6, 2020	September 25, 2020
Androscoggin County ¹⁸	Auburn	Virtual on May 8, 2020 due to COVID-19	November 6, 2020

In addition to the treatment team interviews, PCG completed interviews with state treatment court administrators, members of the Steering Committee, Veterans Justice Outreach Coordinators, and treatment court graduates and non-graduates. These additional interviews provided PCG with further information to frame and support the process evaluation findings.

To gather a consistent set of data, PCG created several qualitative data collection tools including the protocols and forms represented in **Table 2**.

¹⁸ Due to COVID-19, the first site visit for Androscoggin County was postponed and PCG completed the team interviews via teleconference.

Table 2. Qualitative Data Collection Tools

Data Collection Tool	Description
Treatment court team member interview protocol	Uses the NADCP Best Practice Standards as guiding principles to organize the data and frame the questions of the treatment team members.
Treatment team observation form	Documents the treatment team member presence, level of participation, and treatment court participant case discussion during the treatment team meeting.
Treatment court observation form	Documents the amount of time each treatment court participant spent in front of the judge, number and type of behaviors discussed, and number and type of incentives and sanctions received.
Participant focus group consent form	Created for each participant to sign which provide his or her consent to be included in the study.
Participant focus group interview protocol	Gathers input from participants related to their experience with treatment court.
Administrator interview protocol	Gathers input from court administrators about their experience with the management and administration of the specialty courts.
Veterans Justice Outreach Coordinator protocol	Gathers input from VJOs about their experience with treatment court and veteran's justice initiatives.
Treatment court graduate interview protocol	Gathers input from treatment court graduates about their successful completion of treatment court.
Treatment court non-graduate interview protocol	Gathers input from treatment court non-graduates about their unsuccessful completion of treatment court.

Table 3 represents the number of total interviews completed for each treatment court and the number of participants (currently enrolled in a treatment court) in the focus groups.

Table 3. Treatment Court Interviews Completed

Treatment Court	Interviews	Treatment Court Team Role¹⁹	Focus Group Treatment Court Participants
Kennebec	14	VA Liaison Law Enforcement Liaison Probation Officer VA Case Manager (2) Co-Occurring Disorders Case Manager (2) Statewide Treatment Court Coordinator Treatment team Supervisor Judge (twice) Defense Attorney	5

¹⁹ Number of interviews for fall and spring in parentheses

Treatment Court	Interviews	Treatment Court Team Role ¹⁹	Focus Group Treatment Court Participants
		Prosecutor [Assistant DA] Pending Referrals and Screening Case Manager	
Penobscot	14	Case Managers and Supervisor (4) Defense Attorney Probation Officer (2) Law Enforcement Liaison Treatment Providers (3) Prosecutor Judge (2)	5
York	8	Case Manager (2) Probation Officer Defense Attorney Prosecutor Judge (2) Treatment Provider	8
Hancock	11	Defense Attorney Probation Officer Treatment Provider District Attorney Community Advocate Judge (2) Case Manager (2) Recovery Coach (2)	6
Cumberland	10	Defense Attorneys Probation Officer Veteran Mentor Probation Officer District Attorney Case Manager (2) Case Manager Veterans Track Treatment Provider Judge	8
Washington	11	Judge (2) Defense Attorney Prosecutor Probation Officers (2) Treatment Provider (2) Pre-Trial Supervisor Treatment Court Assistant Case Manager	6

Treatment Court	Interviews	Treatment Court Team Role ¹⁹	Focus Group Treatment Court Participants
Androscoggin	8	Probation Officer Case Manager (2) Judge (2) Prosecutor Defense Attorney Treatment Provider	4 ²⁰
Total	76		42

Table 4 represents the additional 18 interviews completed with other key stakeholders, bringing the grand total to 136.

Table 4. Additional Qualitative Data Collection

Stakeholder	Interviews	Role
Administration	1	Manager of Criminal Process and Specialty Dockets
	1	Coordinator of Specialty Dockets and Grants
	1	Executive Director, Maine Pretrial Services
	1	Case Management Director, Maine Pretrial Services
	1	Division Manager, Maine Office of Behavioral Health
Steering Committee	1	Co-Occurring Disorders /Mental Health representative
	1	Clinician, graduate
	1	Researcher, other specialty court graduate
Veterans	1	Veteran's Justice Outreach Coordinator
	1	Veteran's Justice Outreach Coordinator
Treatment Court Graduates	1	Prior Treatment Court graduate (CODC; Kennebec)
	1	Prior Treatment Court graduate (Washington County)
	1	Prior Treatment Court graduate (VTC; Kennebec)
	1	Prior Treatment Court graduate (Penobscot)
Treatment Court Drop-Out	1	Prior Treatment Court drop-out (Penobscot)
Other	3	Professor, Maine Drug Policy Lab, Colby College Principal Court Management Consultant, National Center for State Courts Director, Maine Prisoner Re-Entry Network (MPRN)
Total	18	

Data Analysis

For the interviews, PCG transferred and coded responses into Microsoft Excel spreadsheets organized by county/court and type of respondent, e.g., judge. Each response was classified through color coding as a strength, weakness, deviation from the practice standard or policy,

²⁰ Due to COVID-19, participants were contacted individually for phone interviews.

deviation from other respondents, and potential recommendation. Interviews were combed for quotes which are used throughout the report to illustrate points.

For the court observations, a database was created reflecting all the response categories in the tools. Then, the material from the forms was entered into Excel and analyzed both by county and statewide. The team developed response tables for each type of question, showing percentages for each county. Based on feedback from the Steering Committee, PCG re-categorized *additional treatment* as a separate category from a sanction.

Outcome and Impact Evaluation

PCG performed an outcome analysis, including recidivism, from the data collected from the four computer systems which track this information: Maine Drug Treatment Court Management Information System (DTxC 2.0); the Maine Judicial Information System (MEJIS) the Corrections Information System (CORIS) and the Enterprise Information System (EIS). Maine Pretrial Services' Management Information System (MIS) was used to identify candidates for the comparison group. and the Office of Chief Medical Examiner's mortality database was accessed to identify drug-related fatalities in the treatment and comparison groups. In addition, MPS case managers facilitated collection of entry and exit dates for both the treatment and comparison groups from the county jails. Seven counties provided jail information.

Data Collection Methods

PCG matched clients from the treatment group to a comparison group drawn from Maine Pretrial Services' MIS which includes individuals from across the state who did not participate in a treatment court, drawing data from October 1, 2015 to June 30, 2019. Matching variables for the comparison group are outlined in

Table 5.

Table 5. Outcome Evaluation Matching Characteristics

Matching Variable	Characteristics
Age	Over the age of eighteen
Gender	Male or Female
Race	Person of Color – Yes or No
Year Entering Program	2015, 2016, 2017, 2018, and 2019
Military Status	Yes or No
Class of Offense	A, B, C, D, or E
Criminal History	Yes or No

Data Analysis

PCG identified “entry” and “exit” cohorts which are groups of people who entered or exited the treatment court each year of the study and matched them to a comparison group member using

the criteria above. Federal fiscal years were used to be consistent with the last Maine Treatment Court evaluation completed in 2015. The groups are as follows:

Entry Cohorts: Treatment and comparison groups for people entering:

- Year 1:** 10/1/2015–9/30/2016
- Year 2:** 10/1/2016–9/30/2017
- Year 3:** 10/1/2017–9/30/2018
- Year 4:** 10/1/2018–6/30/2019 (truncated since DTxC stopped on 6/30/2019)

Entry cohorts for the treatment groups were drawn from 431 individuals in DTxC. The entry cohorts for the comparison groups were drawn from 1,226 individuals in Maine Pretrial Services' MIS which includes people from across the state, regardless of the presence of a specialty docket.

Exit Cohorts: Treatment and comparison groups for people exiting:

- Year 1:** 10/1/2015–9/30/2016
- Year 2:** 10/1/2016–9/30/2017
- Year 3:** 10/1/2017–9/30/2018
- Year 4:** 10/1/2018–6/30/2019 (truncated since DTxC stopped on 6/30/2019)

Exit cohorts for the treatment groups were drawn from 231 individuals in DTxC. The exit cohorts for the comparison groups were drawn from 595 individuals in Maine Pretrial Services' MIS. The matching criteria in Table 5 were used to create both the entry and exit comparison groups. Both exact matching and propensity score matching were used to create the comparison groups but generally the exact matches were used in the analysis. When comparisons were made between group performance, statistical tests were administered to determine whether differences in size results were significant or more likely the result of chance. Examples are differences in treatment court graduation rates by gender and conviction recidivism rates by group (treatment vs comparison).

Data files from the Maine Judicial Information System (MEJIS) and the Maine Correctional Information System (CORIS) were obtained to determine recidivism. PCG's analysts matched members of treatment and comparison groups to these other systems to determine who had new arrests and convictions for the recidivism analysis and days on probation and days in prison for the cost benefit analyses. Days in county jail could be derived only on a county-by-county basis, assisted by MPS' staff. In all, seven counties submitted case-specific data by which PCG could determine what members of the treatment and comparison groups were incarcerated in jail using start and end dates for each incident. The results were projected to the larger populations.

Cost Benefit Analysis

PCG conducted a cost benefit analysis using the same treatment and comparison groups. The analysis included differences in the costs of the initial adjudication and for subsequent time periods which also took the cost of recidivism into account.

Data Collection Methods

To establish costs, case management and treatment contracts were obtained from OBH. Judicial salaries were obtained from the Administrative Office of the Courts. The cost of a day in prison and on probation was obtained from the Department of Corrections while the cost of days in jail was obtained from the Maine Sheriffs' Association.

Data Analysis

The costs of case management and treatment were derived from adding the costs of case management, mental health and substance abuse treatment and judicial time (estimated at 20 percent of total judicial time), divided by the number served per year through all the specialty dockets. The costs of incarceration and supervision were added to both the treatment and comparison groups. They were derived by counting the number of days each person in the treatment and comparison groups had spent in prison, jail or on probation and multiplying those by the daily cost of each. If a member of one of these groups had no time in prison, jail or on probation reported, they were not included. Rates of recidivism were added to the incarceration and probation costs at six, twelve and eighteen months to calculate the total costs at each juncture.

Stakeholder Engagement

PCG participated in bi-weekly client meetings, monthly evaluation working group meetings, and monthly Steering Committee meetings, giving periodic presentations on findings to date and obtaining feedback on how to interpret the results.



IV. Management and Administration of Specialty Courts

This section addresses the following management and administrative topics which generally were outside of the purview of the NADCP Best Practice Standards governing the next section of this report: laws and policies; leadership, oversight and funding; Veterans Treatment and Co-Occurring Disorders Courts; and community and recovery support for treatment courts.

Laws and Policies

Authorizing legislation for specialty dockets (4 M.R.S.A. Sections 421–423) is broad and there is no impetus to modify it. Broad authorization provides more flexibility to those administering the program to alter operations as circumstances change. However, there have been two relatively new orders which are perceived as beneficial to the treatment courts.

One is an administrative order, *JB16-1*, effective January 15, 2016, which provides guidance for the establishment and operation of new specialty dockets. Funding and resources need to be identified and presented to the court to be approved, consistent with standards for treatment courts in other counties. Final approval for creating any new specialty dockets is made by the Trial Court Chiefs in consultation with the State Court Administrator and the Chief Justice of the Supreme Judicial Court. The order is intended to lend consistency to the establishment of new specialty dockets.

The second is a recent ruling from the Maine Supreme Judicial Court, *State of Maine v. Brett M. Catruch*, April 23, 2020, which affirms a treatment court can be used as a deferred disposition, defining deferred dispositions as encompassing all models which require an entry of a plea followed by a period of time measuring the success of a defendant's treatment.²¹ In this particular case the bail contract provided clear conditions and cautioned violating them could result in termination from the Veterans Treatment court. The presiding judge is “the final arbiter of his status in treatment court.” During the course of this study PCG heard some people question termination decisions and procedures and even whether a different judge should be called in to sanctify a termination; however, this ruling underscores judicial autonomy in the presence of clear, written agreed-upon conditions for participation.

The major concern with laws and policies *at the start* of the evaluation was that the *Maine Adult Drug Treatment Court Policy and Procedure Manual, Revised 2013* is outdated, and some say ignored as a consequence. Some basic premises such as the use of medication assisted treatment have changed since 2015 when the manual was finalized. A subcommittee of the Steering Committee was appointed in the summer of 2020 to revise the manual and is well on its way. While there are no doubt others, some areas of policy which need updating or clarification are:

- **Eligibility screening and determination:** this is a “hot button” issue, with some people endorsing the wide eligibility net which currently exists and others wanting more guidance on who to exclude. Some have called for a more standardized admission determination process and criteria which expedites admission to treatment courts. There are already

²¹ The full ruling is available for review at <https://law.justia.com/cases/maine/supreme-court/2020/2020-me-52.html>.

plans to address entry processing issues with National Drug Court Institute (NDCI) staff who assisted with similar concerns in Bangor.

- **Drug testing:** with COVID-19, particularly, there are new ways to perform drug testing which are not yet acknowledged.
- **Risk assessment:** there are tools in use or being contemplated which are not referenced.
- **Treatment modes:** some modes which are mentioned (e.g., DSAT) are not used while others which are used (e.g., Moral Reconciliation Therapy) are not mentioned.
- **Phase system:** the phases and requirements need updating due to the addition of Phase 5, the expectations regarding transition and aftercare. (The Participant Handbook has been updated on this matter,)
- **Medication assisted treatment:** this was not permitted when the policy manual was last revised.
- **Termination:** more policy guidance is requested by some on termination policy and procedures; some think judges should recuse themselves and allow participants to request another judge although the *Catruch* ruling cited above obviates the need; some judges are encouraged from other team members to terminate for probation violations, this varies across the state.
- **Training:** any required or optional training and resources to provide it such as the National Drug Court Resource Center should be updated as needed.
- **Due process:** judges note inconsistent practices on jail sanctions and request guidance. The *Drug Court Judicial Benchbook* (NDCI) suggests that when the drug court participant contends he or she did not engage in the conduct which is subject to a jail sanction, the court should give the participant a hearing with notice of the allegations, the right to be represented by counsel, the right to testify, the right to cross-examine witnesses, and the right to call his or her own witnesses but the hearing should be expedited (within two days), consistent with the participant's need to prepare.²²

The Maine Adult Drug Treatment Court issued a revised Participant Handbook on February 27, 2019. Because it is more up-to-date than the formal policy manual, people tend to point to it as a reference. It will need to be updated to reflect changes in the *Policy Manual*.

Leadership, Oversight and Funding

Leadership and oversight are provided by the Judicial Branch, led by the chairman of the Statewide Steering Committee, a judge who also presides over a treatment court. Administrative oversight is provided by the Administrative Office of the Courts (AOC), also within the Judicial Branch, with a designated staff position, the Specialty Docket and Grants Coordinator, who manages day-to-day operations. They report to the Criminal Process & Specialty Dockets Manager who manages all the specialty dockets and is an active participant in the Statewide

²² Marlowe, D. B., & Meyer, W. G. (Eds.). (2011, updated 2017). *The drug court judicial benchbook*. Alexandria, VA: National Drug Court Institute. Available at <https://www.ndci.org/wp-content/uploads/2016/05/Judicial-Benchbook-2017-Update.pdf>, p. 169

Steering Committee. The only other staff within the unit are the Process Auditor and the Court Management Analyst. Judicial time is carved out of existing salaries and functions.

There is no unified statewide budget for specialty dockets. Funding is provided by the legislature to the Judicial Branch to support the aforementioned positions and by the administrative branch through OBH within the Department of Health and Human Services to support case management and treatment services. OBH funding comes from the state general fund, the Fund for Healthy Maine, and the federal Substance Abuse and Mental Health Services block grant, as well as from special funding which has become available to Maine to combat the opioid crisis through the Comprehensive Addiction Recovery Act passed by Congress in 2016.

The Steering Committee is broadly representative not only of all treatment court judges but also of treatment team roles such as prosecutor, defense attorney, case management, former participants and treatment providers. The Committee meets at least quarterly, and more recently monthly due to issues associated with COVID-19. The meetings include input of all the judges as well as special presentations from people of interest; they foster a spirit of information-sharing, cooperation and joint decision-making. The former Steering Committee chair made great strides in unifying court policies, practices and training, in effect creating a statewide system which is now being perpetuated. Participants see the broad inclusiveness of the Steering Committee membership and meeting content as a best practice.

Maine Pretrial Services (MPS), a nonprofit agency, is the primary provider of case management services, although Catholic Charities performed the function in one county for a couple of years, ending in June 30, 2020. Four treatment providers are responsible for the substance use treatment contracts: Central Maine Counseling dba Blue Willow, Wellspring, Catholic Charities and Aroostook Mental Health Services.

MPS has exerted leadership in its tasks beyond case management. Until last year it managed DTxC, the information system used by case managers which had become the source of record, though now decommissioned. The staff spot problems and attempt to access additional resources through its contract, by serving as test sites for national vendors, and even through federal grant efforts. It has worked to expand Veterans Treatment Tracks, for example, beyond Kennebec.

MPS has proved very nimble, the most recent example in the COVID-19 crisis, figuring out new ways to handle drug testing and serve participants remotely. However, MPS lacks administrative authority. An example is in the selection and design of a database to replace DTxC, discussed below. Even though MPS case managers are responsible for data collection they now lack the tools to do so effectively or the means to change it.

PCG's concern about leadership and oversight is structural. While the Judicial Branch oversees specialty dockets, its resources for this purpose are limited. One full-time staff person seems inadequate for statewide oversight plus special tasks. This person is responsible not only for the ADTCs but also for all specialty dockets, numbering 17 courts.²³ He attends many of the treatment team meetings and proceedings, giving advice to team members on policy and practice when warranted. He arranges for trainings and staffs special tasks such as updating the policy manual.

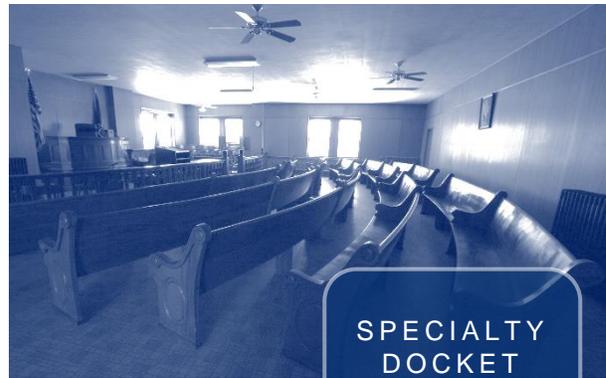
²³ Excerpt from job description (one of six tasks): Coordinates seventeen specialty dockets, consisting of six ADTCs, three family drug treatment courts, one Co-Occurring Disorders and Veterans Treatment Court, and seven domestic violence judicial monitoring dockets. Provides recommendations for improvement to each specialty docket's policies, training, practices and procedures.

Despite the workload, he has received unsolicited praise from people in the field for his knowledge of other systems and the resources he provides.

On the other hand, OBH, within another government branch and agency, the Department of Health and Human Services, is the primary funder of the program through its case management and treatment contracts. Its decisions in handling those contracts have direct impact on the courts' functioning. OBH has been very supportive of treatment courts, especially in recent years as its federal funding to combat the opioid crisis has been channeled to treatment courts as one of its strategies. It has provided more case managers and drug test observers, for example, and even supported this evaluation through a supplement to its MPS contract. However, some of its decisions have been less than sanguine. For example, under the last administration it decided to make case management a service subordinate to the treatment provider contracts in an effort to collect Medicaid reimbursement for case management. While no doubt a noble cause, to save state funding, it did not succeed and proved disruptive.

The second decision was to move the case management information system, DTxC, to OBH's internal Enterprise Information System (EIS). This too has had a negative impact, discussed under the last practice standard below, by eroding the ability to collect and report management information on treatment courts.

There is no dedicated funding for other members of the treatment teams such as probation officers, district attorneys, assistant district attorneys or AAGs. Defense attorneys are compensated through the Maine Commission on Indigent Legal Services, established by Title 5, section 12004-G, subsection 25-A in 2009 as an independent commission whose purpose is to provide efficient, high-quality representation to indigent criminal defendants, among others. The fund is said to have limited resources. **The lack of funding for some treatment team members, especially the assistant district attorneys or AAGs has caused a constraint in the ability to expand specialty dockets** (for further discussion, see *Treatment Team Standard*).



There has been a new level of cooperation and openness under the current administration. The program also is consistently supported by the Governor's Office of Opioid Response whose director participates in the Steering Committee and whose plans include treatment court expansion.

The strategy of using multidisciplinary subcommittees of the Steering Committee to perform tasks such as revising the policy manual has great merit, limited only by the time people have to volunteer. Another is to continue using MPS as a bridging agency, serving both the Judicial Branch and OBH. Since OBH cannot fund another state agency (AOC), it could support a Special Projects Manager at Maine Pretrial Services to work with the Judicial Branch on activities requiring extra staffing. An annual agenda would be set by the Judicial Branch, OBH, and MPS in conjunction with the chair of the Steering Committee to guide initiatives inclusive of implementing priority activities in this report.

Veterans Treatment and Co-Occurring Disorders Courts

Moving beyond Adult Drug Treatment Courts, Maine has established specialty dockets for veterans and individuals with co-occurring mental health and substance use disorders. While the efforts to treat veterans separately appear effective, with graduation rates at 60 percent, the highest in the state, this report suggests co-occurring mental health treatment should be integrated into all current court practices using resources already referenced in the treatment providers' contracts.

Veterans Treatment Courts

There has been a Veterans Treatment Court in Kennebec County since 2011 and a Veterans Treatment Track in Cumberland County since late 2018, with the first veteran admitted in January 2019. MPS is expanding its case management capacity in Penobscot, York and Cumberland to accommodate more veterans.

To better serve the population of justice-involved veterans, the Department of Veterans Affairs has developed targeted Veterans Justice Programs including Veterans Justice Outreach (VJO) staff who are present in Maine and actively working on the expansion of veterans treatment dockets. People believe veterans operate under a different culture and mindset, making it important to keep their courts separate: they usually thrive in a structured environment whereas civilians in these courts typically have not done well with structure in their past lives; they frequently have high mental health needs stemming from PTSD and trauma; and for some, the crimes are not substance abuse-related. There is also said to be a better public response and support for expanded Veterans Treatment Courts.

Sometimes veterans keep their status hidden; they are hesitant outwardly to identify themselves as veterans. There is a system, Veteran Re-Entry Search Services (VRSS), which the Veterans Administration uses to determine how many veterans are in jail by scrubbing certain data points. It allows correctional and other justice systems, including courts, to upload data pertaining to their incarcerated, detained, or court docket population. VRSS then interfaces with the VA/DoD Identity Registry (VADIR) to identify veterans within the list.

In the past, presiding treatment court judges visited every jail in Maine to urge their participation in VRSS. Several county jails have signed on and some use VRSS on a regular basis including those associated with treatment courts: Cumberland, Hancock, and Kennebec. Penobscot has an account but does not use it. The system does not cost the jails money and no special software is needed. If there is an interest in enhancing the identification of veterans who could be eligible for Veterans Treatment Tracks, here is a tool to do so and the VJOs stand by to assist.

PCG's analysis of treatment court data shows, contrary to what we heard, veterans are well represented in treatment courts among those who self-identify; they constitute 3.8 percent of the comparison pool but 9.8 percent of the treatment pool. Efforts to identify veterans, to reach out and to engage them seem to be effective. Using the VRSS system in all courts or jails associated with treatment courts could refine the process by identifying people both who self-identify and who do not. Among the courts where expansion is being considered, Penobscot should activate its VRSS account and York should establish one. The Cumberland County Jail appears to be the most active user.

Veterans Treatment Track expansion is constrained by resources. Some prosecutors argue they do not have enough staff to participate in additional specialty courts, including those focused on veterans. Six of the eight prosecutors on treatment teams are said to support additional Veterans Treatment Tracks, while two are said to oppose them without additional prosecutors. Prosecutors are funded through the Attorney General’s office and other agencies such as the OBH cannot help. On the plus side, the service component is already paid by the Veterans Administration and Medicaid, eliminating that element of the cost for expansion.

Veterans Treatment Courts and Tracks have veteran mentors who can be incredibly supportive and resourceful; some are said to view the court system as adversaries; however, this is contrary to the ethos of treatment courts. This attitude is particularly evident when sanctions are being imposed.

During PCG’s second round of interviews, most courts noted they do not receive many referrals for veterans and currently have only a small number of veterans, if any, in court. Veterans typically have their own mentor and receive ample support and wraparound services. Therefore, further expansion of Veterans Treatment Tracks in all courts may not be necessary at this juncture.

Co-Occurring Disorders Courts

The Co-Occurring Disorders Court started in Kennebec County in 2005. Some think the term *co-occurring court* is a misnomer since 63 percent of people with substance use disorders have been found to have a mental health diagnosis²⁴; in essence all courts either are or should be co-occurring. In recent interviews each court agreed a large number of its participants have a dual diagnosis and having a mental health provider on the team and additional mental health treatment capacity would be largely beneficial to participants. In addition, the OBH contracts with each treatment provider define co-occurring:



CO-OCCURRING
DISORDERS
COURTS

When mental health and substance use disorder diagnoses occur together, each is considered primary and is assessed, described and treated concurrently. Co-Occurring Services consist of a range of integrated, appropriately matched interventions that may include Comprehensive Assessment, treatment and relapse prevention strategies that may be combined, when possible, within the context of a single treatment relationship. Please see Appendix A for further treatment contract requirements that **each treatment provider** be capable of delivering co-occurring services.

²⁴ <https://www.nadcp.org/wp-content/uploads/2018/12/Adult-Drug-Court-Best-Practice-Standards-Volume-2-Text-Revision-December-2018.pdf>, p. 18. The types of mental health disorders are: major depression (16-39%); posttraumatic stress disorder (PTSD) (10%); Anxiety disorder other than PTSD (9%); bipolar disorder 8%.

Community and Recovery Support for Treatment Courts

People in the public generally are not aware of treatment courts. (Readers of this report can probably concur.) The consensus among many interviewed is that more can and should be done to mobilize community support; however, people who work for the government or who are funded by it must be circumspect in their activities; they cannot appear to be lobbying or advocating, for example. The purpose of community support is to obtain tangible help such as businesses willing to employ people in the programs, mentoring support, financial support for extras, and referrals, as well as the encouragement of family members.

Within the legal community and particularly the defense bar, counsel is known to recommend their clients *not* participate due to the longer time they will be under scrutiny; if someone has a prior felony conviction the incentive of a reduced charge at the end is not as great. In small towns where everyone is known to each other, treatment court participants are occasionally seen having gone back to their old ways. All these scenarios dampen community support for treatment courts.

One suggestion, coming from many sources, is to strengthen relationships with the recovery community. The recovery community provides mutual aid and has a unique culture; when people leave treatment court, they must have the support of the community to sustain gains.

Some people in the recovery community are motivated by the works of William White, with a brief paper referenced here.²⁵ He identifies *recovery capital* as the breadth and depth of internal and external resources which can be drawn upon to initiate and sustain recovery from severe addiction. He identifies personal, family/social and community capital. **In total, recovery capital constitutes the potential antidote for the problems which have long plagued recovery efforts: insufficient motivation to change AOD use, emotional distress, pressure to use within intimate and social relationships, interpersonal conflict, and other situations which pose risks for relapse.**²⁶ While Maine's ADTC program itself is constructed to address personal and family capital, the community element needs supplementation.

There is training available in Maine for peer mentors and recovery coaches as well as Certified Intentional Peer Support Specialists for those with mental illness. Sources include the Maine Alliance for Addiction Recovery and Healthy Acadia which is building an alumni community. Maine currently funds five recovery centers, such as the Portland Recovery Community Center. A new OBH contract with the Maine Prisoner Re-Entry Network (MPRN) will provide trained peer and recovery coaches in Kennebec.

²⁵ White, W. & Cloud, W. (2008). Recovery capital: A primer for addictions professionals. *Counselor*, 9(5), 22-27.

²⁶ *Ibid.*



COMMUNITY
AND
RECOVERY
SUPPORT

A retired physician in Hancock County who served as chairman of a planning and implementation committee of the Hancock County Adult Drug Treatment Court developed a “Friends of the Court” program in Hancock County which could be emulated elsewhere as one example of how to mobilize community support.

More discussion is needed on how to foster positive perceptions of all specialty courts and how to work with the recovery community both to support those already in

the program and to generate referrals. Maine needs increased community awareness that treatment courts exist as well as additional community support for people to succeed (see also the discussion of Recovery Peer Support under the Complementary Treatment and Social Services standard).

V. Findings from Best Practice Standards

Target Populations

Standards

Eligibility and exclusion criteria for the Drug Court are predicated on empirical evidence indicating which types of offenders can be treated safely and effectively in Treatment Courts. Candidates are evaluated for admission to the Treatment Court using evidence-based assessment tools and procedures.

Eligibility and exclusion criteria are to be defined objectively and shared with all appropriate members of the treatment team involved in making decisions about admitting individuals to Drug Courts. Drug Court teams should not apply subjective criteria or personal opinions to determine eligibility.²⁷

Offenders most in need for interventions should be high risk for criminal recidivism and high need for treatment for addiction to drugs and/or alcohol. There may be significant variability between populations in relation to their risk and need levels. These individuals should not be treated in the same counseling groups or residential facilities if their treatment needs and/or criminality are highly variable.²⁸

Maine employs many steps involving multiple parties leading to the decision of whether to admit a person to treatment court. Eligibility requirements include age; severity of substance abuse; nature of the current charges; residence of defendant and/or place of offense; stage of proceeding; nature of previous convictions; and “qualified adult offense” defined. Definitive criminal exclusions include murder and sexual assault. Crimes not excluded but requiring increased scrutiny include aggravated assault and aggravated trafficking of scheduled drugs.

Strengths

Eligibility for admission requires participants be high risk for criminal recidivism and high need for substance use treatment due to severity of dependency. All the teams reported utilizing the proper risk assessments to admit participants who are high-risk/high need²⁹. While PCG found 25 percent of the cases had only Class D and E charges (relatively low level) PCG assumes other levels of their profile such as criminal history led to the referral. The assessment process includes a full psychosocial assessment conducted by both the case manager and treatment provider, in part to determine level of substance treatment needed according to American Society of Addiction

²⁷ National Association of Drug Court Professionals. (2018). *Adult drug court best practice standards: Volume I text revision*. Alexandria, VA: NADCP.

²⁸ *Ibid.*

²⁹ These are: MPS Pre-arraignment Screening Intake and/or Addendum; AC-OK: The AC-OK Screen for Co-Occurring Disorders screens in three domains: Mental Health, Trauma and Substance Abuse; MHSF-III: The Mental Health Screening Form identifies possible mental health issues; TCUDS-II with Opiate Supplement: Texas Christian University Drug Screen II identifies individuals with a self-reported history of heavy drug use or dependency; LSI-R:SV: Level of Service Inventory Revised: Screening Version identifies possible criminogenic risk and need; If needed: ODARA: Ontario Domestic Assault Risk Assessment identifies domestic violence.

Medicine (ASAM)³⁰ criteria. Many people interviewed had positive perceptions about eligibility determination:



“It is a team discussion.”

“A lot of consensus-building.”



“Judge makes final decisions.”

Best practice is for referrals, which typically come from a defense attorney or probation officer, to be discussed as a team prior to each court session or during scheduled team meetings. All teams were observed discussing referrals during team meetings and generally forming a team consensus on which participants to admit. Sometimes judges poll the team and then make the call.

Variations

According to policy and procedures, referrals may come from a variety of sources including judges, prosecutors, defense attorneys, pretrial service workers, probation and parole officers, police, case managers, potential participants and their family members. Courts do employ different referral processes, some which are more formal, requiring referral to start at the court clerk’s office.

Regarding admission decisions, some treatment teams afford the prosecutor, in addition to the judge, veto power over an admission. According to the ADTC Manual, final recommendations for admission should come from the team as a whole, with the final order coming from the judge.

In two counties MPS used funding for two new positions in Androscoggin and Kennebec to handle all referrals and screenings; this approach has helped to reduce the wait time between admissions and referrals making the process more efficient and timelier. Some teams now have separate meetings to discuss referrals which allows for more engaged conversation. In addition, Penobscot County Treatment Court has a 72-hour screening after referral policy with the goal of coming to an admission or denial agreement within 30 days of referral. These new updates since PCG’s first visit have allowed for screening and service arrangements to be completed in as little as one week in certain situations. Penobscot had already improved its wait time following an implementation training, reducing its referral decision time from months to weeks.

Concerns

PCG’s concerns are twofold: the subjective discussions about who is suitable for admission, as opposed to the recommended use of objective standards, and the amount of time it takes *in some courts* to enroll participants from the time of referral. In addition, all treatment courts noted the COVID-19 pandemic has caused significant delays in their capacity to screen in pending referrals. For example, case managers often cannot visit potential participants in jail. Observations reported by respondents included:

- people can sit in jail waiting for admission;
- teams receive a lot of anecdotal information from probation that can taint objectivity;

³⁰ Six ASAM criteria include: Acute Intoxication and/or Withdrawal Potential; Biomedical Conditions and Complications; Emotional, Behavioral or Cognitive Conditions and Complications; Readiness to Change; Relapse, Continued Use or Continued Problem Potential; and Recovery Environment.

- prosecutors won't recommend people they don't consider "suitable;"
- people who need lots of community supervision won't be referred.

In fact, about half of participants in all treatment courts wait in jail between referral and admission; two courts have 75 percent of its participants waiting in jail; five courts have half of its participants waiting; and one court has only a quarter of its participants waiting in jail (**Table 6**), creating additional need for a speedier process, with a goal of reaching the 30-day best practice and Maine policy standard.

Table 6. Percent of Participants Waiting in Jail for Admission by Court

Treatment Court	Percentage of Participants who Wait in Jail
Androscoggin	75%
Cumberland	50%
Hancock	50%
Kennebec – CODC	50%
Kennebec – Veterans	50%
Penobscot	25%
Washington	75%
York	50%

Figure 2 includes data from the 2015 report to show a trend line in referral time. There has been a decrease over the years in the number of days from referral to treatment court admission, which is positive. However, the average number is still twice the recommended practice standard of 30 days.

Figure 2. Time from Referral to Admission in Days by Year, 2013–2018

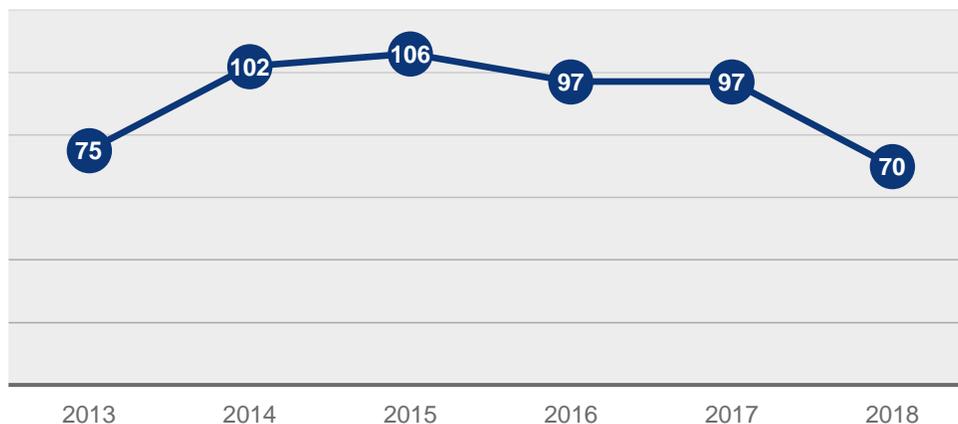
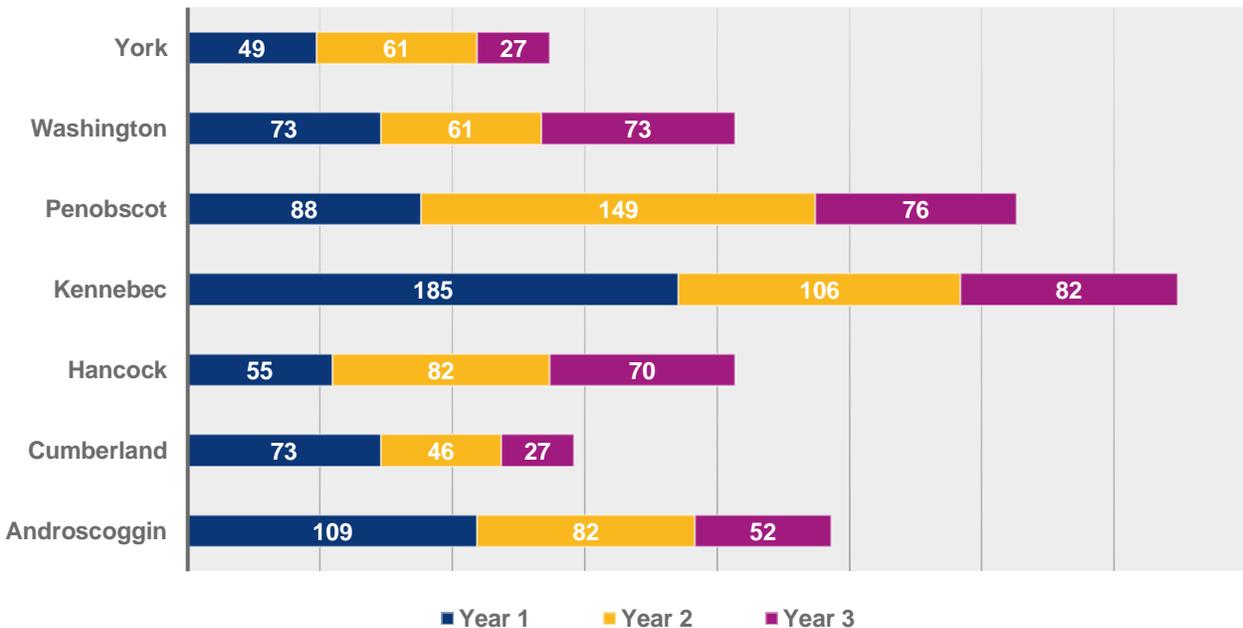


Figure 3 illustrates the days to admission for each of three years by court, showing the changes over time. While Kennebec is the longest because it draws people from all over the state (some of whom need to relocate) there has been improvement there. The yellow segment of each line shows fewer days than the previous year in most cases as does the red, which is more recent. The three years in the graph are federal fiscal years 2016, 2017 and 2018.

Figure 3. Days from Referral to Admission by Court, 2016–2018



In some courts, participants on the waitlist are not screened at the time of referral; instead, they are screened closer to when a spot becomes available. This causes potential participants to sit in jail waiting for a screening, some reportedly for months.

Many explanations are provided for these lengthy wait times and remediation would most effectively be addressed on a court-by-court basis for those with residual concerns: out of county referrals where people have to relocate; capacity of case managers and/or treatment providers to perform timely assessments; amount of time it takes for prosecutors to negotiate good-outcome, bad-outcome agreements with defense attorneys, with pressures mounting as the trial date approaches.

Teams should not be waiting until they have an opening to take a referral. Screenings for risk and need should take place as quickly as is possible from the time they are received, and the admission decision made once the screenings are completed. Level of care (LOC) determinations do not have to be made before admission decisions since the high-risk, high-need assessment, using validated tools, determined a high substance use need. Some of the treatment providers fear they cannot bill for group work if the participant does not have the appropriate level of care.

This barrier could be averted by having the OBH waive the level of care requirement for the first four weeks of treatment court admission.

Several teams utilize “suitability discussions” when deciding which participants to admit to treatment court, for instance based on collateral contacts or personal knowledge instead of on objective assessment criteria. During PCG’s second round of observations, 11 pending referral discussions were observed. Of those, suitability discussions occurred in 36 percent. The nature of these discussions ranged from a participant’s likelihood to relapse, drug-seeking behaviors, history of absconding, probation violations, a prosecutor’s unwillingness to admit, and whether an individual was involved in trafficking. Suitability discussions are contrary both to the policy manual which focuses on objective risk/need criteria as well as practice standards. Research has shown suitability determinations are “not very successful at predicting who will succeed in their program[s].”³¹

Interviewees reported there are people currently in jail who could benefit from this program but who do not know about it or how to apply. Defense attorneys are typically the referral sources for their clients and advocate for the best outcome. Specifically, they should represent interests of their own client, make referrals, expedite admission, and function as a liaison to the criminal defense bar.³²

Maine’s post-plea model also contributes to the long wait times. Treatment courts generally operate on two models for the legal status of participants: 1) pre-plea or deferred prosecution and 2) post-plea or post-adjudication. In a pre-plea treatment court, participants are screened upon arrest by either a pre-trial officer or case manager and diverted into the treatment court system prior to pleading to a drug-related offense. Participants are not required to plead guilty as a condition of participation. Once treatment court has been completed, participants are not prosecuted further, with charges typically dismissed. Failure to complete the program results in prosecution of the original case. This model requires buy-in from the local prosecuting attorney. According to the National Drug Court Institute (NDCI) *Drug Court Judicial Benchbook*, “One perceived advantage of a diversionary drug court is faster case processing because preliminary hearings and discovery are typically not necessary. Perceived weaknesses include the case possibly going ‘cold’ if the participant fails drug court several months after admission.”³³

In the post-plea model like Maine’s, participants must plead guilty to their drug-related offense. Their sentences are suspended while they participate in treatment court. Successful completion results in a reduced sentence. Failure to complete results in sentencing on the agreed upon guilty plea. “As in other post-plea models, the case will not get old, but the additional time that is needed for court preparation and entries of judgment often delay treatment entry. Prosecutors may more readily recommend serious offenders for this model because a final judgment of guilt has been entered.”³⁴

³¹ Rossman, S.B., & Zweig, J.M. (2012). The multisite adult drug court evaluation. National Association of Drug Court Professionals.

³² State of Maine Judicial Branch. (2013). *Maine Adult Drug Treatment Court: Policy and Procedure Manual*. Portland, ME.

³³ Marlowe, D. B., & Meyer, W. G. (Eds.). (2011, updated 2017). *The drug court judicial benchbook*. Alexandria, VA: National Drug Court Institute. Available at <https://www.ndci.org/wp-content/uploads/2016/05/Judicial-Benchbook-2017-Update.pdf>

³⁴ *Ibid.*

Treatment courts may operate both models. It has been suggested that in Maine, treatment court be offered as an option at arraignment for high-risk, high-need candidates, obviating the need for an extensive assessment and negotiation process as well as wait time in jail. While it is difficult to alter the model Maine may consider experimenting with the pre-plea model in an expansion program in the two unserved judicial districts.

Equity and Inclusion

Standards

Individuals who have historically experienced sustained discrimination or reduced social opportunities because of their race, ethnicity, gender, sexual orientation, sexual identity, physical or mental disability, religion, or socioeconomic status receive the same opportunities as other individuals to participate and succeed in the Drug Court.

The concept of equity and inclusion in Drug Courts focuses on establishing policies and practices to ensure participants have equivalent access, retention, treatment, incentives and sanctions, dispositions, and team training.

For the purposes of this section, PCG focuses on access, as the other items will be addressed in other sections.

Strengths

Most courts have accepted individuals with mental health diagnoses, or participants with other specific needs, such as English as a second language, or disabilities. Courts stated they do not have any automatic disqualifiers to enter the court and focus on issues such as level of risk and level of need first and foremost.



“If they are receiving adequate treatment they may still be included. For the most part we'll take anyone who is willing to participate.”



“Whomever applies gets treated the exact same way.”

“Treatment and case management in collaboration with probation work diligently to identify barriers for any client regardless of positionality to seek out treatment support.”

Treatment Team

An analysis of gender equity shows both men and women are represented in the specialty courts equal to their presence in the justice population with drug offenses.

Variations

While courts do not exclude veterans based on their service history, some courts provide them special treatment through designated Veterans Treatment Tracks. Kennebec County has had an established Veterans Treatment Court (since 2011) and Cumberland County has had an established Veterans Treatment Track (since 2018). In each of these counties, relationships with VJOs, treatment providers who work for the VA, are well integrated into the court. VJOs also work across the state in jails to promote the treatment court and to gather referrals.

Concerns

PCG’s major concern is racial equity in the specialty court program. People of color appear to be under-represented in Maine’s treatment courts at a low level of statistical significance ($p < 0.10$). That is, the disparity between the racial characteristics of the pool of people of color in MIS (7.8%) and those who have been admitted to specialty courts (5.1%) shows under-representation of non-whites. Twenty percent of the cases do not have race recorded and have been removed from the comparison.

The phenomenon of disproportionality is addressed in the NADCP practice standards which state: “Evidence suggests African-American and Hispanic or Latino individuals may be underrepresented by approximately three to seven percent in Treatment Courts.”³⁵ That is, Maine is not alone in confronting disparities.

A census of treatment court participants as of November 2020, **Table 7** shows these disparities continue. Black individuals represent under one percent of the Treatment Court population.

Table 7. Treatment Court Cases by Race

Active Cases 11/23/20								
	Androscoggin	Cumberland	Hancock	Kennebec	Penobscot	Washington	York	Total
Cases	22	24	15	15 CODC 6 VTC	27	9	20	138
White	21	23	13	15 CODC 5 VTC	26	8	20	131
Black	1	—	—	—	—	—	—	1
Native American	—	1	2	1 VTC	1	1	—	6

When assessing all treatment court participants between 2015 through 2020 PCG found these racial disparities have persisted over time. However, there are no significant differences in graduation rates for racial minorities who are accepted into Treatment Courts (**Table 8**).

Table 8. Admittance and Graduation by Race

Race/Ethnicity	Percentage of Total Treatment Court Participants	Percentage of Successful Graduations
White/Caucasian	86.4%	59.6%
Black/African American	5.6%	54.4%
Hispanic/Latino	1.2%	63.7%
Asian	0.4%	65.7%
Native American	0.6%	40.7%
Alaska Native/Native Hawaiian or Other Pacific Islander	0.1%	72.7%
Other Race	0.6%	67.2%

³⁵ National Association of Drug Court Professionals. (2018). *Adult drug court best practice standards: Volume I text revision*, page 13. Alexandria, VA: NADCP.

Members of the treatment court report they have not observed any instances of discrimination. Rather, they note they do not receive many referrals for people of color, suggesting the need for raising this issue with the defense bar, jail and probation officers and others who may generate referrals.

Roles and Responsibilities

Standards

The Drug Court judge stays abreast of current law and research on best practices in Drug Courts, participates regularly in team meetings, interacts frequently and respectfully with participants, and gives due consideration to the input of other team members.

The manner in which drug court team members, including the judge, interact with participants, as well as with each other, can influence court outcomes for participants. Participants appear before the same judge throughout their enrollment. The judge regularly attends pre-court staff meetings and presides over the status hearings no less frequently than every two weeks.

Strengths

According to the observation analysis, which reflects two sessions for each court, judges spend the proper amount of time with each participant, averaging a total of 5.5 minutes for each participant per court session (**Table 9**). This reflects time spent only while the judge is on the bench, not the time discussing participants in staffing. Best practice indicates outcomes are significantly better when the judges spends an average of three to seven minutes interacting with each participant during court with three minutes representing the minimum standard.³⁶

Table 9: Average Time Spent with Participants by Court, Two Observations

Treatment Court Observation Results								
	Androscoggin	Cumberland	Hancock	Kennebec	Penobscot	Washington	York	Total
Cases	33	31	30	35	37	19	46	231
Average Time per Person (minutes)	5.7	6.3	4.9	7.7	5.2	3.3	4.5	5.5

Additionally, in cases PCG observed the judges had a friendly and professional demeanor in their interactions with participants. In 73 percent of cases verbal praise from the judge was offered, and in 87 percent of hearings PCG observed, at least one incentive was given (see Rewards and Sanctions). Most focus group participants (*i.e.*, current treatment court participants) also acknowledged having a positive relationship with their judge.



³⁶ National Association of Drug Court Professionals. (2018). *Adult drug court best practice standards: Volume I text revision*. Alexandria, VA: NADCP.



“[The Judge] gets to know you, is stern but understanding, and reinforces how proud he is. He sees your progress and is respectful.”

Treatment Court Participant

Team meetings are held regularly in all courts; even during the pandemic, courts were able to conduct virtual team meetings as well as virtual court hearings with participants.

Additionally, of the team meetings PCG observed, the judges were present in all staffing sessions. Only one of the courts reported any issues about key team members missing staffings, and most team members also reported good and open communication about all staffing-related issues. Before entering the court, participants are made aware of what is expected of them, including their rights as participants.



“The judge is the best.”

“Judge is sincere about helping you.”

Treatment Court Participants

Variations

The courts have differing reporting requirements for hearings by court and by phase. **Table 10** outlines how frequently each court meets as well as the reporting requirements designated for each phase. The Maine Drug Court Participant Handbook (Participant Handbook) allows for variation but states: Phase 1 Weekly or as directed; Phase 2 Weekly or as directed; Phase 3 Bi-weekly or as directed; Phase 4 Monthly or as directed; Phase 5 Monthly or as directed. The Drug Court Manual (which may be out of date on this matter) states participants in Phase 3 or above may appear in court less frequently, if in compliance.

Table 10. Frequency of ADTC Sessions by Phase

	Androscoggin	Cumberland	Hancock	Kennebec	Penobscot	Washington	York
Court Frequency	Bi-weekly	Weekly	Bi-weekly	Bi-weekly	Bi-weekly	Weekly	Weekly
Phase 1	Bi-weekly	Weekly	Bi-weekly	Bi-weekly	Bi-weekly	Weekly	Weekly
Phase 2	Bi-weekly	Bi-weekly	Bi-weekly	Bi-weekly	Bi-weekly	Weekly	Weekly
Phase 3	Monthly	Bi-weekly	Bi-weekly	Bi-weekly	Monthly	Weekly	Bi-weekly
Phase 4	Monthly	Bi-weekly	Bi-weekly	Bi-weekly	Monthly	3 sessions per Month	Monthly
Phase 5	Monthly	Monthly	Bi-weekly	Bi-weekly	Monthly	3 sessions per Month	Monthly

Concerns

In at least one court participants are told to arrive for hearings at the same time the treatment team is meeting, consistently causing a 60 to 90-minute delay before court proceedings begin. This practice sends a negative message about respect for participants' time and in some cases causes an additional impediment to their working.



Some judges have expressed concern over turnover in case management staff. MPS now tries to obtain a two-year commitment from new case managers. PCG conducted a cursory review of Maine pay scales for seemingly comparable positions to determine if the case manager's pay is a factor in filling and maintaining these positions since this was reported by at least one person.

MPS has consistently raised its payment rates over the past several years, from \$15.34 an hour to \$18.00 now. New staff can receive an additional \$2,000 per year for a master's degree and an additional \$2,000 per year for a special certification such as MHRT-C, LADC or CADC on top of their master's degree. Salaries are increased by one dollar per hour per year for the next two years and then by three percent a year in addition to a comprehensive benefit package.

MPS consults the Maine Association of Nonprofits Job Board for guidance. In addition to other non-profits, MPS has to compete with the State for people performing similar functions. **Table 11** provides a comparison of case manager or comparable positions in both non-profit and State settings. It appears the pay at MPS, *when the extras are added*, is comparable to local market rate.

Table 11. Case Management Salary Comparisons

Organization	Job Title	Starting Rate	Annual Wage ³⁷
Maine Pretrial Services	Case Manager	\$18.00 +	\$37,440 – \$41,400
Tetford Housing	Homeless Prevention & Outreach Case Manager	\$17.00	\$35,360
Senior Plus	Care Coordinator	\$18.27 – \$19.71	\$38,000 – \$41,000
Mobius, Inc.	Case Manager	\$18.70	\$38,900
State of Maine, Dept of Corrections	Probation Officer	\$20.21 (average, not starting)	\$42,033
State of Maine, Dept of Corrections	Correctional Care and Treatment Worker	\$18.93 – \$24.00	\$39,374 – \$49,920
State of Maine, Department of Health and Human Services	Social Worker/CPS	\$ 25.32	\$52,666

³⁷ Each wage assumes 40 hours a week, 52 weeks a year.

Incentives, Sanctions and Therapeutic Adjustments

Standards

Consequences for participants' behavior are predictable, fair, consistent, and administered in accordance with evidence-based principles of effective behavior modification.

Policies and procedures concerning the administration of incentives, sanctions and therapeutic adjustments are specified in writing and communicated in advance to Drug Court participants and team members. Participants are given an opportunity to explain their perspectives concerning factual controversies and the imposition of incentives, sanctions and therapeutic adjustments. Participants receive consequences equivalent to those received by others.

Sanctions are delivered without anger or ridicule. The Drug Court places as much emphasis on incentivizing productive behavior as it does on reducing crime and substance use. Participants are not terminated for continued substance use if they are otherwise compliant with their treatment and supervision conditions unless they are not amenable to treatments which are reasonably available in the community.

Strengths

All courts utilize an incentives and sanctions matrix (“the matrix”) to guide them in selecting graduated incentives and sanctions (Appendix B). The matrix is designed to help judges issue sanctions and incentives more equitably across participants and courts based on objective criteria. Best practice standards state “participants receive consequences which are equivalent to those received by other participants in the same phase of the program who are engaged in comparable conduct.”³⁸

Most team members agree jail should be used as a sanction sparingly and only for serious matters. Jail is reportedly used less frequently now than in the past.



“The judge is very slow to issue a jail sanction.”



“Jail sanctions are determined by the [incentives and sanctions] matrix. Typically, jail is determined by repeated service violations or a serious violation”

Treatment Team

Table 12 displays the incentives given to participants during the court sessions observed. Verbal praise and applause were by far the most prevalent. Applause was observed less frequently during remote court sessions, no doubt because there is no audience to offer it. In most instances, therapeutic responses were discussed separately from sanctions.

³⁸ National Association of Drug Court Professionals. (2018). *Adult drug court best practice standards: Volume I text revision*. Alexandria, VA: NADCP.

Table 12. Change in Observed Incentives, Spring to Fall, 2020

Reward Type	Spring Total (N=252)	Fall Total (N=193)	Overall Total (N=444)	Percentage Point Change from Spring to Fall
Verbal Praise	73%	82%	77%	↑ 9
Applause	65%	41%	53%	↓ 24
Other	26%	18%	25%	↓ 8
Phase Advancement	10%	12%	11%	↑ 2
Liberty Pass	8%	11%	10%	↑ 3
Tangible Rewards	5%	7%	6%	↑ 2
Handshake	5%	0%	3%	↓ 5
Jurisdiction Pass	4%	7%	5%	↓ 3
Taken Off House Arrest	2%	0%	1%	↓ 2
Reduced Supervision	1%	3%	2%	↑ 2
Curfew Extension	1%	0%	0%	↓ 1

Table 13 displays the sanctions given to participants during the court sessions observed. Treatment team members did a good job of considering and using therapeutic responses for treatment-related issues and sanctions for behavioral-related issues. In fact, the ability of courts to impose punitive sanctions has decreased due to COVID-19 outbreaks in jails and lack of community service opportunities; the pandemic has allowed teams to devise more inventive sanctions and question the use of punitive sanctions as the most effective approach. Greater supervision and additional treatment (not a sanction, but a response nonetheless) have been used instead, which they have found to be more therapeutic.

Table 13. Change in Observed Sanctions, Spring to Fall, 2020

Sanction Type	Spring Total (N=49)	Fall Total (N=47)	Overall Total (N=52)	Percentage Point Change from Spring to Fall
Other	10%	8%	12%	↓ 2
Essay	5%	3%	4%	↓ 2
Detention – Jail	4%	6%	5%	↑ 2
House Arrest	4%	3%	3%	↓ 1
Verbal Reprimand	4%	6%	5%	↑ 2
Community Service	2%	7%	5%	↑ 5
Increased Supervision	2%	3%	3%	↑ 1

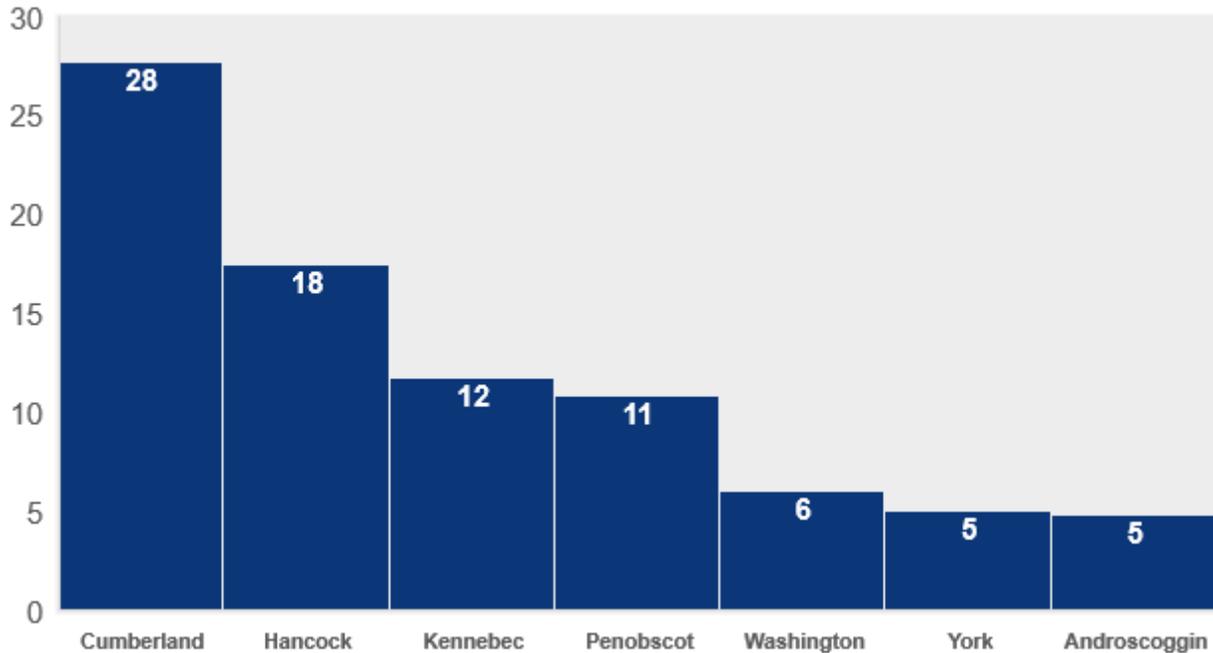
Sanction Type	Spring Total (N=49)	Fall Total (N=47)	Overall Total (N=52)	Percentage Point Change from Spring to Fall
Electronic Monitoring	1%	0%	0%	↓ 1
No Contact Order	1%	0%	0%	↓ 1
Apology Letter	1%	1%	1%	No Change
Written Assignment	1%	0%	0%	↓ 1
Phase Demotion/Freeze	1%	3%	2%	↑ 2
Speech	0%	0%	0%	No Change
Curfew Restriction	0%	1%	0%	↑ 1
Increased Reporting	0%	3%	1%	↑ 3
Increased Treatment	4%	5%	3%	↑ 1

Table 14 summarizes the negative and positive behaviors observed during both the winter and fall court observations combined and compares that to the number of sanctions and incentives given. While positive to negative behaviors were observed at a 5:1 ratio, incentives were given at a ratio of 4:1. Newest research shows incentives should be given at a ratio of 4:1, putting Maine courts within the best practice standard parameters.

Table 14. Ratio of Incentives to Sanctions

	Negative Behavior	Sanctions	Positive Behavior	Incentives
Total	59	52	234	444
Percentage of Participants	31%	25%	88%	90%
Ratio of Positive to Negative Behaviors			5:1	
Ratio of Incentives to Sanctions			4:1	

Figure 4 shows the ratio at which incentives to sanctions are given by court, across the state.

Figure 4. Statewide Ratio of Incentives to Sanctions

Variations

Jail can be given as a sanction but can also result from behavior apart from the treatment court. While this was not observed in most courts, PCG did want to note the practice of arresting participants on probation violations. **While probation officers do have this authority, some arrest for minor offenses (such as a missed drug screen), a practice which treatment team members find to be contrary to the participant’s best interest. Such a scenario can cause conflict among team members.** The NADCP states jail should not be used “unless a participant poses an immediate risk to public safety.”³⁹



“Some person will do something, and they will get in trouble for it and another person will do the same thing and nothing will happen to them.”

Treatment Court Participant

The Participant Handbook states that if a sanction **of more than five days incarceration** or expulsion is being considered, further discussion of the matter will be continued until the next court session and the participant’s counsel will be notified. Further, the judge can incarcerate pending the outcome of the sanction hearing which could be two to four

weeks. Some attorneys expressed concern that the policy violates the participants’ due process rights. Some courts defer all jail sanctions until a hearing with both defense and prosecuting attorneys can be present. The committee modifying Maine’s policy and procedures manual is now debating when hearings should be required in cases involving a jail sanction.

³⁹ National Association of Drug Court Professionals. (2018). *Adult drug court best practice standards: Volume I text revision*. Alexandria, VA: NADCP.

Concerns

While the ratio of positive to negative behaviors recognized in court and the ratio of incentives to sanctions given reach the accepted standard of 4:1, the quality of the rewards is generally cursory and tend not to be progressive in nature.

Participants would appreciate more tangible rewards like going to the front of the line for a drug test, a gift card to help with gas, or money to reinstate their driver's license, as examples. **Many also want rewards or incentives which reduce the burden of treatment court and represent a freedom or easing of restrictions, such as fewer court appearances or a reduced curfew.** Examples are liberty passes, jurisdiction passes, being taken off house arrest, reduced supervision and curfew extension. The Incentive and Sanctions matrix includes some of these, such as reduced curfew, but more could be added such as advancing in the drug testing line position. Fortunately, incentives which reduce the burden of treatment court do not cost money but understandably may require the participant being in a more advanced phase.

Another form of incentive requested is more peer mentors or a peer mentor program. One of the incentives in the matrix is appointing the participant him or herself as a mentor. Some have suggested treatment court graduates who are at least 12 months into their recovery be considered as mentors.

Incentives and sanctions are presented in the Participant Handbook, assuring Maine is complying with the National Drug Court Evaluation recommendations and participants understand the court's leverage, *i.e.*, its authority to impose undesirable consequences when participants violate their contracts. There are more bullet point examples of violations and sanctions than there are of accomplishments and incentives in the Handbook. It would be beneficial to reverse the ratio when the Handbook is updated consistent with the revised Policy and Procedures Manual.

Unfortunately, many participants do not believe sanctions are given equitably as illustrated in these quotes.



“There are several double standards and people lie all the time.”



“Sanctions are not consistent among each person.”

“Punishment is not based on prior acts but your worthiness in the present moment.”

However, what may appear as inequities is addressed in the Participant Handbook: ***Sanctions are imposed on an individual basis. Other participants in similar circumstances may receive different sanctions for conduct which may appear to be the same violation. This is usual and appropriate. You are viewed as an individual and your individual progress, attendance, and history are taken into account before any sanction is imposed.***

Some treatment court team members expressed concerns related to due process; decisions related to sanctions, therapeutic adjustments, and terminations may be decided in staffing without the participant or the participant's attorney present. Ultimately the judge makes the decision, usually after considering the input of the team. (Defense attorneys on the treatment teams are not typically the participants' own attorneys.) The NADCP states “participants are given an

opportunity to explain their perspectives concerning factual controversies and the imposition of incentives, sanctions, and therapeutic adjustments.”⁴⁰

⁴⁰ *Ibid.*

Substance Use Disorder Treatment

Standards

Participants receive substance use disorder treatment based on a standardized assessment of their treatment needs. Substance use disorder treatment is not provided to reward desired behaviors, punish infractions, or serve other non-clinically indicated goals. Treatment providers are trained and supervised to deliver a continuum of evidence-based interventions that are documented in treatment manuals.

The NADCP standard provides guidance related to treatment for Drug Court participants including ensuring participants have access to a full continuum of care for substance use disorder treatment, treatment representation, treatment duration and modalities, and the use of peer support groups. These standards are based on research to ensure maximum success among participants.

Strengths

Treatment providers use evidence-based assessments and treatment modules in each court across the state. Assessments are performed before a participant is admitted to court to determine a diagnosis as well as level of need. The courts utilize a standardized treatment curriculum which includes an Intensive Outpatient Program (IOP) that meets as a group three days a week for three hours a day. Once participants graduate from IOP they receive Moral Recognition Therapy (MRT), often in conjunction with individual counseling.

Introduction of Medication Assisted Treatment (MAT) has made a large difference in the ability of many to succeed. All courts now utilize MAT and all participants have access to it as needed. MAT also is now approved in all jails as statewide policy. However, some county jail doctors do not have the licensing authority to provide MAT treatment to inmates, so their community MAT provider has to agree to continue providing treatment while the participant is incarcerated.

Each Court has a clinically trained treatment provider representative on its team who is solely responsible for providing treatment to treatment court participants. They attend all team meetings and status hearings.



“I believe we’ve had fewer terminations since allowing MAT.”

Treatment team

The Participant Handbook contains extensive lists of Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) meeting places and times.

Variations

Most courts have some form of requirement related to “pro-social, pro-recovery activities.” Specifics vary across courts. Some have developed a list of qualifying activities to meet their obligation which participants report as very helpful.

Some providers offer supplemental treatment, as needed. An effective one for those with both a substance use disorder *and a trauma* history is Seeking Safety⁴¹, currently available on a limited basis in Maine to men and women separately in group settings. Seeking Safety should be added to the list of evidence-based practices referenced in the OBH contracts with treatment providers to remind them of its efficacy with participants who have experienced trauma.

Concerns

Several treatment team members expressed concern about the current capacity to provide mental health services. Some substance use treatment providers report feeling very stretched in how frequently they can meet with individuals as well as with the types of services they can provide based on capacity as well as limitations of the contract. Additionally, some providers say they do not have enough capacity to hold MRT twice weekly as recommended or to meet with participants in one-on-one counseling every week, as recommended.

Mental health treatment often needs to be contracted to a separate service provider, mostly due to capacity issues among treatment providers. Treatment provider contracts include the provision of mental health services as indicated in the Individual Treatment Plan but can be referred elsewhere if needed. OBH indicates it can usually cover the service if billed.

There are no residential living facilities in the state of Maine for veterans with co-occurring disorders and those individuals must be referred to facilities outside of the state (Massachusetts and Pennsylvania, typically) if indicated in the ASAM assessment. This impacts those individuals' capacity to participate in treatment court after already having been admitted.

Lastly, treatment is typically held during the day on weekdays. Participants in the first two phases of the program generally cannot hold jobs due to their high needs and the intensity of treatment but others have expressed desire for a diversified treatment schedule to accommodate their ability to work.

⁴¹ https://www.researchgate.net/publication/289244847_Effectiveness_of_Seeking_Safety_for_Co-Occurring_Posttraumatic_Stress_Disorder_and_Substance_Use

Drug and Alcohol Testing

Standards

Drug and alcohol testing provide an accurate, timely, and comprehensive assessment of unauthorized substance use throughout participants' enrollment in the Drug Court.

The ADTC requires alcohol and other drug testing as part of its comprehensive program of treatment and rehabilitation. The purpose is to provide the ADTC with a safe and reliable process for the collection, documentation, and transfer of urine and other samples for the purposes of analysis in determining whether participants are abstaining from alcohol and drugs.

Results will be used only to determine if the defendant is progressing satisfactorily, if he or she is a risk to public safety, if the treatment plan needs modifying due to the evidence of relapse, or as an aid in determining if the individual should be sanctioned, terminated, or graduated from the program. Under no circumstances shall results be used as evidence of a new crime, a violation of probation or in any other manner not consistent with the goals of the ADTC.

Strengths

All courts consistently, randomly test participants at various times, generally and through the “color” system. The minimum required drug tests according to policy and procedure is twice per week. Treatment team members and focus groups participants all agreed the minimum threshold is being met.

In certain instances, drug testing occurs more frequently. If participants test positive, they will typically receive additional drug tests. Additionally, in instances when a probation officer or case managers does house or curfew checks they have the authority to conduct drug tests. Focus group participants noted all drug tests are random and observed, which is aligned with best practices and policy and procedure.

Variations

Due to COVID-19, treatment courts have had to adapt their drug and alcohol testing procedures. MPS introduced sweat patches as an alternative form of testing. Sweat patches are applied to the skin and worn for a week for 24/7 drug use detection against the most commonly used drugs (marijuana, opiates, cocaine, amphetamines, and PCP). Additionally, the court has begun using saliva tests over video. Saliva tests screen for approximately ten commonly used drugs, and participants test a minimum of three times per week due to cutoff levels. Case managers can observe the administration of the test and any resulting change in the test strip color.

Concerns

Participants stated drug testing can impede their ability to work full time. Some courts may do testing in the evening to avoid work conflicts. However, participants usually have to call in for their “color-call” before 7:00 AM and arrive for testing shortly after. For participants who do not have a mode of transportation, this can also be cumbersome. One participant stated they would have to walk over two miles, each way, rain, sleet, snow or sunshine to complete drug testing requirements. However, drug testing is a necessary requirement.

Complementary Treatment and Social Services

Standards

Participants receive complementary treatment and social services for conditions that co-occur with substance use disorder and are likely to interfere with their compliance in Drug Court, increase criminal recidivism, or diminish treatment gains.

Drug Court participants generally have a range of service needs extending well beyond substance use disorder treatment. This standard addresses an array of needs encountered frequently in Drug Courts, including best practices for delivering mental health treatment, trauma-informed services, criminal thinking interventions, family counseling, vocational or educational counseling, and prevention education to reduce health-risk behaviors.

Strengths

There was consensus in every court that case managers do a good to excellent job in identifying needs and making referrals to complementary treatment and social services. Here are sample comments from various team members.

“

“Case managers and treatment do the best they can in terms of making referrals. Good relationships [exist] between treatment court and shelters and the Next Step program, just a shortage of housing in the community.”

”

“Case management does a really good job at making referrals. Where they need assistance, law enforcement and probation both have connections. Can generally access things we need to access.”

“That's mostly what I do as a case manager; [I am] responsible for getting all released signed for all referrals and ensure safe and secure housing before being admitted into the program.”

“We encourage and connect participants with educational programs. Case management and probation have good relationships with sober housing. Struggle to figure out buses or manage their time.”

Maine treatment courts now have access to a new resource from the Eastern Maine Development Corporation (www.EMDC.org), with headquarters in Bangor, called *Maine's Connecting with Opportunities Initiative*. The EMDC worked in concert with the Maine Department of Labor with strong support from the Governor's Office of Opioid Response to obtain a \$6.2 million multi-year federal Department of Labor grant to support **education, training, employment and peer support** to remediate problems associated with opioid-use disorders. Implementation is regional: The Northeastern Workforce Development Board (www.northeasternwdb.org) is overseeing the project in its region of Aroostook, Hancock, Penobscot, Piscataquis and Washington counties with service provision by EMDC and the Aroostook County Action Program (ACAP); Central Western Maine Workforce Development Board (<http://cwmwdb.org>) is overseeing the initiative in its region

of Androscoggin, Franklin, Kennebec, Oxford and Somerset counties, partnering with the Western Maine Community Action (<https://wmca.org>) for workforce services; Coastal Counties Workforce Inc. (www.coastalcounties.org) serves coastal communities from Waldo to York (including Cumberland, Knox, Lincoln and Sagadahoc) partnering with Workforce Solutions. This detail is being provided to encourage use of this excellent resource. As one case manager commented, participants are walking around with big smiles now because EMDC has allowed for them to be fitted with dentures (a deficit noted in PCG’s Interim report).

Variations

Some counties mentioned “treatment” as being the major supporters of the case managers while others mentioned “probation” in relation to service referrals. Other variations are based on resource availability as well as efforts to experiment in various locations.

Concerns

Concerns relate not to staff effort but to treatment capacity and the availability of specific resources such as housing; while formerly a concern, dental health can now be accessed through *Connecting with Opportunities* discussed above. PCG focuses here on the four neediest areas: **mental health, transportation, housing, and recovery peer support.**

“Blue Willow, Wellspring, Catholic Charities and AMHC – all have licenses for mental health. Mental health and SUD fall under the same umbrella and by separating them we sometimes stigmatize addiction.”

Manager

Mental health: Maine does not require mental health treatment to be represented on the treatment team nor mental health services to be part of the standard service array even though two-thirds of participants typically have some form of mental health diagnosis. The NADCP standards are for participants to be assessed “using a valid instrument” for mental health disorders and that “participants suffering from mental

illness receive mental health services beginning in the first phase...” The standard continues to say that mental illness and addiction should be treated concurrently using an evidence-based curriculum.

It is reported that some people whose mental illnesses are perceived to be too fundamental are rejected from ADTCs and referred to the Co-Occurring Disorders Court or rejected outright. Yet all four of the current treatment providers are dually licensed for substance abuse and mental health and are required in their contracts to provide various forms of counseling if indicated in the Individual Treatment Plan. In addition, they are required to be “co-occurring capable” and to provide substance use disorder and mental health treatment concurrently (see Appendix A).

Treatment courts can and should expect their providers to be capable of serving people with mental illness. While mental health treatment will not be a standard requirement, in all cases, the providers should be held accountable to their contracts to avail people who are in need of treatment. In addition, the treatment provider representative on the team should either represent both substance abuse and mental health through licensure or mental health should be represented separately.

Transportation: Transportation is presented as a major barrier for most participants, particularly in counties outside of southern Maine. While Medicaid will reimburse travel costs to treatment services it will not reimburse trips to treatment court itself. Now some treatment court participants reportedly take covered transportation to a service down the block and then walk to court. It would be preferable to change MaineCare policies, if feasible, to cover people attending treatment court under their specified plans. PCG understands transportation costs are built into the treatment cost and case management does not pass as treatment, which may pose a barrier to this solution from a federal reimbursement perspective.

Another option is ride-sharing contracts using the new technologies of Lyft Business and Uber Health, which have geared up to serve Medicaid clients in other states. Such contracts would address the broader issue of transportation to treatment, not to treatment court itself. In York County some people are obtaining Uber vouchers through General Assistance to cover transportation costs. However, this is not a systemic solution. The advantage of Lyft and Uber is the availability of the resource and the ability to create broader contracts which are partially federally reimbursed. PCG notes some treatment court participants have mentioned problems with these services, and they are not universally available in all counties.

Lyft Business is providing rides for eligible Medicaid patients in ten states plus the District of Columbia, increasing access to care through enrolled Medicaid providers **through the non-emergency medical transportation (NEMT) services provisions of Medicaid**. Uber Health also operates under the NEMT Medicaid rules, enabling healthcare organizations to arrange rides on behalf of others. It has developed an Uber Health dashboard designed to meet healthcare's HIPAA privacy and security standards.

PCG believes the mechanism would be for the Office of Behavioral Health (OBH) to develop contracts with Lyft Business and Uber Health under the Non-Emergency Transportation Services (Section 113) of its MaineCare policy for its current Medicaid-eligible service providers. **OBH may elect to use state funds or vouchers to pay for rides for those not qualifying for MaineCare or to non-eligible appointments, specifically treatment court appearances.**

Other options which have been suggested include using the New England Regional Judicial Opioid Initiative (formed by charter in 2019 under the convening of the National Center for State Courts) and including the chief justices of the six New England states to apply for van transportation through a federal transportation grant; using church vans with volunteer drivers; using the Veterans Administration to transport veterans with its own vans; have courts acquire and use vans; and reduce the need for transportation by not requiring live presence in some instances, particularly in light of the COVID-19 pandemic.



“If they [participants] have to worry about where they’re sleeping at night how are they going to come up with the money needed to reinstate their license, etc. It makes them more likely to relapse.”



Treatment Court Graduate

Housing: Treatment court participants need highly structured step-down facilities to live where they can acclimatize and be safe. While previous efforts at developing housing such as the Community Housing of Maine in Hancock and a sober housing initiative in Androscoggin have had mixed results, the treatment court program cannot be effective without appropriate housing. Treatment court clients need first priority for new housing projects where the

focus should be on **treating** drug use rather than policing it.

The *Maine Opioid Response Strategic Plan* references the need to “increase community-based recovery supports” (Strategy 20) which includes housing, specifically, to increase funding for safe and affordable housing for individuals in recovery.

Some have suggested a housing coordinator be designated to help the teams support and locate various forms of housing.

Recovery peer supports: This is an issue at two levels: the need to assure recovery peers for treatment court participants and the need to use others in recovery as a community support for the program to encourage participation. People report more work is needed to build peer supports within the recovery community. Some believe a peer should be on each treatment team. Others believe the relationship to the recovery community could be improved. The COVID-19 pandemic has stepped up mobilization of recovery supports, and treatment courts should take advantage of lists of names and contacts being developed.

While there are many benefits to utilizing peer supports, some treatment courts in Maine do not link participants to this valuable support. Treatment team members stated the extent of peer support comes from individuals participating in AA and/or NA. Veterans Treatment Track participants do have access to the Veteran Mentors of Maine. Other peer support services include Celebrate Recovery and the Peer Support Network, who provide mentors to individuals in early stages of recovery, as well as from recovery coaches through Healthy Acadia and the Maine Alliance for Addiction Recovery.

Additionally, each court varies in what they require regarding peer supports. For instance, some courts state a participant must be involved with a peer support a certain number of times per week depending on phase, while others encourage engagement with a peer support, and some have no formal peer networks at all.

The current administration in Augusta is interested in supporting chapters of young people in recovery, sometimes making stipends available to support coalitions. For example, *Young People in Recovery* has a national advisory group with Maine representation. In addition, the *Maine Opioid Response Strategic Plan* references the need to “increase recovery coaching services” (Strategy 19) and to “increase community-based recovery supports” (Strategy 20). The Plan addresses not only peer support for individuals in recovery but also broader needs such as housing and community-based recovery centers.

The NADCP noted in its practice standards that Peer Recovery Support Specialists play a helpful part in drug court teams. For example, peer support specialists can be a lifeline for *potential* participants and encourage engagement in the program. They help put participant setbacks in context and can help to instill hope in wellness and recovery potential, reducing health risk behaviors and aftercare. Finally, peer support specialists can provide recommendations and training to members of the team based on area of expertise.⁴²

PCG supports adding trained peer support or recovery coaches to the treatment teams. This would parallel the presence of a mentor in Veterans Treatment Court and add more of the participant's voice to the treatment team process. Some believe attendance of such a person at team meetings could create an "us vs. them" dynamic as has been articulated by Justice for Vets. However, role-specific training should obviate this concern. Maine is already including treatment court graduates in advisory capacities at the state level.

⁴² Substance Abuse and Mental Health Services Administration. (2020). *Implementing a peer mentor program: strategies for engaging peer recovery support specialists in Adult Drug Treatment Courts*. Washington, D.C.

Multidisciplinary Teams

Standards

A dedicated multidisciplinary team of professionals manages the day-to-day operations of the Drug Court, including reviewing participant progress during pre-court staff meetings and status hearings, contributing observations and recommendations within team members' respective areas of expertise, and delivering or overseeing the delivery of legal, treatment and supervision services.

Multidisciplinary teams include, at a minimum, a presiding judge, prosecutor or district attorney, defense attorney, case manager, treatment provider, and, in some instances, a probation officer. Additional participants may include a veterans' liaison (for veteran courts), a law enforcement or sheriffs' liaison and/or a project evaluator. The presiding judge is the ultimate decision-maker for the ADTC team. He or she provides leadership, engages with each participant on a regular basis, facilitates communication, approves the case plan, resolves conflicts, holds all parties accountable, and uses the authority of the court to guide cases and advocate for service integration.

Strengths

There is a high degree of professionalism and cooperation among team members in most courts. Team members praised each other on the hard work they do to support participants of the program to ensure the most positive outcomes. Team members as well as participants typically feel as though the judge and team members care about them and will do whatever they can to help participants succeed.

Case managers typically do a good job of providing detailed participant summaries to the team in written form prior to court. Case managers will write up, print and share updated case sheets of each participant to discuss during treatment team meetings which also include information about individuals who are referred and pending termination. They are incredibly detailed and serve to help the team make agreed upon decisions about individual participants and allow team meetings to operate more efficiently.

Variations

While the policy manual does not require law enforcement on the team, courts without a law enforcement liaison believe the position would be valuable to complete additional bail checks in the field, among other roles. However, some rural communities do not have law enforcement readily available to serve; others would like to see the team composition represent more peer support than the law enforcement route.

Some participants have probation officers, and some do not, depending on how they entered treatment court. Therefore, some have the oversight of both a case manager and a probation officer. Probation officers are permitted to perform bail checks and visit participants in their home, which provides an additional level of supervision. In courts without a law enforcement officer liaison, case managers often contact local police departments to request bail checks, although they report law enforcement is not always responsive. One suggestion is to have a flexible fund to reimburse current or former/retired law enforcement officers to perform such duties.

Concerns

Concerns are the following: need for better time management at treatment team meetings; need to supplement availability of both prosecuting and defense attorneys on some treatment teams; improved data sharing; need for role-specific training; and concerns over secondary trauma exacerbated by the COVID-19 pandemic.

Time management: Treatment team members expressed the need for more frequent team meetings. It was observed that treatment teams do not always have enough time to review each client in as much detail as necessary, especially when problems arise, and at times, do not have time to discuss pending terminations or referrals at all. However, some team members have trouble meeting as frequently as they do, particularly those who participate as a side activity to their typical functions. PCG observed several long and frankly repetitive discussions during the treatment team meetings. Perhaps some time management principles could be tried, limiting discussion to the salient points each member wants to make and then calling time for a decision.

Prosecution and defense attorney availability: Some team members have scheduling conflicts, particularly defense attorneys and prosecutors, which impede their ability to attend team meetings and court proceedings. This is a greater concern in counties that do not have a defense attorney or prosecutor with the sole responsibility to handle treatment court cases, leading to tension on some teams.

Defense attorneys who serve on treatment teams often are not the attorneys assigned to specific participants. Rather, the participants' defense attorneys typically refer their clients to treatment court and then negotiate the plea with prosecutors. The legal representative may participate in team meetings or court proceedings, particularly if a jail sanction is anticipated. The role of the treatment team defense attorney is to assess criminal charge, legal risk and potential plea negotiations, and serve as a client representative for due process and sanctions, particularly related to jail holds and terminations.

Prosecutors are concerned about the time participation in treatment courts takes. Prosecutors perform this task as an "add-on" to their current duties. Unlike treatment providers or defense counsel, their time is not reimbursed. The District Attorney in Penobscot has reconfigured the staffing in her office to allow one person, part-time, to devote herself exclusively to treatment court. While the change has caused some sacrifice to the other attorneys who need to fill in, by all accounts this approach has been successful. Other courts should explore ways to expand the prosecutorial function in a non-traditional manner by re-aligning staff as Penobscot did or by deputizing retired prosecutors or judges to work on a part-time basis with a fund created for their reimbursement. In this scenario, the deputized prosecutors would function under the prosecutor of record with decisions subject to his or her review. However, the deputy would have frontline responsibility for making referrals and negotiating pleas and his or her only workload would be specialty courts. Justice Mills was able to secure some form of substitution for judges to attend a conference; could the same be done for prosecutors?

Data-sharing: In July of 2019, Maine DHHS implemented a new data software, EIS and retired DTxC, which had previously been used to collect, store and share all treatment court data. However, technical malfunctions with the system have impeded data sharing among team members. Case managers and treatment providers can no longer access one another's case notes and there also has been difficulty in creating quarterly reports, which are a major asset to

both team members and administrators who oversee the programs. This is discussed in more detail in *Monitoring and Evaluation* below.

Core and role-specific training: While there is an acknowledgement that training has improved over the past several years (see Appendix C for trainings and conferences that have occurred), several team members requested *required training for all new team members*. When members join a treatment team from any of the disciplines other than case management, they are not required to engage in training. Yet there are basic online programs available that can orient any team member to the tenets of treatment court. One is *Essential Elements of Adult Drug Courts* produced by the National Drug Court Institute.⁴³ Another source is the Center for Court Innovation. All team members should start with a common understanding.

A second area of training needed is the relationship between substance use and mental health disorders and treatment. While they are distinct conditions, about two-thirds with a substance use disorder have a co-occurring mental health diagnosis. The treatment providers are required to deliver co-occurring services. Training on co-occurring concepts and treatment would be useful for all members of the treatment team.

A third need is a more prescriptive training plan across the state for all roles as well as more role-specific training to avoid “role-bleeding.” In fact, role-specific training was initiated in 2020, starting with the defense attorneys who received CLE credit for training presented by a NADCP Board Member. While cancelled due to COVID-19, additional trainings are planned for probation officers, law enforcement officers, and prosecutors by NDCI staff in both Portland and Bangor and will be rescheduled when feasible. A final field request is for training focused on the treatment and recovery process.

Secondary trauma: Service providers who work with individuals with substance use disorder, who are often trauma survivors, are likely to experience vicarious or secondary trauma. Secondary trauma is defined as “the emotional lingering of exposure that service providers have from working with people as they are hearing their trauma stories and become witnesses to the pain, fear, and terror that trauma survivors have endured.”⁴⁴ The COVID-19 epidemic is now stimulating secondary trauma among staff. COVID-19 has accentuated the stress and burden of concern they have for the participants of treatment court they manage.

Staff report in the recent round of interviews that many participants have relapsed and/or have gone AWOL and there have even been multiple overdoses, likely due to isolation. Team members noted that concern for their clients keeps them up at night. This stress can likely lead to secondary trauma for team members which can lead to deleterious effects on both work performance and emotional health. It can impact an individual’s behavior, interpersonal relationships, values and beliefs, and work performance (See Appendix D, Effects of Secondary Trauma).⁴⁵

⁴³ National Drug Court Institute. (2020). *Essential Elements of Adult Drug Courts*. Available at <https://www.ndci.org/resources/online-course-essential-elements-adult-drug-courts/>.

⁴⁴ Tribal Law and Policy Institute. (2018). *Tribal Healing to Wellness Courts: Case Management*. West Hollywood, CA.

⁴⁵ *Ibid.*

MPS has been meeting twice weekly with all case management staff throughout COVID. Staff have been reminded of the availability of Employee Assistance Programs. A seminar on vicarious trauma is being made available and the case management supervisors are aware of the concerns. It would be useful for both judges and other members of the treatment team to explore the role of the pandemic on their emotional well-being and to explore means for alleviating the associated stress. Acknowledging the subject and opening it for discussion among the whole team should be a useful step where not already taken.

Census and Caseload

Standards

The Drug Court serves as many eligible individuals as practicable while maintaining continuous fidelity to best practice standards.

The ADTC census is predicated on local need, obtainable resources and the program's ability to apply best practices. The topics addressed in the standards are Drug Court census, supervision caseloads and clinician caseloads.

Strengths

During the 2019 calendar year there was a total of 295 active participants in the Adult Drug Treatment Courts, Co-Occurring Disorders Court, Veterans Treatment Court and Veterans Treatment Track, an increase of 11.3 percent over the previous year and the largest number in any calendar year.⁴⁶ Treatment courts are not supposed to impose *arbitrary* restrictions on the number of participants it serves. Instead, the numbers can be constrained by local need, obtainable resources, and the program's ability to apply best practices. In general, this appears to be the case.

MPS case managers have caseloads limited to 25 per case manager. The practice standards suggest that if caseloads *exceed thirty*, operations are monitored more carefully. This does not appear to be needed in Maine, although Cumberland's caseloads at the end of 2019 were reaching the limit. This is no longer the case, particularly with admissions there virtually halted since the COVID-19 pandemic. There are also two case manager supervisors who oversee all of the local case managers.

The ability to accommodate veterans in a separate track is expanding across the state, with case managers being added to courts with this particular focus in Penobscot, York and Cumberland (which already serves veterans separately).

Capacity cannot be expanded without adequate case management and drug testing capacity. MPS requested and received additional staff, some with a July 1, 2020 authorization, to support the existing capacity and to allow for expansion. These included drug test observers and case managers with a focus on expanding the capacity to serve veterans. Some of the positions are vacant or in the process of being filled.

Using authorized positions, **Table 15** reflects a snapshot of current census (November 2020) and capacity assuming a 1:25 census for each case manager. Not addressing other members of the treatment team here, the table illustrates unused case management capacity.

⁴⁶ State of Maine Judicial Branch Report to the Joint Standing Committee on Judiciary, 129th Legislature Second Regular Session, February 14, 2020.

Table 15. Capacity Analysis

		Active Cases							
		Androscoggin	Cumberland	Hancock	Kennebec	Penobscot	Washington	York	Total
Cases	Winter	24	29	14	19 CODC 14 VTC	31	7	28	166
	Fall	22	24	15	15 CODC 6 VTC	27	9	20	138
Case Managers	Winter	2 after 7/1/2020	2	1	3	2	1	2	13
	Fall	2	3	1	3	2	1	2	14
Capacity 1:25	Winter	50	50	25	75	50	25	50	325
	Fall	50	75	25	75	50	25	50	350
Unused Capacity – Winter 2020									159
Unused Capacity – Fall 2020									212

Variations

While some courts have two case managers assigned from MPS, their census does not approach 25 per case manager, with the past exception of Cumberland. This is not because the demand is insufficient but because some team members have the perception or at least have adopted the stance that the guidance of 25:1 applies to the entire county and not to individual case managers. Other reasons are the backlog in referral process and the lack of awareness of the program on the part of some offenders. Some prosecutors also report having insufficient capacity to handle more than 25 participants at a time, even if there were more than one case manager. Some treatment court teams believe they could expand capacity if court could be offered more than once a week and if there were additional case managers.

Concerns



“If we expand capacity, education is needed among law enforcement and defense attorneys so we can fill slots.”



“They aren’t making deals that make it worth it. A straight sentence seems easier.”

“The drug-using community sees Treatment Court as a trap. There is a lack of clarity about the legal options.”

“There is a wide perception among those in the justice system that Treatment Court is excessively difficult to get through. The only real difficult part is the time commitment, particularly in the first phase. People are very supportive.”

“[Treatment Court] encompasses your whole life. You have to be willing.”

PCG observed during the first round of interviews a consensus that demand exceeds capacity *in theory*, if not always in practice, in most of Maine’s courts. Even so, people acknowledge that the referrals do not always represent the actual treatment demand, which is the number of defendants in Maine who could benefit, including veterans. However, during PCG’s second round of interviews only one treatment court stated demand exceeds capacity while two others reported their capacity was equal to demand (**Table 156**). Five reported the ability to handle more participants. None have a waiting list. Census is down from previous months in part due to COVID-19, in part due to graduations and in part due to the factors enumerated below. Several judges expressed concern about their reductions in numbers, magnifying the need to address these issues.

Table 156. Treatment Court Demand Versus Capacity for More Participants

Treatment Court	Demand vs. Capacity	Able to Handle More Participants
Androscoggin	Equal To	No
Cumberland	Less Than	Yes
Hancock	Less Than	Yes
Kennebec – CODC	Equal To	No
Kennebec – Veterans	Less Than	Yes
Penobscot	More Than	No
Washington	Less Than	Yes
York	Less Than	Yes

Team members in Androscoggin noted that they would have to add a docket for the judge to manage additional participants; they have funding to expand, recently hired an additional case manager and anticipate the court doubling in size over the next five years. In Hancock County, team members stated they can handle more cases but are not seeing referrals. Defense attorneys

may avoid suggesting drug court because it is a lot of work as they have to follow participants through the process; nonetheless they would like to see a Public Service Announcement or more marketing to defense attorneys on the benefits of treatment courts.

Some question whether there are legal or political issues which interfere with referrals, with treatment court viewed as a punitive response because of its length and difficulty even though it is intended to be precisely the opposite. In one county a sheriff reportedly did not know ADTCs accepted people where alcohol was the drug of choice.

Factors beyond case management capacity that inhibit the expansion of treatment court census include:

Perceptions of potential participants and defense counsel:

- Awareness of the difficulty of treatment courts and therefore the unwillingness to commit;
 - difficulty means a longer time commitment than many sentences
 - the need to stop using substances
 - rigorous monitoring and drug testing
 - disruption to work schedules, especially during the early phases.
- The fear that the “bad outcome” resulting from failure in treatment court will be worse than a deal which could have been negotiated which did not include treatment court.
- The deterrence of not being able to erase a prior felony conviction even if the person succeeds in treatment court.

Admission process:

- The opt-in vs opt-out model in Maine, requiring time to negotiate plea deals before proceeding.
- Making recommendations and admission decisions based on “suitability discussion” rather than following the three requirements: high risk, high need, and no prohibited conviction such as murder or sexual assault.
- Excluding people who have trafficked drugs even though they fit the criteria.
- Excluding people from other counties if they will not relocate.
- Excluding people whose mental health needs appear as if they cannot be addressed.
- Excluding people whose community supervision needs seem too great.
- Serving fewer people of color than are represented in the group from whom participants are selected.

Treatment team and service capacity:

- Limits set by district attorneys or assistant attorneys general on the number of cases based on the time each case takes.
- Limits on treatment service availability, particularly mental health treatment.

- Limits on housing availability, making treatment initiation unfeasible.

Each of these is rooted in some element of truth. One of the more difficult is the perception that participating in treatment court and failing will take longer than doing time. Several previous participants reported the consequence for attempting and *being terminated* from treatment court being greater than the terms of their sentences without treatment court which included time served. The scenario was observed this winter in treatment team negotiations. These stories get around and make it difficult to recruit people for treatment court.

Some defense counsel hang back before accepting a plea agreement to get a better offer closer to the trial date; it used to be grounds for malpractice to accept the first offer. Prosecutors should value the case like any other, not create a bigger stick for those joining the treatment court. They should give the best offer up front which addresses the crime itself and the substance use disorder. Other people, however, facing long jail sentences for their crimes and in some cases losing custody of their children, will accept pretty much any personal risk associated with failing treatment court to avoid being sent to prison. Some questions to consider are:

- Is there a way to make trying treatment court and failing no more consequential from a sentencing perspective than not trying at all?
- Is there a desire for a pre-plea option in Maine?
- Is there a way to erase prior felony convictions, through a change in legislation, not just the present one?

Even with excess capacity, there are arguments to be made for expanding the locations of treatment courts since people need to be in close physical proximity to participate. **Table 167** reflects the percentage of out-of-county referrals treatment courts throughout Maine have received between 2015 and 2020.

Table 167. ME Pretrial Treatment Court Out of County Referrals

County	Percentage of Referrals
Aroostook	2.1%
Franklin	4.4%
Knox	4.8%
Lincoln	3.4%
Oxford	5.3%
Sagadahoc	4.2%
Waldo	4.1%
Total Percentage of Out-of-County Referrals	28.3%

As a matter of equity, treatment courts should be available in each judicial region. An analysis of the regions demonstrates Regions VI and VIII, highlighted below, are the two who lack ADTCs and would constitute likely candidates. Five of the seven counties with referrals in Table 17 are represented in these regions.

- **Region I:** York Superior Court, Biddeford District Court, Springvale District Court, York District Court
- **Region II:** Cumberland Superior Court, Portland District Court, Bridgton District Court

- **Region III:** Androscoggin Superior Court, Lewiston District Court, Franklin Superior Court, Farmington District Court, Oxford Superior Court, South Paris District Court, Rumford District Court
- **Region IV:** Kennebec Superior Court, Augusta District Court, Waterville District Court, Somerset Superior Court, Skowhegan District Court
- **Region V:** Penobscot Superior Court, Bangor District Court, Lincoln District Court, Millinocket District Court, Newport District Court, Piscataquis Superior Court, Dover-Foxcroft District Court
- **Region VI: Knox Superior Court, Rockland District Court, Lincoln Superior Court, Wiscasset District Court, Sagadahoc Superior Court, West Bath District Court, Waldo Superior Court, Belfast District Court**
- **Region VII:** Hancock Superior Court, Ellsworth District Court, Washington Superior Court, Machias District Court, Calais District Court
- **Region VIII: Aroostook Superior Court, Caribou District Court, Fort Kent District Court, Houlton District Court, Madawaska District Court, Presque Isle District Court**

The **Opioid Response Strategic Plan** calls for the expansion of treatment courts under Strategy 18, Support Alternatives to Incarceration. One of its “priority future activities” is to pilot and evaluate an enhanced treatment court program which includes additional case management services.

Monitoring and Evaluation

Standards

The Drug Court routinely monitors its adherence to best practice standards and employs scientifically valid and reliable procedures to evaluate its effectiveness.

The nine standards relate to the ability to monitor outcomes such as criminal recidivism and in-program outcomes such as attendance at scheduled appointments and drug and alcohol test results. Some of the recommended processes are having an electronic database, assuring timely data entry and monitoring admission rates, services delivered, and outcomes achieved.

Strengths

MPS has been responsible for data and management reporting. It has issued quarterly reports to the Steering Committee and Judicial Branch on admissions, terminations, pending cases, graduations and the current census. These data have been driven by DTxC; the case management system used throughout the state's specialty courts for many years. Use of DTxC was suspended on June 30, 2019 due to the age of the system and its lack of support from the developer. Data collection was moved to the State's Enterprise Information System (EIS) which accommodates other behavioral health activities at DHHS. A module was developed to accommodate the needs of specialty courts.

Most case managers provide a one-page summary of each participant at each treatment team meeting. The information includes background such as the phase and time in program, often the goals, what was achieved since the last meeting, and concerns. Special achievements or problems are also noted. The judges find these reports, which represent case-specific monitoring, extremely helpful.

The State of Maine Judicial Branch issues a Report to the Joint Standing Committee on Judiciary each year. The 2019 Annual Report on Maine's Drug Treatment Courts was issued on February 14, 2020. It contains a table for each court showing: Served, Active, Graduated, Terminated and Pending as well as the change from the previous year in both numbers and percentages. This is useful descriptive data.

Variations

When case management was contracted to Catholic Charities in Androscoggin for a couple of years the case managers there did not use DTxC consistently, if at all. This caused a lot of extra work for people trying to gather even rudimentary data about treatment court participants. For this evaluation PCG was able to gather information from Catholic Charities on about 70 clients served in Androscoggin during the years they performed case management.

Concerns



“DTxC ended because the previous administration wanted to move all of our records in to one dashboard/data center – that has failed – it has not gone well.”



“DTxC ended because it is no longer supported by the manufacturer.”

“There have been a lot of issues pulling reports and data out of it [EIS] to create the reports. ...There has been a lot of staff turnover on the [state] data team.”

Management

While EIS is said to have about 50 percent of the same information as DTxC, there are reportedly glaring errors in its design. For example, assigning a court location to a client is reportedly done in a text field rather than a drop-down choice, leading to the potential of inconsistent reporting and difficulty running reports. PCG’s review of the EIS manual and some screen shots of the system confirm the difficulties. There is consensus that little to no useable data has yet been able to be retrieved from EIS, even though it has been the only system operating for over a year; there are no known standard reports. MPS can capture “event” data like number of graduations but not the number of active cases; nor can it drill down to the court level.

There is some push for having data managed by the Judicial Branch’s new system under development, Odyssey. However, the court is reluctant to introduce the clinical and treatment data assembled in treatment court into its system. Others think an off-the-shelf package designed for treatment courts should be purchased or operated online to replace DTxC and EIS. Some meetings with the technical staff operating EIS have occurred to address the data and reporting concerns. However, it is not even clear that EIS contains what is needed and there is no ostensible evidence of progress. In the meantime, MPS has reviewed and identified a product used by other treatment courts around the country which would be suitable for Maine, at a very reasonable cost.

PCG considers the lack of information is one of the most serious problems identified in the evaluation thus far, particularly in light of the bifurcated management structure and slim staffing discussed in the first section. When the administrative staff is slim, people can use data to get a picture of what is transpiring. Practice standards suggest the need for a skilled, independent evaluation no less frequently than every five years. This report constitutes five years since Maine’s last comprehensive evaluation. During the periods in between, each month the database should be able to provide, for the current month and year to date:

- Number Served
- Number Active
- Number Graduated
- Number Terminated
- Number Pending
- Demographics of Population (age, race, gender)

They also recommend that programs collect *performance information* continually and meet annually to review it and make self-corrective actions. The database and reporting functions should be able to capture the following performance measures routinely for current participants.⁴⁷

- **Retention:** the number of participants who completed the treatment court divided by the number who entered the program
- **Sobriety:** the number of negative drug and alcohol tests divided by the total number of tests performed
- **Recidivism:** the number of participants arrested for a new crime divided by the number who entered the program, and the number of participants adjudicated officially for a technical violation divided by the number who entered the program
- **Units of Service:** the numbers of treatment sessions, probation sessions, and court hearings attended
- **Length of Stay:** the number of days from entry to discharge or the participant's last in-person contact with staff

Units of service and length of stay are useful variables to determine if the intensity and duration of the treatment court experience correlated with the outcomes.

Recidivism here refers to in-program recidivism. Longer-term outcomes include a return to any criminal activity most commonly measured by new arrests, new convictions or new incarcerations. For example, the Bureau of Justice Assistance tracks this information for three years after federal inmates are released from jail or prison. The treatment court standards suggest the importance of categorizing recidivism by the level (felony, misdemeanor or summary offense) and nature (drug, property, theft, violent, technical violations, traffic and prostitution) of the new offense. This report provides some examples of how to measure arrest and conviction recidivism and provides a baseline for future assessment.

⁴⁷ National Association of Drug Court Professionals. (2018). *Adult drug court best practice standards: Volume II*, page 62. Alexandria, VA: NADCP.

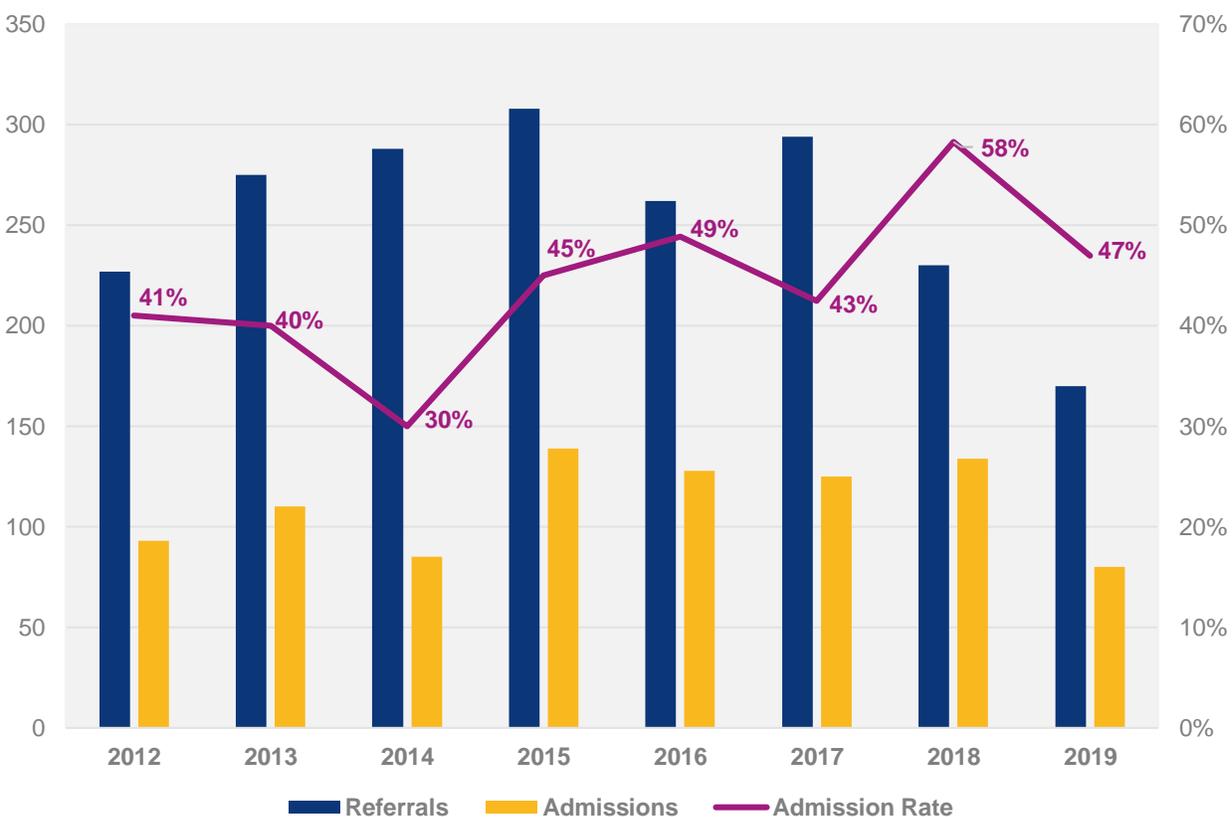
VI. Findings from Descriptive and Outcome Analyses

This section encompasses the rates of admission for those referred; for those not admitted, the amount of time it takes to get that decision; the rates of graduation for those admitted; the relationship between admission and graduation rates and then recidivism rates both for the treatment and comparison groups. It concludes with an analysis of mortality due to overdose. **Maine’s treatment court participants have statistically significant lower arrest and conviction rates than people with comparable characteristics and criminal records who are adjudicated traditionally.**

Admission Rates

Figures 5 through 7 show what percent of people who are referred to treatment court are admitted, from several perspectives. **Figure 5** presents a longitudinal perspective, from 2012 to 2019, averaging all of the courts. It shows admission rates statewide have varied from 30 to 58 percent over the past decade, with a high noted in 2018.

Figure 5. Treatment Court Admission Rates by Year, 2012–2019



Reportedly not all referrals meet the qualifications of high risk and high need with a qualifying offense. **Figure 6** shows nearly half of those not admitted is due to participant refusal. The second most prevalent reason for not being admitted is legal (26%) followed by clinical (12%).

Figure 6. Reasons Participants are Not Admitted

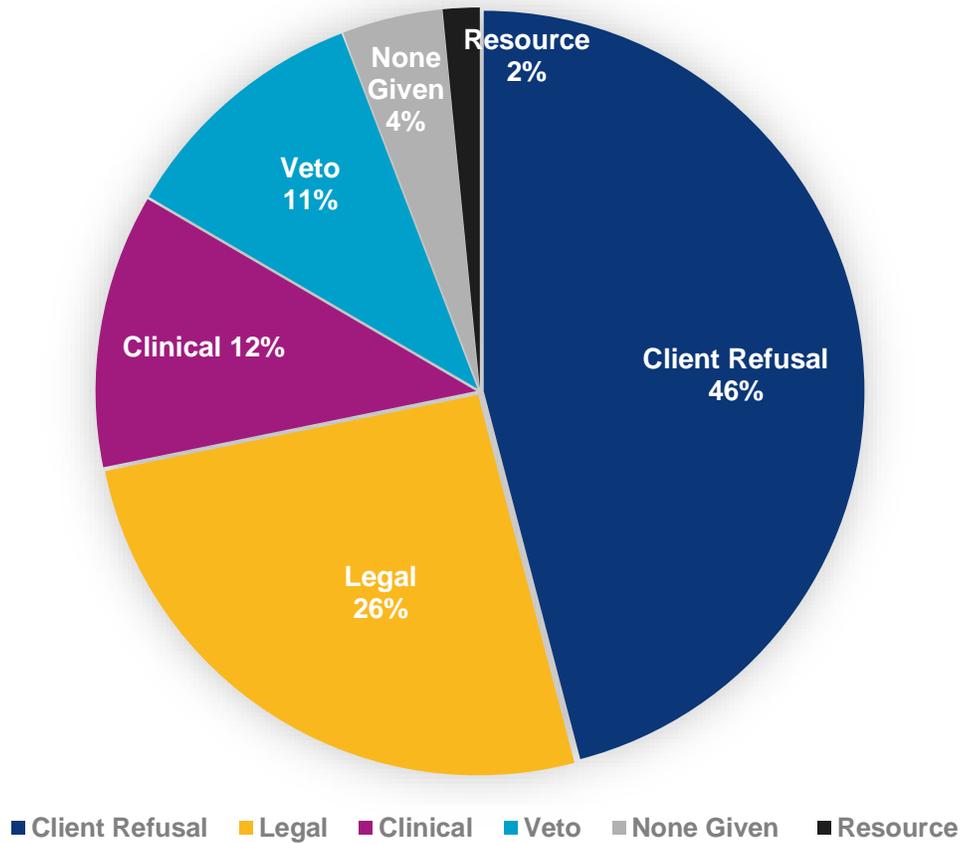
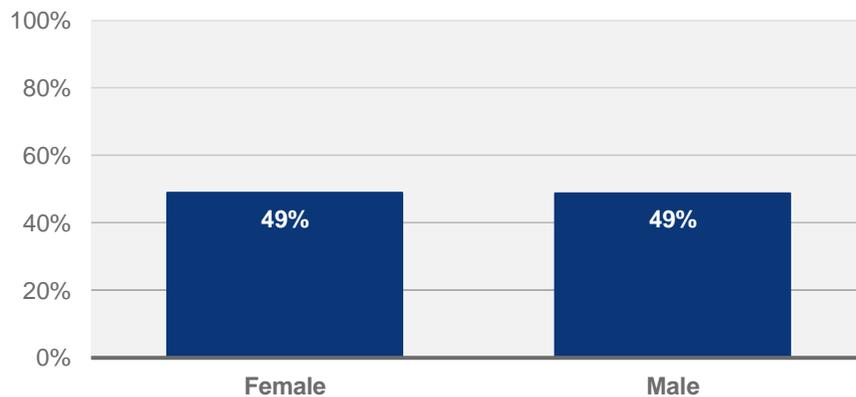


Figure 7 shows there is no difference in admission rates by gender.

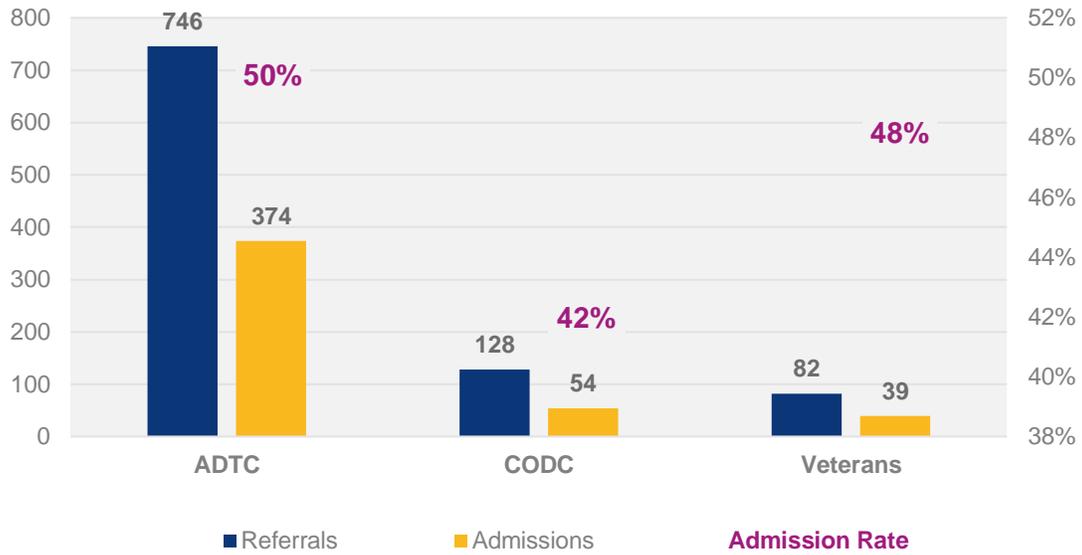
Figure 7. Treatment Court Admission Rates by Gender 2012–2019



Admission rate and volume by court type is shown in **Figure 8**. This analysis seeks to determine whether the type of treatment court (drug, co-occurring or veterans) affects admission rate. During the course of the current study, October 1, 2015–June 30, 2019, there were 956 treatment court referrals, 746 (78%) Adult Drug Treatment Court referrals, 128 (13%) Co-Occurring Disorders

Court referrals and 82 (9%) Veterans Treatment Court referrals. Among the court types, admission rates are highest for the Adult Drug Treatment Court (50%) followed closely by the Veterans Treatment Court (48%), while the Co-Occurring Disorders Court accepts 42 percent.

Figure 8. Admission Rates and Volume by Court Type, 2016–2019



The average days from referral to a decision *not* to admit is shown in **Figure 9**. It takes about a month now (34 days). Generally, during this period, about half of the individuals who are referred are waiting in jail. The decline in time is commendable, however.

Figure 9. Average Days from Referral to Rejection: 2012-2019

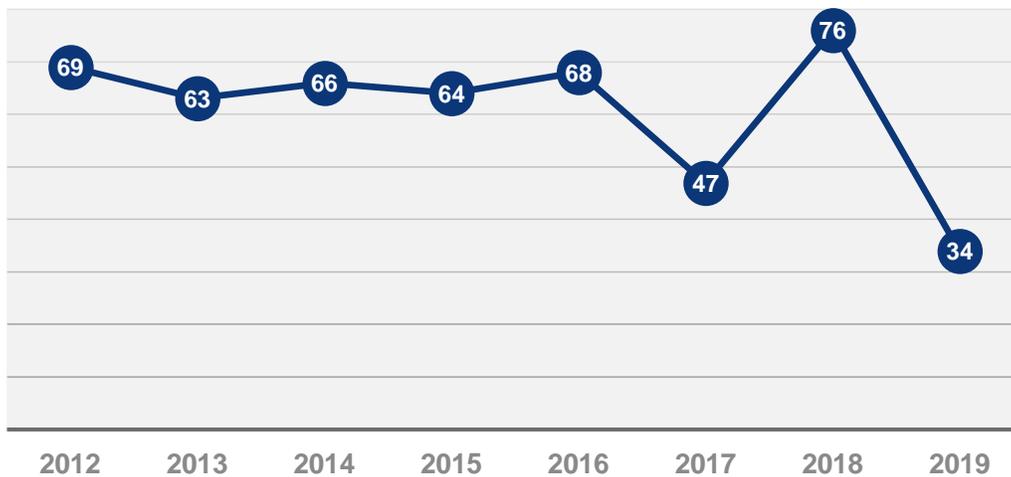
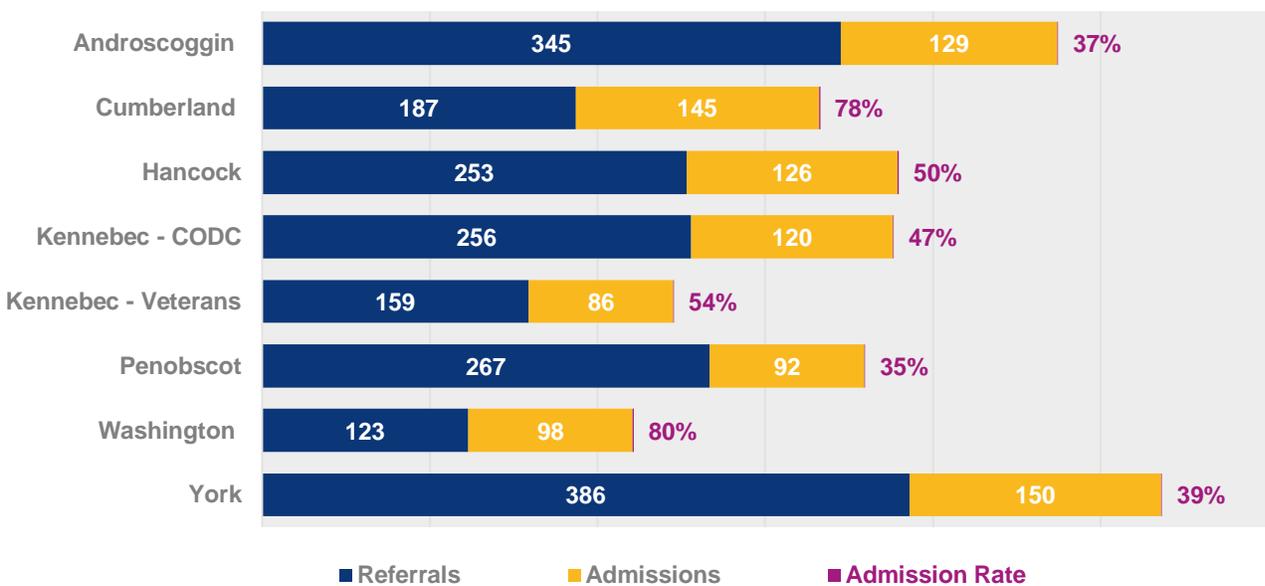


Figure 10 shows whether and to what degree referral and admission rates vary by court. The two courts in Kennebec (415), followed by Androscoggin (345) have had the most referrals, over the course of the study while Washington has had the least (123).

Figure 10 also shows there is a vast difference in admission rates across the state, with the highest being in Washington County (80%), followed closely by Cumberland (78%), and the lowest being in Penobscot (35%) and Androscoggin (37%). However, the Androscoggin data is incomplete due to the years the case management function was not handled by Maine Pretrial Services.

Figure 10. Referrals, Admissions and Admission Rates by Court, 2016–2019



Graduation Rates

Graduation from treatment court takes 17.8 months, on average. The combined participation time of those who graduate and those who do not is 15.5 months. This section shows the rates of graduation from the various treatment courts. The number of graduates is shown in relation to the number who withdrew or were expelled before graduation.

There has been considerable fluctuation in graduation rates over the past several years, ranging from 46 percent to 61 percent. Rates over 50 percent are consistent with other states' studies. **Figure 11** provides a longitudinal view, dating back to 2013 (FFY014). For each year, the figure shows the number who graduated, the number who withdrew or were expelled and the rate of graduation.

Figure 11. Graduation Rates by Year, 2013–2019

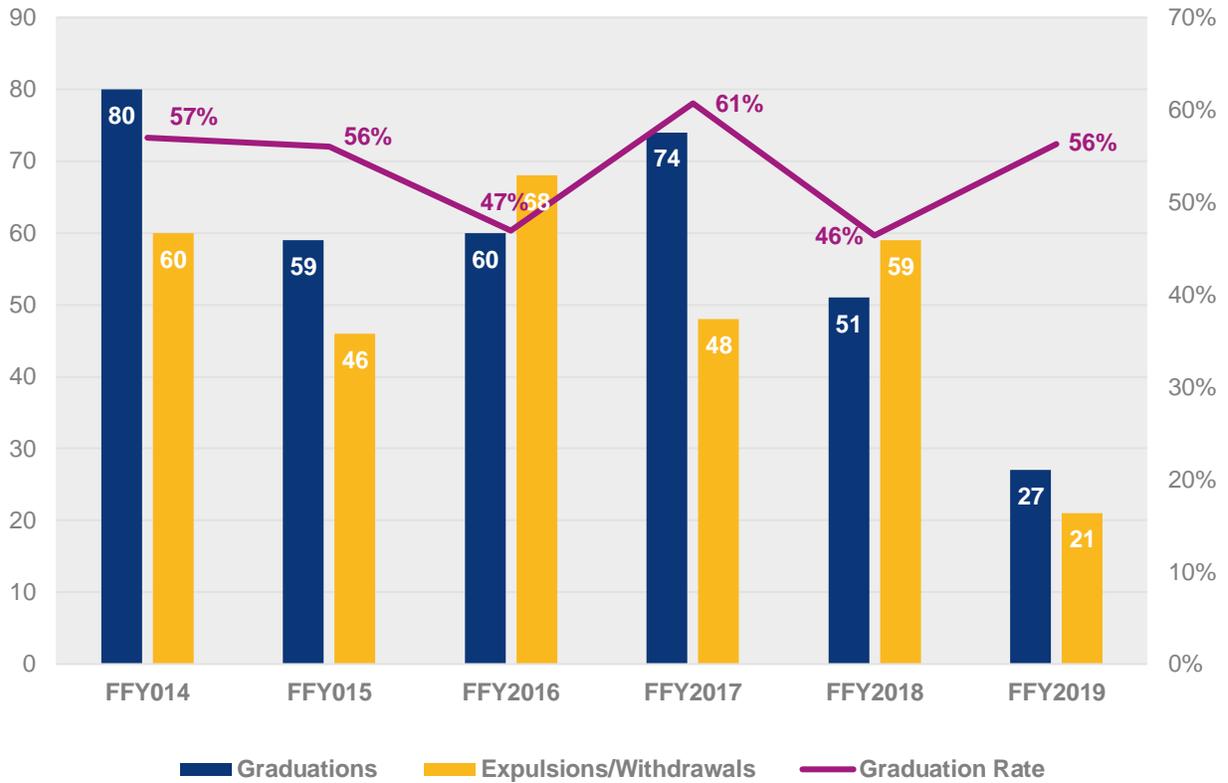
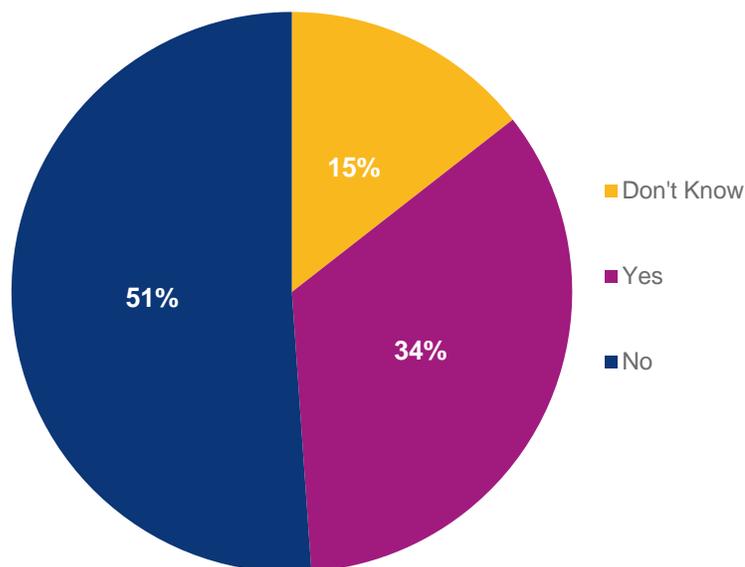


Figure 12 provides information on whether those who were discharged (expulsion/withdrawal) had committed a new crime as the reason for discharge. This was true in about a third of the cases. However, data was recorded in only 85 percent of the cases.

Figure 12. New Crime as Reason for Discharge



The next analysis, **Figure 13**, is graduation rate by court type (drug, veterans and co-occurring), averaging data over three years. The Veterans Treatment Court has the highest graduation rate (60%) followed closely by the Adult Drug Treatment Courts (52%); the CODC is lowest at 46 percent which may be reflective of the challenges presented by the population. The statewide average graduation rate is 52 percent.

Figure 13. Graduation Rates and Volume by Court Type, 2016–2019

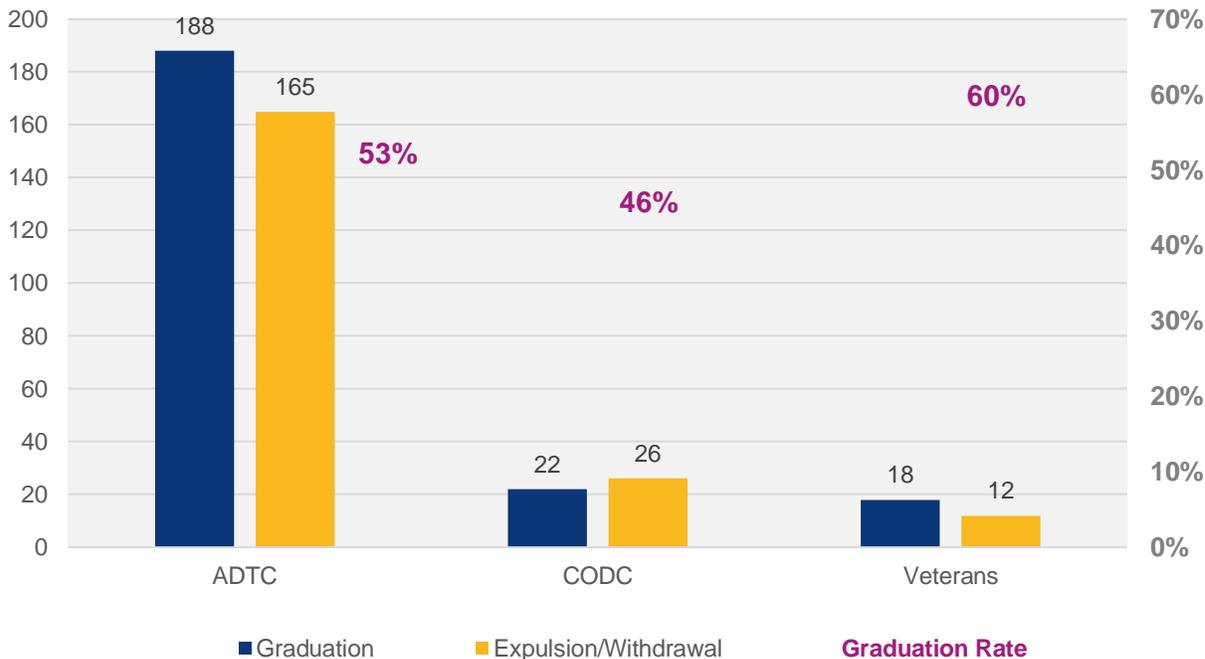


Figure 14 shows how the graduation rates differ by court location. There is a fairly broad range from a low of 42 percent in Androscoggin County to a high of 60 percent in Kennebec, which includes a Veterans Treatment Track (which has a higher graduation rate). These averages represent nearly four years of data from 2016 to 2020.

Figure 14. Graduation Rate by Court Location, 2016-2020

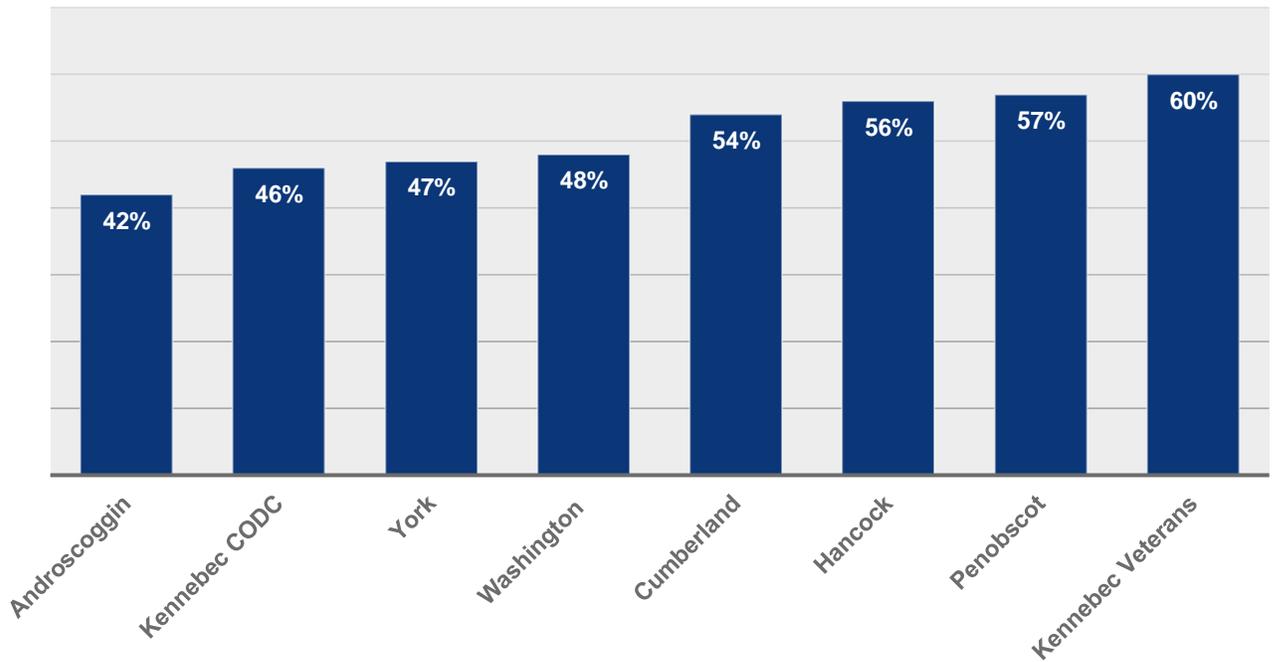
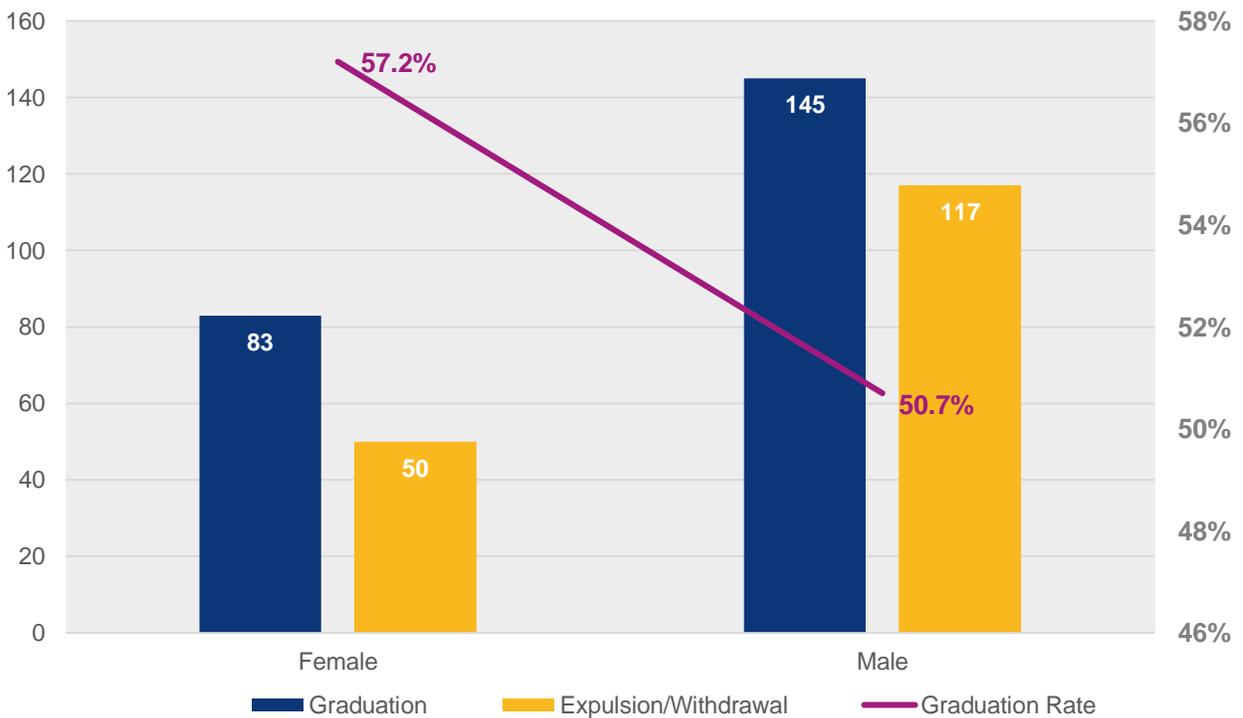


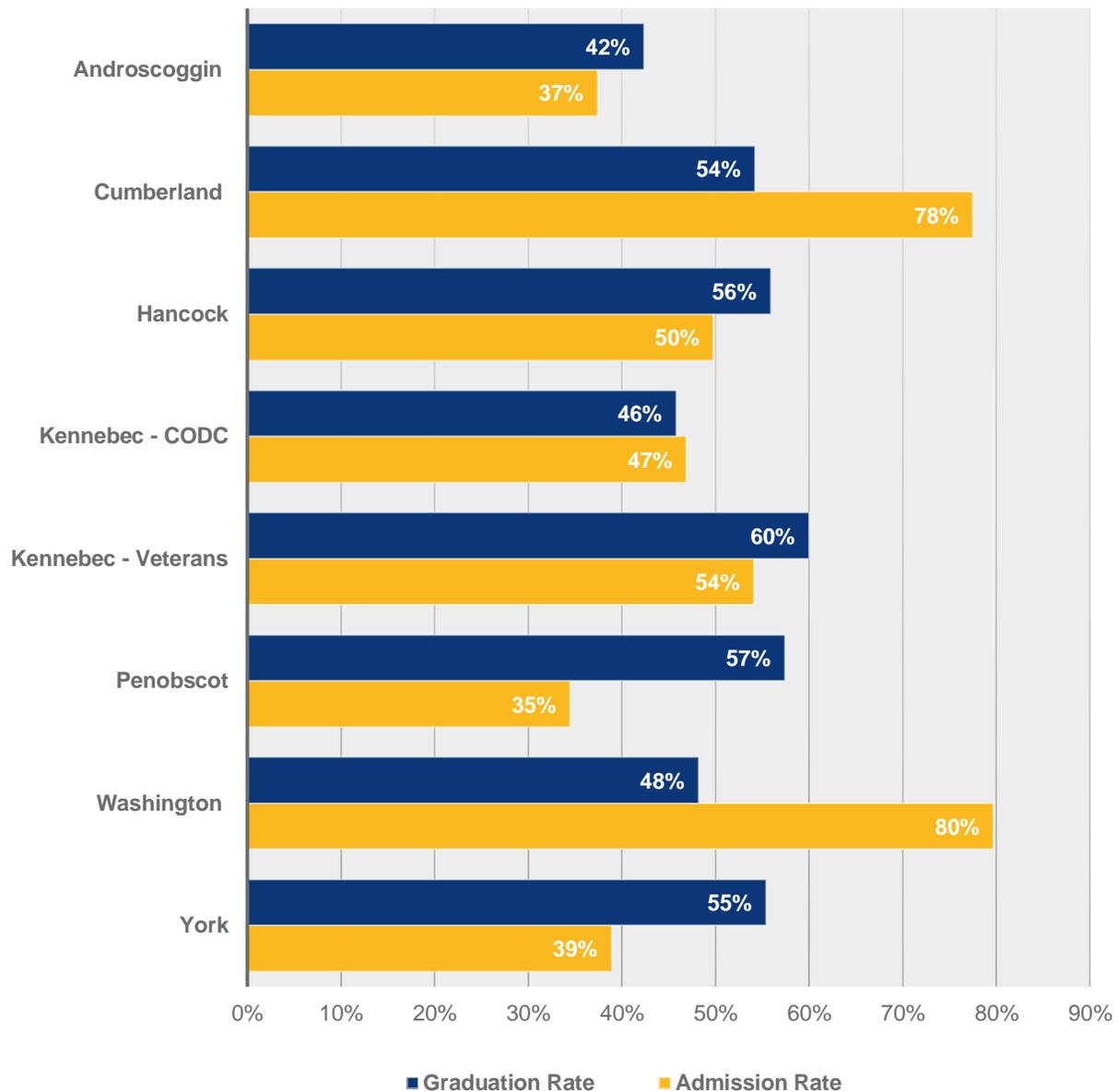
Figure 15 presents graduation rates by gender; females have a higher rate, 57 percent compared to 51 percent for males. The difference **is not** statistically significant.

Figure 15. Graduation Rate by Gender, 2016–2020



A logical question is whether the courts which are more selective in who they accept (low admission rates) have greater success in who completes the program (high graduation rates). **Figure 16** compares admission and graduation rates by court.

Figure 16. Admission and Graduation Rates by Court, 2016 – 2019



There is in fact a small difference, but not in the expected direction. High admission rates are slightly correlated with high graduation rates, but not at a significant level. The correlation findings vary by court, as Penobscot, which has the lowest admission rate also has the highest graduation rate, contrary to the findings across the state. However, Androscoggin, which has the second lowest admission rate, has the lowest graduation rate.

By calculating the r-squared, which tells how much of the variation is explained by the correlation, the answer is about 13 percent; that is, **87 percent of the variation is due to other factors** such as the availability of services, program monitoring or interactions with the court.⁴⁸ The analysis leads to the conclusion for courts not to constrain who is admitted due to the fear that they will not graduate.

Other states: The *Multi-Site Adult Drug Court Evaluation* (2011) found that, by 18 months from admission, 59 percent had graduated, 26 percent were terminated, and 15 percent dropped out. Jurisdictions in the study varied greatly from a high of 92 percent graduation rate in Guam to a low of 35 percent in Kentucky. The length of time to graduation among 21 programs was 17.3 months compared to 17.8 months in Maine. A meta-analysis by Mitchell et al. (2012)⁴⁹, found that among 92 sites, 50 percent had graduation rates of 26 to 50 percent whereas only 13 percent had rates of 51 to 75 percent. In another study, Marlow et al. finds that most courts' graduation rates range from 50 to 75 percent⁵⁰. While national data is varied, Maine does as well as most.

Recidivism

This section shows the rates of arrest and conviction recidivism, comparing the treatment and comparison groups. It also compares those who graduated from treatment court with those who were expelled or withdrew to determine potential differences in conviction recidivism.

Arrest Recidivism after Program Exit

Figure 17 measures new arrests *after people have exited the treatment program or have completed their sentences* in the comparison group. The treatment group includes those who entered and departed from the program either by graduation or by expulsion/withdrawal during federal fiscal years 2016, 2017, 2018 and 2019. The years 2018 and 2019 are not included in the 24-month measure since sufficient time has not yet elapsed to measure 24 months.

Between 12 and 20 percent of people who participated in treatment court were arrested between six and twenty-four months after leaving the program, whether by graduation, expulsion or withdrawal. In contrast, between 31 percent and 47 percent of those in the comparison group were arrested during those same time frames. The 24-month arrest recidivism rate dips for the treatment and comparison groups even though the data is cumulative because of a smaller sample size at that juncture (the 2018 and 2019 groups had not yet been released for 24 months) and those who had been (2016–2017) have lower recidivism rates. That is, the 24-month marker shows recidivism for those who departed the program in 2016 and 2017 only.

⁴⁸ As a caution, PCG used only seven data points here (seven courts), diminishing the reliability of correlations due to such small numbers.

⁴⁹ Mitchell, O., Wilson, D. B., Eggers, A., & MacKenzie, D. L. (2012). Assessing the effectiveness of drug courts on recidivism: A meta-analytic review of traditional and non-traditional drug courts. *Journal of Criminal Justice*, 40(1), 60-71.

⁵⁰ Huddleston, C. W., Marlowe, D. B., & Casebolt, R. (2008). Painting the current picture: A national report card on drug courts and other problem solving court programs in the United States (Vol. 2, No. 1). *Alexandria, VA: National Drug Court Institute*.

At 12 months the difference between the treatment and comparison groups is 27 percentage points which translates to 208 percent and at 24 months 26 percentage points which is a 137 percent difference. In layman's terms, arrests were more than twice as high for the comparison group after one year, and over one and a third as high after two years.

Arrest rates of the Treatment Court participants are lower at a statistically significant level, meaning the differences would not have been derived from chance.

Figure 17. Arrest Recidivism Rates of Treatment and Comparison Groups

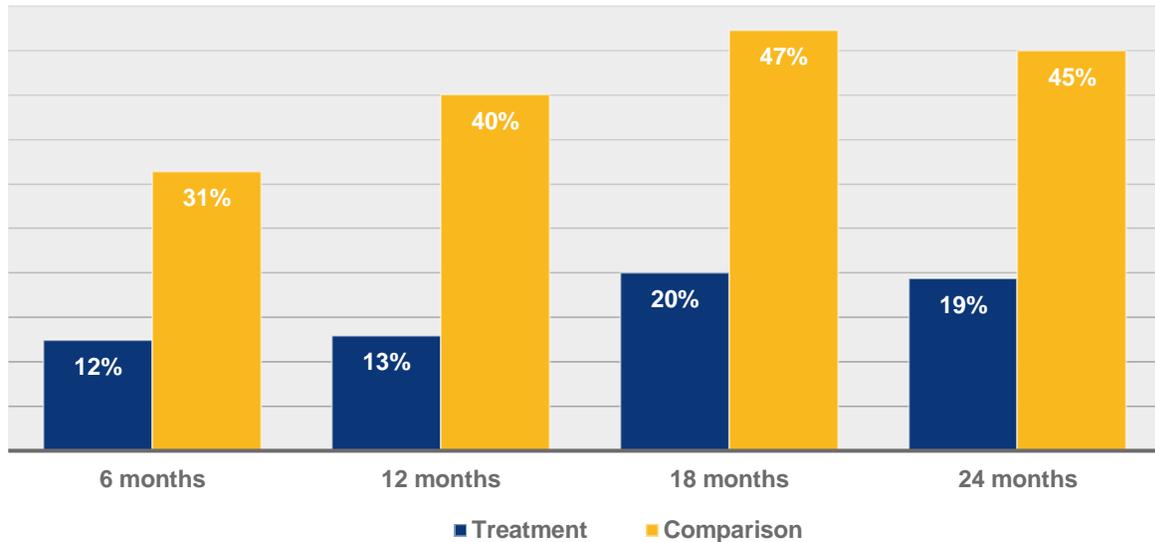
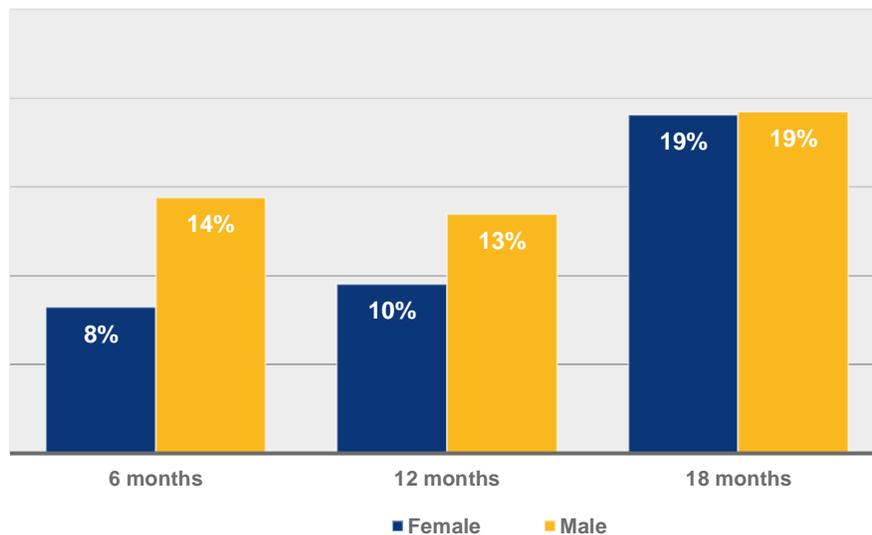


Figure 18 presents arrest recidivism for the treatment group by gender. Males have higher rates at six and 12 months, but the differences are not statistically significant. The rates even out by 18 months.

Figure 18. Arrest Recidivism by Gender: Treatment Group



Comparisons to other studies: Rempel et al. (2003) found a nine-percentage point reduction in post-program arrests at 12 months. **Maine does better.** Roman et al. (2003) found that within a one-year follow-up period, 16.4% of the sample had been arrested and charged with a serious offense, and within a two-year follow-up period, 27.5% of the sample had been arrested and charged with a serious offense. This compares to 13 percent at 12 months and 19 percent at 24 months in Maine. **Maine does better.** The Multi-Site Adult Drug Court Evaluation (2011) found that 52 percent of treatment court offenders compared with 62 percent of comparison offenders were re-arrested over 24 months. For both the treatment and the comparison groups, **Maine does better.**

Conviction Recidivism after Program Exit

Figure 19 measures new convictions after people have exited the treatment program or have completed their sentences in the comparison group. The treatment group includes those who entered and departed from the program either by graduation or expulsion/withdrawal during federal fiscal years 2016, 2017, 2018 and 2019.

As seen for arrests, the 24-month recidivism rate dips for the treatment group even though the data is cumulative because of a smaller sample size (the 2018 and 2019 groups had not yet been released for 24 months) and those who had been (2016–2017) have lower recidivism rates. That is, the 24-month marker shows conviction recidivism for those who departed the program in 2016 and 2017 only. As would be expected, there are somewhat fewer convictions than arrests for both groups but the differences between the two are still dramatic. At 12 months the difference between treatment and comparison groups is 24 percentage points which translates to 218 percent and at 24 months 35 percentage points which is 583 percent difference. At 18 months, where there are more cases to count, the difference was 25 percentage points or 167 percent. In layman’s terms, convictions were more than twice as high for the comparison group after one year and one and two-thirds higher after 18 months.

Conviction rates of those in Maine treatment courts are lower at a statistically significant level, meaning the differences would not have been derived from chance.

Figure 19. Conviction Recidivism Rates of Treatment and Comparison Groups, 2016–2019

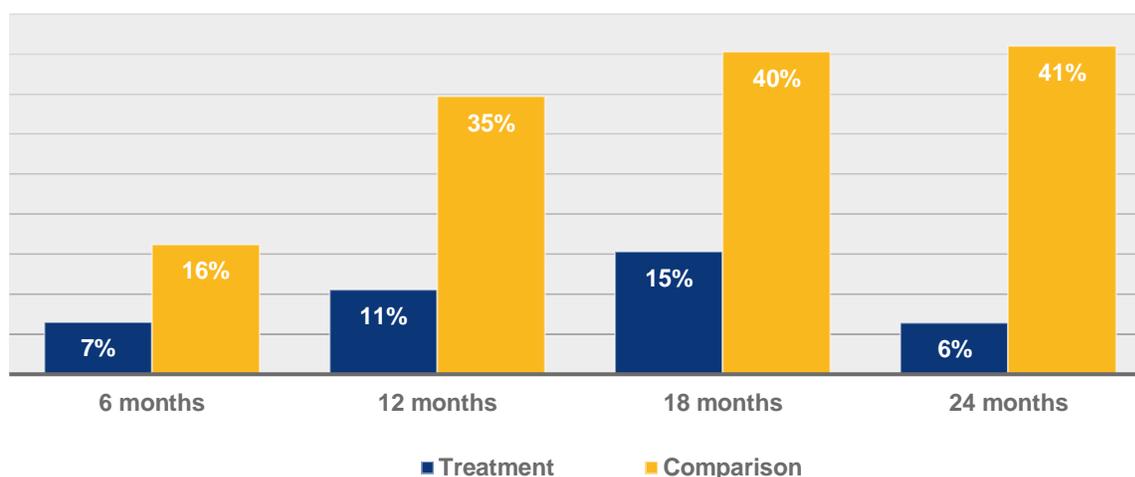
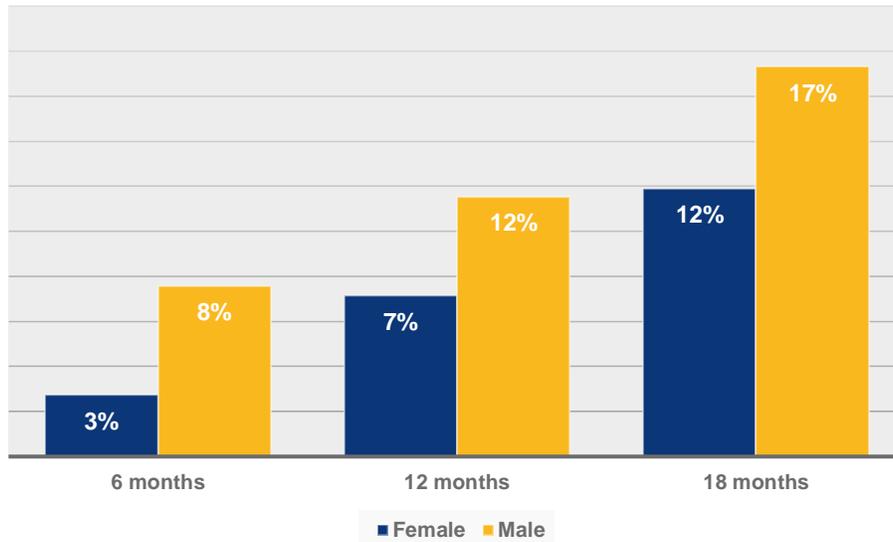


Figure 20 shows the same information for the treatment group, conviction recidivism, by gender. Again, the rates are higher for males but not statistically significant.

Figure 20. Conviction Recidivism by Gender: Treatment Group



Comparisons to other studies: Rempel et al. (2003) reported an average nine percentage point reduction in “criminal activity” twelve months post program. Multi-Site Adult Drug Court Evaluation (2011) found that Drug Court participants reduced the number of criminal acts over an 18-month period by more than half, “a truly remarkable effect size.” A meta-analysis conducted by Mitchell et al. (2012)⁵¹ found any effect Drug Courts have on recidivism is not limited to the short-term. Reduced recidivism during and after treatment appears to last for at least three years. Drug-related recidivism generally goes from 50 percent without Drug Court to 38 percent with Drug Court, **higher recidivism rates than found in Maine.**

Figure 21 examines the treatment group alone. It asks whether graduation from treatment court vs expulsion or withdrawal makes a difference in post-program convictions. It shows that at six months there is virtually no difference and at 24 months the graduates do no better and even somewhat worse than those who withdrew for any reason. That is, both those who graduate and those who do not do better than the comparison group, as demonstrated above. For example, the 18-month conviction rate of either graduates (13%) or dropouts (18%) is half that of the comparison group (40%). Treatment Court appears to have a both an initial and residual positive impact on all who participate, regardless of whether they graduate.

⁵¹ Mitchell, O., Wilson, D. B., Eggers, A., & MacKenzie, D. L. (2012). Assessing the effectiveness of drug courts on recidivism: A meta-analytic review of traditional and non-traditional drug courts. *Journal of Criminal Justice*, 40(1), 60–71.

Figure 21. Conviction Recidivism Rate of Treatment Group by Exit Type

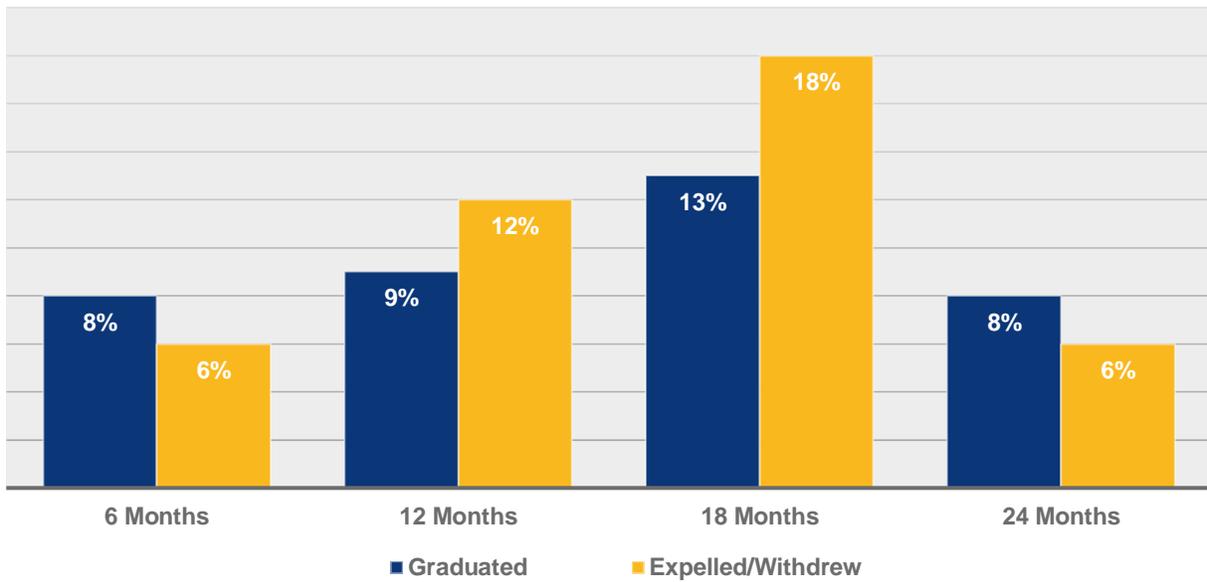


Figure 22 makes that impact overt by separating those who graduated from those who were expelled or withdrew from each other as well as from the comparison group when measuring new convictions at six-month intervals post program.

Figure 22. Conviction Recidivism by Treatment Exit Type and Comparison Group

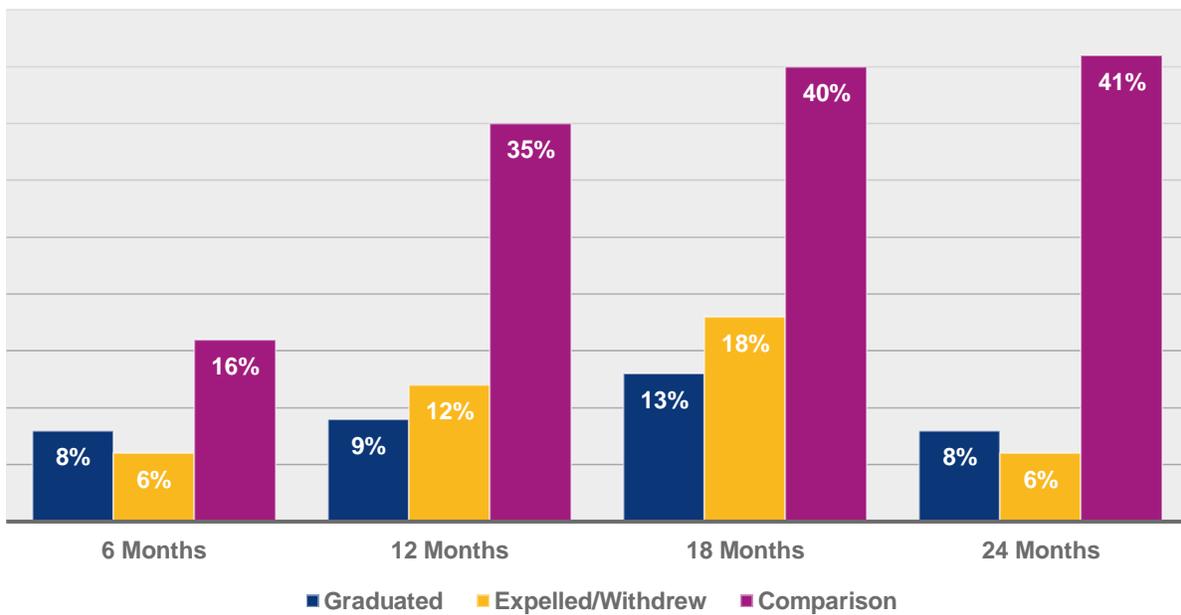
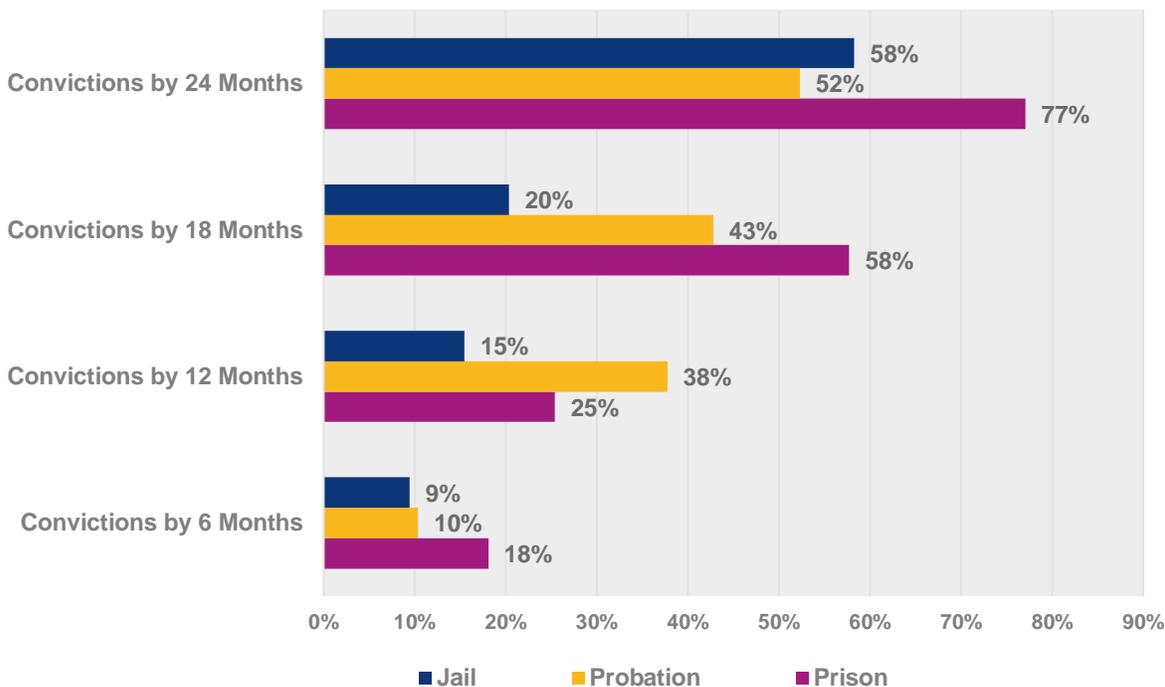


Figure 23 shows recidivism of members of the comparison group only by whether they had been in prison, jail or on probation before (only one-third of our comparison group were found to have one of these three). It shows by the end of two years, 77 percent of those who had been in state prison before would be convicted of a new crime.

Figure 23. Comparison Group Recidivism by Prior Time in Jail, Probation or Prison



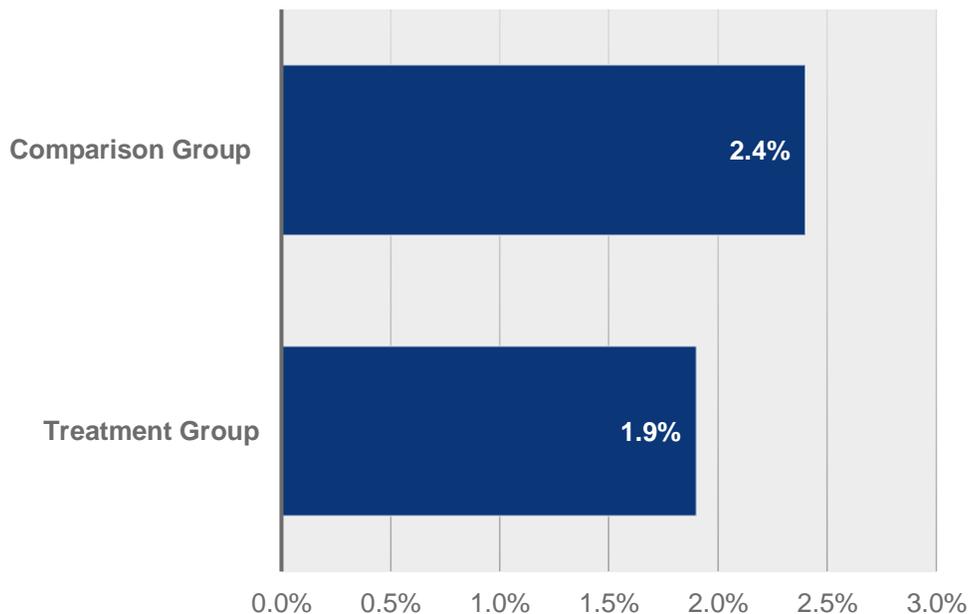
Mortality

Using data from the Chief Medical Examiner, PCG examined all overdose deaths during the study period to determine whether there was a difference between treatment court participants and the comparison group. **Figure 24** uses PCG’s “entry cohort” for the analysis, individuals who entered either the treatment or comparison groups between 2015 and 2019, with deaths calculated through June 30, 2019.

During the period, 2.4 percent of the comparison group members and 1.9 percent of the treatment group members died from an overdose. In plain language, *over four years* we can expect about two out of a hundred people in either group to die of a drug overdose (**Figure 24**).



Figure 24. Rates of Death Due to Drug Overdose, Treatment and Comparison Groups



While the proportion of deaths for the comparison group is slightly larger than for the treatment group the differences are not statistically significant (chi squared tests, $p < 0.05$ level).

VII. Cost Benefit Analysis

Treatment Courts in Maine do produce a cost savings to the state, even when the incarceration costs of those who do not succeed in treatment court are taken into account.

These cost savings are magnified by the reductions in recidivism rate of treatment court participants, just discussed. The savings equate to a 12 percent reduction from traditional adjudication costs to a 28 percent savings by 18 months when lower recidivism rates are taken into account. These savings are derived solely from the direct costs of treatment, case management, judicial time, probation and incarceration (both state prison and county jails). They do not include ancillary benefits such as increased taxes and child support paid by those who become contributing members of society.

Table 8 presents a description of the treatment and comparison groups used in the cost benefit analysis by the Charge Class based on the Maine law which brought them into the study. Class A, encompassing the most serious crimes, represented three percent of each group. Most were charged with Class B and C offenses, felonies which can result in up to ten years of incarceration; two-thirds of each group had Class B or C charges. About a quarter in each group had Class D or E charges.

Table 18. Treatment and Comparison Groups by Charge Class

Charge Class	Description	Sentence ⁵² , ⁵³	Comparison Group	Treatment Court Participants
A	Manslaughter, gross sexual assault and aggravated trafficking in scheduled drugs.	Up to 30 years and \$50,000 fine, 4 year minimum	3%	3%
B	Trafficking in drugs , some sexual assault cases, aggravated assault cases and motor vehicle DUI involving serious bodily injury.	Up to 10 years and \$20,000 fine, 2 year minimum	23%	32%
C	Aggravated OUI with two or more priors, felony habitual offender charge, Aggravated Criminal Mischief or felony theft.	Up to 5 years and \$5000 fine, 1 year minimum	42%	35%
D	Domestic violence assault cases, assault and OUI/DUI/DWI (driving under the influence).	Up to 364 days and \$2,000 fine	24%	19%
E	Operating on a suspended license, disorderly conduct and theft under \$1,000.	Up to 180 days and \$1000 fine	2%	6%
Not Available	Other Felony		6%	5%
Total			100%	100%

⁵² Title 17-A: MAINE CRIMINAL CODE, Part 2: Substantive Offenses

⁵³ In some instances, minimums do not apply.

Treatment Group Costs

Case Management and Treatment: Average treatment costs for each person enrolled in a treatment court is \$8,488 per year or a total of \$10,964 for 15.5 months, which is the average duration of treatment court, counting both those who complete and those who do not.

Elements considered in the treatment costs are case management, treatment and judicial time. Case management costs are based on a review of case management contracts between OBH and MPS; treatment costs are based on a review of the treatment contracts between OBH and the four treatment contractors: Central Maine Counseling dba Blue Willow, Catholic Charities, Aroostook Mental Health and Wellspring. All of these contracts cover both the treatment courts and the Family Recovery Courts, with the cost division estimated to be 75 percent for the former and 25 percent for the latter. Thus, the proportional costs were applied to the treatment courts. In addition, PCG assumed 275 persons per year statewide were served based on numbers reported in annual reports over the study period.

Case Management	\$2,100 per person per year
Treatment	\$5,888 per person per year
Judicial Time	\$500 per person per year

Since the average length of stay in treatment court is 15.5 months, PCG multiplied the annual cost by 1.29166 to arrive at the total cost, \$10,964 per treatment court admission. Again, this represents all admissions since PCG cannot predict who will graduate and is the standard practice for treatment court evaluations.

Probation and Incarceration: Treatment court participants incur considerable probation and incarceration costs as well, totaling on average \$27,229 per person from entry to discharge date; if they were still under DOC supervision by August 2020, the last date for which PCG had CORIS data, this date was used as the discharge date. The costs are based on the daily rates below and the number of days calculated for each of the 368 people in the treatment group. PCG could obtain jail data from only seven counties and made a projection of total days based on the data received.

Jail	\$141 per day
Prison	\$123 per day
Probation	\$4.86 per day

Of note, probation and incarceration costs of \$27,229 are more than twice the case management and treatment costs themselves. However, Maine's experience is superior to but consistent with the national MADCE study, which found that incarceration costs for the offense which led to treatment court admission remain high due to the large number of people who drop out of treatment court; however, consistent with MADCE, reductions in recidivism produce long-term cost reductions.

Maine can demonstrate savings both for the initial treatment cases, including those who graduate and those who do not, and for at least 18 months post-graduation due to reduced rates of recidivism.

Table 19 shows the average cost of the treatment group both at exit and over 18 months, at six-month intervals, taking recidivism into account. The exit cost includes both the treatment/case management component (\$10,964) and the probation/incarceration components (\$27,229). The subsequent time frames include probation/incarceration only since treatment generally is not repeated, applying the recidivism rates PCG calculated for this study.

Table 19. Cost of Treatment Group from Exit to 18 Months, Including Recidivism

Time	Cost
Exit	\$ 38,193
6 months	\$ 41,235
12 months	\$ 42,974
18 months	\$ 44,712

Comparison Group Costs

Comparison group participants cost an average of \$43,461 at exit, taking into account prison, probation and jail costs, calculated identically to the treatment group, the average number of days per person by type of cost (prison, probation, jail), weighted to create the same size grouping (393 to 368). Only cases in the comparison group with *any* probation, jail or prison time were included in the analysis. **Table 0** shows the cost of the comparison group at exit and at six-month intervals, taking recidivism rates for the comparison group into account.

Table 20. Cost of Comparison Group from Exit to 18 Months, Including Recidivism

Time	Cost
Exit	\$ 43,461
6 months	\$ 50,414
12 months	\$ 58,672
18 months	\$ 60,845

Table 21 shows how the incarceration and probation costs were derived in aggregate for both the treatment and comparison groups, reflecting the average days spent per person in each category (prison, probation and jail). Note that the treatment group includes those who completed treatment court and those who did not. These days were multiplied by the cost per day obtained from the Maine Department of Corrections (prison and probation) and the Maine Sheriff's Association (jail).

Table 171. Costs Per Person for Incarceration and Probation by Group

Group	Prison Costs		Probation Costs		Jail Costs		Total Cost per Person
	Avg. Days	\$123/day	Avg. Days	\$4.86/day	Avg. Days	\$141/day	
Treatment⁵⁴	102	\$ 12,546	410	\$ 1,993	90	\$ 12,690	\$ 27,229
Comparison⁵⁵	232	\$ 28,536	982	\$ 4,773	72	\$ 10,152	\$ 43,461

Cost Benefit

The savings which can be attributed to treatment court is 12 percent at time of exit, climbing to 28 percent at 18 months when taking the differentiation in recidivism rates into account (**Table 182**). Placing a person in treatment court costs \$5,268 less than traditional adjudication when taking treatment, case management, judicial time and both probation and incarceration costs into account. These figures do not include ancillary benefits such as increased taxes and child support paid by those who become contributing members of society.

Table 182. Treatment Group Savings from Exit to 18 Months

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

Other states: Maine's results are consistent with those of other states. Adult drug treatment courts have proven to be highly cost-effective (U.S. Government Accountability Office, 2011). Treatment courts reduce incarceration time over the long term but not necessarily on the initial case which precipitated treatment court participation. During the 18-month tracking period of the Multi-site Study, treatment court participants did spend fewer days incarcerated than the comparison group (63 vs. 95 days) although the effect was not significant.⁵⁶ The gap was greater

⁵⁴ Costs encompass both those who complete the program and those who were terminated.

⁵⁵ Costs encompass anyone who spent time on probation, in jail or in prison.

⁵⁶ MADCE Volume 4. Chapter 4. Do Drug Courts Reduce Crime and Incarceration? P. 80

at 24 months (32 vs. 59 days). The MADCE concludes that drug courts nearly eliminate custodial time among those who graduate, but those benefits are counterbalanced by the high sentences imposed on those who fail the program. In short, “the ultimate, long-term reductions in incarceration drug courts produce stem largely from the reductions they produce in re-offending, which in turn leads to less incarceration on *future* cases.”⁵⁷

Reductions in criminal behavior applied broadly across all groups. PCG’s results align with the national study which “strongly support[s] increasing the numbers of offenders who can enroll for the intervention to have a truly systemic effect on drug-related crime; expanding treatment courts, or comparable programs, to far greater numbers of offenders is perhaps the most pressing policy imperative to emerge from the latest drug court research.”⁵⁸

⁵⁷ Rossman, S. B., Roman, J. K., Zweig, J. M., Rempel, M., & Lindquist, C. H. (2011). The multi-site adult drug court evaluation: The impact of drug courts.

⁵⁸ *Ibid.*

VIII. Recommendations

The recommendations are organized into the following categories: structural and management; judicial proceedings and treatment team; and community relations. Each recommendation identifies a target who should take the lead on implementation and a priority which suggests its importance. Very high should be addressed in the next 90 days; high in the next six months; and medium in the next year.

Recommendations for judicial proceedings and treatment team should be addressed by each court, starting with the Steering Committee for a statewide discussion and then moving to individual courts. The judge should share the report with the treatment team and then in a workshop the team should discuss each of the judicial proceedings and treatment team recommendations, decide which to address and make assignments within the team.

Community relations recommendations should be addressed by the Steering Committee with appropriate assignments made for their implementation.

Structural and Management

1. Acquire a new case management system to replace DTxC and currently EIS.

Target	OBH
Priority	Very High

MPS has reviewed several systems which are functioning in treatment court settings in other states and has provided recommendations to OBH for their suitability to Maine. These are not expensive but are sorely needed to fill the management information gap which is now 18 months long.

2. Fund a Special Projects Manager at MPS to implement joint initiatives.

Target	OBH
Priority	High

Since OBH cannot fund another state agency (such as the Administrative Office of the Courts [AOC]), it should consider supporting a Special Projects Manager at MPS to work with the Judicial Branch on activities requiring extra staffing (see Recommendations 14-17). If followed through, an annual agenda should be set by the Judicial Branch, OBH, and MPS, in conjunction with the chair of the Steering Committee, to guide initiatives inclusive of implementing priority activities in this report.

3. In revising the Policy and Procedure Manual, address issues identified in the field and update the Participant Handbook accordingly.

Target	Judicial Branch
Priority	High

These issues include the following: a) provide guidance on when certain offenses (e.g., drug trafficking, violent offenses) should result in exclusion from treatment court; b) provide guidance on when a jail sanction should precipitate a separate hearing and the acceptable timeframe, if required; c) provide guidance on when participants should be terminated and any procedural due process required; d) reinforce that Maine policy does not permit “up front jail time” as part of the sentence; and e) reinforce that negotiated sentences cannot be stiffer for entering treatment court and failing than not entering at all.

4. **Require core training for all new treatment team members and revive training plans as soon as feasible focusing on co-occurring disorders as an expectation; role specific training; treatment and recovery; and use of community supports.**

Target	Judicial Branch	All new members of treatment teams should be required to take the online Essential Elements of Adult Drug Courts ⁵⁹ within three months of joining the team. Current members with little or no treatment court training should do so as well. Training is needed on the relationship between substance use disorder and mental health treatment. While they are distinct conditions, about two-thirds with substance use disorder have a co-occurring mental health diagnosis. Treatment providers are required in their contracts to deliver co-occurring services and the treatment team should understand that as an expectation including during the process of deciding who to admit. In addition, while ongoing training plans have been stymied in the pandemic, there is a continued call in the field for role specific training to avoid “role bleeding” as well as treatment and recovery training and enhanced use of peer and community supports. These should be delivered as soon as feasible, including on-line options.
Priority	High	

5. **Create new ADTCs in judicial Regions VI and VIII.**

Target	Judicial Branch	There are two judicial regions with no ADTC, Veterans Treatment, or Co-Occurring Disorders Courts. In concurrence with the Governor’s Office of Opioid Response recommendations, treatment courts should be expanded, logically, in the regions where none exist now: Regions VI and VIII.
Priority	Medium	

As part of the expansion, consider experimenting with pre-plea model in the expanded jurisdictions to expand referrals and reduce referral times. In addition, MPS may wish to consider continuing its tracking of out of county referrals as a measurement of counties who are not served but have the greatest need, for treatment court expansion.

6. **Institute activities to support case managers in light of the pandemic.**

Target	MPS	Treatment team members report experiencing extreme stress and secondary trauma during the pandemic due to their concerns about participants. Treatment team members have reported that during the pandemic there have been increases in client overdoses, and more clients are absconding, as well. MPS should develop support activities for treatment team members to address and alleviate pandemic-related stress.
Priority	Very High	

⁵⁹ National Drug Court Institute. (2020). Essential Elements of Adult Drug Courts. Available at <https://www.ndci.org/resources/online-course-essential-elements-adult-drug-courts/>

7. Allocate funds for transportation to treatment court if Medicaid cannot pay.

Target	OBH	Participants report that their transportation can be paid to treatment but not to court itself; this is due to Medicaid reimbursement policy. Many walk from treatment to court. OBH should supplying funds from other sources or vouchers to cover the cost of transportation to treatment court for those who need it.
Priority	Very High	

Judicial Proceedings and Treatment Team

8. In courts which exceed 45 days to admission, develop a streamlined referral process; limit “suitability discussions” consistent with best practice standards.

Target	Judicial Branch	At a Steering Committee meeting courts with shorter referral times can share what they did so that the others could consider what would work for them.
Priority	High	

Examples:

- a. Support staff, such as clerks, should be engaged in the treatment court process and be trained on the benefits of treatment courts. Penobscot has a 72-hour screening after referral policy (goal is 30 days) which was facilitated by assigning a clerk to the treatment court who moves the process and supports the treatment team.
- b. Treatment teams could use their additional case managers, if applicable, to handle screening and referrals to help support the timeliness between admission and referral.
- c. Case managers could interview people in jail to promote early referrals.

People who meet high risk and high need criteria without disqualifying offenses should be admitted to treatment court.

9. Enhance the availability of prosecutorial or Assistant District Attorney time.

Target	Office of the Attorney General	Either adopt Penobscot’s model of moving prosecutorial resources to create a part-time post, focused exclusively on treatment court, or find other resources to attain a part-time prosecutor who will work under the auspices of the elected District Attorney.
Priority	High	

10. Diversify rewards and sanctions.

Target	Judicial Branch	Most rewards given are verbal praise and applause; when participants request passes (e.g., for travel or extended curfew) they are generally provided but rarely initiated by the court. Participants value rewards which mitigate drug court requirements and represent a freedom, or easing of restrictions, such as fewer court appearances or a reduced curfew. Courts have had to develop more inventive sanctions due to COVID-19, with jail and even community service discouraged.
Priority	High	

Instead, they tend to be using increased supervision (e.g., more check-ins) as well as additional therapeutic responses. Judges think these are working well and have vocalized reconsidering the use of punitive sanctions and instead taking more therapeutic approaches.

One tool which is available to enhance supervision, which has been utilized in Kennebec County, is **ReConnect**. It helps keep track of participants' whereabouts by tagging participants' locations and faces during morning check-ins. While taking supervision to another level of intrusiveness, ReConnect can be particularly useful in the pandemic when face to face contact is constrained. Every court has access to the application.

11. Enhance mental health capacity both on the treatment team and in the provision of services; require mental health representation on Treatment Team. (Office of Behavioral Health, Judicial Branch)

Target	Judicial Branch
Priority	High

Some courts are satisfied with available mental health treatment but at least half are not. If courts are not satisfied with mental health treatment the judge, case manager and other treatment team members should meet with OBH and the treatment provider under OBH contract for their court to discuss the adequacy of mental health assessment and treatment options, the way the provider is adhering to its OBH contract requirements (*below*), and steps needed to improve consistent access to mental health treatment, including how to expedite mental health screenings:

Ensure the following counseling is provided to all participants, when included in the Individualized Treatment Plan:

- i. Individual Counseling based on an individual need or the integrated individualized treatment plan;*
- ii. Family Counseling;*
- iii. Group Counseling which shall consist of Intensive Outpatient Services, substance use disorder group, or Dialectical Behavioral Therapy (DBT) depending on the level of care required of the Comprehensive Assessment; and*
- iv. Aftercare Services, if clinically appropriate.*

In addition, due to the prevalence of mental health disorders within the population with substance use disorders, courts should have mental health overtly represented on the Treatment Team. If the current representative is dually licensed, he or she could fulfill the role. Otherwise, a person with mental health credentials should be added.

12. Add a peer representative (recovery coach) to the treatment team.

Target	Judicial Branch
Priority	Medium

To emphasize the importance of peer support in recovery and to balance the oversight and supervision functions with the support functions, many are advocating for a peer voice on the treatment team. This person should help serve as a link to the recovery community for each person who wants it, which is most participants. Many peers are in recovery themselves and some have "lived experience" in

the justice system, including imprisonment. Maine has 800 trained peer recovery coaches and more are planned through the Maine Alliance for Addiction Recovery and other organizations. There are programs to certify peers and groups such as Healthy Acadia⁶⁰ do not require people to be in recovery to be certified, creating choice among models. The Steering Committee should support uniform implementation of peer recovery representatives for consistency across treatment courts. It could work with the peer recovery program to identify and enlist the help of properly trained recovery coaches.

13. Expand use of VRSS to identify veteran candidates for treatment court.

Target	Judicial Branch
Priority	Medium

VRSS is a free application which identifies people in jail who are veterans. Among the courts where expansion is being considered, Penobscot should activate its VRSS account and York should establish one. The Cumberland County Jail appears to be the most active user now and can be used as a

reference for how it is working.

Community Relations

14. Address racial disparity in treatment courts particularly among African Americans who are under-represented.

Target	MPS Special Projects
Priority	High

Maine, as elsewhere in the US has fewer Black participants in treatment court proportionally than in the adjudicated population from which candidates are drawn. Some say the problem is lack of referrals, which derive largely from defense counsel. This recommendation is classified under *community*

relations because PCG accepts the reasoning for the problem and believe both defense attorneys, jail and probation officers and other community members should be engaged in resolving it since they are primary referral sources. This starts with being taught about the issue and the benefits of treatment court, and then working together to create strategies for addressing it. Team members want to see training, public service announcements and marketing to legal defenders, law enforcement and probation officers across the state to raise awareness of treatment courts including their effectiveness and how they are an underutilized tool for fostering racial justice. One element of the training and public relations is treatment courts are underutilized yet effective with people of color.

15. Strengthen relations with the recovery community.

Target	MPS Special Projects
Priority	High

The recovery community provides mutual aid and has a unique culture; when people leave treatment court, they generally need the support of the community to sustain gains. There are burgeoning groups and supports for recovery in the community; examples are Portland Recovery Community

Center, Healthy Acadia and the Maine Prisoner Re-Entry Network (MPRN) which recently received an OBH grant to foster relationships of trained people in recovery with those in in jails

⁶⁰ Healthy Acadia in Hancock County offers free 30-hour Recovery Coach Academy training through an Office of Behavioral Health grant.

and treatment court, initially in Kennebec. Some courts have stronger connections to recovery and support groups in the community than others; some work primarily with AA and NA while others have more expansive relations. All courts are encouraged to expand their relations both to foster formal peer supports and to enhance informal community supports. For some participants these relations are critical to successful aftercare.

16. Foster positive perceptions of specialty courts in the community.

Target	MPS Special Projects
Priority	Medium

Maine needs increased community awareness that treatment courts exist and are effective. The findings of this report can be one tool to illustrate effectiveness. Others are the testimony of people who have succeeded in these programs, at least one of whom has exemplified herself at the national level. A speaker's bureau of graduates could be organized to address local groups. The community can provide tangible support by providing jobs, gift cards, recreational activities and friendship as well as referrals. The coordinator should work with the Court Communication division to design and launch a public information program.

17. Explore creating an emergency fund to support participants with basic needs such as cell phones, car insurance, gas, transportation and housing.

Target	MPS Special Projects
Priority	Medium

There are new resources to support participants such as the EMDC grants to assist with employment, training and housing. Case managers should make the most of these resources. However, funds may be needed for other basics such as cell phones and car insurance. Working with community foundations, rotary clubs, chambers of commerce, a GoFundMe page, a small emergency fund could be created to assist treatment court participants with recovery and community integration.

Next Steps

The Steering Committee should develop a process for considering the recommendations and a plan for moving the most salient ones forward. PCG can assist with the process in the second year of its evaluation contract, upon renewal. This includes working with the Court Communication Division to prepare a draft press release and public presentation of the outcomes.

Appendix A. Co-Occurring Contract Language for Treatment Providers

CO-OCCURRING DISORDERS 1. Co-Occurring Disorders (MH/SA)

In support of the Department statewide initiative to create a system that is welcoming to patients with Co-occurring Mental Health and Addiction Disorders, the agency agrees to the following: (a.) The Provider shall not deny services to any person solely on the basis of the individual's having a known mental illness along with a known substance use/abuse disorder or because that individual takes prescribed psychoactive medications or participates in medication assisted treatment of their substance use. (b.) The Provider shall develop a written protocol or policy that describes its service approach to people with co-occurring mental illness and substance abuse or other co-occurring conditions.

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Version DHHS 2020.1 (c.) The Provider shall document the implementation of a training plan for staff in the interrelationship of mental illness and mood-altering substances, the identification of available co-occurring resources, and the referral and treatment process. (d.) The Provider shall institute a discrete screening process for identifying people with complex, co-occurring needs and diagnoses using a standard tool to be provided by the Department, currently the AC-OK. 2. Co-occurring Disorder Capability Development: The goal of the Department is that all providers are required to be Co-occurring Capable. (COD-C) This expectation is reflected in DHHS policy and current SAMHS regulation.

A COD capable program “is organized to welcome, identify, engage and serve individuals with co-occurring MH disorders and to incorporate attention to these issues in all aspects of program content and documentation. Such programs provide services that incorporate understanding of and approaches to mental health problems as they relate to and affect the substance abuse disorder. For more information, please refer to the Regulations for Licensing and Certifying of Substance Abuse Treatment Programs 14-118 CMR Chapter 5, Effective February 29, 2008, specifically sections 1.15-1.17.1, section 1.75, and section 5.1.

Providers are required to be fully COD capable by implementing the following: (a.) Providers will create and communicate a formal statement of intent to become COD capable to all staff. (b.) Providers will organize a formal Continuous Quality Improvement (CQI) process that addresses this goal. (c.) Providers will perform an organizational self-assessment of COD capability for each program using either the Maine Co-occurring Self-Assessment Tool or the COMPASS EZ. (d.) Providers will develop an action plan based on this self-assessment with measurable and achievable targets determined by the program. (e.) Providers will demonstrate that their CQI process tracks outcomes related to CODC targets. (f.) Providers will demonstrate that their policies and procedures reflect attention to welcoming people with co-occurring diagnoses, improved screening, assessment, documentation, and treatment planning for people with COD, improved coordination of care for people with COD, and improved staff competency in providing services for people with COD. SAMHS will provide assistance with and tracking of requirements in this Rider section at site visits of Block Grant contracted agencies. Requirement of a brief narrative related to COD-C status will be added to the year-end reporting requirement.

Appendix B. Incentive and Sanction Matrix

Step 1. Identify the Behavior

Easier/Proximal	Moderate	Difficult/Distal
<ul style="list-style-type: none"> Attendance at treatment Attendance at other appointments Home for home visits Report to UA Timeliness Payment 	<ul style="list-style-type: none"> Honesty Testing Negative Participating in Prosocial Activities Employment Progress toward Tx Goals Progress in Tx 	<ul style="list-style-type: none"> Complete Tx LOC Extended Abstinence/Negative Tests Treatment Goals Completed Phase Goals Completed Program Goals Completed

Step 2. Determine the Response Level

		Easier/Proximal	Moderate	Difficult/Distal
Distal ↓ Proximal	Phase 1	Small	Medium	Large
	Phase 2	Small	Medium	Large
	Phase 3		Small	Large
	Phase 4		Small	Large
	Phase 5		Small	Medium

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

3a. Incentive Response

Small	Medium	Large
<ul style="list-style-type: none"> Fishbowl Decision Dollars Example for other participants in court Handshake Candy ≤ 1-day reduction of curfew 	<p>Any small and/or:</p> <ul style="list-style-type: none"> ≤ 3-day reduction of curfew Choice of Gift Certificate Supervisor Praise Written Praise Positive Peer Board Certificate Reduction in CS hours Reduction in program fees 	<p>Any small, medium or:</p> <ul style="list-style-type: none"> Framed Certificate Travel Pass Larger Gift Certificate Position as Mentor to New P participants Reduction of Curfew

3b. Therapeutic Response

	Phase 1	Phase 2	Phase 3	Phase 4
Single Event	<ul style="list-style-type: none"> Behavior Chain Cost/Benefit Analysis 	<ul style="list-style-type: none"> Behavior Chain Cost/Benefit Analysis 	<ul style="list-style-type: none"> Behavior Chain 	<ul style="list-style-type: none"> Behavior Chain
Continued Progress		<ul style="list-style-type: none"> Change in LOC 	<ul style="list-style-type: none"> Aftercare Frequency Re-evaluate Pharmacological Interventions 	<ul style="list-style-type: none"> Aftercare Frequency Re-evaluate Pharmacological Interventions

3c. Supervision Responses

Phase 1	Phase 2	Phase 3	Phase 4
<ul style="list-style-type: none"> Change in Curfew Status 	<ul style="list-style-type: none"> Reduced Contacts Reduction in Home Visits 	<ul style="list-style-type: none"> Reduced Contacts Reduce Home Visits Reduce in External Monitoring Devices 	<ul style="list-style-type: none"> Reduced Contacts Decreased Drug Testing

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

Step 1. Identify the Behavior

Low (Less Immediate)	Moderate	High (More Immediate)	Very High
<ul style="list-style-type: none"> Late for Scheduled Event Missed payment 	<ul style="list-style-type: none"> Missed UA Failure to Complete Assignments 	<ul style="list-style-type: none"> Unexcused Absence Alcohol Use Drug Use Tamper w/ UA or device Dishonesty 	<ul style="list-style-type: none"> Criminal behavior (new crimes, drinking and driving) Arrest

Step 2. Determine the Response Level

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

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

3a. Sanction/Punishment Responses

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

3b. Therapeutic Responses

Level 1	Level 2	Level 3	Level 4	Level 5
<ul style="list-style-type: none"> • Behavior Chain • Cost/Benefit Analysis • Skill Development • Thought Restructuring • Homework/Practice • Thinking Report 	<p>Level 1 plus:</p> <ul style="list-style-type: none"> • LOC Review 	<p>Level 1, 2, plus:</p> <ul style="list-style-type: none"> • Referral Medication Eval • Treatment team Review/Round Table 	<p>Level 1, 2, 3, plus:</p> <ul style="list-style-type: none"> • Re-Assessment 	

3c. Supervision Responses

Level 1	Level 2	Level 3	Level 4	Level 5
<ul style="list-style-type: none"> • ≤ 1 additional report days/week • Official Letter in File 	<ul style="list-style-type: none"> • ≤ 2 additional report days/week • Home Visit • Curfew 	<ul style="list-style-type: none"> • Continuous Testing • GPS/Electronic Monitoring • ≤ 3 additional report days/week • Home Visit • Increase frequency UA Test • Contingency Contract • Additional Court Report • Case Conference 	<ul style="list-style-type: none"> • ≤ 4 additional report days/week • Contingency Contract • Electronic Monitor Device • Case Conference • Curfew 	

Appendix C: Training Events

2017

March 27–28, 2017 Drug Court Tune Up Training by NADCP/NDCI

September 25, 2017 Statewide Standards by NADCP

October 16–19, 2017 Moral Reconciliation Therapy training by Correctional Counseling Inc. (developer of MRT)

November 29–30, 2017 Treatment court judges and AOC staff attended NEADCP Conference

2018

April 30, 2018 MAT protocol development training by NDCI/ONCDP for all teams

August 22–24, 2018 VTC Implementation Training by Justice for Vets for Kennebec VTC

October 15–17, 2018 VTC team travel to Buffalo (NY) VTC for mentor court visit

November 28–29, 2018 All treatment court judges, and AOC staff attended NEADCP Conference

2019

April 3–5, 2019 NDCI 3-day ADTC Implementation Training for Bangor ADTC.

June 10–12, 2019 Center for Court Innovation training on VTC for Kennebec VTC

July 15, 2019 1st Annual Governors Opioid Response Summit

July 18, 2019 9th Annual Maine Military & Community Network Conference

October 15, 2019 CODC, VTC, Cumberland ADTC toured IMHU at the prison

September 11, 2019 VA Mental Health Summit at Togus

October 25, 2019 Incentives and Sanctions training by NDCI for Cumberland, Androscoggin, and York ADTCs

November 20–21, 2019 Most treatment court team members attended NEADCP conference

Appendix D: Effects of Secondary Trauma

