

# A BETTER PATH FOR MAINE

**The case for  
decriminalizing  
drugs**

**ACLU**  
Maine

+



Maine Center for  
**Economic Policy**







# TABLE OF CONTENTS

<b>ACKNOWLEDGEMENTS</b>	<b>4</b>	<b>THE COSTS OF CRIMINALIZATION</b>	<b>27</b>	People with substance use disorder do not find lasting recovery in prison or jail nor are they able to get adequate treatment there	<b>43</b>
<b>EXECUTIVE SUMMARY</b>	<b>6</b>	The financial cost of criminalizing people who use drugs	<b>27</b>	Deferred dispositions and drug courts expand punitive efforts to control and surveil people	<b>46</b>
<b>METHODOLOGY</b>	<b>9</b>	The state continues to prioritize criminalization when public health measures would be cheaper	<b>29</b>	<b>DECRIMINALIZATION WORKS</b>	<b>49</b>
A note on data limitations	<b>9</b>	Criminalizing people who use drugs is ineffective and harmful	<b>30</b>	More than 20 years after decriminalizing drug possession, Portugal has seen dramatic increases in health and safety and reductions in incarceration	<b>49</b>
What are we talking about?		Criminalization of drugs compounds racial inequality in the legal system	<b>32</b>	Change is coming to the United States	<b>51</b>
An introduction to language and definitions	<b>10</b>	The criminalization process traumatizes people who use drugs and leaves lasting damage	<b>35</b>	<b>RECOMMENDATIONS</b>	<b>52</b>
<b>INTRODUCTION</b>	<b>12</b>	People living in poverty and with low income are disproportionately harmed by criminalization	<b>37</b>	<b>CONCLUSION</b>	<b>54</b>
Why do people use drugs? All kinds of reasons, none of which should be criminalized	<b>12</b>	<b>THE LEGAL SYSTEM'S APPROACH IS NOT A HEALTH APPROACH</b>	<b>39</b>	<b>APPENDICES</b>	<b>56</b>
Mental health, trauma and substance use in Maine	<b>15</b>	The role of law enforcement, charged with investigating crime and enforcing laws, conflicts with the role of health care providers caring for patients	<b>39</b>	APPENDIX I: Other terms you should know	<b>56</b>
<b>AN OVERVIEW OF MAINE'S CRIMINAL DRUG LAWS</b>	<b>18</b>	Criminalizing drug possession prevents people from completing treatment	<b>42</b>	APPENDIX II: Calculating the cost of criminalizing drug use	<b>56</b>
Maine relies on plea deals, rather than trials, to determine peoples' guilt	<b>20</b>				
Incarcerating people for drug possession when they have substance use disorder violates the Eighth Amendment's ban on cruel and unusual punishment	<b>22</b>				
<b>THE CURRENT CHRONIC CRISIS: OPIOIDS IN MAINE</b>	<b>23</b>				

# ACKNOWLEDGEMENTS

This report is a joint project of the ACLU of Maine and the Maine Center for Economic Policy (MECEP). Winifred Tate, Associate Professor of Anthropology at Colby College, is the report's lead author. Meagan Sway, Policy Director at the ACLU of Maine, and James Myall, Economic Policy Analyst at Maine Center for Economic Policy, are co-authors. It was edited by Anita Little.

We are extremely grateful to Zoe Brokos, who conducted interviews and provided key expertise and insight.

We would also like to thank Alison Beyea, qainat khan, Michael Kebede and Zach Heiden at the ACLU of Maine; Garrett Martin and Dan D'Ippolito at MECEP; and Michael LeVert of Stepwise Data Research for their review and feedback.

We thank Wendy Smith, Bruce Noddin, Rosie Boyce, Mikki Rice, Matt Gunn, Bobby Payzant, Gen Lysen, Chantal St. Laurent, and others who wished to remain anonymous, for their time, expertise, and giving us feedback on the report.

Finally, we are indebted to — and grateful for — the people who agreed to be interviewed for the report. This report would not be possible without the willingness of people to share their experiences of the harm of criminalization.







# EXECUTIVE SUMMARY

## OBJECTIVES AND SCOPE

No one should die or have their life derailed because they, or someone they love, uses drugs. But that is what is happening in Maine because of criminalization: There are very real economic and social costs because Maine criminalizes drug use and possession. We talked to more than 150 people — those who have been arrested for drug crimes, their family members as well as prosecutors, defense attorneys, treatment providers and harm reduction workers. In these pages, we'll detail the enormous toll that drug laws take on our communities.

Our data is pulled from interviews conducted in person, over the telephone and on Zoom. We also submitted public records requests and reviewed academic public health research, as well as local and national media stories covering drug policy.

The report illustrates the harm that criminalization does to individuals and their families and how much money the state has spent to do so. Our recommendations will not only help people who use drugs, but will mean wiser investments of public funds.

We hope this report will make a new way in Maine, one that turns away from old systems of punishment and towards an investment in communities and connection.

## II. FINDINGS

Criminalizing people who use drugs has significant adverse economic and social costs. These policy choices make the possibility of a healthy life less likely for people who use drugs.

Of the 38,893 arrests made by Maine law enforcement agencies in 2019, around one in eleven — 3,614 — were for drug-related offenses. These arrests were mostly for low-level offenses. Almost three quarters of drug arrests were made for charges of drug possession.

Every year, state and local governments in Maine spend \$111 million criminalizing people who use drugs. The impacted individuals themselves then pay another \$33 million towards the cost of criminalization and incarceration.

Maine has chosen to prioritize and invest in criminalization of drug use over a public health approach. Increases to spending on treatment have been well-outpaced by increases to spending on criminalization. Between 2014 and 2019, inflation-adjusted spending on substance use treatment through the MaineCare system increased 2 percent. However, over the same period, state and local spending on corrections increased 13 percent, while spending on police enforcement increased 14 percent.

Maine's law enforcement spends \$8,427 alone for each drug-related arrest. This amount could cover seven months of rent in Cumberland County, two-thirds of the cost of educating a public school student for a whole year, or four months of intensive outpatient treatment for someone on MaineCare.

A year in state prison costs more than twice as much as it would cost to provide housing, weekly counseling and medication-assisted treatment for a year at current MaineCare reimbursement rates.

The investment in criminalization is not an effective way to keep people alive and healthy. It achieves the opposite. Criminalization places lawyers and police in charge of health care decisions. The isolation and disconnection of prison or jail time can interrupt treatment and lead to an increased likelihood of overdose after release. And the criminal records that people get from drug charges means they are forever branded as criminals, making employment, housing and other necessary processes very difficult to get and keep. People who use drugs face stigma because of all this criminal punishment.

Criminalization also compounds racial disparities in our criminal legal system. Enforcement of drug laws is where we see the most dramatic difference between how white people and Black people are treated by the legal system. Black people who use drugs are more than 3.5 times as likely to be arrested for drug possession as white people who used drugs in Maine. The disparities get worse the higher the charge.

The tools the legal system uses to keep people from incarceration for drug use — deferred dispositions and drug courts — replicate the harms that criminalization causes. Instead of investing in these avenues, we should look at other places that have created real alternatives, like Portugal and Oregon. These places have used decriminalization initiatives to strengthen public health endeavors and reduce their incarcerated populations. Maine is ready for this path forward.

### III. RECOMMENDATIONS

Policymakers in Maine can and must turn away from old models that rely on punishment. Instead, they should do the following:

- Decriminalize the use and possession of drugs by completely removing from our laws all criminal punishments for these acts
- Invest in treatment and recovery-related housing
- Invest in public and mental health
- Invest in community connection
- Improve data collection about drug criminalization and make it publicly available

Maine has a once-in-a-generation opportunity to invest in people. The State of Maine is projected to have an unprecedented budget surplus of \$1.2 billion over the next two state fiscal years. The federal government has also allocated hundreds of millions more in financial aid to the state and local governments in Maine through the American Rescue Plan Act of 2021. County, municipal and tribal governments in Maine will receive just over \$500 billion to assist in economic recovery from the COVID-19 pandemic. Evidence has shown that the COVID-19 pandemic coupled with the economic recession had an outsized impact on people with substance use disorder and 2021 was the worst year yet for drug overdoses in Maine. Now is the time to turn away from harmful policies and instead invest in our communities.



## EXCERPT FROM THE PORTLAND PRESS HERALD

**The criminal justice system has for decades now played a central role in addressing addiction in our communities. On any measurable scale, it has failed.**

**Charging and incarcerating people with substance use disorder has turned sick people into criminals. It has ruined hopes of stable housing and gainful employment. To those laid low by trauma and disconnection, it has added more.**

**At the same time, drugs are more plentiful and stronger than ever. More people are dying than ever.**

**It's not working. It's costing lives. It must change.**

**Why? Because if someone has a problem with substance use, they won't find the help they need in jail, where they are isolated from family and community, and addiction treatment and other health care are spotty at best.**

**Instead, jail provides a criminal record that must be explained on every application for housing, education and employment, making it exceedingly difficult to get a foothold back in society.**

**Jail, too, makes worse the problems of mental health, neglect and trauma that often lead to substance misuse. And it rarely improves things; those recently released from incarceration are at an extremely high risk of overdose.**

**And if it's a parent who is incarcerated, those problems are easily passed onto the next generation.**

**Incarcerating people who suffer from a clear, though complex, health problem is simply not getting it done. Here and there, there are stories of people shocked into sobriety by the threat of jail. But those are the exceptions — the criminal justice system more often than not pulls people in and doesn't let go.<sup>1</sup>**

---

<sup>1</sup> Editorial Board, "Our View: Maine Drug Laws Only Making Bad Situation Worse," Portland Press Herald, June 9, 2021, <https://www.pressherald.com/2021/06/09/our-view-maine-drug-laws-only-make-bad-situation-worse/>.

# METHODOLOGY

The report is based on more than 150 interviews conducted in person, over Zoom and on the telephone; information provided to the ACLU of Maine and MECEP based on public information requests; and a review of academic public health research regarding drug use.

Between February 1, 2021 and November 30, 2021, we interviewed 22 people who use drugs and have been prosecuted for their use and three family members of people who have been prosecuted for their drug use. We also interviewed 11 prosecutors and defense attorneys who work on drug cases regularly, as well as 10 treatment providers.

The authors also analyzed the ongoing research conducted by the Maine Drug Policy Lab at Colby College. Since 2019, the Maine Drug Policy Lab research team has completed 20 interviews with incarcerated women in Aroostook and Kennebec county jails; 24 life history interviews with women in recovery or in active use; 20 interviews with participants in Maine Adult Drug Treatment Courts; 16 interviews with law enforcement personnel; and 28 interviews with health care providers and recovery personnel. We have also attended multiple community events addressing drug use and what the collective response should be.

COVID-19 impacted the research for this report as we had to conduct most interviews by Zoom and phone, and the amount of fieldwork we were able to conduct was reduced.

Indigenous communities in Maine have been profoundly affected by substance use disorder and overdose death. In part because of COVID-19 complications, we were unable to conduct planned research, and hope that future work can focus on this.

Interviews happened individually and in private. All interview subjects were offered anonymity, and all named subjects authorized the use of their quotations.

MECEP and the ACLU of Maine submitted a series of data requests regarding arrests, prosecutions, case outcomes and demographics for drug offenses to a number of government bodies, including the Maine Attorney General, Maine District Attorneys, the Maine Judicial Branch, the Maine Department of Corrections, county correctional facilities and the Maine Commission on Indigent Legal Services.

In addition, the authors reviewed a wide range of academic studies and policy reports on drug consumption, the history of drug policy, the impact of arrest and incarceration on individuals and communities, harm reduction strategies, treatment for substance use disorder and pathways to recovery. We also studied testimony on drug policy legislation before the Maine legislature and media coverage of drug-related issues in Maine and the United States.

## A NOTE ON DATA LIMITATIONS

Gathering reliable data on Maine's law enforcement and incarceration systems is incredibly difficult. Relatively little data is posted publicly online, and as a result, researchers have to rely on Freedom of Access requests to state agencies for information. These requests can be both time-consuming and expensive. Some particularly concerning gaps in the data on Maine's criminal legal system include limitations in the Maine State Police criminal database as well as lack of access to court records and severely limited data on county jails.<sup>2</sup>

<sup>2</sup> Some of the specific limitations include: (1) The Maine State Police maintain a criminal record database, but are unable to provide information such as how many individuals in Maine have criminal records, let alone the number of individuals in the state with drug-related arrest records; (2) There is no easy public access to court records in Maine. While the Judicial Branch is gradually transitioning to an electronic records system, this new system includes a fee structure which would make large scale data retrieval prohibitively expensive for researchers, and requires researchers to take up the time of administrators in the Administrative Office of the Courts to retrieve basic information; and (3) County jails are particularly opaque. Most post no record of the number of individuals incarcerated, demographic information, the crimes for which they are held, or the length of pretrial incarceration.



A significant portion of this report was made possible by data gathered for a small series of reports by the Council of State Governments' Justice Center in 2019.<sup>3</sup> One-time reports like these offer the public a window into Maine's criminal legal system — but this window should not be limited to occasional reports from out-of-state organizations. As CSG noted in its recommendations to the legislature, improving data collection and availability must be a top priority for lawmakers to address problems in the criminal legal system.<sup>4</sup>

## WHAT ARE WE TALKING ABOUT? AN INTRODUCTION TO LANGUAGE AND DEFINITIONS<sup>5</sup>

**“People who use drugs”** avoids judgmental or stigmatizing language, and acknowledges that people use drugs for many reasons. The vast majority do not have substance use disorder or experience problematic substance use.

**“Criminalization”** is the act of making something illegal. People involved in criminalized activities are subject to control by the legal system, including surveillance, arrest and punishment such as fines and incarceration.

**“Substance use disorder”** is characterized by a chronic relapsing brain disorder where one repeatedly consumes drugs despite negative

consequences. The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, known as the DSM-5, includes 11 criteria for substance use disorder that fall into four categories:

- Impaired control, such as using more than intended or being unable to stop or reduce use;
- Social problems, such as neglecting responsibilities or abandoning activities;
- Risky use; and
- Physical dependence, such as needing more drugs to achieve the same effect, increased tolerance, or having withdrawal symptoms when a substance is not used.

**Resumption of use**, commonly referred to as a relapse, is a symptom of substance use disorder.

**“Problematic use”** describes drug use that may not meet all the criteria for substance use disorder, but that creates harm to the person who uses drugs, their family or their community. Problematic substance use is complex, and involves a range of biochemical and contextual factors. Many of the harms identified with problematic use may result from drug policies that criminalize drug use, rather than drug use itself. For example, increased rates of HIV and Hepatitis C infections among people who use drugs are the result of the lack of access to sterile syringes, but are not inherent to drug use.

**“Recovery”** is defined by people in different ways, not all involving being substance-free. For the purposes of this report, we use the federal Substance Abuse and Mental Health Services Administration's (SAMHSA) working definition: “[a] process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their

---

<sup>3</sup> See Council of State Governments, *Justice Reinvestment in Maine*, <https://csgjusticecenter.org/projects/justice-reinvestment/past-states/maine/> (accessed December 27, 2021).

<sup>4</sup> See Council of State Governments, “Policy Framework: Justice Reinvestment in Maine Improving Supervision and Data Collection,” January 2021, [https://csgjusticecenter.org/wp-content/uploads/2021/01/JR-Maine-Policy-Framework\\_FINAL.pdf](https://csgjusticecenter.org/wp-content/uploads/2021/01/JR-Maine-Policy-Framework_FINAL.pdf).

<sup>5</sup> We provide these terms to help people understand the language we use in the report and to avoid harmful or stigmatizing language to the extent possible. Language is fluid and responds to changing social norms and pressures. In many communities, people who identify as part of that community can use language that would be stigmatizing and harmful coming from people outside that community.



full potential.”<sup>6</sup> According to SAMHSA, there are four major dimensions that support a life in recovery:

- **Health.** Overcoming or managing one’s disease(s) or symptoms — for example, abstaining from use of alcohol, illicit drugs and non-prescribed medications if one has a [substance use] problem — and for everyone in recovery, making informed, healthy choices that support physical and emotional wellbeing;
- **Home.** A stable and safe place to live;
- **Purpose.** Meaningful daily activities, such as a job, school, volunteerism, family caretaking or creative endeavors, and the independence, income and resources to participate in society; and
- **Community.** Relationships and social networks that provide support, friendship, love, and hope.<sup>7</sup>

“**Treatment**” for substance use disorder is complex, and there is no single treatment that is right for everyone. Quick and easy access to treatment is vital. The process can include:

- **Withdrawal (also known as detoxification or detox)** is not treatment, but is the first step. Treatment for withdrawal addresses symptoms, which can be extremely debilitating, including muscle pain, anxiety, fatigue, sweating, vomiting, diarrhea, depression and insomnia. Alcohol is the only substance for which withdrawal can be fatal.
- **Outpatient behavioral treatment** includes a wide variety of programs for patients who visit a behavioral health counselor on a regular schedule. Most of the programs involve individual or group drug counseling, or both.

- **Inpatient or residential treatment** can include 24-hour structured and intensive care, including safe housing and medical attention.
- **Medication-Assisted Treatment** (also known as “MAT”). Medications are available for treatment of opioid, tobacco and alcohol use disorders.<sup>8</sup> Medication-assisted treatment usually refers to one of three medications for opioid use disorder: methadone, buprenorphine and naltrexone. Acting on the same targets in the brain as heroin and morphine, methadone and buprenorphine suppress withdrawal symptoms and relieve cravings. Methadone and buprenorphine remain highly regulated by the federal Drug Enforcement Agency (DEA). In contrast, naltrexone blocks the effects of opioids at their receptor sites in the brain and should be used only in patients who have already been detoxified. Medication-assisted treatment is also known as opioid agonist treatment, and is the safest and most effective treatment for opioid use disorder. Opioid agonist treatment is particularly critical for pregnant people with opioid use disorder, as withdrawal can cause miscarriage and other fetal harms.

---

<sup>8</sup> Some drug policy experts argue that “medication-assisted treatment” should be simply known as “treatment” for substance use disorder, and that distinguishing some treatment as “medication-assisted” is stigmatizing. Because the designation of medication-assisted treatment is widely used in Maine and widespread acceptance of medication-assisted treatment as a treatment modality is relatively new, we have opted to use the term “medication-assisted treatment” when discussing treatment programs that offer medication as an option.

---

<sup>6</sup> US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, “SAMHSA’s Working Definition of Recovery,” 2012, p. 3. <https://store.samhsa.gov/sites/default/files/d7/priv/pep12-recdef.pdf>,

<sup>7</sup> Ibid.

# INTRODUCTION

Maine has a drug problem, but not in the way you think. The state's problem is how it treats people who use drugs and how it under-resources the infrastructure for recovery. Both problems are rooted in the state's drug policy. For more than 100 years, Maine has criminalized people who use drugs. It has subjected them to surveillance, arrest, incarceration and lifelong criminal records. These policies make our state worse off. They generate more harm, waste money and prevent people who want help from getting it.

This report takes a deep look at the harms caused by criminalizing people who use drugs, and the disastrous consequences for our communities. Arrest and incarceration have become commonplace but the fact is that these are radical, extreme measures. They not only take away people's freedom and opportunities, but also their ability to maintain housing, employment, family and community connections. Arrest and incarceration have significant financial and social costs for the individual, their family and their community. Putting people who use drugs into the criminal legal system does not help them. We show why doing more of the same — criminalizing people who use drugs — does not just waste money, it creates more trauma and harm.

We hear often about reducing stigma in the public response to the current overdose death crisis. Campaigns will focus on changing the language we use to talk about people who use drugs. These steps are important, but to truly reduce stigma, we must change laws — not just individual attitudes. Our laws determine society's values. They establish who is a victim and who deserves to be punished. When something is criminalized, it cannot be

destigmatized. In order to eradicate the stigma of substance use disorder, we must decriminalize drug use and possession.

There is a clear consensus for a public health approach to address the needs of people with substance use disorder. It is time to ensure our policies center and support that approach. In order to do so, we must decriminalize the possession and use of drugs in our state and invest in our communities.

## **WHY DO PEOPLE USE DRUGS? ALL KINDS OF REASONS, NONE OF WHICH SHOULD BE CRIMINALIZED**

People use drugs — alcohol, cannabis, stimulants and narcotics — for a range of reasons. They use substances to relax after a long day at work, or to treat themselves for psychological and physical distress. Opioids can help people in pain from workplace injuries. Stimulants help people stay awake and alert for physically demanding jobs with irregular shifts, or to stay safe while living on the street.<sup>9</sup> Many people who use drugs are self-medicating for trauma, depression and anxiety when they do not have access to adequate legal health care. Substances help people manage the stress of daily life.

---

<sup>9</sup> A 2021 study of post-eviction drug use and overdose death in Vancouver found that “a sizable minority of participants reported initiating or intensifying methamphetamine use — often alongside opioids — post-eviction to “stay awake and alert” or “get through the day” as they attempted to keep safe and protect their possessions while living on the street.” Ryan McNeil et al., “Navigating Post-Eviction Drug Use Amidst A Changing Drug Supply: A Spatially-Oriented Qualitative Study Of Overlapping Housing And Overdose Crises In Vancouver, Canada,” *Drug and Alcohol Dependence* vol. 222 (2021), p. 108666.

While 92,000 people in Maine over the age of 12 consumed some kind of illicit substance<sup>10</sup> in 2018-2019, rates of problematic use were much lower. Just 17,000 (less than 20 percent) were dependent on those substances, while an additional 3,000 (3 percent) were engaged in problematic use, according to the National Survey on Drug Use and Health.<sup>11</sup>

Of all the substances consumed by people in Maine, alcohol is the most widely used, with significant and wide-ranging health effects.<sup>12</sup> Excessive alcohol consumption causes significant organ damage, and for people who are physically dependent, alcohol withdrawal can be fatal, unlike withdrawal for other substances. On average, 450 people in Maine each year die from alcohol-induced causes.<sup>13</sup>

As a society, we regulate who can drink alcohol, who can sell alcohol and how it can be produced. This keeps people from dying from adulterated or toxic moonshine. At the same time, we recognize that adults have the right to

consume alcohol without the fear of arrest and the isolation of incarceration, whether they are celebrating a social occasion or suffering from the end stages of alcoholism-induced liver failure due to cirrhosis. We limit alcohol consumption by age, regulate its production to ensure minimal quality standards and determine how it can be safely used.

The vast majority of people who use drugs do not experience problematic substance use. They use drugs recreationally, and it does not interfere with their daily life. Most people who try illegal drugs do not become dependent or develop substance use disorder. Many who use drugs regularly for a period of time in their life stop without any outside treatment or support. One famous study used the “natural experiment” of soldiers returning from the war in Vietnam to analyze how people who used drugs to cope with a traumatic environment stopped. While 35 percent of enlisted men reported using heroin while deployed abroad, 88 percent of them spontaneously stopped once they returned to the United States.<sup>14</sup>

Research on people in the upper and middle class who use drugs without experiencing substance use disorder, and on the majority of people who use drugs who stop without seeking outside support, is very difficult. Upper- and middle-class people who use drugs can manage their drug use in the privacy of their own homes. People who use drugs are generally reluctant to expose themselves because drug use is illegal and highly stigmatized. Consequently, the full range of experiences of people who use drugs hasn’t been analyzed.

People with physical dependence or substance use disorder consume drugs to maintain their physical wellbeing. We often hear that people

---

**10** SAMHSA uses the term “illicit drug use” to include use of illegal substances such as heroin, cocaine, and methamphetamine, as well as the misuse of legal substances such as prescription medications. Because cannabis use is decriminalized in Maine, this report excludes cannabis use from this definition.

**11** US Department of Health and Human Services, Substance Abuse and Mental Health Services Agency, “National Survey on Drug Use and Health, Restricted-Use Data Analysis System,” 2018-19, retrieved via <https://rdas.samhsa.gov/>. SAMHSA uses the term “substance abuse” rather than problematic use.

**12** For comprehensive statistics, see US Department of Health and Human Services, Center for Disease Control and Prevention, “Deaths from Excessive Alcohol Use in the United States,” <https://www.cdc.gov/alcohol/features/excessive-alcohol-deaths.html>; Marissa B. Esser et al., “Deaths and Years of Potential Life Lost From Excessive Alcohol Use — United States, 2011–2015,” *Morbidity and Mortality Weekly Report*, vol. 69 no. 39 (2020), pp. 1428–1433, <https://www.cdc.gov/mmwr/volumes/69/wr/pdfs/mm6939a6-H.pdf>.

**13** US Department of Health and Human Services, Center for Disease Control and Prevention, “Multiple Causes of Death Mortality Data,” 2017-2019 annual average, Deaths from alcohol-related poisonings and all other alcohol-induced causes, retrieved via <https://wonder.cdc.gov/mcd.html>.

---

**14** Lee N. Robins et al., “Vietnam Veterans Three Years after Vietnam: How Our Study Changed Our View of Heroin,” *The American Journal on Addictions*, vol. 19 no. 3 (2010), pp. 203–211.



with substance use disorder deserve treatment and support, and that we cannot arrest our way out of this problem.<sup>15</sup> Yet people with substance use disorder continue to be arrested, and most who come into the criminal legal system do not get the support they need. These are among the most vulnerable people in our communities. This report focuses on their experiences.

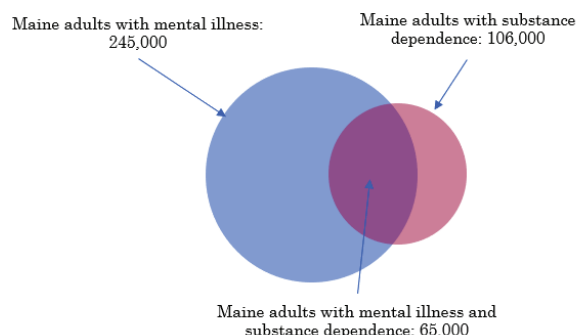
<sup>15</sup> See, e.g., Caroline Losneck, “Portland Chief: ‘We Cannot Arrest Our Way Out’ of Opioid Crisis,” *Maine Public*, April 7, 2016, <https://www.mainepublic.org/health/2016-04-07/portland-chief-we-cannot-arrest-our-way-out-of-opioid-crisis>; Taylor Kinzler, “Opioid Epidemic in Maine: Operation Hope,” *WABI-5*, June 26, 2017, <https://www.wabi.tv/content/news/Opioid-Epidemic-in-Maine-Operation-Hope-430858513.html>.

**“There is a clear consensus for a public health approach to address the needs of people with substance use disorder. It is time to ensure our policies center and support that approach. In order to do so, we must decriminalize the possession and use of drugs.”**

#### **PERSONAL HISTORY: RECOVERY WITHOUT CRIMINALIZATION<sup>16</sup>**

*As a young adult in Vermont, Sarah was sent to an inpatient residential treatment program for drinking and smoking cannabis. After 20 days of inpatient treatment, she moved back in with her family. She started using cocaine and heroin recreationally after moving to Portland. Ecstasy was cheap and widely available, and Sarah quickly learned how to sell it. This extra money allowed her to buy other drugs that were also readily available — klonopins, cocaine, crack, heroin and Xanax — daily, for several months. She met a man who eventually became her first husband, and drug use took a back burner in her life. Sarah focused on her domestic life and caring for her step-daughter. They enjoyed frequent vacations, but her husband was also emotionally and physically abusive. When the abuse became too much, Sarah left her husband and his daughter, whom she loved as her own child. She turned back to drugs at this point and started using prescription stimulants and heroin on a daily basis. Later that year, she reunited with a man who she had been in a relationship with before her marriage. He took buprenorphine in order to not rely on illicit opioids, which were rapidly becoming more dangerous. Sarah tried his Suboxone strips for the first time and felt the same relief and comfort that heroin brought, but without the danger of overdose caused by an adulterated street supply or the risks of buying off the street. It was consistent and safe. As she finalized her divorce from her first husband, she was able to get relief from buprenorphine without the heavy nod or anxiety about legal or employment repercussions that came from heroin. Sarah knew that it helped her feel less anxious and helped her get through the deep trauma of divorce and separation from her step-child. She continued to use buprenorphine and figured out how much was too much, how much felt good and safe, and how to keep her tolerance manageable, so she wasn’t constantly increasing the amount she needed to use. As Sarah settled into a new life with her new partner, they used buprenorphine bought from friends. This was her daily remedy to avoid other substances that were higher risk and more dangerous. Eventually, she was able to get a prescription of her own. Sarah was never arrested or incarcerated for her drug use or possession. She did not face the disruption of her employment, her housing or her relationships. Despite relapses and drug use during different periods of her life, Sarah achieved recovery with the support of her friends, her partner and ultimately her medical doctor.*

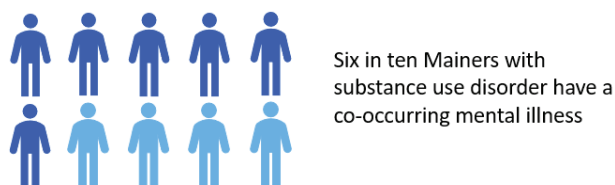
<sup>16</sup> Name changed by request, interview on September 11, 2021.



**Figure 1: Many people in Maine experience co-occurring mental illness and substance use disorder**

SOURCE: NATIONAL SURVEY ON DRUG USE AND MENTAL HEALTH, 2018-19<sup>1</sup>

**F1** SAMHSA uses the term “substance dependence” which corresponds with our use of the term “substance use disorder.”



**Figure 2: Six in ten people in Maine with substance use disorder have a diagnosed co-occurring mental illness**

SOURCE: NATIONAL SURVEY ON DRUG USE AND MENTAL HEALTH, 2018-19

## MENTAL HEALTH, TRAUMA AND SUBSTANCE USE IN MAINE

The research for this report focused on people who have been involved with the criminal legal system because of their substance use. In the vast majority of these cases, people reported using substances to manage untreated mental health issues related to poverty, lack of access to comprehensive medical care and experiences of trauma. All of the women interviewed for this report, and the vast majority of the men, described significant trauma histories and mental health challenges. In the stories they told, they used substances because of barriers to other forms of treatment and because of a lack of social support.

Research demonstrates a high correlation between adverse childhood experiences (ACEs) and substance use disorder. The ACEs framework has drawn attention to the lifelong consequences of adverse childhood experiences, including higher rates of problems with substance use.<sup>17</sup>

### PERSONAL HISTORY<sup>18</sup>

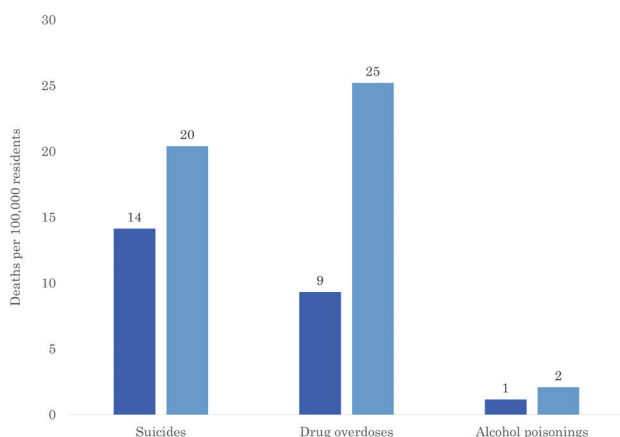
*For me, it was always more of a mental health issue than it was a substance issue. I'm going to be honest, substances were never the problem. They were the solution. They were what was saving me from pretty early suicide. ... I had no idea what I was going to do. And I was severely, severely depressed already. I felt really disengaged from everyone I had grown up with. Part of that was race, part of that was just what I was into, part of that was just general, severe social anxiety. So I'd say in college, around 19, or 20, is when things really started just escalating really fast. In the summers, I was homeless ... I came back with the intention of living with a friend, and we had a falling out. I ended up living that summer out of my car. I was holding down a nine-to-five, more or less, work in retail, and the only way that I could really do it because I was sleeping so [badly] was to utilize uppers in whatever capacity they would come.*

<sup>17</sup> See Daniel J. Bryant et al., “Association of Adverse Childhood Experiences (ACEs) and Substance Use Disorders (SUDs) in a Multi-Site Safety Net Healthcare Setting,” *Addictive Behaviors Reports*, vol. 12 (2020), p. 100293; see also William Garriott and Eugene Raikhel, “Addiction in the Making,” *Annual Review of Anthropology*, vol. 44 no. 1 (2015), pp. 477-491; Leire Leza et al., “Adverse Childhood Experiences (ACEs) and Substance Use Disorder (SUD): A Scoping Review,” *Drug and Alcohol Dependence*, vol. 221 (2021), p. 108563.

<sup>18</sup> Interview on April 28, 2021.

### PERSONAL HISTORY<sup>19</sup>

*[At age] 14, 15 is when I really hit the drugs hard. When I was 13, they had me on one milligram of Xanax three times a day. That's a lot for a 13 year old, but my anxiety was so high, and they assumed that was the only thing they could do for me. And, you know, that's how doctors are. They push medication on people, and pretty much at 13, I didn't know any coping skills. I grew up poor, 26 schools in 10 years, we moved around so much. At 15, I started right off the bat shooting heroin, smoking crack. Doing the hard, hard drugs. A lot of it was to numb all the mental health issues. I didn't want to feel all the hurt and anger and pain of growing up. My childhood was not good at all, not at all.*



**Figure 3: Increases in drug overdose deaths have been accompanied by increases in other 'deaths of despair'**

SOURCE: MECEP'S ANALYSIS OF CDC MORTALITY DATA. DATA REFLECTS THE UNDERLYING CAUSE OF DEATH

Opioid misuse is part of a wider pattern of substance use and declining mental health. During the period in which drug overdose deaths have risen fastest, rates of suicide and deaths caused by alcohol use have also risen, albeit more slowly.<sup>20</sup> The switch from

prescription to illicit opioids, and the continuing increase in alcohol misuse and suicide rates suggests that the misuse of opioids should be seen as a symptom of a wider trend, not a discrete problem. One way to think about opioid misuse is to go beyond the treatment of physical pain to the treatment of psychic pain, or mental distress. Opioids, including illegal opioids like heroin and non-pharmaceutical fentanyl, have similar neurological and physical effects to alcohol — a short-term high, followed by drowsiness and mental numbness. Studies suggest for people misusing pain medication for reasons other than treating physical pain, excessive alcohol use is also significant.<sup>21</sup>

### PERSONAL HISTORY<sup>22</sup>

*I was dealing with all of this pain and depression and all of that because I dealt hard with [the death of my brother and sister]. Actually, in a roundabout way, I didn't deal with any of it. I just kind of closed it up and medicated it with drinking. I got with this guy, he was an addict ... And I told him how bad it was. But I dealt with it. ...And at that time, it was oxy. That's what his thing was, and that was it. This was 2013. Prescriptions were really big on the streets. And it pretty much went downhill from there.*

In their 2015 report and later book, Princeton economists Anne Case and Angus Denton documented increasing mortality rates and lowered average life spans of white non-Hispanic men, arguing that the primary cause was the increases in so-called “deaths of despair:” drug use, alcohol and suicide.<sup>23</sup> It is

<sup>19</sup> Interview on March 5, 2021.

<sup>20</sup> US Department of Health and Human Services, Centers for Disease Control, Mortality Data (Underlying Cause of Death), 2008-2019, retrieved via CDC Wonder, <https://wonder.cdc.gov/ucd-icd10.html>.

<sup>21</sup> Traci C. Green et al., “Typologies of Prescription Opioid Use in a Large Sample of Adults Assessed for Substance Abuse Treatment,” *PLoS ONE*, vol. 6 no. 11 (2011), <https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0027244>.

<sup>22</sup> Interview on September 4, 2019. Edited for clarity.

<sup>23</sup> Anne Case and Angus Denton, “Rising morbidity and mortality in midlife among white non-Hispanic Americans in the 21st century,” *PNAS*, vol. 112 no. 49 (2015), pp. 15078-15083.



important to note, however, that persistent and pervasive health inequalities and the cumulative effects of systemic racism mean that even with these declines in white male mortality, the life expectancy of people of color, and particularly Black men, remains much lower than that of white men.<sup>24</sup> Other scholars have attributed the increasing death rate to majority white communities' rejection of expanded access to health care — a rejection fueled by racial resentment.<sup>25</sup>

Maine certainly shares many of these characteristics: It is the oldest state in the country; it is the second whitest; the state has suffered an economic decline in rural and micropolitan areas. Former Governor Paul LePage refused to expand Medicaid during his tenure in office — despite the measure passing five times in the legislature and finally by ballot initiative. Medicaid expansion did not occur in the state until 2019.

In 2018 and 2019, people in Maine with substance use disorder were more than twice as likely as other people in the state to be without any health insurance coverage.<sup>26</sup> Lack of access to affordable health care both increases substance use and makes life harder for people who use substances.

People without access to health care — either for physical ailments or mental health concerns — are more likely to turn to substance use as a form of self-medication, and the cost of treatment can be a substantial barrier to better health.

Widening access to services can reverse these trends. According to several studies, Medicaid expansion has improved mental health, and reduced suicide and overdose rates in states that adopted it.<sup>27</sup> Indeed, since Maine expanded its program in 2019, over 18,000 Mainers have been able to get access to substance use treatment who did not previously have it.<sup>28</sup>

#### PERSONAL HISTORY<sup>29</sup>

*[Drug use was] an escape. It was freedom. It was peace. It was a refuge for me. It allowed me to not think about what I had done. The only way I could cope with that was to get that few hours away. I was able to sleep. They call it a nod period, you're not really sleeping. But to me, it was peace. And that's why it's so hard for me. I don't deal with emotions very well. It's emotions that are my trigger. It's not necessarily seeing people high, knowing I'm around it, any of that stuff. It's when I get an emotion that I don't want to feel.*

**24** Timothy J. Cunningham et al., “Vital Signs: Racial Disparities in Age-Specific Mortality Among Blacks or African Americans — United States, 1999–2015,” *Morbidity and Mortality Weekly Report*, vol. 66 no. 17 (2017), pp. 444–456; see also Maureen R. Benjamins et al., “Comparison of All-Cause Mortality Rates and Inequities Between Black and White Populations Across the 30 Most Populous US Cities,” *JAMA Open Network*, vol. 4 no. 1 (2021), p. e2032086.

**25** Jonathan Metzl, *Dying of Whiteness: How the Politics of Racial Resentment Is Killing America's Heartland* (New York: Basic Books, 2019).

**26** US Department of Health and Human Services, Substance Abuse and Mental Health Services Agency, “National Survey on Drug Use and Health, Restricted-Use Data Analysis System,” 2018–19 data, retrieved via <https://rdas.samhsa.gov/>. The National Survey on Drug Use and Health uses the terms “substance use dependence” and “substance use abuse” to define these categories. The definitions for these groups largely overlap with our definition of substance use disorder.

**27** See, e.g., Anna E. Austin et al., “Association Between Medicaid Expansion and Suicide Mortality Among Nonelderly US Adults,” *American Journal of Epidemiology*, vol. 190 no. 9, (2021), pp. 1760–1769; Mark Borgschulte and Jacob Vogler, “Did the ACA Medicaid Expansion Save Lives?,” IZA Institute of Labor Economics, DP No. 1255 (2019), available at <https://ftp.iza.org/dp12552.pdf>; Nicole Kravitz-Wirtz et al., “Association of Medicaid Expansion With Opioid Overdose Mortality in the United States,” *JAMA Network Open* 3(1):e1919066 (2020), available at <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2758476>.

**28** Maine Department of Health and Human Services, *MaineCare (Medicaid) Update*: October 4, 2021, <https://www.maine.gov/dhhs/data-reports/mainecare-expansion> (accessed December 28, 2021).

**29** Interview on October 9, 2019.

# AN OVERVIEW OF MAINE'S CRIMINAL DRUG LAWS

Like federal law, Maine law organizes drugs into categories, called “schedules,” listing out all drugs in Schedules W through Z.<sup>30</sup> Most drugs sold on the street, including cocaine, methamphetamine, heroin and fentanyl are Schedule W drugs. Possession of any amount of a Schedule W drug, no matter how small the amount, is a crime.<sup>31</sup>

A person who is found by police in possession of Schedule W drugs may be charged with three main types of crime: possession, furnishing or trafficking.<sup>32</sup> These crimes represent a continuum, from the least serious, possession,<sup>33</sup> to furnishing (giving another person drugs),<sup>34</sup> to the most serious, trafficking (giving another person drugs in exchange for something of value).<sup>35</sup> For all of these crimes, people may be

charged based solely on the amount of drugs they have on them at the time of arrest, regardless of whether they intended to share or sell the drugs. The amount of drugs a person possesses and that person’s prior convictions determine the eligible sentence for each of these crimes.

<sup>30</sup> 17-A M.R.S. §1102.

<sup>31</sup> *Id.* § 1107-A(1)(C).

<sup>32</sup> There are also separate, less-frequently charged crimes for marijuana cultivation, when people are caught cultivating outside of the medical or recreational cannabis laws, *id.* at §§1105-D, 1117; importation of scheduled drugs, *id.* at §§1118, 1118-A; operation of a methamphetamine lab, *id.* at §§1105-D, 1124; acquiring drugs by deception, *id.* at §1108; and stealing drugs, *id.* at §1109.

<sup>33</sup> *Id.* §1107-A(1) (defined as “intentionally and knowingly possess[ing] what that person knows or believes to be a scheduled drug”).

<sup>34</sup> *Id.* § 1101(18) (defining furnishing as “[t]o furnish, give, dispense, administer, prescribe, deliver or otherwise transfer to another; or [t]o possess with the intent to do any” of those things).

<sup>35</sup> *Id.* §1101(17) (defining trafficking as “[t]o make, create, manufacture; [ ] grow or cultivate, except for marijuana; [t]o sell, barter, trade, exchange or otherwise furnish for consideration; or [t]o possess with the intent to do any” of those things).

## What Do These Weights Equal?



**200 milligrams is equivalent  
to the weight of a raindrop**



**2 grams is equivalent to the  
weight of half a sugar packet**



**4 grams is equivalent to the  
weight of four paperclips**

## DRUG POSSESSION

For people without prior trafficking or furnishing convictions, possession of 200 milligrams or less of most Schedule W drugs is punishable by up to 364 days in prison and a \$2,000 fine.<sup>36</sup> Possession of more than 200 milligrams of those drugs is at least a Class C crime, punishable by up to five years and a \$5,000 fine.<sup>37</sup>

Prior convictions for drug trafficking or furnishing any time in a person's past can increase what otherwise would be a misdemeanor drug possession charge into a felony, also punishable by up to five years in prison and a \$5,000 fine.<sup>38</sup>

## DRUG FURNISHING

Possession of just 200 milligrams of meth or oxycontin, or 2 grams of cocaine, heroin or fentanyl, gives rise to a permissible inference<sup>39</sup> of drug furnishing, regardless of whether the drugs were intended for personal use or sharing.<sup>40</sup> Furnishing of Scheduled W drugs is a Class C crime, punishable by up to five years in prison and a \$5,000 fine.<sup>41</sup>

Prior felony drug convictions any time in a person's past can increase the furnishing charge to aggravated furnishing, which is a Class B crime, punishable by up to 10 years in prison and a \$10,000 fine.<sup>42</sup>

---

**36** Possession of less than 200 milligrams of heroin, oxycodone, hydrocodone, hydromorphone, methamphetamine, and fentanyl powder and less than 2 grams of cocaine is a Class D crime. 17-A M.R.S. §1107-A(1)(C).

**37** A person possessing more than 200 milligrams but less than 4 grams of those drugs could be charged with felony possession, 17-A M.R.S. §1107-(B), drug furnishing, *id.* §1106, or drug trafficking, *id.* §1103(3).

**38** *Id.* §1107-A(1)(B-1).

**39** We discuss permissible inferences in the section below.

**40** *Id.* §1106(3).

**41** *Id.* §1106(1-A)(A).

**42** *Id.* §1105-C(1)(B)(1).

## DRUG TRAFFICKING

Possession of 4 grams of heroin or fentanyl creates a permissible inference that a person is guilty of drug trafficking.<sup>43</sup> Drug trafficking is a Class B crime, punishable by up to 10 years in prison and a \$10,000 fine.<sup>44</sup>

Prior felony drug convictions any time in a person's past can increase the trafficking charge to aggravated trafficking, which is a Class A crime, punishable by up to 30 years in prison and a \$50,000 fine.<sup>45</sup>

### A NOTE ABOUT DRUG TRAFFICKING CHARGES

Increased tolerance, a symptom of substance use disorder, means that using the same amount of a substance has a diminishing effect over time. The amount of substances consumed in a day depends on the person's physiology, their tolerance and the kind of substance used. Because of this, increasing punishment according to weight more heavily penalizes people whose bodies metabolize drugs quickly and need more to keep withdrawal symptoms at bay. Allowing drug trafficking convictions based only or mainly on the amount of drugs a person has on them similarly punishes people with advanced substance use disorder. The science of drug use and our interviews with people who have been charged with trafficking show that it is rarely big-time drug sellers who are ensnared by drug trafficking laws. These trafficking laws do the same or worse harm to vulnerable people by imposing harsher sanctions and more stigmatizing convictions based on the amount of drugs a person carries at any one time.

---

**43** *Id.* §1103(3)(C-1).

**44** *Id.* §1103(1-A)(A).

**45** *Id.* §1105-A(1)(B).



#### PERSONAL STORY<sup>46</sup>

*We would sell some tickets [100-200 milligrams each]. We weren't making money. We would get — if we were lucky — a place to sleep for the night, a pack of cigarettes, and some food to get by. ...We were homeless junkies, sleeping in a tent behind the jail ... When I got arrested, I was doing seven to 10 grams a day.*

### MAINE RELIES ON PLEA DEALS, RATHER THAN TRIALS, TO DETERMINE PEOPLES' GUILT

In Maine, like the rest of the country, the overwhelming majority of drug possession cases are resolved through some form of plea deal. In 2019, just half of one percent (0.5 percent) of drug possession cases were resolved at trial.<sup>47</sup> Plea agreements have essentially replaced trials as the method by which drug cases are resolved. Because prosecutors decide who to charge, what to charge and what sentences they are willing to propose to a judge, they wield tremendous power. “In a world of guilty pleas, the prosecutor’s determinations of what to charge

and what bargain to offer are the ball game.”<sup>48</sup>

Several laws enhance Maine prosecutors’ power and diminish defendants’ bargaining positions:

#### **No requirement to prove intent to secure a trafficking or furnishing conviction.**

Until October 2021, Maine law defined possession of more than 200 milligrams but less than 2 grams of heroin or fentanyl powder as illegal drug furnishing and possession of 2 grams or more of those drugs as illegal drug trafficking, regardless of whether a defendant intended to share the drugs or use the drugs personally.<sup>49</sup> Two grams of heroin or fentanyl is the amount that many people with substance use disorder or dependence consume in a day. Daily consumption for people with severe substance use disorder can be significantly more.

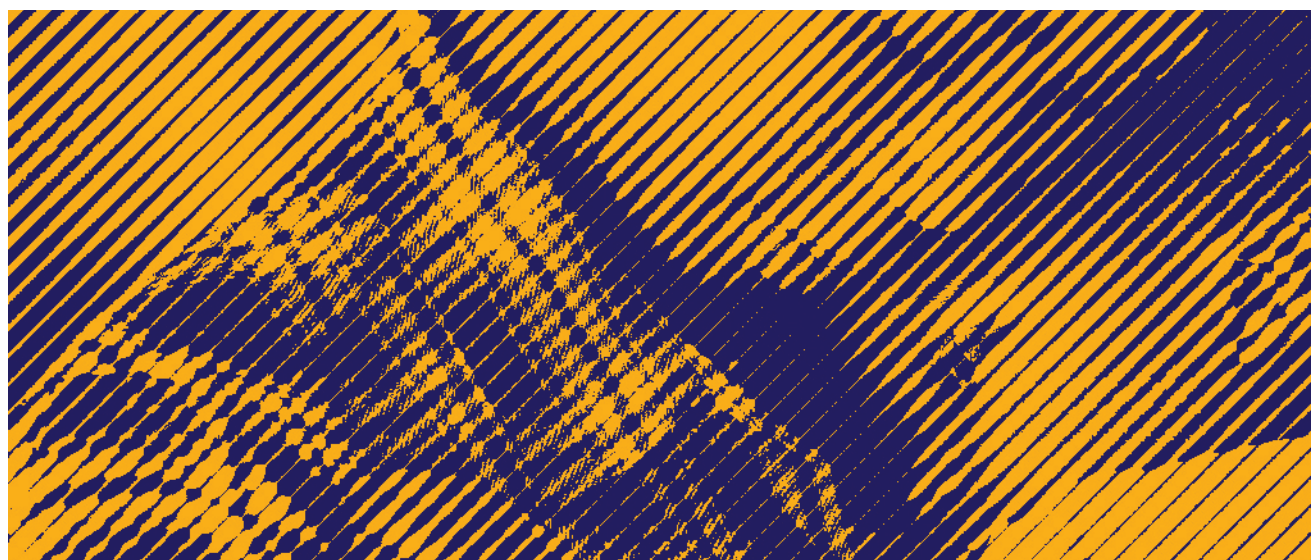
While the legislature did change parts of the trafficking and furnishing laws in 2021, it left in the law that possession of certain amounts of drugs creates a permissible inference of trafficking or furnishing. A permissible inference is a statutory evidentiary tool that allows a jury

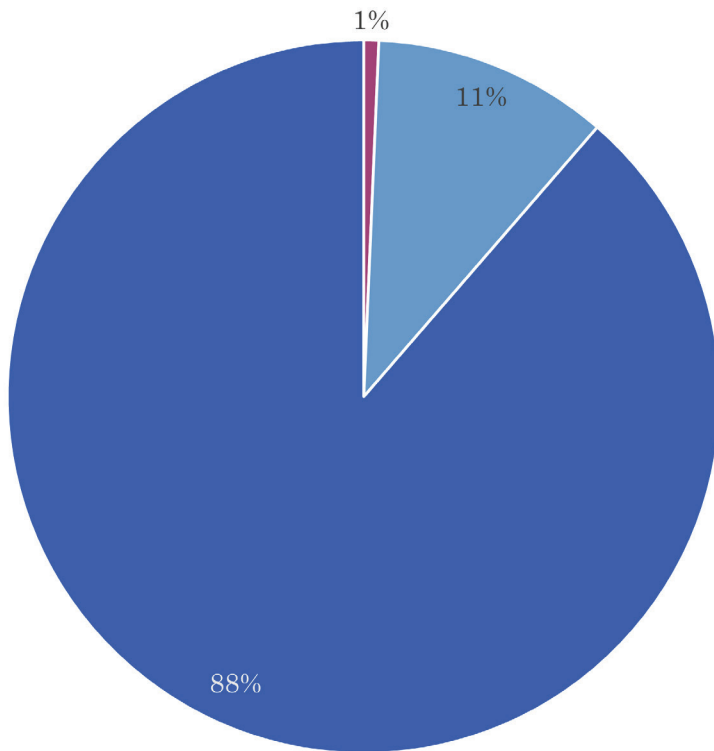
<sup>46</sup> Interview on February 21, 2021.

<sup>47</sup> Calculation based on MECEP’s analysis of data received from Maine Administrative Office of the Courts for drug charges brought in 2019 and resolved by December 2021.

<sup>48</sup> Adriaan Lanni and Carol Steiker, “A Thematic Approach to Teaching Criminal Adjudication,” 60 St. Louis U. L.J. 463, 469 (2016).

<sup>49</sup> This changed with P.L. 2021, ch. 396, § 1.





**Figure 4: The vast majority of drug cases are resolved by plea deal in Maine**

SOURCE: MECEP'S ANALYSIS OF DATA OBTAINED FROM ADMINISTRATIVE OFFICE OF THE COURTS

- Charges resulting in trial
- Charges dismissed before trial
- Charges resulting in guilty plea

to infer an element of a crime if there is proof of another fact that is commonly associated with that element. In the case of drug trafficking and furnishing, this means that if the prosecution can prove that a defendant intentionally or knowingly possessed a certain amount of drugs, the judge or jury may infer the defendant was guilty of trafficking or furnishing drugs. This makes it easier for prosecutors to get convictions and makes going to trial riskier for defendants.

#### **The use of prior felony convictions to increase the seriousness of current criminal charges.**

For many drug crimes, if a defendant has a prior felony drug conviction at any time in their past, the prosecution can charge them with a more serious (“aggravated”) crime that carries a longer sentence and higher possible fine.<sup>50</sup>

<sup>50</sup> See 17-A M.R.S. §§ 1105-A(1)(B), 1105-B(1)(B), 1105-D(1)(A), 1105-E(1)(A), 1107-A(1)(A).

**Statutory mandatory minimum sentences.** For certain felony drug charges, judges may not sentence defendants to less than 3 to 9 months imprisonment.<sup>51</sup> The higher the felony the prosecutor charges, the higher the mandatory minimum sentence, making it riskier for defendants to go to trial.

**Enhanced financial penalties.** Courts can order defendants to pay additional financial penalties if the prosecution proves the value of the drugs that were the basis for the conviction.<sup>52</sup> For example, if the prosecution charges someone with drug possession and can prove that the drugs the defendant is accused of possessing were worth \$500, the judge can impose an additional \$500 fine as part of the sentence. This gives defendants a financial incentive to plead guilty to avoid extra fines.

<sup>51</sup> See *id.* at § 1125(3).

<sup>52</sup> *Id.* §1126(1).

## INCARCERATING PEOPLE FOR DRUG POSSESSION WHEN THEY HAVE SUBSTANCE USE DISORDER VIOLATES THE EIGHTH AMENDMENT'S BAN ON CRUEL AND UNUSUAL PUNISHMENT

Not everyone who is arrested on drug charges has a substance use disorder, but many do. Some supporters of criminalizing drug use have said that these laws are necessary to protect people from their own behavior. For example, one Maine District Attorney told the legislature's Criminal Justice and Public Safety Committee that she uses charges and bail conditions to pressure people into treatment.<sup>53</sup> Such an argument may be well-intentioned, but good intentions cannot convert unconstitutional cruel and unusual punishment into something legally acceptable. Criminal sentences, even those imposed out of concern for the health of the person charged, are punishment, and punishing someone for their medical condition is cruel and unusual.

As Supreme Court Justice Abe Fortas wrote more than half a century ago, "the foundation of individual liberty and the cornerstone of the relations between a civilized state and its citizens [is that c]riminal penalties may not be inflicted upon a person for being in a condition he is powerless to change."<sup>54</sup> The Supreme

Court addressed this issue in *Robinson v. California*, where the court found that it would violate the Eighth Amendment's ban on cruel and unusual punishment to imprison someone for "even one day" just for being a person with substance use disorder.<sup>55</sup> The court compared it to putting someone in jail for having a common cold. In order to fully honor the reasoning behind the *Robinson* decision, we ought not punish people who possess or use drugs merely for possessing or using them.

Even for those who use drugs who do not have substance use disorder, penalizing drug possession with criminal sanctions violates the civil liberties principle that the criminal law should not be used to impose the government's idea of morality and personal responsibility. If a person harms others or puts others at risk, there are separate criminal and civil laws for that. As an example, we impose criminal penalties on people who drive while intoxicated,<sup>56</sup> but being intoxicated in the privacy of one's own home is not a crime.<sup>57</sup> The same principle should apply to other substances: what a person does with their own body, so long as it does not harm others, should not be a crime.

---

<sup>53</sup> Testimony of District 6 District Attorney Natasha Irving on behalf of Maine Prosecutors' Association before the Joint Standing Committee on Criminal Justice and Public Safety, *An Act To Make Possession of Scheduled Drugs for Personal Use a Civil Violation: Hearing on LD 967*, 130th Legislature, April 30, 2021, available at <http://www.mainelegislature.org/legis/bills/getTestimonyDoc.asp?id=157454> (last accessed February 8, 2022).

<sup>54</sup> *Powell v. Texas*, 392 U.S. 514, 567 (1968) (Fortas, J., dissenting, joined by Douglas, Brennan, & Stewart, JJ.); see also, *Kahler v. Kansas*, 140 S. Ct. 1021, 1039 (2020) (Breyer, J. dissenting) ("A defendant who, due to mental illness, lacks sufficient mental capacity to be held morally responsible for his actions cannot be found guilty of a crime."); see also *Harper v. Zegeer*, 296 S.E.2d 873, 875 (App. Ct. W. Va. 1982) (criticizing *Powell* for allowing criminal punishment for alcoholics, who have a behavioral health condition that vitiates the voluntariness requirement of criminal culpability, and holding that incarceration of people with alcoholism violated West Virginia's prohibition of cruel and unusual punishment).

---

<sup>55</sup> *Robinson v. California*, 370 U.S. 660, 667 (1962). Despite this, the court took pains to emphasize that it did not find laws that punish someone for possessing or ingesting drugs illegal, just laws that punish people because they have a disease, *id.* at 666. To say that it violates the Eighth Amendment to punish someone because of their substance use disorder, but not for engaging in a defining characteristic of that disorder, splits hairs too finely. It is difficult to justify that distinction on any basis other than hostile animus towards people who use drugs.

<sup>56</sup> 29-A M.R.S. §2411.

<sup>57</sup> Maine law does punish public intoxication if a person drinks liquor within 200 feet of a posted notice or after being told by police not to drink in public, 17 M.R.S. §2003-A.



# THE CURRENT CHRONIC CRISIS: OPIOIDS IN MAINE

The situation in Maine exemplifies what has been called a “triple wave epidemic,” with opioid use at the center of steady increases in overdose deaths.<sup>58</sup> At every turn, state laws attempting to limit access to these drugs made the situation more dangerous. Overprescribing by physicians began the expansive use of opioids, encouraged by aggressive marketing from pharmaceutical companies. The legal restrictions on prescribing pain medication forced people to turn to street drugs like heroin. Fentanyl emerged as a major danger to people who use drugs in the late 2010s.

The first wave in Maine dates to the late 1990s, when prescription opioid medication became widely used in the state. The aggressive and false marketing of highly addictive OxyContin encouraged, and in some cases rewarded, high levels of prescribing. In the 1990s, Purdue Pharma hid evidence that their opioid products were highly addictive, and worked to block regulation by Congress into the 2000s.<sup>59</sup> By 2008, Maine had the highest rate of residents in treatment for addiction to prescription medication. At eight times the national average, 386 people per 100,000 were in treatment, according to the U.S. Substance Abuse and Mental Health Services Administration.<sup>60</sup> In 2016, Maine ranked first in

the nation in per-capita prescription rates of long-acting/extended-release opioids.<sup>61</sup>

The second wave in Maine began in the mid-2010s, as obtaining legal prescriptions became increasingly difficult. Opioid prescription rates in Maine peaked in 2011, with just over 93 prescriptions written annually per 100,000 residents. Since then, the prescribing rate has fallen in half, with just over 44 prescriptions per 100,000 residents issued in 2019.<sup>62</sup> People who had developed a dependence on prescribed opioids began to use heroin obtained on the black market to prevent withdrawal. Between 2009 and 2019, the proportion of people in Maine who used illicit drugs other than cannabis was essentially unchanged, at 7.4 percent of the population.<sup>63</sup> Yet within this group, patterns of drug use shifted. Rates of prescription pain reliever misuse dropped significantly over the decade, while heroin use increased fourfold.<sup>64</sup>

<sup>58</sup> Daniel Ciccarone, “The Triple Wave Epidemic: Supply and Demand Drivers of the US Opioid Overdose Crisis,” *International Journal of Drug Policy* vol. 71 (2019), pp. 183–188.

<sup>59</sup> Patrick Radden Keefe, *Empire of Pain: The Secret History of the Sackler Dynasty*, (New York: Doubleday, 2021).

<sup>60</sup> Zach Howard, “Maine Sore Spot in Nation’s Prescription Drug Scourge,” *Reuters*, April 21, 2011, <https://www.reuters.com/article/us-oxycontin-epidemic-idUSTRE73K38Q20110421>.

<sup>61</sup> Shannon Monnat (Federal Reserve Bank of Boston), “Drugs, Death, and Despair in New England,” *Communities and Banking*, (2016), p. 25 <https://www.bostonfed.org/-/media/Documents/cb/2016/fall/Drugs-Death-and-Despair-in-New-England.pdf>.

<sup>62</sup> State of Maine, *Maine Drug Data Hub*, <https://mainedrugdata.org/> (accessed December 28, 2021). In 2016, legislation limited opioid prescriptions by amount (up to 100 milligrams) and in time (up to 7 days for acute pain and 30 days for chronic pain). P.L. 2015, ch. 488, §13.

<sup>63</sup> US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, “National Survey on Drug Use and Health, Restricted-use Data Access System,” 2008–09 and 2018–19 data, retrieved via <https://rdas.samhsa.gov/>. The share of people in Maine aged 12+ who used illicit drugs other than marijuana in the past year did increase from 7.4% in 2008–09 to 7.9% in 2018–19, but that increase was within the margin of error and not statistically significant.

<sup>64</sup> *Ibid.*

**PERSONAL HISTORY:  
FROM PRESCRIPTION MEDICATION  
TO HEROIN TO OVERDOSE DEATH<sup>65</sup>**

*Jane [named changed] started illegally using prescription medication with her boyfriend. The high from the pills treated her undiagnosed depression and eased her grief after the death of family members. When they could no longer buy pills on the street, they switched to heroin.*

*"It was great. I had energy. I could do anything. I felt great. Nothing bothered me, you know? I didn't have a care in the world. Like I didn't think about all the bad things. It was like, you know, I was happy. It made me happy.*

*Once you get that feeling, you look for it again when you come off it. So, you know, he was using oxys on a regular basis. ... Back then we were getting \$30 for 30 [mg pills]. When 30s became scarce on the street, in the beginning of 2016, he introduced me to heroin because we couldn't find oxys. He's like, we need heroin, it's the same thing. So I dabbled in it a little bit. I didn't really care for it, so I did it for a little while. But that day we happened to go get some, and I did the same heroin he did. I don't know if he got more and hid it from me or not. Because the last time we did any was at 3 o'clock that afternoon. And it was 8 o'clock at night, when I found him ... When I walked around the living room, he was collapsed on the living room floor. I tried to wake him up, I pumped on his chest. I called 911. I called his mom. I tried to revive him. I did everything 911 asked me to do. He wasn't coming to. By the time they got there, they made me leave the room, and then one of the paramedics came out and said that they couldn't revive him. Gone ... I had never injected, always snorted. I never ever injected anything. I went into a spiral after that. And instead of it going, 'Oh, hey, smarten up,' I went the other direction."*

The third wave started as higher-potency fentanyl began to circulate in the black market, leading to escalating overdose death rates. As heroin became more difficult to find, distributors added fentanyl. Fentanyl is a synthetic opioid approved and regulated by the FDA for medical use as an anesthetic and for pain relief after surgery. Fentanyl is 40 times more powerful than heroin by weight.

By 2016, harm reduction activists noted the product on the street that was being sold as heroin had almost none. According to the Maine Drug Enforcement Agency, "samples of purported heroin and cocaine now routinely contain fentanyl, making them difficult to distinguish, absent laboratory analysis."<sup>66</sup>

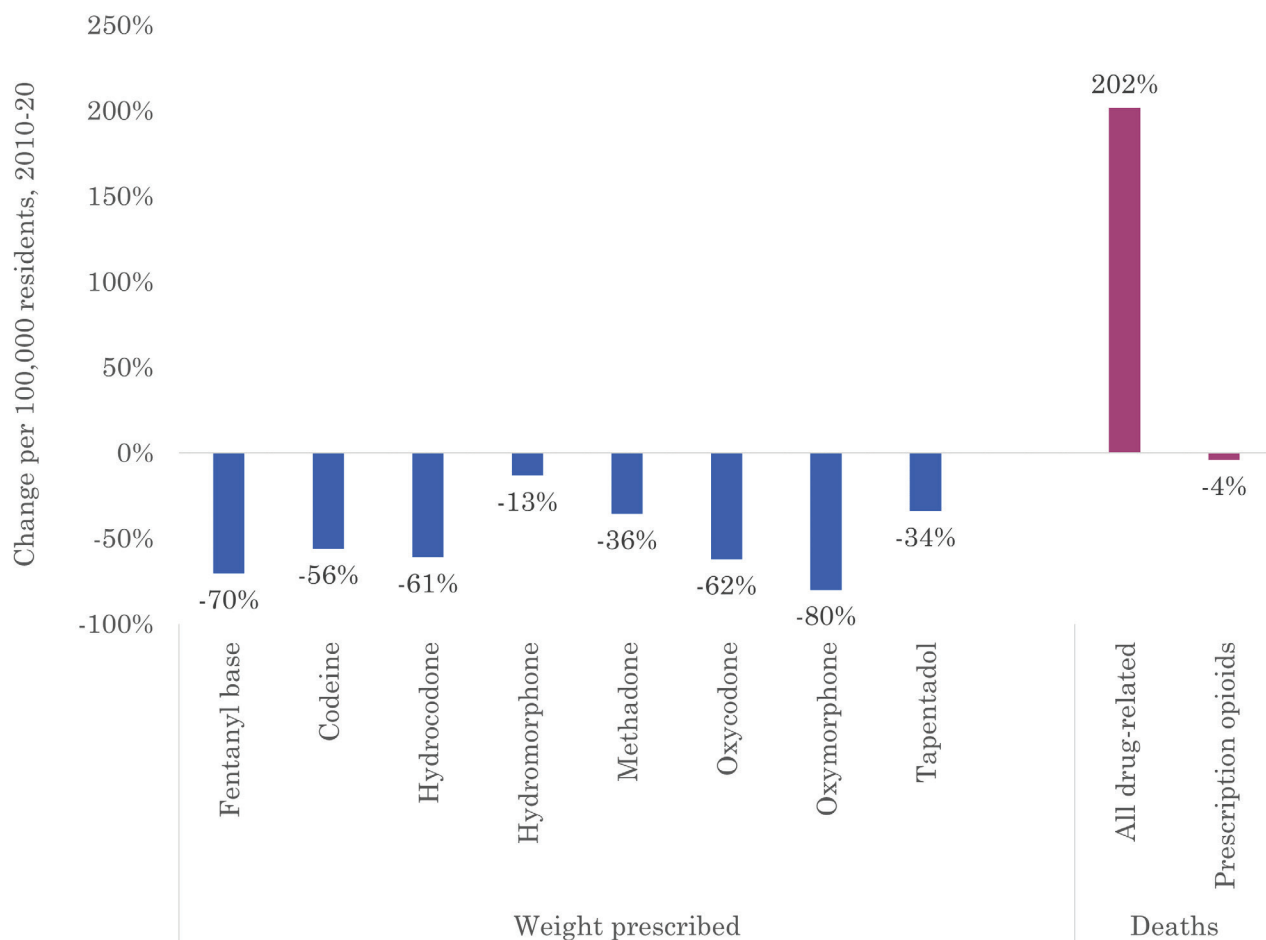
The use of non-regulated fentanyl and its chemical cousins resulted in highly variable potency. People who use drugs did not know what they were taking and were unable to calculate the dose. Overdose reports increased. The inconsistency of its strength made its effects hard to predict: A 0.1 gram injection of the new product could cause an overdose one day and barely be enough to prevent withdrawal symptoms the next. The change in product also meant a change in use amounts required to not feel debilitating withdrawals. Whereas heroin's effects last six to eight hours and usually people with substance dependence ingest two or three times a day, fentanyl doesn't last as long and the physical and psychological symptoms of withdrawal become noticeable two to three hours after use. As heroin became less available, reports of daily use amounts increased quickly.

---

<sup>66</sup> Maine Department of Public Safety, "Maine Drug Enforcement Agency Annual Report 2019," p. 10, <https://www.maine.gov/dps/mdea/documents/2019AnnualReport.pdf>.

---

<sup>65</sup> Interview on August 9, 2019. Edited for clarity.



**Figure 5: Interrupting access to pharmaceuticals hasn't reduced deaths**

SOURCE: MECEP'S ANALYSIS OF US DEPARTMENT OF JUSTICE, AUTOMATED REPORTS AND CONSOLIDATED ORDERING SYSTEM DATA, 2010-2020

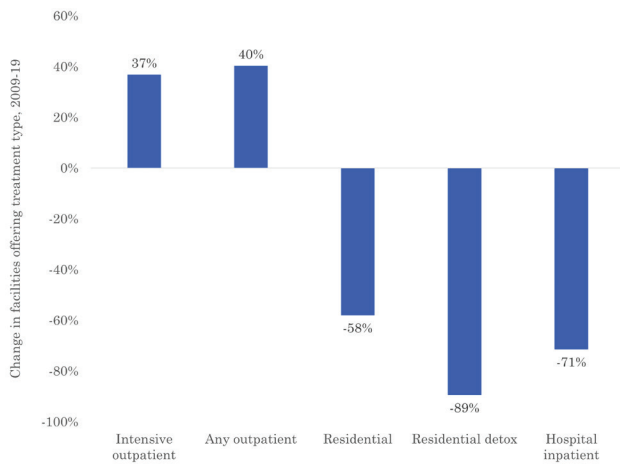
#### PERSONAL HISTORY<sup>67</sup>

*Your tolerance builds up with fatty [fentanyl]. You might start out with a \$20 ticket [100-200 milligram shot], getting [extremely] high but two weeks later you're doing half gram shots. And it wears off in two hours. So you're doing a half gram every two hours, at least, just to feel normal ... I was doing gram or gram-and-a-half shots — shots that could kill other people. Every hour, on the hour, just barely getting high. Just enough to get out of bed in the morning.*

The number of overdose deaths in Maine show the impact of this shift. In 2010, 127 people in Maine died of opioid overdoses, nearly all of whom were only using pharmaceutical opioids, meaning opioids that were produced in regulated laboratories. By 2019, while the number of deaths from pharmaceutical opioids alone had more than halved (to 48), the number of deaths involving non-prescription opioids, heroin and illegally

<sup>67</sup> Interview on February 21, 2021.





**Figure 6: Since 2009, facilities are increasingly offering outpatient treatment, with fewer residential treatment and detox facilities available**

SOURCE: US SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES AGENCY, TREATMENT EPISODE DATA SET, 2009-19 DATA

produced fentanyl, had skyrocketed to 268.<sup>68</sup> Maine's policies had successfully reduced the supply of pharmaceuticals, but these had been replaced by deadlier, unregulated alternatives.

The fourth wave in Maine has begun. People are using a combination of substances, such as opioids and stimulants together.<sup>69</sup> Fentanyl is almost always found as a co-intoxicant with other substances. In 2020, two-thirds of drug deaths in the state included fentanyl and another substance.<sup>70</sup> Increasingly, drug deaths have included not just narcotics like heroin, but also stimulants such as cocaine and amphetamines.<sup>71</sup> In this fourth wave, reliance on

medication-assisted treatment alone is increasingly insufficient and the spike in polysubstance use requires investment in broader treatment and recovery supports.

While there has been a welcome expansion of outpatient treatment options in Maine, residential treatment options have dramatically declined. Medically-supervised detox is extremely difficult to access in Maine, leaving people who want treatment without options. For people with severe substance use disorder, residential treatment remains a critical intervention. The sharp reduction in such options is devastating to people seeking extended support for their recovery.

**Figure 7: Drug-related charges filed in Maine in 2019**

SOURCE: MECEP'S ANALYSIS OF DATA RECEIVED FROM THE ADMINISTRATIVE OFFICE OF THE COURTS

Possession	3890
Trafficking	755
Aggravated trafficking	724
Trafficking prison contraband	242
Furnishing	190
Possession of hypodermic apparatuses	108
Stealing drugs	53
Aggravated furnishing of scheduled drugs	44
Illegal importation of scheduled drugs	36
Operating a meth laboratory	28
Use of drug paraphernalia	7
Aggravated operating meth laboratory	7
Cultivating marijuana	3
Acquiring drugs by deception	2
Trafficking or furnishing imitation scheduled drug	2
<b>Total</b>	<b>6091</b>

<sup>68</sup> Marcella H. Sorg, *Maine Drug Death Report for 2019*, April 8, 2020, [https://digitalcommons.library.umaine.edu/cgi/viewcontent.cgi?article=1007&context=mcspc\\_healthsafety](https://digitalcommons.library.umaine.edu/cgi/viewcontent.cgi?article=1007&context=mcspc_healthsafety).

<sup>69</sup> Daniel Ciccarone, "The Rise of Illicit Fentanyl, Stimulants and the Fourth Wave of the Opioid Overdose Crisis," *Current Opinion in Psychiatry*, vol. 34 no. 4, (2021), pp. 344-350.

<sup>70</sup> Marcella H. Sorg, *Maine Drug Death Report for 2020*, April 2021, p. 3, <https://www.maine.gov/tools/whatsnew/attach.php?id=5041404&an=2>.

<sup>71</sup> *Id.* p. 1.

# THE COSTS OF CRIMINALIZATION

Of the 38,893 arrests made by Maine law enforcement agencies in 2019, around one in eleven — 3,614 — were for drug-related offenses.<sup>72</sup> These arrests were mostly for low-level offenses: almost three quarters of drug arrests were made for charges of drug possession.<sup>73</sup>

From the 3,614 drug-related arrests in 2019, prosecutors filed 6,901 drug charges. Of those, nearly 4,000 (58 percent) were for possession of drugs or syringes.<sup>74</sup>

In 2019, people charged and convicted of drug possession — meaning they possessed less than 200 milligrams of most drugs — were sentenced to a median 90-days incarceration in county jail and a median fine of \$400.<sup>75</sup>

Drug-related convictions have contributed significantly to Maine's drastic growth in our jail and prison populations. While our incarceration rate of 328 per 100,000 residents is among the lowest in the United States, it is far above global norms. Maine's rate of incarceration is equivalent to those of semi-authoritarian regimes such as Russia, Turkey and Nicaragua.<sup>76</sup>

## THE FINANCIAL COST OF CRIMINALIZING PEOPLE WHO USE DRUGS

Maine dedicates substantial resources to the criminalization of drug use. In 2019 alone, the state spent at least \$111 million on this project.<sup>77</sup> Some of those investments included:

- \$30.5 million on drug-related arrests
- \$34 million on pretrial incarceration of people charged with drug crimes
- \$4.6 million on prosecuting people for drug crimes
- \$38.6 million on incarcerating people for drug convictions

The system is also incredibly costly to the people who are criminalized, costing individuals \$32.5 million a year in bail, fines and fees, payments to attorneys for those who can afford them, and lost earnings.<sup>78</sup>

## ARRESTS

Maine spent \$328 million on law enforcement in 2019. It spends approximately \$30.5 million a year to arrest people for drug-related crimes, which amounts to \$8,400 per person arrested.<sup>79</sup>

<sup>72</sup> Maine Department of Public Safety, Uniform Crime Reporting Division, *Crime in Maine 2019*, November 4, 2020, p. 9, <https://www.maine.gov/dps/msp/sites/maine.gov/dps/msp/files/inline-files/Crime%20in%20Maine%202019.pdf>.

<sup>73</sup> *Id.* at p. 77.

<sup>74</sup> Calculation based on MECEP's analysis of data received from the Maine Administrative Office of the Courts for drug charges brought in 2019 and resolved by December 2021.

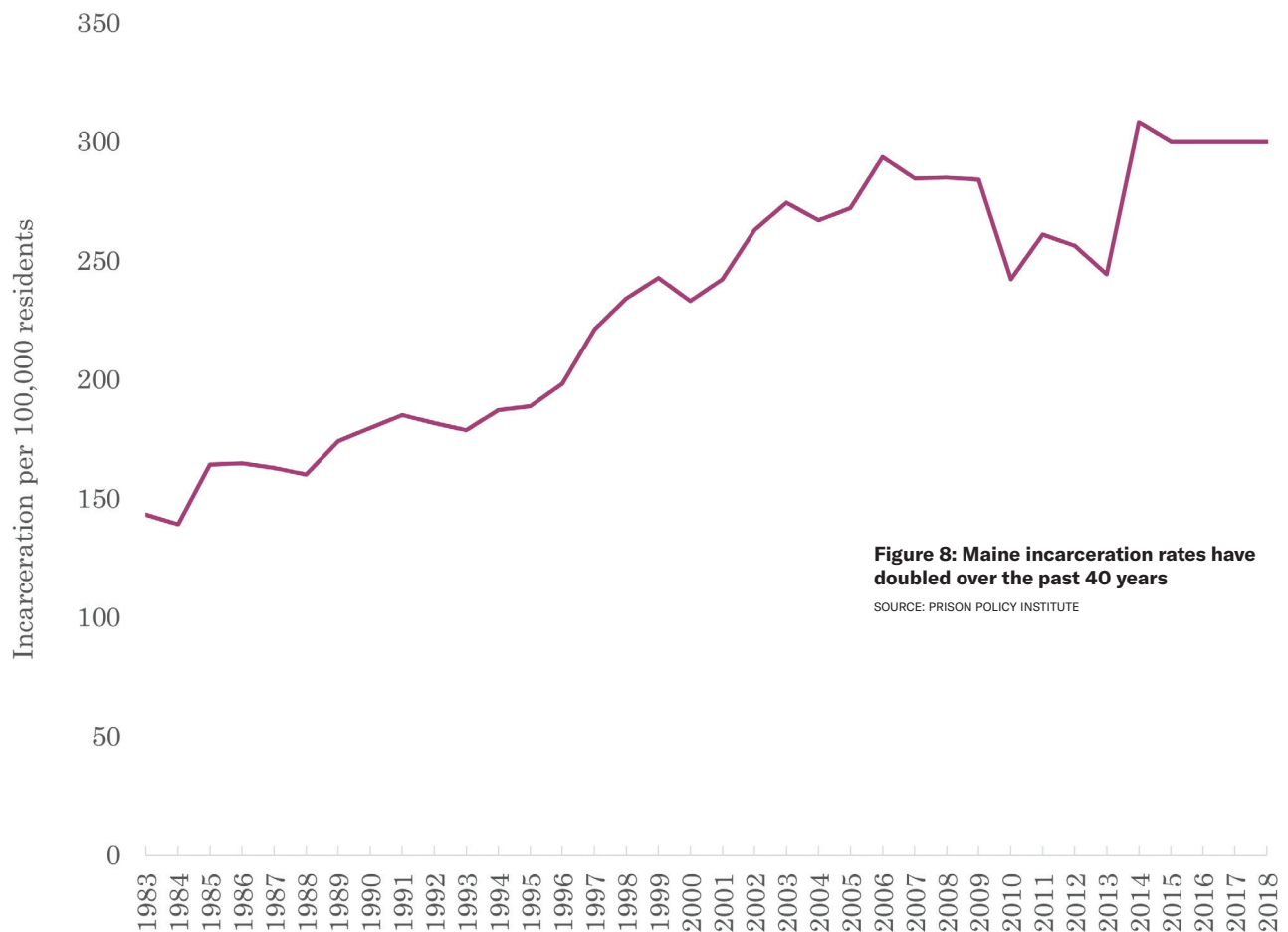
<sup>75</sup> *Ibid.*

<sup>76</sup> Emily Widra & Tiana Herring, "States of Incarceration: The Global Context 2021," Prison Policy Initiative, September 2021, <https://www.prisonpolicy.org/global/2021.html> (accessed December 27, 2021).

<sup>77</sup> Please see Appendix II for the calculations we used to reach this number.

<sup>78</sup> For more detailed calculations, see Appendix II.

<sup>79</sup> Calculation based on total police protection costs of \$327.8 million in 2019 and 38,893 arrests by state and local agencies in 2019. US Census Bureau, *State and Local Government Finances, 2019*, <https://www.census.gov/data/datasets/2019/econ/local/public-use-datasets.html> and Maine Department of Public Safety, Uniform Crime Reporting Division, "Crime in Maine 2019."



**Figure 8: Maine incarceration rates have doubled over the past 40 years**

SOURCE: PRISON POLICY INSTITUTE

## PRETRIAL DETENTION

Keeping someone in county jail for just one day costs Maine taxpayers \$141.<sup>80</sup> By applying the average length of pretrial detention (adjusted by crime) to the number of people facing drug charges, we estimate that Maine spends \$34 million annually on the pretrial detention of people charged with drug crimes.

<sup>80</sup> The total annual cost to operate county jails in 2019 was \$86,574,654, according to audited financial statements for Maine's counties. According to the US Bureau of Justice Statistics, the average daily jail population in Maine in 2019 was 1,670. US Bureau of Justice Statistics, "Mortality in Local Jails, 2000-2019 - Statistical Tables," table 18 p. 22, <https://bjs.ojp.gov/content/pub/pdf/mlj0019st.pdf>. Accordingly, the daily cost per person is \$141.

## PROSECUTING CASES

In 2019, Maine spent \$4.6 million per year prosecuting drug crimes. This included approximately \$2 million on prosecuting, \$1.7 million on adjudicating and \$870,000 defending them.<sup>81</sup> Though lower than the law enforcement or incarceration costs, this is still a tremendous amount considering only half of one percent of drug cases went to trial that year.

<sup>81</sup> See Appendix II for detailed calculations.



## INCARCERATION AND PROBATION

Incarceration accounts for most criminalization costs by far. Based on the typical sentence length for county jails and state prison, Maine invests \$39.9 million incarcerating people for drug convictions. It spends approximately \$1.5 million on probation for people convicted of drug crimes.<sup>82</sup>

## THE STATE CONTINUES TO PRIORITIZE CRIMINALIZATION WHEN PUBLIC HEALTH MEASURES WOULD BE CHEAPER

The state budget reflects the state's priorities. Based on its spending in recent years, Maine has chosen to prioritize and invest in criminalization of drug use over a public health approach. Increases to spending on treatment were well-outpaced by increases to spending on criminalization. Between 2014 and 2019, inflation-adjusted spending on substance use treatment through the MaineCare system increased two percent.<sup>83</sup> However, over the same period, state and local spending on corrections increased 13 percent, while spending on police enforcement increased 14 percent.<sup>84</sup>

The costs of criminalization exceed the costs of a public health approach to drug use. For example:

The state spends an average of \$8,427 per arrest just on police costs. That is two-thirds of what

the state spends every year on a student in public school (\$12,442.95),<sup>85</sup> more than seven times the median monthly rent for housing in Cumberland County in 2019 (\$1,187), and more than four times the cost of MaineCare reimbursement for intensive outpatient treatment programs for a month (just over \$2,000).<sup>86</sup>

*Maine spends  
\$8,427 per arrest.  
What could that buy?*



**7 months of rent in  
Cumberland County**



**2/3 of the cost of educating  
one public school student  
for one year**



**4 months of intensive  
outpatient treatment for  
someone on MaineCare**

<sup>82</sup> Please see Appendix II for detailed calculations.

<sup>83</sup> Maine Office of Fiscal and Program Review, "MaineCare Mental Health and Substance Abuse Expenditures," October 31, 2019, <https://www.maine.gov/governor/mills/sites/maine.gov.mentalhealthworkgroup/files/inline-files/MH%20and%20SA%20Spending%20-%20SFY%2014%20-%20SFY%2019.pdf>. Figures adjusted for inflation using the Consumer Price Index for Medical expenditures (CPI-M). Per-capita calculation using US Census Bureau population estimates.

<sup>84</sup> US Census Bureau, "State and Local Government Finances," 2019. Figures adjusted for inflation using the Consumer Price Index (CPI-U). Per-capita calculation using US Census Bureau population estimates.

<sup>85</sup> Maine Department of Education, Resident Student Per Pupil Operating Costs, 2018-19, <https://www.maine.gov/doe/funding/reports/perpupil> (accessed January 16, 2022).

<sup>86</sup> Intensive outpatient treatment programs typically include between six and twenty hours per week of treatment. A course of five sessions per week for four weeks would cost just over \$2,000. 10-144 C.M.R. ch. 101 ch. III, § 65, <https://www.maine.gov/sos/cec/rules/10/ch101.htm> (accessed December 28, 2021). Based on the current MaineCare reimbursement rate of \$102 per day of treatment for code H0015: Intensive Outpatient Treatment.

Keeping someone incarcerated for 30 days in Maine cost an average of \$4,223 in 2019.<sup>87</sup> This is almost four times the median monthly rent for housing in Cumberland County in 2019, (\$1,187),<sup>88</sup> more than twice the cost of MaineCare reimbursement for intensive outpatient treatment programs for a month (just over \$2,000)<sup>89</sup> and almost 10 times the cost of the MaineCare reimbursement rate for a month of medication-assisted treatment. (See Figure 9)

A year in state prison costs \$54,300.<sup>90</sup> This is more than twice as much as it would cost to provide housing, weekly counseling and medication-assisted treatment for a year at current MaineCare reimbursement rates.<sup>91</sup> Even when increasing the cost of treatment to reflect the reality that current MaineCare rates are much lower than the true costs,<sup>92</sup> the cost of a year of housing, treatment and recovery is far below the cost of a year of incarceration. (see Figure 10)

<sup>87</sup> Calculation based on total cost of jail operations in Maine (from county audited financial statements), divided by the average daily jail population.

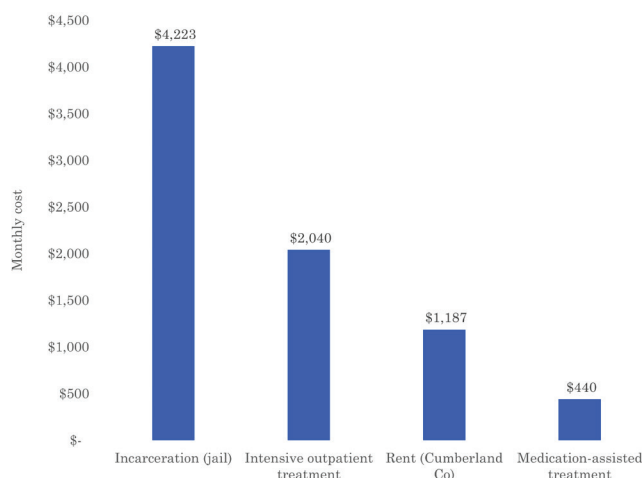
<sup>88</sup> US Census Bureau, American Community Survey, 2019 data.

<sup>89</sup> Intensive outpatient treatment programs typically include between six and twenty hours per week of treatment. A course of five sessions per week for four weeks would cost just over \$2,000. 10-144 C.M.R. ch. 101 ch. III, §65 <https://www.maine.gov/sos/cec/rules/10/ch101.htm> (accessed December 28, 2021). Based on the current MaineCare reimbursement rate of \$102 per day of treatment for code H0015: Intensive Outpatient Treatment.

<sup>90</sup> Total cost based on Maine Department of Corrections budget for prison facilities, divided by average daily inmate population. See Maine Department of Corrections, “MDOC Adult Data Report, July 2020,” August 11 2020, <https://www.maine.gov/corrections/sites/maine.gov.corrections/files/inline-files/July2020MonthlyAdultDataReport.pdf>.

<sup>91</sup> See 10-144 C.M.R. ch. 101 ch. III, § 65: Behavioral Health, Code H0020: Medication Assisted Treatment, <https://www.maine.gov/sos/cec/rules/10/ch101.htm> (accessed December 28, 2021).

<sup>92</sup> The Maine Hospital Association estimates that, on average, MaineCare reimburses 62% of the true cost of care. See Maine Hospital Association, “Taking the Financial Pulse of Maine’s Hospitals: An Overview” (2017) p. 6, [http://www.themha.org/Finance/Publications/MHA-Financial-Report\\_22017.aspx](http://www.themha.org/Finance/Publications/MHA-Financial-Report_22017.aspx) (accessed Jan 16, 2022).



**Figure 9: Incarcerating someone for a month in jail is much more expensive than treatment or recovery supports**

SOURCES: MECEP’S ANALYSIS OF MAINE COUNTY BUDGETS; PRISON POLICY INSTITUTE DATA; MAINECARE BENEFITS MANUAL; US CENSUS BUREAU, AMERICAN COMMUNITY SURVEY, 2019 DATA

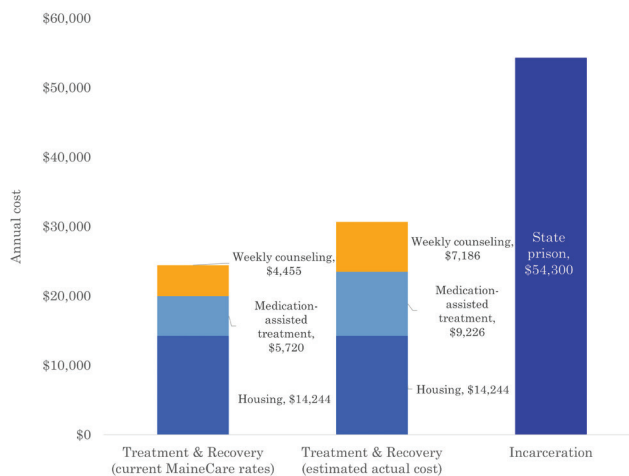
Note: Counseling costs assume one hour of counseling per week for a year. Housing costs represent the median rent for Cumberland County in 2019. The “estimated actual cost” of treatment was based on the assertion by the Maine Hospital Association that Medicaid covers 62 percent of the book cost of treatment.<sup>93</sup>

What’s more, money spent on law enforcement and incarceration is not equivalent to money spent on care and treatment. Law enforcement and incarceration do not address the underlying causes of substance use and, in fact, create more trauma and harm. It is more cost-effective to offer people treatment and recovery support than punish them with arrest and incarceration.

## CRIMINALIZING PEOPLE WHO USE DRUGS IS INEFFECTIVE AND HARMFUL CRIMINALIZATION INCREASES OVERDOSE DEATH

Criminalization and incarceration accelerate overdose death. People with substance use disorder released from incarceration are often not provided with adequate connection to services — particularly those released from jail

<sup>93</sup> Ibid.



**Figure 10: Providing treatment and recovery services for a year is far cheaper than incarceration, even after increasing MaineCare rates**

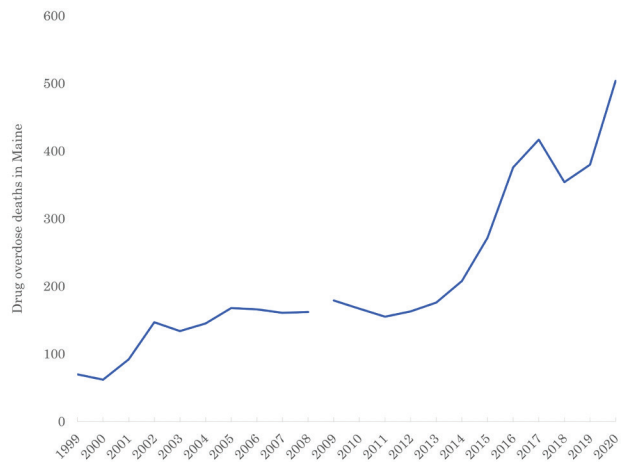
SOURCES: MECEP'S ANALYSIS OF MAINE DEPARTMENT OF CORRECTIONS DATA; US CENSUS BUREAU, AMERICAN COMMUNITY SURVEY, 2019 DATA; UNIVERSITY OF MAINE DATA; MAINECARE BENEFITS MANUAL.

— and people who use drugs often find that their tolerance has decreased while incarcerated. A 2020 study finds that drug overdose is the leading cause of death after release from prison. Within the first two weeks after release, the risk of death from drug overdose is 12.7 times higher than the general population, with the risk significantly higher for women.<sup>94</sup>

Criminalization also increases the danger of drug use, because drug production and ingredients are not regulated. Many people using drugs do not know that they are consuming fentanyl, or the potency of the drugs they are taking, making them especially vulnerable to overdose. Until October 2021, it was illegal in Maine to possess or use fentanyl testing strips that could alert people to the presence of fentanyl in their drugs.<sup>95</sup>

<sup>94</sup> Elizabeth Needham Waddell et al., “Reducing Overdose after Release from Incarceration (ROAR): Study Protocol for an Intervention to Reduce Risk of Fatal and Non-Fatal Opioid Overdose among Women after Release from Prison,” *Health & Justice* vol. 8 no. 18 (2020). doi: 10.1186/s40352-020-00113-7.

<sup>95</sup> This changed with P.L. 2021, ch. 434, § 6.



**Figure 11: Drug overdose deaths in Maine have increased more than three-fold over the past decade**

SOURCES: MECEP'S ANALYSIS OF DATA FROM US CENTERS FOR DISEASE CONTROL (1999-2008) AND MAINE ATTORNEY GENERAL'S OFFICE (2009-20)

Criminalization also means that people are afraid to call for medical assistance in the case of an overdose. In 2019, Maine became one of 40 states to enact a “Good Samaritan Law.”<sup>96</sup> This law protects a person who calls 911 to report an overdose and the person who is overdosing from prosecution for a few low-level crimes, but not anyone else in the home.<sup>97</sup> It also does not protect anyone, including the person who called for help, from being searched by police when they arrive at the scene. People who share or trade drugs with someone who fatally overdoses can be charged with contributing to the death, which is punishable by up to a 30-year prison sentence.<sup>98</sup> Everyone at the scene of an overdose is also vulnerable to eviction or Department of Health and Human Services intervention, which could result in having their children taken away. These fears prevent people from accessing medical care in overdose cases and make people witnessing overdoses face an agonizing choice.

<sup>96</sup> P.L. 2019, ch. 137.

<sup>97</sup> 17-A M.R.S. §1111-B.

<sup>98</sup> *Id.* §§1105-A(1)(K); 1105-B(1)(D), 1118(1)(I).



## PERSONAL HISTORY<sup>99</sup>

*My friend that I lost recently, his whole family was left behind. He had a son and a daughter. His son is best friends with my son. He was a very, very dear friend of mine. He'd been clean for a while. He ended up using something, we think it was not what he was really told it was. It killed him. People ended up putting him in a car, driving to Medford Mobile and dropping him off. [He was] in the backseat, dead. It killed me to find out that that's how he went. That someone couldn't make that 911 call, or wouldn't, I should say. A lot of people are scared [to call] because they're afraid they're going to get in trouble.*

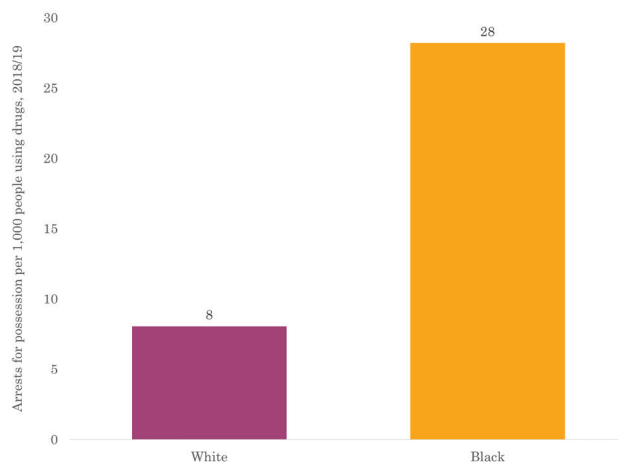
## CRIMINALIZATION OF DRUGS COMPOUNDS RACIAL INEQUALITY IN THE LEGAL SYSTEM

For more than 100 years, the United States and Maine governments have made laws prohibiting the possession and sale of particular drugs. Enforcement of these laws disproportionately target Black, Indigenous and other communities of color. The impact of systemic racism is cumulative as people move through the legal process, exacerbating racial disparities the deeper a person gets dragged into the system.

Maine led the 19th century movement against the use of alcohol, passing various laws outlawing the manufacture, sale and possession of alcohol between 1846 and 1933. During this period, Catholic immigrants — especially Irish and French-Canadians — were explicitly targeted by the so-called temperance laws, despite the widespread use of alcohol by people of all backgrounds. Historical records show Catholic and Black Mainers were arrested and incarcerated at much higher rates than white protestants.<sup>100</sup>

<sup>99</sup> Interview on September 10, 2019.

<sup>100</sup> James Myall, "Race and Public Policy in Maine: Past, Present, and Future," *Maine Policy Review* vol. 29 no. 2, (2020) pp. 27-29, <https://digitalcommons.library.umaine.edu/cgi/viewcontent.cgi?article=1860&context=mpr>.



**Figure 12: Black people who use drugs are three and a half times as likely to be arrested for drug possession as white people who use drugs in Maine**

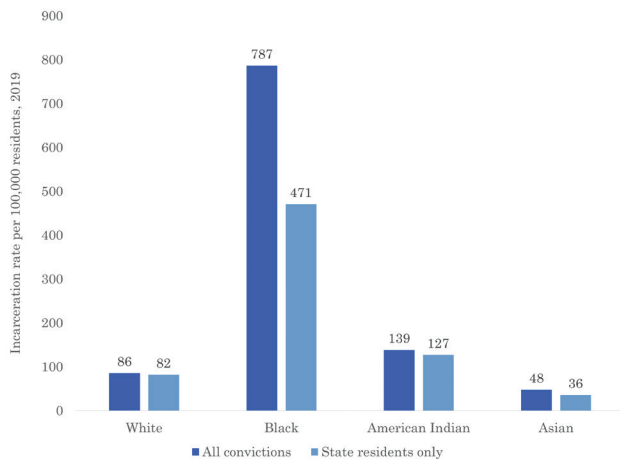
SOURCE: MECEP'S ANALYSIS OF US SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION, NATIONAL SURVEY ON DRUG USE AND HEALTH, RESTRICTED-USE DATA ANALYSIS SYSTEM, 2018-2019 DATA; FEDERAL BUREAU OF INVESTIGATION, UNIFIED CRIME REPORT, 2019

Maine was also an early adopter of laws against other substance use, and passed one of the nation's first laws against drug possession by non-medical personnel. In 1913, anyone other than doctors and pharmacists was forbidden from possessing substances including cannabis, heroin, morphine, codeine and other "narcotic or hypnotic drugs."<sup>101</sup> This took place against a national backdrop of racist stereotypes that associated drug use with people of color. "Stigmatizing images of 'cocaine crazed Negroes,' 'Chinese opium dens' and 'reefer madness' among Mexicans have permeated the popular imagery of who a substance user is and what they look like. Despite these pervasive and concurrent racialized narratives, during this same time, narcotic use and overdose were at record levels among whites."<sup>102</sup>

The federal 1986 Anti-Drug Abuse Law instituted new mandatory minimum sentences for drug crimes, including the grossly unequal sentencing structures for powder cocaine,

<sup>101</sup> P.L. 1913, ch. 211.

<sup>102</sup> Sonia Mendoza et al., "Race, Stigma, and Addiction," in *The Stigma of Addiction: An Essential Guide*, Jonathan D. Avery and Joseph J. Avery, eds. at 134, (2019) pp. 131-152, [https://doi.org/10.1007/978-3-030-02580-9\\_8](https://doi.org/10.1007/978-3-030-02580-9_8).



**Figure 13: Incarceration rates are higher for Black, Indigenous people than white people in Maine, even after excluding out-of-state residents**

SOURCE: MECEP'S ANALYSIS OF COUNCIL OF STATE GOVERNMENTS, JUSTICE REINVESTMENT IN MAINE, SECOND PRESENTATION

associated with white use, and crack cocaine, associated with Black use and sale. In Maine, crack cocaine and powder cocaine were treated differently, too. Although not as stark as the federal disparities that treated the same amount of crack 100 times more harshly as powder cocaine, the crack cocaine to powder cocaine disparity was 3.5 to 1 under Maine law until October 2021.<sup>103</sup>

Current patterns of drug-related arrests by Maine law enforcement continue to show clear racial disparities that are worse than enforcement of other types of laws.<sup>104</sup> For example, while survey data shows that Black people use illicit and illegal drugs at a similar rate to white people,

they are three and a half times as likely to be arrested for drug possession charges as white people who use drugs.<sup>105</sup> Indigenous people in Maine are twice as likely as white people to be charged with drug possession, and three times as likely to be charged with the lowest level of drug possession.<sup>106</sup>

A 2019 report shows that these disparities are not driven by arrests and convictions of out-of-state residents. Even when looking solely at in-state residents, Black people in Maine are almost six times as likely to be incarcerated as white residents.<sup>107</sup> Rates of incarceration are also disproportionately high for Maine's indigenous population.<sup>108</sup>

Cannabis, which was legalized by Maine voters in 2016 but remains illegal at the federal level, provides another example. Survey data shows that white people in Maine are more likely to use cannabis than Black people in Maine.<sup>109</sup> Yet in any given year, Black people are four or five times as likely to be arrested for cannabis possession in the

<sup>105</sup> This disparity increases to more than six times as many when drug sales, trafficking and manufacturing arrests are included. US Department of Health and Human Services, Substance Abuse and Mental Health Services Agency, "National Survey on Drug Use and Health, Restricted-Use Data Analysis System," 2018-19, US Federal Bureau of Investigation, "Uniform Crime Report" data, 2019, US Census Bureau, "American Community Survey 2019" population data.

<sup>106</sup> Calculation based on MECEP's analysis of data received from Maine Administrative Office of the Courts for drug charges brought in 2019 and resolved by December 2021.

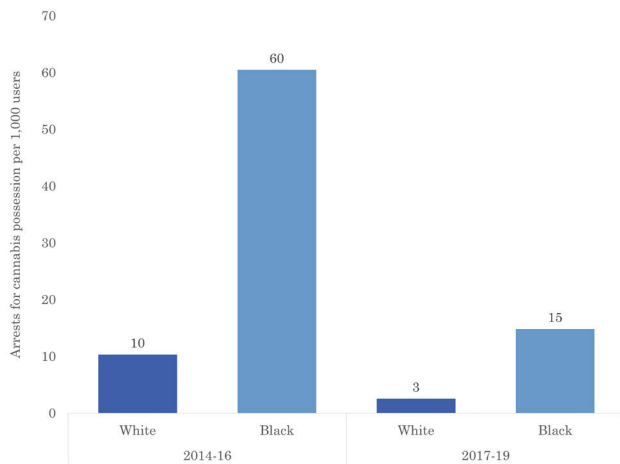
<sup>107</sup> Ben Shelor et al., "Justice Reinvestment in Maine: Second Presentation," p. 42.

<sup>108</sup> Ibid. Per-person incarceration rates calculated using US Census Bureau, population estimates for 2019. The rate of incarceration per 100,000 residents was 82 for white residents, 471 for Black residents and 127 for indigenous people.

<sup>109</sup> US Department of Health and Human Services, Substance Abuse and Mental Health Services Agency, "National Survey on Drug Use and Health, Restricted-Use Data Analysis System," 2002-17, retrieved via <https://rdas.samhsa.gov/>.

<sup>103</sup> P.L. 2021, ch. 396, §§ 3-5.

<sup>104</sup> See Ben Shelor et al., "Justice Reinvestment in Maine: Second Presentation," Council of State Governments, November 25, 2019, p. 23 <https://csgjusticecenter.org/wp-content/uploads/2020/10/JR-in-Maine-second-presentation1.pdf> (pointing out that "racial disproportionality is more pronounced in drug arrests than in total arrests.") The report also found profound disproportionality in prison sentences across the board: felony cases filed (5 percent of felonies filed are against Black people), p. 32; prison sentences (12 percent of prison sentences are for Black defendants), p. 41; and the most serious felony prison sentences (23 percent of Class A felony sentences and 19 percent of Class B felony sentences are given to Black people), id.



**Figure 14: Even after cannabis legalization, Black people are still disproportionately arrested for possession charges in Maine**

SOURCE: MECEP'S ANALYSIS OF SAMHSA BEHAVIORAL RISK FACTOR SURVEILLANCE SURVEY DATA, FBI UNIFORM CRIME REPORTS, US CENSUS BUREAU, AMERICAN COMMUNITY SURVEY DEMOGRAPHIC DATA

state.<sup>110</sup> As a result, Black cannabis users are between seven and nine times more likely to be arrested for possession than white cannabis users. While the legalization of cannabis use under state law in 2017 greatly reduced the number of arrests of both Black and white people, the racial disparity in arrests remains incredibly high.

When it comes to drug possession charges, Black people face harsher sentences than white people as well. While the median sentence of incarceration for all drug possession cases in 2019 was 90-days jail time, it was twice as long for Black defendants.<sup>111</sup>

**110** US Federal Bureau of Investigation, "Uniform Crime Report data," 1999-2019, retrieved via Crime Data Explorer, <https://crime-data-explorer.app.cloud.gov/explorer/national/united-states/prelim-quarter>.

**111** Based on MECEP's analysis of data received from Maine Administrative Office of the Courts for drug charges brought in 2019 and resolved by December 2021.

Interviews with defense lawyers also reported the harsher treatment of their Black clients. According to one lawyer, Black defendants are offered long sentences, and "because the offers are bad, they end up going to trial more often and they get more publicity," perpetuating the stereotype that Black people are more likely to use or sell drugs.<sup>112</sup>

The stigma against Black people as drug traffickers leads to false accusations with real consequences. One defense attorney described a client who faced more than a year of surveillance by the Department of Health and Human Services (DHHS), removal of her child from her home and felony drug trafficking charges, based on racist and false allegations. The charges were brought after her kindergartener could not name the Black man who dropped him off at school to a school administrator. The school reported the mother for child endangerment. DHHS opened a case against her, and the caseworker accused the woman of being a drug trafficker because of her frequent trips to Massachusetts, where her family lived. The child was removed from her home, and the mother faced an indictment for felony drug trafficking. The prosecutor offered to drop the trafficking charges if the mother would plead guilty to child endangerment. All charges were eventually dropped, after a year of the family's separation and intense intervention from DHHS.<sup>113</sup>

**112** Defense attorney, interview on November 25, 2020.

**113** Defense attorney, interview on May 12, 2021. The lawyer later confirmed this description of events. Because of the laws protecting privacy around child protective matters, we were unable to independently confirm the details of the case.

## THE CRIMINALIZATION PROCESS TRAUMATIZES PEOPLE WHO USE DRUGS AND LEAVES LASTING DAMAGE

Being arrested can be a devastating experience, no matter what the end result of the case is.

“The fact of being arrested may itself have this effect, but so do the procedures that typically happen after arrest: fingerprinting, mug shots, strip-searches, and other procedures, including jail confinement. An extensive research literature also describes the psychological effects of both short-term and long-term incarceration on those incarcerated.”<sup>114</sup> A 2019 report observed, “Even a few days in jail can be especially devastating for people with serious mental health and medical needs, as they are cut off from their medications, support systems, and regular healthcare providers. Even worse, many people are in jail in the midst of a health crisis, such as mental distress or substance use withdrawal. Yet history has shown that jails are unable to provide effective mental health and medical care to incarcerated people.”<sup>115</sup>

Years of research show that criminal convictions and incarceration in prison create “significant negative effects on employment.”<sup>116</sup> They also suggest that arrest alone, even for minor offenses, may have long-term effects on employment

stability.<sup>117</sup> As an example, a national study of young people convicted of their first offense found that being incarcerated for a relatively short time (an average of four months) “significantly reduces the probability of employment relative to individuals who were also convicted for the first time but were not incarcerated.”<sup>118</sup>

Arrest and incarceration of a parent or caregiver can also significantly harm their children. One study showed that the incarceration of a parent or caregiver led to psychological distress and increased substance use among youth.<sup>119</sup> “A caregiver’s sudden absence from a child’s life can mean loss of income and instrumental support such as transportation or help with homework, and anxiety about the caregiver’s well-being. Caregiver incarceration has documented associations with negative outcomes including increased trauma symptoms, physical health problems, antisocial behavior, and youth incarceration.”<sup>120</sup>

After the incarceration is over, the harm continues. Having a criminal record means people with records lose access to housing,

<sup>114</sup> Affidavit of Steven E. Barkan at ¶15, *Gaul v. York Cnty.*, No. CV-19-164 (Me. Super. Ct. May 10, 2021) (citing Craig Haney, “The Psychological Effects of Imprisonment,” pp. 584-605 in *The Oxford Handbook of Sentencing and Corrections*, edited by J. Petersilia and K. R. Reitz (New York: Oxford University Press, 2015)).

<sup>115</sup> Alexi Jones and Wendy Sawyer, “Arrest, Release, Repeat: How Police and Jails Are Misused to Respond to Social Problems,” Prison Policy Initiative, August 2019, <https://www.prisonpolicy.org/reports/repeatarrests.html> (accessed Dec. 28, 2021).

<sup>116</sup> Affidavit of Steven E. Barkan at ¶17(a), *Gaul v. York Cnty.* (citing Bruce Western, *Homeward: Life in the Year after Prison* (New York: Russell Sage Foundation, 2018); Devah Pager, *Marked: Race, Crime, and Finding Work in an Era of Mass Incarceration* (Chicago: University of Chicago Press, 2009).

<sup>117</sup> Affidavit of Steven E. Barkan at ¶15, *Gaul v. York Cnty.* (citing IACP/UC Center for Research and Policy, *Deconstructing the Power to Arrest: Lessons from Research* (Cincinnati: IACP/UC Center for Research and Policy, University of Cincinnati, 2018); Eisha Jain, “Arrests as Regulation,” *Stanford Law Review* vol. 67 (2015) pp. 809-67; Shawn D. Bushway, “The Impact of an Arrest on the Job Stability of Young White American Men,” *Journal of Research in Crime and Delinquency* vol. 35(4) (1998), pp. 454-79; Terence P. Thornberry and R.L. Christenson, “Unemployment and Criminal Involvement: An Investigation of Reciprocal Causal Structures,” *American Sociological Review* vol. 56 (1984), pp. 609-27)).

<sup>118</sup> Robert Apel and Gary Sweeten, “The Impact of Incarceration on Employment During the Transition to Adulthood,” *Social Problems* vol. 57(3) (2010), pp. 448-79, p. 468.

<sup>119</sup> Elizabeth I. Johnson et al., “Household Member Arrest and Adolescent Substance Use: The Mediating Roles of Parenting and Youth Psychological Distress,” *Criminal Justice and Behavior* vol. 46(8) (2019), pp. 1088-105.

<sup>120</sup> James M. Conway et al., “Impact of Caregiver Arrest on Minor Children: Implications for Use of Family Impact Statements in U.S. Courts,” *Justice Policy Journal* vol. 13(2) (2016), pp. 1-17, p. 2.



financial support or educational opportunities. Approximately 190,000 people in Maine — one in six people over the age of 12 — have an arrest record of some kind.<sup>121</sup> Unlike in many states, most people in Maine have no realistic way to seal their criminal record. A pardon from the governor — a long and cumbersome process that is rarely successful — is the only way for people in Maine to remove what can be a significant barrier to economic opportunity.

In addition to the barriers to employment, criminal records for drug offenses also can keep people and their families from finding stable housing for years after they have served their sentence. All applicants to federally-assisted housing, whether by voucher, public housing, rural housing or Section 8 project-based rental assistance, face obstacles based on drug, alcohol and criminal record histories.<sup>122</sup> The explicit reason for this has been to ensure that only “deserving” applicants are given help.<sup>123</sup> Even if a person with a history of drug use or a criminal record is accepted into a federally-assisted housing program, by law their lease must say that the entire household can be evicted for any one person’s illegal drug-related activity.<sup>124</sup> These provisions not only deem people who use illegal drugs as undeserving of having their basic needs met, they affect entire families — encouraging family members to ostracize their own so as to keep a roof over their heads.

<sup>121</sup> US Department of Health and Human Services, Substance Abuse and Mental Health Services Agency, National Survey on Drug Use and Health, Restricted-Use Data Analysis System, 2018-19.

<sup>122</sup> Marah A. Curtis et al., “Alcohol, Drug, and Criminal History Restrictions in Public Housing,” *Cityscape: A Journal of Policy Development and Research*, vol. 15 no. 3, (2013), pp. 37-52, <https://www.huduser.gov/periodicals/cityscape/vol15num3/ch2.pdf>.

<sup>123</sup> *Id.* at 38.

<sup>124</sup> See 24 CFR §§ 982.553 (public housing), 982.310(c) (section 8 Housing Choice), 7 CFR §3560.156(c)(15) (USDA rural housing).

The compounding damages of criminalizing drug use, from arrest to post-incarceration, lasts for years. The effects range from the individual trauma of arrest to the lasting harms experienced by families and communities, making it difficult to find stability and long-term recovery.

#### PERSONAL HISTORY ON THE IMPACT OF ARREST<sup>125</sup>

*Sam [name changed] grew up with what he described as alcoholic parents. When he was 20, he got hurt on the job, shattering his heel and ankle, and was prescribed OxyContin. What began with a prescription led to more intense substance use. When asked about when his drug use became problematic, he replied, “For me, it was really the first time I got arrested for it.” During a traffic stop, police discovered he had been driving with a suspended license because of an unpaid fine. They searched his car and found drugs. Sam was charged with drug trafficking based on the weight of the drugs they found — drugs Sam says were for his personal use — and he spent two years incarcerated.*

*After leaving prison, his use escalated. In 2017, he was arrested and again charged with drug trafficking after selling a gram of heroin to a confidential informant who was wearing a wire. At the time, he was using between two to five grams a day, and he was selling to maintain his own drug use. While in prison, he began some treatment programs, but they did not prepare him for reentry. “They didn’t even have a plan set up for me when I walked out the door at all ... I’m 41 years old, and I don’t even know how to live a normal life at all. So yeah, I literally had to figure everything out. And I had to do it on my own.” After a relapse, he found a Suboxone treatment program and has been in recovery for a year. “I’ve lived a pretty rough life, I’m lucky to be alive, really. A lot of my friends didn’t make it, a lot of people.” He ended the interview by sharing that a friend had died of an overdose that same morning.*

<sup>125</sup> Interview on February 20, 2021.

## PEOPLE LIVING IN POVERTY AND WITH LOW INCOME ARE DISPROPORTIONATELY HARMED BY CRIMINALIZATION

People living in poverty bear the brunt of criminal laws, including drug laws. Wealth protects people from criminal prosecution. People with private space in their own homes can use whatever substances they want and hide their use. People with health insurance and enough money can pay for treatment, including expensive in-patient rehabilitation. If wealthier people are arrested, they can afford cash bail to avoid pretrial detention, lawyers to defend them and negotiate on their behalf and fines that are assessed by the court or offered as an alternative to a harsh sentence.

Legal defense is tremendously costly and can drive a struggling family to financial ruin. Consider, for example, that half of all Mainers are unable to handle an unexpected \$400 expense without going into debt.<sup>126</sup> One criminal defense attorney described what is required to receive court-appointed, publicly-funded legal assistance in their county: take a full work day to travel to the courthouse to meet with the financial screener and disclose under oath personal financial information (including income, household makeup and expenses) that could be incriminating if people are working under the table. Many people are declared by the courts to be “partially indigent,” which means they are responsible for monthly payments to the Maine Commission on Indigent Legal Services to cover part of their attorney’s fees. If defendants post cash bail, that money can be used to pay attorney’s fees and court fines, and any remaining money might not be returned for months past the close of the case.

<sup>126</sup> James Myall, “Could You Cover an Unexpected \$400 Expense? Most Mainers Could Not,” Maine Center for Economic Policy, June 26, 2018, <https://www.mecap.org/blog/could-you-cover-an-unexpected-400-expense-nearly-half-of-mainers-could-not/> (accessed December 28, 2021).

Maine has no public defender system, and prosecutors effectively decide who is eligible for court-appointed counsel by deciding the level of charges and whether or not to certify a case as jail-requested or not. For cases where the prosecutor does not pursue a jail sentence, court appointed attorneys are generally not provided: In 2019, 60 percent of clients charged with misdemeanors represented themselves.<sup>127</sup>

*“I’ve seen this in misdemeanor drug possession cases ... Prosecutors will say it’s a fine-only case and make the case not eligible for court-appointed counsel as a result of that. And so despite the fact that those all act as predicate offenses, in other words, if it happens again, you have higher penalties. And despite the fact that there are so many collateral consequences in terms of access to employment, benefits, housing, everything else and a legal driver’s license in the state of Maine, which is no small thing. We are in a position where prosecutors are making those calls, essentially, with no accountability, no oversight, no one is like checking on that and there’s no transparency about their motivations. So they might have a really weak case or case with a pretty questionable Fourth or Fifth Amendment violation and they just certify it no jail, and then it never gets a lawyer’s eyes on it.”<sup>128</sup>*

The outcomes for people with low income are worse because they lack money, not because the facts of their case make them more deserving of punishment. The costs, both social and financial, set them back further than people with high income. It makes it much more likely people with low income get trapped in the revolving door of criminalization.

<sup>127</sup> Calculation based on MECEP’s analysis of data received from the Maine Administrative Office of the Courts for drug charges brought in 2019 and resolved by December 2021.

<sup>128</sup> Criminal defense attorney, interview on May 7, 2021.

## ADDITIONAL COSTS AND FEES FOR INCARCERATED INDIVIDUALS

Being charged with a crime is expensive. In addition to fines levied against incarcerated people as part of their sentence, once someone is incarcerated they face even more costs. The accumulation of costs can lead to additional hardship for incarcerated peoples' families, or significant debt for the people themselves upon release. These costs include:

Telephone calls from county jails and state prisons in Maine are made available through contracts with private for-profit companies. These companies charge from \$3.44 to \$5.65 for a 15-minute in-state phone call.<sup>129</sup> In-state phone calls in the state prison system cost 9 cents per minute.<sup>130</sup> Access to other forms of communication, such as email or video calls, also comes with steep charges. In 2019, at the Maine State Prison, messages of 160 characters (less than a Twitter post) cost between \$10 a month for 250 messages to \$50 a month for 2,000.<sup>131</sup>

Room and board charges may be levied against people incarcerated in Maine's county jails. These can be as high as \$80 a day.<sup>132</sup>

Sanctions for breaking prison rules incur a mandatory \$5.00 minimum fine and can result in fines of up to \$100 per incident, especially for drug-related infractions.<sup>133</sup>

Depositing money to the account of an incarcerated individual at Maine State Prison costs approximately \$4.80 per transaction.<sup>134</sup>

Work programs within the state prison system pay wages that are far below the state's minimum wage, often less than a dollar per hour.<sup>135</sup>

Work release programs for incarcerated people in Maine do fall under the state's minimum wage laws. However, the jails and prisons are allowed to garnish incarcerated individuals' wages to cover room and board costs.<sup>136</sup>

Probationary supervision for individuals released from incarceration in Maine can cost them up to \$50 a month, despite the fact that most newly-released individuals face difficulty finding employment.<sup>137</sup>

<sup>129</sup> Calculation based on authors' analysis of data compiled by Courtney Allen, Maine Recovery Advocacy Project, and Winifred Tate, Maine Drug Policy Lab of Colby College in April 2021.

<sup>130</sup> Testimony of Maine Department of Corrections Commissioner Randall A. Liberty before the Joint Standing Committee on Criminal Justice and Public Safety, *An Act To Prohibit Excessive Telephone, Video, and Commissary Charges in Maine Jails and Prisons: Hearing on LD 1175*, 130th Legislature, April 14, 2021, p. 3, available at <http://www.mainelegislature.org/legis/bills/getTestimonyDoc.asp?id=153031>.

<sup>131</sup> Susan Sharon, "Maine Prisons Introduce Secure Tablets and Texting - With a Fee For Inmates," *Maine Public*, January 17, 2019, <https://www.mainepublic.org/maine/2019-01-17/maine-prisons-introduce-secure-tablets-and-texting-with-a-fee-for-inmates>.

<sup>132</sup> 17-A M.R.S. §1751.

<sup>133</sup> *Maine Department of Corrections Policy No. 20.1, Prisoner Discipline* (last revised November 6, 2019), available at [https://www.maine.gov/corrections/sites/maine.gov.corrections/files/inline-files/39212241\\_0.pdf](https://www.maine.gov/corrections/sites/maine.gov.corrections/files/inline-files/39212241_0.pdf).

<sup>134</sup> Cost as of December 27, 2021, determined by accessing Maine Department of Corrections, Money Deposit Service, <https://www.maine.gov/online/correctionsdeposit/main.cgi>.

<sup>135</sup> Wendy Sawyer, "How much do incarcerated people earn in each state?," *Prison Policy Institute*, April 10, 2017, <https://www.prisonpolicy.org/blog/2017/04/10/wages/> (accessed December 28, 2021); see also Maine Department of Corrections Policy 25.03, *Work Opportunities and Industries* (last revised October 4, 2010), p. 7, <https://www.maine.gov/corrections/sites/maine.gov.corrections/files/inline-files/INDUSTRIES%2C%20GENERAL%20PROCEDURES%2025%2003%20%5B1%5D.pdf> (accessed December 28, 2021).

<sup>136</sup> 30-A M.R.S. §1605.

<sup>137</sup> 17-A M.R.S. §1204(1); Mack Finkel, "New data: Low incomes – but high fees – for people on probation," *Prison Policy Institute*, April 9, 2019, [https://www.prisonpolicy.org/blog/2019/04/09/probation\\_income/](https://www.prisonpolicy.org/blog/2019/04/09/probation_income/) (accessed December 28, 2021).

# THE LEGAL SYSTEM'S APPROACH IS NOT A HEALTH APPROACH

## THE ROLE OF LAW ENFORCEMENT, CHARGED WITH INVESTIGATING CRIME AND ENFORCING LAWS, CONFLICTS WITH THE ROLE OF HEALTH CARE PROVIDERS CARING FOR PATIENTS

Our criminal drug laws mean that law enforcement are tasked with making decisions about health care, which they are not trained to do. Police, prosecutors, judges and probation officers often make judgments about the medical treatment of criminal defendants — including overriding the clinical decision of health care providers — without training and without access to medical records.

### POLICE

In part because of cuts in social services over the past several decades, police are increasingly expected to manage poverty, mental illness and problematic substance use.<sup>138</sup> But their legal mandate and training are distinct from social work. The police are charged with enforcing the law and maintaining public safety. Law enforcement officers are only required to be high school graduates and complete the 18-week Basic Law Enforcement Training Program at the Maine Criminal Justice Academy. None of the listed courses focus on substance use disorder and public health approaches. In 2020, officers

were required to take a two-hour course, “Law Enforcement Approach to Substance Use Disorder.”<sup>139</sup> Social workers and health care providers, in contrast, have extensive training in providing services, including a college degree, and if they want to provide clinical services, often a master’s degree, as well.

One report examining opioid overdoses in New Hampshire highlighted the “conflict between the police’s primary goal of enforcing the laws and EMS’ primary goal of saving patients’ lives.”<sup>140</sup> The report analyzed these clashing roles amidst difficult conditions. Police must investigate calls and gather evidence of criminal wrongdoing and law-breaking. “In juxtaposition to the police’s role, EMS providers seek to ‘really focus on the caregiver role.’”<sup>141</sup> The report documented how some EMS providers found “police presence as enforcers of the law hindered their ability to treat and transport patients for additional services.”<sup>142</sup>

<sup>138</sup> See Alexandra Natapoff, “Gideon’s Servants and the Criminalization of Poverty,” *Ohio State J. Crim. Law*, vol. 12, no. 2 (2015), pp. 445-464.

<sup>139</sup> From the Maine Criminal Justice Academy website, <https://www.maine.gov/dps/mcja/training/mandatory/index.htm> (accessed February 9, 2022).

<sup>140</sup> Andrea Meier et al., “NDEWS Hotspot Report: Understanding Opioid Overdoses in New Hampshire, Phase II of a National Drug Early Warning System (NDEWS) HotSpot Rapid Epidemiological Study,” *Dartmouth College Center for Technology and Behavioral Health* (2017), p. 53 (emphasis removed) <https://ndews.org/wordpress/files/2020/07/NDEWS-Hotspot-Report-06-26-17-reduced-27.2MB-1.pdf>.

<sup>141</sup> *Ibid.*

<sup>142</sup> *Ibid.*



Many police officers we spoke to in Maine objected to the idea that their purpose is to provide health care or connections to services. As one sergeant said, “I’m old school. I want to help them, but I don’t have time. I don’t think it’s part of my role... Old school means I’m here ... I came, I saw, I arrested. How you got there isn’t my problem. Old school is: I’m arresting you and that’s it.”<sup>143</sup> In interviews, police said that their job required them to arrest people on parole who resume use in order to prevent them from possibly being a public safety threat in the future through impaired driving, or robberies or theft that might happen. Other officers compared the danger of drug possession to impaired driving, even though drug possession and use in and of itself does not endanger others.

### PROSECUTORS AND JUDGES

Prosecutors — who choose what charges to bring against defendants, assess evidence and decide what plea deals to offer and what negotiations to accept — generally only have access to police reports when making these decisions. They cannot consult with the defendant. Nor do they have the necessary health information to make referrals or the health expertise to recommend a course of treatment. Yet prosecutors decide who gets affordable cash bail, who gets referral to a rehab program or drug court and who gets a deferred disposition. Some prosecutors remain resistant to basic public health measures, such as providing naloxone to prevent overdose deaths of people charged with drug crimes. According to one District Attorney, naloxone is not distributed at arraignments to people charged with drug crimes. She added that although she personally is trying to promote it, the idea of distributing Narcan is a “radical idea” among some prosecutors.<sup>144</sup>

---

**143** Police officer, interview on October 10, 2019.

**144** Testimony of District 4 District Attorney Marianne Lynch on behalf of the Maine Prosecutors’ Association before the Joint Standing Committee on Criminal Justice and Public Safety, *An Act to Amend Certain Provisions of Maine’s Drug Laws: Hearing on LD 1675*, 130th Legislature, May 14, 2021.

Criminal defense lawyers report judges and prosecutors deny their clients access to treatment when they cannot pay cash bail. One attorney relayed the story of a client who was approved for a long-term treatment program and who found an available bed at a place where there was usually a five to six month waiting list. The judge ordered that the client could only be released with \$10,000 bail and a contract with Maine Pretrial Services.<sup>145</sup>

*“If the person had money, they would have been able to get out and get treatment. I kept asking, what is the problem with letting them go and get treatment? The case is not going to be wrapped up [for] 5-6 months, so why sit in jail instead of residential treatment? They said that the residential treatment was not a lockdown facility. But if they had money, they could go. The person is not a flight risk, it is not like they have any place to go.”<sup>146</sup>*

### SHERIFFS

Sheriffs have direct control over who can access health care while incarcerated in county jails.<sup>147</sup> As one doctor who works in several Maine jails said, “Sheriffs should not be in charge of addiction treatment. They get to decide what food [people who are incarcerated] eat, and when they go to bed. But they should not be able to decide on the treatment and mental health programs they have access to ... In some cases, sheriffs don’t believe in counseling, so inmates end up over-medicated because they can’t get counseling.”<sup>148</sup>

---

**145** A pretrial contract is a binding agreement made between defendants and Maine Pretrial Services with conditions that can include not using or possessing alcohol or illegal drugs, submitting to searches and drug testing, participating in substance use or mental health treatment, and/or a curfew. These conditions are subject to monitoring by Maine Pretrial Services; violations may result in bail revocation. See the Maine Pretrial Services website: <http://mainepretrial.org/programs.asp>.

**146** Criminal defense attorney, interview on May 4, 2021.

**147** The exception is the Two Bridges Regional Jail, that covers both Sagadahoc and Lincoln Counties and is run by a jail administrator.

**148** Doctor practicing addiction medicine, interview on May 25, 2021.

Sheriffs' ability to make arbitrary and damaging decisions about jail health care was dramatically demonstrated in June 2020. Hancock County Sheriff Kane unilaterally canceled a contract between the Hancock County Jail and Healthy Acadia to provide recovery coaching for people in the jail with substance use disorder. Sheriff Kane did this because he objected to Healthy Acadia's June 10, 2020 statement supporting Black Lives Matter, a group he falsely labeled a "terrorist group."<sup>149</sup> Healthy Acadia revised its statement to remove a reference to Black Lives Matter and added support for a joint statement from the Maine Chiefs of Police Association, the Maine Sheriffs Association, the Maine Prosecutors Association and the Maine Department of Public Safety. Despite a public outcry, Sheriff Kane refused to back down. For more than six months, people incarcerated in the Hancock jail had no access to recovery support services until the Sheriff relented.<sup>150</sup>

## PROBATION OFFICERS

Probation officers also have significant power over treatment access for the people they supervise. Many people who are on probation are given restrictions that prohibit the use of alcohol or drugs, or in some cases even prohibit being in the presence of people drinking or possessing drugs. Probation officers have a great deal of discretion in how they sanction people for probation violations, including sending people back to jail for what are called technical violations. A technical violation happens when no new crime has been committed, but the person is still subject to

probation revocation. According to a 2021 Council of State Governments report, "[i]n 2017, 44 percent of Maine's prison admissions were due to probation violations. Forty-one percent of those revocations were for a technical violation of probation such as failed drug tests or failure to comply with programming."<sup>151</sup> The study found probation in Maine characterized by "high caseloads, staff turnover, lack of specialized training, lack of capacity for specialized caseloads..."<sup>152</sup> Probation officer training includes "mandatory eight-week in-service initial training on firearms and situational awareness and six-week training on programs and policies," plus 40 hours of annual professional development training — none of which "focuses on evidence-based principles of interventions in community corrections."<sup>153</sup>

Treatment providers we interviewed reported frustration with the power of probation officers to overturn their medical decisions. Examples included probation officers refusing to approve people to be transferred from jail to a treatment facility, and not allowing people they supervise to receive medication-assisted treatment. As one treatment provider said, "The treatment person should be the person who approves, not them. I feel like I keep hitting my head on the cement wall, and it means I can't help people."<sup>154</sup> Another provider stated, "Probation officers are not clinicians, and neither are judges. It baffles me that they have the authority to say who needs treatment and whether or not it needs to be long-term, short-term, or otherwise."<sup>155</sup>

---

<sup>149</sup> Bill Trotter, "Hancock County Sheriff Won't Let Group Help Inmates Battle Addiction over Its Support for Black Lives Matter," *Bangor Daily News*, January 28, 2021, <https://bangordailynews.com/2021/01/26/news/hancock/hancock-county-sheriff-barred-group-from-helping-addicted-inmates-after-it-backed-black-lives-matter/>.

<sup>150</sup> Jennifer Osborne, "Jail coaching contract to be restored; calls for sheriff's resignation," *Mount Desert Islander*, January 3, 2021, <https://www.mdislander.com/maine-news/jail-contract-to-be-restored-calls-for-sheriffs-resignation>.

---

<sup>151</sup> Council of State Governments, *Justice Reinvestment in Maine Improving Supervision and Data Collection*, January 2021, p. 4, [https://csgjusticecenter.org/wp-content/uploads/2021/01/JR-Maine-Policy-Framework\\_FINAL.pdf](https://csgjusticecenter.org/wp-content/uploads/2021/01/JR-Maine-Policy-Framework_FINAL.pdf).

<sup>152</sup> *Ibid.*

<sup>153</sup> *Id.* p. 10.

<sup>154</sup> Counselor, interview conducted on August 24, 2021.

<sup>155</sup> Clinical social worker, interview conducted on August 24, 2021.

## PERSONAL HISTORY: CHANTEL ST. LAURENT<sup>156</sup>

*I cannot tell you how frustrating it is to watch people be incarcerated for their substance use disorder. I see people get their foot in the door at treatment, just to be pulled out by the justice system. They end up in this vicious cycle, never getting the treatment they desperately need and want. People want help. People reach out for help, only to be put on a waiting list for MONTHS due to limited funding and available resources. I see people gain traction and stability in their recovery only to be denied housing and employment because of previous charges. This work we do on the front lines weighs heavy on my heart most days. It is a matter of life or death. I do not know if the people I see today are going to make it back tomorrow. The systemic barriers are tragic and are decimating our communities. At the end of my use, I was homeless, living out of my car, jumping from place to place with my 2-year-old little girl. I could not go a day without using. I was full of shame and guilt. I was hopeless, and I did not care if I lived or died. I had been arrested multiple times, but instead of being isolated with incarceration I was afforded the opportunity to seek treatment. I attended over 7 different facilities before I found recovery. What I needed was to heal from my trauma through connection. I needed to know I was not alone, and I thank God to know that I am not.*

## CRIMINALIZING DRUG POSSESSION PREVENTS PEOPLE FROM COMPLETING TREATMENT

Delivering treatment for substance use disorder requires significant special training, which can include years of additional coursework and residencies for doctors, and a master's degree for

clinical social workers and counselors. In March 2016, the American Board of Medical Specialties announced that addiction medicine has gained official recognition as a medical specialty. Addiction medicine specialists must address the complex dimensions of substance use disorder, including the physiological impacts of physical dependence, withdrawal and cravings. They must also assist patients with what are called the social determinants of health: the impact of discrimination, poverty, lack of stable housing and income on chronic diseases like substance use disorder. The standard of care for substance use disorder includes medication-assisted treatment, but also must include “multimodal interventions that take a holistic approach to remission and recovery; incorporate a long-term, continuity of care view; and account for individual trajectories of disease.”<sup>157</sup> The structure of jails and prisons does not allow for this kind of specialty medicine.

For people with substance use disorder who are fortunate enough to be able to access treatment in the community, arrest and incarceration interrupts, and in many cases, ends it. All the health care providers interviewed for this report concurred. Here we quote two, both specialists in addiction medicine.

Dr. Kinna Thakrar, an infectious disease specialist in Portland, Maine, shared: “The last time one of my patients was arrested for drug possession, we never saw him at my medical clinic again. He had been excited to start treatment for endocarditis (a heart infection) and for his substance use. Sadly, our first reaction when he didn’t show up to clinic was to check the obituaries. And then the local jails, which is where he was located. Just three weeks into his

<sup>156</sup> Testimony of Chantel St. Laurent before the Joint Standing Committee on Criminal Justice and Public Safety, An Act To Make Possession of Scheduled Drugs for Personal Use a Civil Penalty: Hearing on LD 967, 130th Legislature, April 30, 2021, reprinted with permission, available at [https://mainelegislature.org/legis/bills/display\\_ps.asp?snum=130&paper=HP0713PID=1456](https://mainelegislature.org/legis/bills/display_ps.asp?snum=130&paper=HP0713PID=1456).

<sup>157</sup> Yngvild Olsen, “What Is Addiction? History, Terminology, and Core Concepts,” *The Medical Clinics of North America*, vol. 106 no. 1 (2022), pp. 1–12, p. 9, PMID: 34823724. doi: 10.1016/j.mcna.2021.08.001 <https://pubmed.ncbi.nlm.nih.gov/34823724/>.

treatment, he never ended up completing it.”<sup>158</sup>

Dr. Nick Gallagher, an addiction medicine doctor in Augusta, Maine, agreed, saying, “There is no evidence that people do better getting treatment in jail. Putting people in jail disrupts any momentum that you have. I have had patients that just disappear. I have a lot of patients on probation, whose probation conditions include that if you resume use, you go back to jail. If they get sent to jail, they get separated from all the stability they have on the outside. If they are working, they lose their job. If they have an apartment, they can’t pay their rent and lose their housing. If what was going on in jail was working, my patients would come out better, but they come out worse.”<sup>159</sup>

People with substance use disorder who need treatment must be evaluated and treated by medical professionals; criminalization means their care is secondary to their punishment.

### **PEOPLE WITH SUBSTANCE USE DISORDER DO NOT FIND LASTING RECOVERY IN PRISON OR JAIL NOR ARE THEY ABLE TO GET ADEQUATE TREATMENT THERE**

The vast majority of people with substance use disorder cannot find recovery while incarcerated. The key tenets of recovery include building connections and community, identifying and understanding triggers, and building the skills to navigate the challenges of life. This is impossible to do while incarcerated. Therapy, intensive outpatient groups and other core elements of treatment for substance use disorder that can

help people find recovery are not available in jails or prisons. As one doctor said, “In jail, they just get Suboxone alone. I have never once had someone say, I’m taking Suboxone alone. There are so many more things that go into treatment than just getting medication: peer support, support from a physician, regular programs, NA meetings, counselors.”<sup>160</sup>

#### **PERSONAL STORY<sup>161</sup>**

*It is not hitting rock bottom that makes the change, when you tease it out. It is actually what you did, what the person did, all that hard work, something within you, which is hard to show. The story of rock bottom is an old narrative, like that old ad with the fried egg in the frying pan, “your brain on drugs.” We are not focusing enough on the impact of trauma, how much that gets in the way and interferes with the goals that somebody might have for themselves. A lot of people who use drugs have some kind of history of trauma, and a lot of people experience traumatic things when they are getting high. Law enforcement are not trained in recognizing those cues in a way that is not further traumatizing. [Even when there is a program], it’s not like you get an option, there is one program that is supposed to work for every single person. This is particularly an issue now, as programs that are offered in jails and prisons are specifically tailored to opioids, with MAT. People who use other drugs, such as stimulants, do not have any options.*

#### **TREATMENT IN PRISONS**

The Maine Department of Corrections has made strides in recent years to address the number of incarcerated people with opioid use disorder, implementing a pilot program in 2019 to provide

<sup>158</sup> Testimony of Dr. Kinna Thakrar before the Joint Standing Committee on Criminal Justice and Public Safety, An Act To Make Possession of Scheduled Drugs for Personal Use a Civil Penalty: Hearing on LD 967, 130th Legislature, April 30, 2021, reprinted with permission, available at [https://mainelegislature.org/legis/bills/display\\_ps.asp?snum=130&paper=HP0713PID=1456](https://mainelegislature.org/legis/bills/display_ps.asp?snum=130&paper=HP0713PID=1456).

<sup>159</sup> Dr. Nicholas Gallagher, interview on May 6, 2021. Dr. Gallagher is medical director at MaineGeneral Addiction Medicine, his opinions do not represent those of his employer.

<sup>160</sup> Ibid.

<sup>161</sup> Harm reduction worker, interview on September 10, 2021.



medication-assisted treatment to some residents.<sup>162</sup> Despite these efforts, the structural limitations of incarceration mean that people are still unable to access the health care they need. In interviews with health care providers and formerly incarcerated people, several identified that though they were part of the Department of Corrections' medication-assisted treatment program and were given medication, they were not able to access additional recovery support services.<sup>163</sup> Additionally, medication-assisted treatment through the Department of Corrections is only offered to people who are within six months of release from prison, meaning that most people spend more than a year, on average, incarcerated without this medication-assisted treatment.<sup>164</sup>

## TREATMENT IN JAILS

Since 2019, some Maine jails have offered limited access to medication-assisted treatment. Jails deny people access to medication-assisted treatment for multiple reasons, including that the type of charge they face makes them ineligible, or that a person must enter the jail with a prescription in order to be eligible.<sup>165</sup> These reasons for refusal go against medical best practices and prevent people from accessing the health care to which they are legally entitled.

Most incarcerated people endure withdrawal symptoms with little to no medical intervention. These symptoms can be excruciating: severe abdominal pains, vomiting, diarrhea, dehydration, tremors, headaches and muscle pain over multiple days. For those who request and are granted medical attention, they may be given some pain medication. They are kept in their cell during withdrawal. If they are in jail, they are most likely kept in a “dry cell” — a cell without running water or a flushing toilet. Due to persistent staffing issues, a person might sit in a dry cell for a week as they detox.

Detailed reporting from each jail is unavailable. However, the July 2020 Board of Visitors Report for the Franklin County Detention Center revealed many significant issues with the health care provided there, including access to treatment for substance use disorder.<sup>166</sup> The jail facilities are described as “very small” and the staffing “stretched thin” and “too few” to cover the shifts. Mental health services are “determined by unclear criteria;” high demand for those services “does not mean they are available.”<sup>167</sup> While people who arrive with preexisting Suboxone prescriptions may continue their prescriptions, “inductions of MAT are not available” and so people who have not

---

**162** Mary Lindsey Smith et al., “Evaluation of Maine Department of Corrections Medication-Assisted Treatment Pilot Program,” Cutler Institute (February 2020), <https://www.maine.gov/corrections/sites/maine.gov.corrections/files/inline-files/EvalofMaineDOCMATPilot03.03.2020.pdf>.

**163** Formerly incarcerated person, interview on November 8, 2021; harm reduction worker, interview on September 10, 2021; clinical social worker, interview on August 24, 2021; doctor practicing addiction medicine, interview on May 25, 2021; formerly incarcerated person, interview on April 28, 2021.

**164** Maine Department of Corrections Data Team, “2020 Year End: MDOC Adult Data Report,” Maine Department of Corrections, March 17, 2021, <https://www.maine.gov/corrections/sites/maine.gov.corrections/files/inline-files/2020%20Year%20End%20Adult%20Data%20Report.pdf>.

**165** December 15, 2021 email from Deputy Commissioner Ryan Thornell containing Q3 data report to Maine DOC from the county jails.

---

**166** Every county jail facility is required to have a board of visitors that meets quarterly, and according to a 2003 law must include five members appointed by the sheriff, inspect the jail facilities and offer recommendations for mental health treatment. Many counties, including Penobscot, Lincoln and Sagadahoc, Piscataquis, and Androscoggin, have only started meeting in 2019 or 2020. See Judy Harrison, “Penobscot County Didn’t Have a Jail Board of Visitors. Then a Former Inmate Said the Law Required One,” Bangor Daily News, September 16, 2021, <https://bangordailynews.com/2019/09/16/news/bangor/penobscot-county-didnt-have-a-jail-board-of-visitors-then-a-former-inmate-said-the-law-required-one/>.

**167** Andrew Robinson et al., “Board of Visitors Annual Report Franklin County Detention Center, Farmington,” Maine, July 2020, p. 8, [https://www.franklincounty.maine.gov/\\_files/ugd/82d82c\\_d095cc32a5cd46cc88e6f023822067a8.pdf](https://www.franklincounty.maine.gov/_files/ugd/82d82c_d095cc32a5cd46cc88e6f023822067a8.pdf).

already been prescribed medication-assisted treatment are forced to experience withdrawal.<sup>168</sup>

Release from incarceration, especially from jail, is generally not coordinated with service providers on the outside, so people who leave jail cannot find services, and whatever treatment they may have been able to access while incarcerated is discontinued. One doctor who provides medical care to incarcerated people in jails said, “Another big problem we have is that we have no system for working a plan for someone [when] they get sprung. If they get released on bail or are done with their sentence, we don’t know what is happening. They disappear, we have no idea where they go. The people controlling the sentence and the arrest should be in league with the treatment providers, but instead we are working at cross purposes and not coordinating.”<sup>169</sup>

The COVID-19 pandemic has shown how difficult it is to pursue recovery in jail and prison. During this time, many people were in their cells 23 hours a day. They had no visits, no counseling, no case management meetings and no AA meetings. They were only allowed out of their cells at mealtimes. Many have contracted COVID-19 amidst outbreaks at several county jails and state prisons. According to the *Portland Press Herald*, more than 330 incarcerated people across the state have contracted COVID-19 to date.<sup>170</sup> Jason Daigle died on September 20, 2020 from a stroke, and the medical examiner listed COVID-19 as a contributing factor in his death. Mr. Daigle died awaiting trial after he could not afford \$2,500

bail on drug charges.<sup>171</sup> Instead of providing treatment, incarceration for drug use and possession has been life-threatening.

What limited access to medication-assisted treatment that exists in Maine jails is the result of a lawsuit, *Smith v. Aroostook County*.<sup>172</sup> The Aroostook County sheriff was so resistant to providing medication-assisted treatment in his jail that he fought a lawsuit brought by Brenda Smith, a woman facing a 40-day jail sentence, who requested to continue her medication-assisted treatment while she served her time. Smith had successfully maintained her recovery for five years with treatment that included prescription buprenorphine, but jail administrators denied her repeated requests to continue taking her medication. In an order granting Smith a preliminary injunction to continue taking her medication, the judge found that, “[Sheriff Gillen and the Aroostook County Sheriff Department]’s representatives lacked a baseline awareness of what opioid use disorder was despite serving a population that disproportionately dies of that condition.”<sup>173</sup> Aroostook County spent several hundred thousand dollars fighting the lawsuit, unsuccessfully appealing the decision against the sheriff to the First Circuit Court of Appeals and paying Ms. Smith’s plus its own legal costs.

<sup>168</sup> *Ibid.*

<sup>169</sup> Doctor practicing addiction medicine, interview on May 25, 2021.

<sup>170</sup> Keith Edwards, “10 Virus Cases among Inmates, Staff in Kennebec Jail Outbreak,” *Portland Press Herald*, November 30, 2021: B.2, <https://www.proquest.com/docview/2604292063/citation/42F6740C0A614B80PQ/39>.

<sup>171</sup> Megan Gray, “COVID-19 Cited as Factor in Death of York County Inmate as Jail Outbreak Is Declared Over,” *Portland Press Herald*, October 23, 2021, <https://www.pressherald.com/2020/10/23/covid-19-cited-as-factor-in-death-of-york-county-jail-inmate-as-outbreak-is-declared-over/>.

<sup>172</sup> *Smith v. Aroostook Cnty.*, No. 1:18-cv-352-NT (D. Me. filed Nov. 5, 2018). The ACLU of Maine represented the plaintiff, Brenda Smith, in this case.

<sup>173</sup> *Smith v. Aroostook Cnty.*, 376 F.Supp.3d. 146, 160 (D. Me. 2019).

#### PERSONAL STORY: KAYLA KALEL<sup>174</sup>

*Let me be clear in saying that even though our culture wants us to believe that those moments of extreme pain and misery, long hours of being locked in a cell, or getting the news that a loved one has passed away while we were in prison will be enough to keep us on the straight and narrow, and that they will serve as powerful memories that motivate us to stay away from substance use - COULD NOT BE FURTHER FROM THE TRUTH.*

*The message that we send people who are already suffering is that they are less than human, that they belong in a cell all hours of the day except one, that they should drink water out of a bowl like a dog, that whatever they have done warrants the forcing of eating breakfast, lunch, and dinner within feet from the very same spot they go to shit. We give cop-out responses like: “Sorry we don’t have enough staff on right now.” When you put in the 37th request for an infected tooth that has been bothering you for months, and has caused you to lose out on a week’s worth of real sleep because the pain is unbearable. When an incarcerated person goes to see the doctor complaining of severe stomach pain only to be turned away and told that they “just need to drink more water” and on release from prison, find out that they had Stage Three cancer — you know a system is broken. But the word broken has always been weird to me. The criminal justice system and the war on drugs – created to keep certain populations of people oppressed, silenced and living in generational poverty – is working. We know through research and lived experience that when a person has access to housing, education, employment, social supports, empathy, purpose and connection within their community, and recovery support services on the whole continuum — that recovery and safety is not only possible, it’s also highly likely.*

*The war on drugs was a waste of money, has killed and was linked to the deaths of so many amazing people and negatively changed and puts scars on the lives of so many Americans. Even if you’re in recovery, and experienced some of these things, we still have to take a really hard look at some of the ideas, biases and social norms that we carry around as truths. Part of ending stigma and discrimination is unpacking the way in which we view and interact with the world, unpacking the things we have been taught, allowing ourselves to identify the things that are wrong (with ourselves, with our communities and with the systems in our communities) and the procedures, laws, and ideas that are causing harm. We need to be willing to admit and take responsibility for the fact that even though we have tried to go through life with good intentions, sometimes our ideas and judgements of others are wrong, hurtful and harmful. It just seems so insane to me that we know that our current criminal “justice” system is literally causing recidivism, relapse, and overdose, instead of promoting recovery, treatment and empathy. Time for change, ya’ll.*

#### DEFERRED DISPOSITIONS AND DRUG COURTS EXPAND PUNITIVE EFFORTS TO CONTROL AND SURVEIL PEOPLE

The Maine criminal legal system uses two methods to divert people from incarceration. One is the use of “deferred dispositions” and the other

is called a “specialty court.”<sup>175</sup> Neither of these presents an alternative to criminalization. They require people to give up their presumption of innocence, plead guilty and give up any right to

<sup>174</sup> Facebook, personal post, November 18, 2020. Reprinted with permission.

<sup>175</sup> Maine offers three different specialty courts: Adult Drug Treatment Court, Veterans Court, and a Co-Occurring Disorders Court. For the purposes of this report we focus on the Adult Drug Treatment Court.

appeal.<sup>176</sup> They also leave people with a permanent criminal record even if they successfully complete the programs.<sup>177</sup> Any treatment that participants can access through these programs is at the discretion of law enforcement and court officials. Participants must meet onerous requirements, including frequent drug testing, surveillance from probation officers and case managers and mandatory counseling and group therapy. In many cases, these conditions make it impossible to keep employment — an additional program requirement — which is necessary for survival, because the programs offer no financial support to participants.

Combined, deferred dispositions and drug court programs cover a very small percentage of cases filed against defendants. In 2019, only 295 people went through Maine's six drug courts,<sup>178</sup> not all of whom were facing drug charges.<sup>179</sup> Between 2014 and 2019, approximately 6 percent of deferred dispositions were used on drug possession cases.<sup>180</sup> For many, if not most, participants, these programs are difficult to navigate and extend the risk of incarceration. In many cases, these alternatives greatly extend a person's time under state surveillance or in custody and are much more expensive than treatment.

---

**176** See, e.g., *Maine Treatment Court Plea Agreement and Waiver of Rights Court Form CR-238*, revised November 2019, <https://mjbportal.courts.maine.gov/CourtForms/FormsLists/DownloadForm?strFormNumber=CR-238> (accessed December 29, 2021).

**177** Defendants are allowed to withdraw their guilty plea after they have successfully completed the terms of the deferred disposition agreement. 17-A M.R.S. §§1903(1), (2). In that case, the charges filed may be considered “confidential criminal record history information” under Maine law, 16 M.R.S. § 703(2)(G), which would limit the dissemination of the records but not erase them.

**178** Public Consulting Group, “Maine Adult Drug Treatment Court Evaluation Report,” December 2020, p. 2, <https://www.courts.maine.gov/about/reports/adtc-evaluation-report-2020.pdf>.

**179** *Id.* at p. 74.

**180** Cutler Institute, “The Use of Deferred Dispositions in Domestic Violence and Sexual Assault Cases in Maine,” February 2021, p. 50 [https://cpb-us-w2.wpmucdn.com/wpsites.maine.edu/dist/2/115/files/2017/10/Deferred\\_Dispositions\\_Report\\_FINAL.pdf](https://cpb-us-w2.wpmucdn.com/wpsites.maine.edu/dist/2/115/files/2017/10/Deferred_Dispositions_Report_FINAL.pdf).

Both avenues also reproduce the structural racism that results in the disproportionate punishment of Black people in Maine for drug crimes. For the cases in which data on race is available, Black people are less likely to receive deferred dispositions than white people, and those who do have fewer prior arrests than white people.<sup>181</sup> Black people are also less likely to be referred and admitted to drug courts in Maine. A 2020 report by Public Consulting Group for Maine Pretrial Services found that racial disparity was a “major concern”<sup>182</sup> for Maine’s specialty courts.

## DEFERRED DISPOSITIONS

To access what is called “deferred disposition,” the prosecutor and the accused must enter an agreement, and the accused must plead guilty to the crime.<sup>183</sup> Sentencing is delayed while the defendant completes a series of obligations, which could include courses (which the defendant must pay for), community service, notifying the district attorney’s office if they move, written apology letters or treatment for substance use disorder. All participants must pay up to \$50 per month for an “administrative supervision fee”<sup>184</sup> for the duration (which could last between a few months and several years).<sup>185</sup> If deemed successful by the prosecutor, the State will then reduce or dismiss the charges.

The obligations faced by defendants with deferred dispositions can be extremely onerous,

---

**181** Ben Shelor et al., “Justice Reinvestment in Maine: Second Presentation,” p. 36. 5.4 percent of white people charged received deferred dispositions, compared with 3.3 percent of Black people, *id.* Black people with deferred disposition had an average of 1.11 prior arrests, compared to 1.31 prior arrests for white people, *id.*

**182** Public Consulting Group, “Maine Adult Drug Treatment Court Evaluation Report,” p. 27.

**183** 17-A M.R.S. §1902. The only charges eligible for a deferred disposition are misdemeanor and Class C felonies (the lowest level of felony), and, as of October 2021, Class B drug felonies. 17-A M.R.S. §1901.

**184** 17-A M.R.S. §1902(1)

**185** Public Consulting Group, “Maine Adult Drug Treatment Court Evaluation Report,” p. 8.



especially for people who are poor, with irregular work schedules, unstable housing and other challenges. One defense attorney used the example of her client who had successfully maintained his medication-assisted treatment program and kept his job, but had not been able to find time for another requirement: an evaluation from a clinical provider. This put his successful completion of the deferred disposition in jeopardy. The lawyer described the rigorous demands of the deferred disposition agreement: he must keep his employment, perform additional community service, complete mental health evaluations and counseling as well as so-called substance abuse evaluations and counseling, and participate in weekly supervision check-ins. “If I tried to add all those things into my life, I would fail,” his attorney said. “It’s impossible.”<sup>186</sup>

#### ADULT DRUG TREATMENT COURTS

Drug courts do not offer an alternative to the legal system’s punishment-based approach. Instead, they reproduce the harms of the drug war at large: they are incredibly resource-intensive, require people to give up their constitutional rights, subject participants to intense surveillance, put lawyers and law enforcement in charge of medical decisions and punish people for resumption of use (a defining characteristic of a substance use disorder). And, despite claims that drug courts save lives, the 2020 Maine Adult Drug Treatment Court Evaluation Report found no statistically significant difference in the fatality rate from drug and alcohol overdoses between the treatment court group and the comparison group.<sup>187</sup>

In drug courts, the presiding judge maintains control over the proceedings, including treatment decisions. System actors — including the judge, probation officer, other law

enforcement and prosecutors — outnumber the treatment providers on the team. Law enforcement and court officials are trained to identify criminal actors and punish them, and most drug court team members have limited experience with treatment and recovery protocols and needs. While drug court team members receive limited training, these different attitudes shape how treatment is delivered through drug court, how sanctions are assigned and how terminations are conducted.

Even when they disagree with treatment decisions, treatment providers can be ignored and overruled. As one provider reported:

*“The judge has the final say, and something that I’ve kind of struggled with is staying in my treatment role... It’s not really my role to recommend a jail sanction because it’s not treatment. That’s not a good solution. So that’s been kind of hard for me [seeing the judge order people to jail] ... ultimately it comes down to the judge and whatever he feels is best for the client.”<sup>188</sup>*

Judges and law enforcement in drug courts continue to incarcerate people for resumption of use. The 2020 Maine Adult Drug Treatment Court Evaluation Report found that participants have been jailed for violations such as missing a drug test, and may be kept in jail for two to four weeks while the judge decides on what sanction to impose for the violation.<sup>189</sup> This approach is contrary to treatment best practices, and exposes people who are trying to achieve or maintain recovery to severe harms of incarceration while also trying to manage a substance use disorder. It is not an acceptable alternative to decriminalization.

---

<sup>186</sup> Defense attorney, interview on May 7, 2021.

<sup>187</sup> Public Consulting Group, “Maine Adult Drug Treatment Court Evaluation Report,” p. vii.

---

<sup>188</sup> Clinical social worker, interview on May 13, 2020.

<sup>189</sup> Public Consulting Group, “Maine Adult Drug Treatment Court Evaluation Report,” p. 35.

# DECRIMINALIZATION WORKS

## **MORE THAN 20 YEARS AFTER DECRIMINALIZING DRUG POSSESSION, PORTUGAL HAS SEEN DRAMATIC INCREASES IN HEALTH AND SAFETY AND REDUCTIONS IN INCARCERATION**

Portugal decriminalized possession of all drugs in 2001. A small country of 10 million in southern Europe, it responded to the high rate of overdose death and high rates of injection drug-related illnesses, including HIV, Hepatitis C and others. At the time, Portugal was responsible for 50 percent of all the drug-induced new HIV cases in the European Union (with only two percent of the EU's population).<sup>190</sup> In 1999, 44 percent of people incarcerated in Portugal were there for drug-related reasons.<sup>191</sup>

Portuguese politicians were ready for a new approach. They commissioned a study of experts, including doctors providing clinical care directly with people using heroin. Under their leadership, the commission recommended decriminalization of all drugs for “drug users.”<sup>192</sup> This recommendation was adopted by the Council of Ministers in 2001 and enacted nationwide.

Under current law, anyone found using drugs,

regardless of the type of drugs, is brought before a Discussion Commission that decides the appropriate response. Officially called a Commission for the Discussion of Drug Addiction, it includes a lawyer or judge, a healthcare worker and a social worker. Together they assess the level of risk faced by the “drug user”. Criminal prosecution, a criminal record and incarceration are not on the table for anyone. Recommendations can include no further action, counseling, or referrals to government-provided drug treatment programs. Some users are asked to pay a fine, do community service, or may be prevented from being able to go certain places or work in certain roles.<sup>193</sup> This system does not legalize drugs, and it is still illegal to sell or traffic drugs.

As a result of the decriminalization of drug possession, more money became available for treatment and support services. Newly created visiting nursing and social work programs increased access to harm reduction services, including access to safer use supplies, contributing to the reduction in HIV and Hepatitis C transmission.<sup>194</sup> The Portuguese model reduces stigma, so people can seek treatment without the fear of criminal punishments. Counseling and treatment are voluntary.

---

**190** Transform Drug Policy Foundation, *Drug Decriminalisation in Portugal: Setting the Record Straight*, May 13, 2021, <https://transformdrugs.org/blog/drug-decriminalisation-in-portugal-setting-the-record-straight> (accessed December 22, 2021).

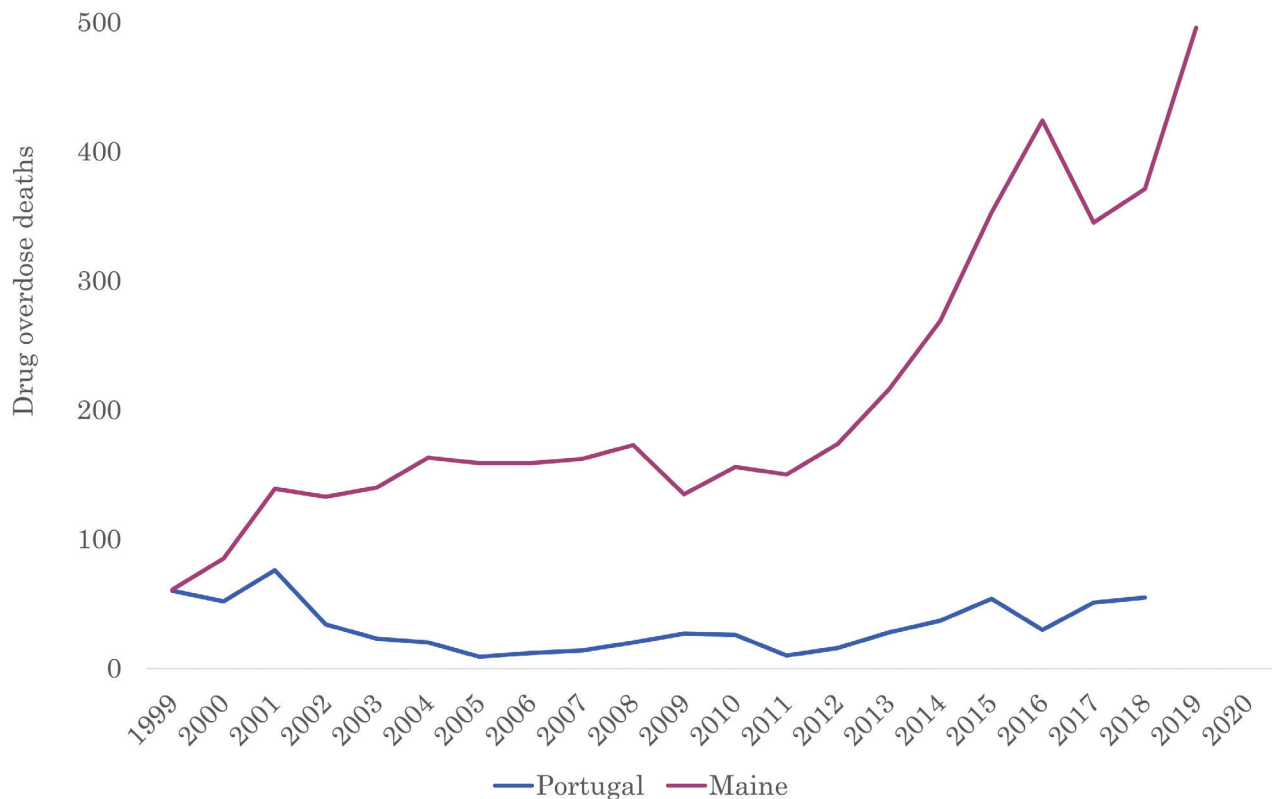
**191** Caitlin Elizabeth Hughes and Alex Stevens, “What Can We Learn From The Portuguese Decriminalization of Illicit Drugs?,” *The British Journal of Criminology*, vol. 50 no. 6 (2010), pp. 999–1022, p. 1010. This figure includes crimes committed while under the influence of drugs, and to fund drug consumption.

**192** A drug user is defined as someone with at maximum a 10-day supply for personal use. These amounts are set by law but can take into account different drug use histories.

---

**193** Tiago S. Cabral, “The 15th anniversary of the Portuguese drug policy: Its history, its successes and its future,” *Drug Science, Policy and Law*, vol. 3 (2017), doi: <https://doi.org/10.1177/2050324516683640>.

**194** Naina Bajekal, “Want to Win the War on Drugs? Portugal Might Have the Answer,” *Time*, August 1, 2018, <https://time.com/longform/portugal-drug-use-decriminalization/> (accessed December 22, 2021).



**Figure 15: Decriminalization has reduced drug overdose deaths in Portugal while deaths in Maine have soared**

SOURCES: MECEP'S ANALYSIS OF US CDC MORTALITY DATA AND EUROPEAN MONITORING CENTER FOR DRUGS AND DRUG ADDICTION, 2021 STATISTICAL BULLETIN

By 2008, approximately 75 percent of people who used opioids in Portugal opted into treatment.<sup>195</sup> The proportion of people incarcerated in Portugal for drug offenses fell to 15.7 percent in 2019. HIV infection rates dropped from 104.2 cases to 4.2 cases per million in 2015.<sup>196</sup> Between 1999 and 2018, drug overdose deaths in Portugal remained low, even as they rose in the rest of the European Union.<sup>197</sup> Over

the same period in Maine, they dramatically increased from 53 per million to 299 per million.<sup>198</sup> In 2019, the rate of overdose death in Portugal was six deaths per million, compared to the EU average of 23.7 in 2019,<sup>199</sup> and the US rate of 216 per million.<sup>200</sup> The number of deaths from overdose in Portugal is now one of the lowest in the European Union.

<sup>195</sup> Austin Frakt, "Pointers From Portugal on Addiction and the Drug War," *The New York Times*, October 5, 2020, <https://www.nytimes.com/2020/10/05/upshot/portugal-drug-legalization-treatment.html>.

<sup>196</sup> Naina Bajekal, "Want to Win the War on Drugs? Portugal Might Have the Answer."

<sup>197</sup> Transform Drug Policy Foundation, *Drug Decriminalisation in Portugal: Setting the Record Straight*.

<sup>198</sup> US Department of Health and Human Services, Centers for Disease Control and Prevention, *Mortality Data (Underlying cause of death), 1999-2018*, retrieved via CDC Wonder, <https://wonder.cdc.gov/>.

<sup>199</sup> Transform Drug Policy Foundation, *Drug Decriminalisation in Portugal: Setting the Record Straight*.

<sup>200</sup> US Department of Health and Human Services, Centers for Disease Control and Prevention, *Mortality Data (Underlying cause of death), 2019*, retrieved via CDC Wonder, <https://wonder.cdc.gov/>.

At the same time, drug use in Portugal remains relatively low. For every 1,000 Portuguese residents, between three and seven individuals are thought to have problematic opioid use, compared with just under 12 out of every 1,000 Mainers.

The results from this turn away from criminalization and toward health care are clear: reduced rates of overdose deaths and dramatic reductions in the harms associated with drug use.<sup>201</sup>

## CHANGE IS COMING TO THE UNITED STATES

In 2020, Oregon voters passed Measure 110, which decriminalized possession of small amounts of drugs, offered a health screening or the option to pay a fine instead, and expanded funding for treatment services and recovery supports in the state. While the programs are only beginning to be implemented, more than \$302 million dollars will be directed toward public health and recovery organizations over the next two years.<sup>202</sup> And thousands of people will not face the devastating consequences of incarceration and a criminal record.

---

**201** For more, see Caitlin Elizabeth Hughes and Alex Stevens, "What Can We Learn From The Portuguese Decriminalization of Illicit Drugs?," *The British Journal of Criminology*, vol. 50(6) (2010), pp. 999–1022; Susana Ferreira, "Portugal's Radical Drugs Policy Is Working. Why Hasn't the World Copied It?," *The Guardian*, December 5, 2017, <https://www.theguardian.com/news/2017/dec/05/portugals-radical-drugs-policy-is-working-why-hasnt-the-world-copied-it>; Chris Brown, "How Europe's Heroin Capital Solved Its Overdose Crisis," *CBC News*, 2016, <https://www.cbc.ca/news2/interactives/portugal-heroin-decriminalization>.

**202** Drug Policy Alliance, "Drug Decriminalization in Oregon, One Year Later," November 3, 2021, <https://drugpolicy.org/press-release/2021/11/drug-decriminalization-oregon-one-year-later-thousands-lives-not-ruined>.

## THE MAINE LEGISLATURE WENT FURTHER THAN ANY OTHER LEGISLATURE IN THE COUNTRY IN 2021 TOWARDS DECRIMINALIZING POSSESSION OF DRUGS FOR PERSONAL USE

In June 2021, the Maine House of Representatives passed LD 967, An Act To Make Possession of Scheduled Drugs for Personal Use a Civil Penalty. This bill would have decriminalized possession of small amounts of drugs and offered a connection to treatment for those who wanted it. Although the bill failed in the Maine Senate, the Maine legislature came closer than any other state legislature in 2021 to decriminalizing possession and use of small amounts of drugs.

This is a path that is supported by the majority of people in Maine.

A 2021 statewide poll conducted by Robert Glover and Kary Sporer at the University of Maine found that over 73 percent of respondents expressed positive responses (somewhat agree, agree, or strongly agree) with decriminalization of possession for personal use.<sup>203</sup> Another 2021 poll by the ACLU of Maine found that 60 percent of registered voters favor decriminalization, including 74 percent of self-identified Democrats and 57 percent of self-identified Independents. The poll found that self-identified Republicans were split on the issue, with 44 percent supporting and 43 percent opposing. The support was statewide, with a majority of urban, rural and suburban voters all approving of decriminalizing personal possession of drugs.<sup>204</sup>

---

**203** Robert Glover and Karyn Sporer, "Research Roundup: What Does Recent Survey Research Suggest about Mainers' Attitudes Towards Drug Policy Reform," *Scholars Strategy Network Maine*, 2021.

**204** Patinkin Research Strategies April 5-10, 2021 statewide poll of 590 registered Maine voters.



# RECOMMENDATIONS

## WE MUST DECRIMINALIZE DRUG POSSESSION AND USE

To achieve long-term and sustainable change, Maine must decriminalize use and possession of drugs. This means the state must stop arresting, prosecuting, incarcerating and generally punishing people who use drugs or possess drugs for their personal use. What constitutes personal use should be determined and updated regularly by experts: health care professionals who work with people who use drugs and people who have used or are using drugs. Decriminalizing personal possession will reduce stigma, remove barriers to healthier living for people who use drugs and avoid the added trauma and disruption of incarceration.

## INVEST IN MAINE COMMUNITIES

While our central recommendation is decriminalizing drug possession and use, this action is necessary but not sufficient to address the harms of criminalization. Preventing problematic substance use and supporting recovery from substance use disorder require what we all need for thriving communities: stable housing, accessible mental health treatment and support, meaningful connection to community and opportunities for sustainable work.

## INVEST IN TREATMENT AND RECOVERY-RELATED HOUSING

In our conversations with people in recovery across the state of Maine, they relayed that the most immediate and important policy change needed is investment in safe, affordable and low-barrier housing. Housing is both a harm reduction tool and also a necessary component for people to find stability, community and connection.

The need for housing is particularly acute for people with substance use disorder. They do not have access to in-patient treatment services or housing once treatment is completed. The dire shortage of medical detox beds, in-patient rehabs, recovery residences and most importantly, funding to support these services across the state, means that people are more likely to be criminalized for their drug use and less likely to find an off-ramp from problematic use. Expanded Medicaid eligibility has put treatment in financial reach for more people in Maine, but this will be insufficient without access to housing and appropriate treatment. The state has made a good start expanding medication-assisted treatment and intensive outpatient programs. Now it must expand treatment options that provide housing and include those addressing substance use other than opioids.

Now, we have a once-in-a-lifetime chance to invest in housing. The State of Maine is projected to have an unprecedented budget surplus of \$1.2 billion over the next two state fiscal years.<sup>205</sup> Additionally, the federal government has allocated hundreds of millions more in financial aid to the state and local governments in Maine through the American Rescue Plan Act of 2021. County, municipal and tribal governments in Maine will receive just over \$500 billion to assist in economic recovery

---

**205** Michael Allen et al., "Report of the Maine State Revenue Forecasting Committee," November 30, 2021, p. ii, <https://legislature.maine.gov/doc/7642> (accessed Jan 14, 2022); Christopher Nolan, et al., "Report of the Maine State Revenue Forecasting Committee," March 1, 2022, p. ii, <https://legislature.maine.gov/doc/8382> (accessed March 15, 2022).

from the COVID-19 pandemic.<sup>206</sup> In order to provide real alternatives to criminalization, Maine state and city governments must act immediately to invest in safe, affordable, low-barrier housing.

#### **INVEST IN PUBLIC HEALTH AND MENTAL HEALTH**

In order to get at the root of many peoples' problematic substance use, we must invest in community programs that address trauma and poverty. People must be able to find help at the level that is appropriate to their needs and abilities, at low or no cost. This means supporting a continuum of care — from peer support to residential treatment — in communities across the state. The programs must be easy to access and have low barriers to participation.

The state should also increase resources to better support harm reduction practitioners and practices. Harm reduction is a set of policies and practices that meet people where they are, in order to reduce the harms caused by problematic substance use and the criminalization of drug use. These can include overdose prevention sites, where people can use drugs in a medically-supervised setting, Good Samaritan laws that protect people from

criminal charges when they call for help in the case of an overdose, syringe service programs, testing facilities and more.

#### **INVEST IN COMMUNITY CONNECTION**

Flourishing communities can provide the connection and belonging that prevent problematic substance use and enable recovery. Revitalizing our communities requires investment in public institutions that bring people together and create a strong foundation for collective care. Maine and its municipalities should invest in public transportation, parks, libraries, schools and recreation centers. Doing so will allow families to find the support and connection they need to thrive, and will help communities be more resilient when their members struggle.

#### **IMPROVE DATA COLLECTION AND MAKE IT PUBLICLY AVAILABLE**

In order to know the full impact and costs of the various state and local systems that work together to criminalize people who use drugs, the public must have access to data about those systems. Maine state and municipal governments must make data about drug crime enforcement publicly available and easily accessible. This should include collection and public reporting by police and sheriffs departments, county jails, District Attorneys' offices, the Office of the Attorney General and the judicial branch. The data must be publicly accessible and low-cost.

---

**206** Maura Pillsbury, "American Rescue Plan Act Funding Creates Opportunities for Maine Counties," Maine Center for Economic Policy, October 8, 2021, <https://www.mecp.org/blog/american-rescue-plan-act-funding-creates-opportunity-for-maine-counties/> (accessed January 14, 2022).

**Decriminalizing personal possession will reduce stigma, remove barriers to healthier living for people who use drugs and avoid the added trauma and disruption of incarceration.**

# CONCLUSION

Maine invests \$111 million per year to arrest, prosecute and incarcerate people who use drugs. This system of criminalization is not only ineffective, it is harmful: despite an increase in arrests, we continue to lose our friends and neighbors in higher numbers every year. Criminalization increases overdose deaths, compounds racial inequalities and is generally traumatizing. Police and lawyers are not medical professionals, and the criminal legal system is not equipped to address problematic substance use.

Maine is ready for change. Decriminalizing drug use and possession is a crucial harm reduction step that is necessary to end the stigmatization of people who use drugs or have substance use disorder. Decriminalization, coupled with investments in our communities in housing, health care and civic life, are the best answers to problematic substance use and overdose deaths.







**Together, we can  
choose a new  
path forward.**



# APPENDICES

## APPENDIX I: OTHER TERMS YOU SHOULD KNOW

**Opioids** reduce pain by binding with the receptors that register pain. There are a range of opioids, from natural to synthetic.

**Natural opioids** are derived from the opium poppy, including morphine and codeine.

**Semi-synthetic opioids** are further refined, including heroin made from morphine, and the powerful prescription drugs hydrocodone and oxycodone.

**Synthetic opioids** are produced entirely in laboratories, including fentanyl and its analogues, which are “chemical cousins” – closely related chemical compounds that have similar effects but varying strength.

**Fentanyl** is a synthetic opioid widely used as an anesthetic in surgery, and as an extended-release skin patch as treatment for chronic pain. Fentanyl analogues, also known as novel psychoactive substances, have slightly different chemical structures and vary in strength. The dramatic increase in overdose death is directly related to the increasing presence of fentanyl and fentanyl analogues in the drug supply. The danger to users is that opioids also depress the respiratory system. When a person takes more than their system can tolerate – an amount that varies widely according to individual physiology and prior drug use – lowered breath rates leads to unconsciousness and death. The name overdose in many cases is a misnomer, as people are not taking more than their usual dose but are poisoned by drug supplies that are contaminated with fentanyl or fentanyl analogues.

**Stimulants** speed up speed up messages sent between the brain and the body. They can make a person feel more alert and energetic.

**Cocaine** is extracted from the coca plant and used as an anesthetic; it can be snorted, smoked or injected as a powder. Crack cocaine, which is pharmacologically identical to powder cocaine, tends to be cheaper and faster acting, with a shorter high.

**Methamphetamine** is part of the amphetamine chemical family, which were widely used to reduce fatigue and suppress appetite after World War II. Methamphetamine lasts longer and has stronger effects because it travels through the blood-brain barrier more quickly than amphetamines, but its effects are not substantially different. The way the drug is consumed can also intensify how its effects are felt. Methamphetamine can be prescribed to treat Attention Deficit Hyperactivity Disorder and narcolepsy, but its medical use is limited, and amphetamines, prescribed as Adderall, are much more widely used.

**Polysubstance use** is when people use different substances in different combinations. Mixing different substances, including alcohol, can produce damaging results, even death. The rate of polysubstance use in Maine is increasing, and is found in the majority of overdose deaths.

## APPENDIX II: CALCULATING THE COST OF CRIMINALIZING DRUG USE

The economic cost of criminalizing drug use consists of many components and calculating the total cost is a multi-step process. These costs fall into three main categories: the cost of police and pretrial detention; the cost of legal proceedings at trial; and the cost of post-conviction incarceration and probation. Below is a guide describing how we reached the estimates in this report.

### COSTS OF POLICING AND ARRESTS

In 2019, law enforcement agencies spent almost \$328 million on law enforcement activities, and made 38,893 arrests.<sup>207</sup> That's the equivalent of \$8,427 per arrest. Maine police agencies made 2,578 arrests on drug possession charges and 1,036 arrests for drug trafficking or manufacturing charges.<sup>208</sup> The total cost of arrests for drug charges was therefore almost \$30.5 million.

Note that this figure does not account for the federal funds the state spends on drug enforcement activities.

### COSTS OF PRETRIAL DETENTION

Maine pays approximately \$33.6 million every year on pretrial detention of people charged with drug crimes. We reached this number by applying the average length of pretrial detention (adjusted for class of crime)<sup>209</sup> to the number of individuals facing drug charges, multiplied by the daily cost of jail. The mean length of detention ranges from just under 32 days for people charged with misdemeanors, to almost 141 days for those charged with Class A

offenses.<sup>210</sup> Every day a person spends in jail costs the public \$141.<sup>211</sup>

### INDIVIDUALS SPEND APPROXIMATELY \$100,000 EVERY YEAR ON COSTS RELATED TO BAIL

People who are arrested for drug crimes are constitutionally entitled to bail, but many remain in jail pending trial because they cannot afford the cost of bail conditions. These costs can come in the form of cash bail, a treatment bed or other conditions that require money. Comprehensive and up-to-date statewide data is not available, but a 2015 study found that the majority of the people in Maine's jails were held pretrial.<sup>212</sup> A December 2021 snapshot of people held at Maine's largest jail, Cumberland County Jail, suggests that not much has changed: 4 in 5 people were being held pretrial.<sup>213</sup>

Cash bail amounts vary considerably. In 2016, the average cash bail ranged from \$722 per person for a Class E misdemeanor to an average

**210** Calculation based on the average length of pretrial detention for all detainees in 2015 (the most recent year for which data is publicly available), adjusted for the class of offenses with which those arrested on drug charges were held, and the share of detainees who cannot post bail. For average length of detention by offense class, see Robert E. Mullen, "Report of the Intergovernmental Pretrial Justice Reform Task Force," Dec. 2015, p. 9, <https://www.courts.maine.gov/about/reports/report-pretrial-justice-reform-task-force-dec2015.pdf>.

**211** The total annual cost to operate county jails in 2019 was \$86,574,654, according to audited financial statements for Maine's counties. According to the US Bureau of Justice Statistics, the average daily jail population in Maine in 2019 was 1,670. US Bureau of Justice Statistics, "Mortality in Local Jails, 2000-2019 - Statistical Tables," table 18 p. 22. <https://bjs.ojp.gov/content/pub/pdf/mlj0019st.pdf>. Accordingly, the daily cost per prisoner is \$141.

**212** Robert E. Mullen, "Report of the Intergovernmental Pretrial Justice Reform Task Force," Dec. 2015, p. 3 n.1.

**213** MECEP's analysis of Cumberland County Jail data from December 16, 2021. This is similar to recent reports from other jails. See, e.g., Dillon Holloway, "Sheriff discusses overcrowding at Penobscot County Jail," Fox 22 WFVX Bangor, September 1, 2021 ("[Sheriff Troy] Morton says 70 percent of the jail population is directly impacted by pretrial cases"), <https://www.foxbangor.com/news/item/sheriff-discusses-overcrowding-at-penobscot-county-jail/>.

**207** US Census Bureau, *Census of State and Local Finances* 2019.

**208** Maine Department of Public Safety, Uniform Crime Reporting Division, "Crime in Maine 2019."

**209** The main class of crime for which individuals were arrested on drug charges was estimated using Ben Shelor et al., "Justice Reinvestment in Maine: Second Presentation," pp. 13, 20.

of just under \$36,000 for a Class-A felony.<sup>214</sup> Altogether, defendants on drug possession and trafficking charges posted almost \$12 million in bail in 2019.<sup>215</sup> This money is applied to court fines and fees or attorney's fees if a defendant is convicted of a crime, and is returned to the defendant or person who paid the bail if they are not convicted.

In addition to the amount of cash bail handed over, defendants who are released pretrial by bail commissioners, as opposed to judges, are responsible for a nonrefundable \$60 fee paid directly to the bail commissioner. These fees total over \$100,000 a year for people arrested on drug charges.<sup>216</sup>

### INDIVIDUALS LOSE A COMBINED \$16.3 MILLION EACH YEAR IN LOST EARNINGS WHILE INCARCERATED PRETRIAL

While held in pretrial detention, individuals also lose money because they are unable to work.

---

**214** Robert E. Mullen, "Report of the Intergovernmental Pretrial Justice Reform Task Force," Dec. 2015, p. 9.

**215** Note that in 2021, the Maine legislature eliminated cash bail for most class E crimes, P.L. 2021, ch. 397. This will reduce the total amount of bail posted for drug crimes in the future. Calculation based on average bail posted for pretrial detainees in Maine in 2015, adjusted to reflect the class of offenses for which individuals were arrested, and the share of detainees posting bail. For the average bail posted in Maine in 2015, see Robert E. Mullen, "Report of the Intergovernmental Pretrial Justice Reform Task Force," Dec. 2015. For the classes of offenses under which drug offenders were charged, see Ben Shelor et al., "Justice Reinvestment in Maine: Second Presentation," pp. 13, 20. For the proportion of people who were released on bail, data was collected from Maine's county jails. While statistics were not available for all jails, based on data from Androscoggin, Cumberland, and Piscataquis Counties, plus the Two Bridges Regional Jail, 47% of people were released on bail in 2019. This is someone higher than the 36% finding in Marie VanNorstrand et al., "Pretrial Case Processing in Maine: A Study of System Efficiency and Effectiveness," September 2004, p. 16, <http://mainepretrial.org/resources/case-processing-study.pdf>.

**216** Calculation based on the number of individuals arrested on drug charges in 2019, and the proportion of arrestees who post bail. Number of individuals charged on drug offenses based on data from the Maine Administrative Office of the Courts, 2019. Share of detainees released on bail based on data from Maine County jails for calendar year 2019.

Lost earnings were calculated based on the average annual earnings of 35-44 year-olds in Maine with a high school diploma, adjusted for the race and gender of individuals arrested on drug charges.<sup>217</sup> The average daily lost earnings for individuals while incarcerated was \$68 per day, meaning that an individual detained for 30 days would lose over \$2,000. Based on the number of people held pretrial and the length of time for which they are held, individuals detained on drug charges lose a total of just over \$16 million per year in lost earnings while held pretrial.

In many cases, individuals detained for any significant length of time would also lose their current employment, increasing the cost beyond the time they are held. There may be other spillover effects too, such as losing housing through the inability to pay rent.

### COST OF PROSECUTING DRUG CRIMES

Maine spends approximately \$4.6 million to charge, prosecute and sentence people for drug crimes.

Maine spends approximately \$2.0 million on drug prosecutors. Drug cases in Maine are prosecuted by the Attorney General's Office and local district attorneys' offices. The Attorney General's Office spends more than \$770,000 annually on staff specifically dedicated to drug cases.<sup>218</sup> The eight assistant attorneys general

---

**217** Average annual earnings for Mainers with a high school diploma or lower qualification by race and gender from US Census Bureau, American Community Survey data 2015-2019, retrieved via <https://usa.ipums.org/usa/>. Race and gender of arrestees from Ben Shelor et al., "Justice Reinvestment in Maine: Second Presentation," pp. 13, 20.

**218** According to information provided by the Office of the Maine Attorney General on November 1, 2021. The office dedicates 8 assistant attorneys-general and one secretary associate position to prosecuting drug crimes. The AG's office also provided the salary band and step level of each individual, allowing us to calculate their annual salary on State of Maine salary schedules. These personnel would account for \$773,822 of costs annually.

dedicated to drug cases close an average of 900 drug cases each year.<sup>219</sup> It costs almost \$1.3 million each year for district attorneys to prosecute drug cases. There are eight district attorneys in the state, with their own offices and budgets. Assuming that district attorneys' offices are responsible for prosecuting the remaining 2,737 drug cases not handled by the Attorney General's office, these cases make up 5.8 percent of the criminal caseload statewide.<sup>220</sup> Applying this proportion to total spending in district attorneys' offices in 2019 produces an estimate of \$1.3 million in costs to prosecute drug cases each year.<sup>221</sup>

Maine spends approximately \$1.7 million every year on judges and other court staff to adjudicate drug charges. A precise accounting of the cost of adjudicating substance use charges in Maine state courts is not available, due to the difficulty of calculating the exact share of personnel time and costs associated with drug cases.<sup>222</sup> As an approximation, the average cost of adjudicating a case within the Maine judicial system was used. This amounts

to \$456 per case.<sup>223</sup> Applied to the 3,637 drug cases prosecuted in Maine in 2019<sup>224</sup> results in a total cost to the state of just under \$1.7 million annually.

The state spends \$870,000 each year on public defense attorneys for drug cases; individuals contribute an additional \$38,000. When someone is charged with a crime, they can hire a lawyer to represent them, have a lawyer appointed to them by the court or represent themselves. A small minority of defendants (13 percent) can afford to retain private counsel.<sup>225</sup> More commonly (in 82 percent of felony cases and 25 percent of misdemeanor cases),<sup>226</sup> the court appoints an attorney, either partially or fully-funded at state expense. Defendants represent themselves in the remainder of the cases (8 percent of felony cases and 60 percent of misdemeanor cases).<sup>227</sup>

In Maine, court-appointed defense attorneys are overseen and paid by the Maine Commission Indigent Legal Services (MCILS), which contracts with private attorneys. The average

**219** "Program Evaluation Report: Office of the Attorney General," November 1, 2019, p. 28, <https://www.maine.gov/ag/docs/Program-Evaluation-Report-11-1-2019.pdf>.

**220** "Maine Judicial Branch: Annual Report 2019," p. 2, <https://www.courts.maine.gov/about/reports/ar2019.pdf>.

**221** District attorneys' offices are funded jointly by Maine counties and the Attorney General's office. The total budget for district attorneys' offices is calculated from county budgets in 2019 and Maine Open Checkbook, <https://opencheckbook.maine.gov/> (accessed Jan 15, 2022).

**222** Ideally, a cost analysis would be based on the share of personnel time within the judicial system dedicated to prosecuting drug cases. Such a detailed breakdown across all parts of the judicial system was not available for this report.

**223** Calculation based on the total number of cases brought before the Maine Judicial Branch, divided by the number of cases brought for drug offenses, with this ratio applied to the total Judicial Branch expenses. For the total number of cases filed, see "Maine Judicial Branch: Annual Report 2019," p. 2. The number of cases brought for drug offenses comes from Maine Administrative Office of the Courts data, for cases filed in 2019 and resolved by December 2021. For total judicial branch expenses, see "Maine Judicial Branch: Annual Report 2019," p. 3. Note that a more precise accounting method undertaken in Vermont produced a significantly higher marginal cost per-case, the equivalent of \$1,158 in 2019 dollars. See Max W. Schulster et al., "Criminal Justice Consensus Cost-Benefit Working Group: Final Report," April 2014, <https://legislature.vermont.gov/Documents/2014/WorkGroups/SIU%20Funding%20Study%20Committee/Results%20First%20and%20Outcomes%20Evaluations%20of%20SIUs/W~Max%20Schlueter~Cost-Benefit%20Working%20Group%20-%20Final%20Report~10-8-2014.pdf>.

**224** Data from the Maine Administrative Office of the Courts for cases filed in 2019 and resolved by December 2021.

**225** *Ibid.*

**226** *Ibid.*

**227** *Ibid.*



cost per case paid by MCILS in 2019 was \$719.<sup>228</sup> The total annual state cost for indigent legal services for drug defendants is just under \$910,000.<sup>229</sup>

If a defendant has income above 110 percent of the federal poverty level,<sup>230</sup> they can be required by the court to cover some of the cost of their court-appointed attorney. Individuals collectively pay about \$38,000 per year towards the cost of court-appointed attorneys.<sup>231</sup> The net cost to the state for MCILS attorneys in drug cases each year is just under \$870,000.

**Individuals pay an estimated \$1 million every year on private attorneys to defend them against drug charges.** While fewer defendants hire private counsel to represent them, the cost per case is significantly higher. For this analysis, we estimate private attorneys cost defendants

---

**228** Based on the Maine Commission on Indigent Legal Services budget of \$19.7 million for FY20 and caseload for FY19. See Maine Office of Fiscal and Program Review, "Total Appropriations and Allocations: All Funds, 2020-2021 Biennium," <https://legislature.maine.gov/doc/3080> (accessed December 28 2021); Maine Office of Program Evaluation and Government Accountability, "Maine Commission on Indigent Legal Services (MCILS) – An evaluation of MCILS's structure of oversight and the adequacy of its systems and procedures to administer payments and expenditures," November 2020, p. 23, <http://legislature.maine.gov/doc/4769> (accessed December 28, 2021).

**229** Calculation based on the total number of drug cases prosecuted in 2019, adjusted for the share of all defendants who rely on appointed counsel. Data from Maine Administrative Office of the Courts.

**230** 94-649, Code Me. R. ch. 401, §§1(F), Appendix A (July 2021). 110 percent of the federal poverty level in 2021 was \$29,150 for a family of four.

**231** Based on FY 2017 recovery amounts. Amounts prorated based on estimated MCILS expenses for drug cases. Sixth Amendment Center, April 2019, pp. 49-51, <https://sixthamendment.org/maine-report/> (accessed December 28, 2021). Note that the Maine Legislature raised the reimbursement rate for MCILS attorneys to \$80 per month in 2021, P.L. 2021 ch. 398, § A-22, which will increase the cost of indigent defense attorneys in future.

\$1,200 per case.<sup>232</sup> For the estimated 392 defendants facing drug charges with private counsel in 2019,<sup>233</sup> costs amounted to just over \$1 million per year.

## POST-CONVICTION COSTS

**Every year the state pays an estimated \$40.2 million on post-conviction incarceration and probation for people convicted of drug crimes.**

People convicted of drug crimes face sentences of incarceration in either state prison or local jail, probation or fines. Sentences often include each of these punishments.

Incarceration accounts for by far the largest portion of the costs of drug criminalization. The annual cost of imprisonment in state prison for one person is \$54,300.<sup>234</sup> Based on the typical length of sentences to state prison, sentences to state prison for drug charges result in \$33.2 million in costs.<sup>235</sup> Sentences to county jails

---

**232** While MCILS reimbursed attorneys at a flat rate of \$60 per hour in 2019, fees for private attorneys are higher. This calculation assumed an hourly rate of \$100 per hour for private counsel, based on estimates provided in "The Right to Counsel in Maine: Evaluation of Services Provided by the Maine Commission on Indigent Legal Services," Sixth Amendment Center, April 2019, pp. 93-94.

**233** Estimate based on data provided by Maine Administrative Office of the Courts breaking out the types of legal representation for felony and misdemeanor defendants in 2019. Adjusted for the share of drug defendants facing felony and misdemeanor charges.

**234** Total cost based on the Maine Department of Corrections budget for prison facilities, divided by average daily inmate population. See Maine Department of Corrections, "MDOC Adult Data Report, July 2020," August 11 2020, <https://www.maine.gov/corrections/sites/maine.gov/corrections/files/inline-files/July2020MonthlyAdultDataReport.pdf>.

**235** Calculation based on the average daily cost of incarceration in the state prison system, sentencing for drug offenses and average length of sentences by class of charge. See Ben Shelor et al., "Justice Reinvestment in Maine: Second Presentation" pp. 38, 40, and Ben Shelor et al., "Justice Reinvestment in Maine: Third Presentation" Council of State Governments, December 11, 2019, p.45, [https://csgjusticecenter.org/wp-content/uploads/2020/10/ME-Third-Presentation\\_12.11.19\\_FINAL.pdf](https://csgjusticecenter.org/wp-content/uploads/2020/10/ME-Third-Presentation_12.11.19_FINAL.pdf).

result in a further \$5.4 million in annual costs.<sup>236</sup>

Probation services through the Maine Department of Corrections cost the state an estimated \$1.6 million in annual costs for people with drug sentences.<sup>237</sup>

**Every year, individuals pay an estimated \$680,000 in court fines and at least \$120,000 in monthly probation fees.** Court fines for drug offenses accounted for an estimated \$680,000 in additional costs to individuals in 2019.<sup>238</sup> Individuals on probation in Maine are assessed a monthly fee which can range from \$10 to \$50 per month.<sup>239</sup> While the precise total spending on probation fees is not publicly available, based on the \$10 per month minimum fee and the typical length of time spent on probation, individuals convicted of drug offenses spent almost \$120,000 on

---

**236** Based on a daily cost of \$141 per prisoner (see note 207). Jail sentencing based on Figures from “Ben Shelor et al., “Justice Reinvestment in Maine: Second Presentation,” pp. 38, 40, 45 and Ben Shelor et al., “Justice Reinvestment in Maine: Third Presentation” Council of State Governments, p.18.

**237** Based on Maine Department of Corrections budget for adult community corrections, divided by the average number of individuals supervised on probation, adjusted to account for sentencing patterns among drug defendants. For Maine Department of Corrections, Adult Community Corrections budget, see, Maine Office of Fiscal and Program Review, “Total Appropriations & Allocations All Funds 2018-2019 Biennium,” p. 147, <https://legislature.maine.gov/doc/2572>. For the average number of individuals on probation in 2019 see US Bureau of Justice Statistics, “Probation and Parole in the United States, 2019,” p. 22, <https://bjs.ojp.gov/content/pub/pdf/ppus19.pdf>. For the number of individuals with drug charges receiving probationary sentences, see “Ben Shelor et al., “Justice Reinvestment in Maine: Second Presentation,” pp. 38, 40, 45 and Ben Shelor et al., “Justice Reinvestment in Maine: Third Presentation,” p.18. <https://csgjusticecenter.org/publications/justice-reinvestment-in-maine-third-presentation/>.

**238** MECEP’s analysis of data from the Maine Administrative Office of the Courts, based on all fines paid for drug-related cases filed in 2019.

**239** See 17-A M.R.S. §1204(1); Mack Finkel, “New data: Low incomes – but high fees – for people on probation, Prison Policy Initiative, [https://www.prisonpolicy.org/blog/2019/04/09/probation\\_income/](https://www.prisonpolicy.org/blog/2019/04/09/probation_income/) (accessed December 28, 2021).

probation fees in 2019.<sup>240</sup>

There are a number of additional fees paid by individuals in incarceration, from expensive telephone call rates to daily “room and board charges.” Many of those are detailed in the body of the report but not calculated here.

Each year, individuals incarcerated as part of a sentence lose \$18 million in forgone earnings. As with pretrial incarceration, post-conviction incarceration deprives individuals of the opportunity to work and earn income.<sup>241</sup> Based on the length of sentences for individuals convicted of drug charges,<sup>242</sup> and at a rate of \$68 per day in lost earnings, individuals incarcerated while serving a sentence lose just under \$18 million annually.

This does not include the impact of reduced employment chances post-release for people who now have a criminal record.

The loss of these earnings primarily harms the individual and their family. However, there is also a wider public cost through the loss of state and local tax revenues. These tax losses are estimated at almost \$5 million per year.<sup>243</sup>

## UNCOUNTED COSTS

There are additional costs to both the public purse and individuals which are harder to

---

**240** Ben Shelor et al., “Justice Reinvestment in Maine: Second Presentation,” pp. 38, 40, 45; Ben Shelor et al., “Justice Reinvestment in Maine: Third Presentation,” p.18.

**241** A small number of individuals are granted the opportunity to work at the state prison’s prison industries, or to participate in work release programs. However, these numbers are relatively small, and a large portion of the earnings go back to the prison or jail to cover room and board. Those earnings are not included in this calculation.

**242** Ben Shelor et al., “Justice Reinvestment in Maine: Second Presentation,” pp. 38, 40.

**243** Using average effective state and local tax rates from Institute for Taxation and Economic Policy, “Who Pays? A Distributional Analysis of the Tax Systems in All 50 States, Sixth Edition” 2016, <https://itep.org/whopays/> (accessed December 28, 2021).

estimate, and are not included here. For example, the costs incurred by separating families when parents, especially mothers, are incarcerated away from their children. While the state pays for court cases, child protective

services and foster care placement, criminalized parents and their children bear emotional and social costs which are hard to measure in dollars and cents, but are no less real.

**Figure 16: Private costs from drug criminalization incurred each year**

	Possession Charges	Sale, Trafficking and Manufacturing Charges	Total drug charges
Police investigation and arrests	\$21,725,117	\$8,730,497	\$30,455,614
Pretrial detention	\$12,240,025	\$21,389,156	\$33,629,181
Legal adjudication	\$1,295,659	\$362,295	\$1,657,954
Prosecution	\$1,102,902	\$927,576	\$2,030,479
Indigent legal services	\$338,226	\$567,173	\$905,399
Indigent legal services reimbursement	-\$11,624	-\$26,041	-\$37,665
Incarceration – jail	\$2,015,513	\$3,417,579	\$5,433,091
Incarceration – state prison	\$5,040,858	\$28,169,505	\$33,210,363
Probation	\$371,941	\$1,202,122	\$1,574,062
Lost tax revenue from earnings	\$801,633	\$2,163,554	\$2,965,187
Fines	-\$110,325	-\$573,231	-\$683,556
Probation fees	-\$27,195	-\$87,897	-\$115,092
<b>Total</b>	<b>\$44,782,729</b>	<b>\$66,242,288</b>	<b>\$111,025,017</b>
Arrests	2,578	1,036	3,614
Average per arrestee	\$17,371	\$63,940	\$30,721
Lost earnings while incarcerated pretrial	\$5,498,413	\$10,394,712	\$16,343,125
Bail commissioner fees	\$73,340	\$29,473	\$102,812
Indigent legal services reimbursement	\$11,624	\$26,041	\$37,665
Private attorneys' fees	\$309,657	\$161,005	\$470,662
Lost earnings while incarcerated on sentence	\$3,265,757	\$14,473,728	\$17,739,485
Discount earnings for taxes	-\$801,633	-\$2,163,554	-\$2,965,187
Fines	\$110,325	\$573,231	\$683,556
Probation fees	\$27,195	\$87,897	\$115,092
<b>Total</b>	<b>\$8,944,679</b>	<b>\$23,582,532</b>	<b>\$32,527,211</b>
<b>Arrests</b>	<b>2,578</b>	<b>1,036</b>	<b>3,614</b>
<b>Average per arrest</b>	<b>\$3,470</b>	<b>\$22,763</b>	<b>\$9,000</b>





