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Substance Abuse Needs Assessment For Therapeutic Community in Maine

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SUBSTANCE ABUSE NEEDS ASSESSMENT FOR A THERAPEUTIC COMMUNITY IN MAINE

Prepared for The Maine Lighthouse Corporation

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EXECUTIVE SUMMARY

Background

The Margaret Chase Smith Policy Center at the University of Maine was contracted by The Maine Lighthouse Corporation to estimate the level of need and demand for a community-based adult therapeutic community (TC) residential substance abuse treatment program in Maine, to estimate referral volume and patterns, and to assess the potential barriers to successful referral and treatment. Funding for the project was provided through a planning grant to The Maine Lighthouse Corporation from the Maine Health Access Foundation (MeHAF).

This study focuses on a type of residential substance abuse treatment not currently licensed as such in Maine. Project findings are intended to inform both policymakers and the substance abuse services community more generally regarding residential substance abuse treatment needs statewide.

The residential treatment program proposed by The Maine Lighthouse Corporation is based on New York's Daytop therapeutic community model, which has three phases: Phase I, an initial assessment and entrance period, lasting 2-4 weeks; Phase II, a 9-12 month period of living and working in the TC, with increasing levels of responsibility and privileges; and Phase III, community re-entry over a 3-6 month period. Sixteen-bed facilities are proposed for Phases I and III, to be located initially in the southern part of the state, and a 60-bed facility for Phase II in Limestone (Aroostook County). Adding these 92 beds to the current complement of residential services would represent a 36% increase over Maine's current adult residential treatment bed capacity of 256.

Methods

In conducting this study, we analyzed quantitative and qualitative information from existing data sources, and conducted qualitative interviews with key respondents. Existing data sources included database information provided by the Office of Substance Abuse from its treatment data system (TDS), published reports, and unpublished data and reports from several organizations. We interviewed 30 representatives from the substance abuse provider community, including nearly all agencies providing adult substance abuse residential services (9 agencies), a small sample of other providers (3 agencies), staff at two hospitals that offer a range of substance abuse services (including residential) and officials and staff from the Office of Substance Abuse and the Maine Association of Substance Abuse Programs. From the legal/criminal justice community, we interviewed 15 individuals from nine organizations, including drug court judges, state corrections officials and staff, the assistant attorney general in charge of drug case prosecutions, the state's drug court coordinator, administrators and staff at the state's two largest county jails, and representatives from two major organizations that work with corrections clients.

In this study, we worked from the assumption that a Maine therapeutic community would draw both from the criminal justice-involved population and from a subset of people in the community similar to those already receiving substance abuse services. We also assumed that a Maine adult therapeutic community would admit clients from a range of adult subpopulations, including both men and women, those with and without co-occurring

disorders of substance abuse and mental illness, and people addicted to a variety of substances (either singly or in combination).

Findings

Client Profiles: We compared the "profile" of clients treated in New York's Daytop TC program with several populations in Maine: "high recidivists" (three or more prior lifetime admissions) in residential treatment in 2004, drug court clients, and those in the state corrections and community corrections systems. Although there are some similarities with Daytop clients, Maine's potential population "pool" for a therapeutic community appears to have somewhat different characteristics than Daytop residential TC clients. Comparing the characteristics of Maine' high-recidivist residential treatment clients with Daytop client characteristics, the Maine profile includes: nearly twice as many women (30% compared to 17%); fewer who are employed full or part time (3% compared to 12%); fewer with criminal justice involvement (48% compared to 68%); more who have alcohol as a primary drug (62% compared to 12%). The short-term shelter and detox population in Maine differs even more markedly from the Daytop population, being more often male, older, homeless, unemployed, and much more often alcoholic, with few reporting secondary or tertiary drugs. The Maine shelter and detox population also reports involvement with criminal justice less frequently than do those in Maine who are in residential treatment, thus much less frequently than Daytop clients.

Clients currently in Maine's drug court are much "higher functioning" (e.g., employed, married, with stable living situations) than Daytop clients or Maine's high recidivist clients receiving residential treatment. A higher proportion of Maine drug court clients report opiates as their primary drug (41%), compared with Maine high recidivists (25%) or Daytop TC clients (27%). Maine's drug court and community corrections populations have a higher proportion of females (each with 23%) compared with the Daytop TC (17%). Maine's drug court, correctional system, and community corrections clients are somewhat less likely than Daytop clients to have had prior substance abuse treatment.

Projecting Need and Demand: Despite the profile differences mentioned above, there is a population in Maine that has client characteristics appropriate for a therapeutic community in terms of severity of addiction and other demographic features. In addition, it is likely that there are an unquantifiable number of people not captured by existing data sources who would be potential TC clients.

Existing data do not allow projection of a single, exact "number of beds" for a therapeutic community. However, based on information about clients currently receiving residential services, on waiting lists for services, and on the judgments of many of our interview respondents, a program size of 30-60 beds for the long-term treatment phase of a therapeutic community program would seem reasonable in Maine.

We assessed the potential population size for a therapeutic community in several ways.

- In 2004, 1,114 adult clients received residential treatment (12.7% of the treatment population of 8,764 unique individuals); 526 (47.2%) of the residential clients were high recidivists; and almost half (252) of the high recidivists had criminal justice involvement. A subset of the high recidivists would be likely TC candidates, most likely many of those with criminal justice involvement.

- A population size based on estimates provided by two key informants suggested that a range of 1-5% of all people presenting for substance abuse services are potential TC candidates. Applying this to the total of the 8,764 unique adult Maine clients receiving treatment in 2004, we could project 88-438 individuals. The mid-point of the range is 3.25%, or 306 individuals.
- For the criminal justice population, an indicator of demand can be derived from the number wait-listed through Maine Pre-Trial Services for residential treatment (133 waited an average of two months during 2004). Extrapolating from the counties that Maine Pretrial serves to the total state population, there are estimated to be 247 individuals in jails on wait lists for residential treatment. (The OSA treatment data system figures include those referred by criminal justice and admitted in 2004, some of whom are also included in Maine Pre-Trial's wait list figures.) A subset of these would be TC-appropriate.

We also estimated the population for the proposed 60 bed Phase II facility, with a 16 bed intake/assessment (Phase I) facility, by constructing a spreadsheet formula using Daytop's experience with completion rates at various stages of treatment. Half of those who enter Phase I will go to Phase II and 28% of Phase II admissions will successfully complete. (In other words, for every 100 people admitted to Phase I, 50 will go to Phase II and 14 will "graduate.") Thus, an average of 6% of admissions are discharged each month (non-completers). Based on these assumptions and projections, to maintain an equilibrium census of 60, 210 individuals would need to be admitted to the screening/referral facility (Phase I) each year.

Interview respondents identified the need for expansion of residential treatment:

- There was consensus that more long-term adult substance abuse residential treatment beds are needed in Maine.
- Most (over two-thirds) of the providers interviewed were supportive of therapeutic community programs, in principle, and thought that a therapeutic community could be a good addition in Maine's continuum of care.
- Criminal justice representatives supported additional long-term residential beds in any structured treatment program, including a therapeutic community.
- There was strong support, especially among criminal justice respondents, for developing additional treatment options and systemic changes that would allow for more diversion of people into treatment in place of incarceration.

Concerns and Potential Barriers to Referral and Treatment in a Therapeutic Community:

- Sustainability of a new program of the size proposed was a major concern, especially of those associated with substance abuse service provision. The most important potential barriers cited were ongoing funding, staffing, and integration in the current treatment and correctional systems.

  --Currently, the two primary sources for funding substance abuse residential treatment are MaineCare (Medicaid) and direct grants from the Office of Substance Abuse or Department of Health and Human Services. Recent MaineCare changes imposing enrollment caps and limiting coverage levels for single adults will have a major impact on funding substance abuse residential treatment. The majority of the population likely to be candidates for a TC are single adults.

  --Even though it is acknowledged that treatment is more effective—and less expensive—than incarceration for those with substance abuse, shifting funds

from corrections to treatment systems has to date not been done, and would require major policy and legislative initiatives.
--The criminal justice system would be one of the primary sources for TC clients. To insure ongoing referrals, judges, district attorneys and defense lawyers would need to be well-informed about the TC program, and convinced that it offered a secure treatment environment that could prevent present or future incarceration and maintain the public's safety.

- Respondents mentioned that there are a number of sub-populations of adults in Maine with unique or specialized needs, for whom additional or different treatment alternatives are needed, including residential services: women, people with co-occurring disorders of mental illness and substance abuse, people coming out of the correctional system, and those on opioid-replacement therapy. Some expressed reservations about the suitability of the TC model for women and for people with some kinds of mental illness. A substantial number suggested that women should be in separate treatment programs from men.

Conclusion

In conclusion, the Maine substance abuse population includes a subgroup that would be appropriate for referral to a TC in terms of clinical and social severity. All respondents agreed that there is a statewide need for additional substance abuse residential treatment capacity. Most were supportive of the therapeutic community model. Based on judgments of our respondents, a TC size of 30-60 would be reasonable. Based on our projections, a 30-60 bed TC would require intake admissions of between 105 and 210 per year.

SUBSTANCE ABUSE NEEDS ASSESSMENT FOR A THERAPEUTIC COMMUNITY IN MAINE

INTRODUCTION

The Margaret Chase Smith Policy Center at the University of Maine was contracted by The Maine Lighthouse Corporation to estimate the level of need and demand for a community-based adult therapeutic community (TC) residential program in Maine to treat substance abuse, estimate referral volume and patterns, and assess the potential barriers to successful referral and treatment completion. Support for the project was provided through a planning grant to The Maine Lighthouse Corporation from the Maine Health Access Foundation (MeHAF).

Assessing *need* involves documenting the presence in Maine of a population of potential clients whose characteristics most closely match those who typically benefit from TC treatment. Assessing *demand* focuses on estimating how many clients with those characteristics would be referred and be likely to enter treatment. In order to accomplish this assessment it is necessary to develop a framework that incorporates an understanding of the present system of referral, treatment and financial support by analyzing existing databases and interviewing stakeholders and experts in the treatment and criminal justice communities.

The focus of this study is to analyze need and demand for a new type of long-term residential substance abuse treatment in Maine. Project findings also are intended to inform the substance abuse services communities more generally regarding needs associated with residential treatment, including needs for information about clients and services statewide. Finally, through the involvement of Maine stakeholders/experts in this process, we hope that the results of this project will be useful to them and to policymakers concerned with substance abuse services.

Therapeutic Community

The traditional therapeutic community is distinguished from other major drug treatment modalities in several ways, including coordinating a comprehensive range of interventions and services in a single treatment setting (vocational counseling, work therapy, recreation, group and individual therapy, and educational, medical, family, legal, and social services). An important feature of the TC model is that the primary “therapist” and teacher in the TC is the community itself, consisting of peers and staff members who serve as role models, with staff members also serving as authorities and guides in the recovery process. The community as a whole is seen as providing a crucial 24-hour context for continued learning in which individual changes in conduct, attitudes, and emotions are monitored and mutually reinforced in the daily regimen (Galanter and Kleber 2004, 86).

Because the term “therapeutic community” has been used in a variety of ways, there is ambiguity about the therapeutic community and its uniqueness as a treatment model. Historically, therapeutic communities have had a reputation of being hierarchical in structure, and somewhat punitive in practice. Although “earning” increasing privileges and levels of responsibility is still an important component in TCs, many programs today, including

Daytop, have changed a good deal, both in their philosophical emphasis and in their practices. The current emphasis is for individuals to develop their capacity for "right living" interactively within a community context.

Several residential programs in Maine use elements of the therapeutic community approach, and some consider themselves to be "modified therapeutic communities." One adolescent program is explicitly a therapeutic community, and is a member of the national TC organization.[1] The only program in Maine that was formally designated by the state as a therapeutic community was run in the state prison system in 1999-2003 (Hawke and DeLeon 2001). Although there is still a treatment program in the prison, its structure and emphasis have changed, as have the length of time and the service provider, and it is no longer considered a therapeutic community.

Maine Lighthouse Proposal. The Maine Lighthouse Corporation has proposed establishing a long-term (up to 12-months or more) residential substance abuse treatment program using New York's Daytop therapeutic community model. The program model is structured in three phases. Phase I, the initial entrance period, lasts 2-4 weeks, and involves bio-psycho-social assessments and introduction to the TC philosophy and routine. Phase II is a 9-12 month period of living and working in the TC, with increasing levels of personal and social responsibility and privileges. Phase III involves community re-entry over a 3-6 month period, with daily work or education and development of a local social support network; clients live in a safe and sober home environment that continues the TC philosophy.

In Maine, the Lighthouse Corporation is proposing that Phases I and III have 16 beds each and be located initially in the southern part of the state, while Phase II would be located at Limestone (Aroostook County) where The Maine Lighthouse Corporation has identified a suitable facility. Determining the appropriate size for the Phase II component is one of the primary reasons for initiating the needs assessment reported here. However, Maine Lighthouse Corporation is currently suggesting a 60 bed facility for Limestone, based on earlier feedback and planning activities. Locating Phase I in southern Maine is based on considerations of accessibility to/for the target population and proximity to referral sources such as hospitals, detox centers, the largest county jail, and drug court. Lighthouse plans also include having initial interviews of prospective clients in their own location (community, or criminal justice facility) in order to increase state-wide accessibility. The reintegration facility, Phase III, would be located in a place where there is access to public transportation, job or education opportunities, and social support networks. Although the Phase III program is planned to be located initially near the Phase I site in southern Maine to share resources and staff as appropriate, Maine Lighthouse suggests that there should eventually be several Phase III locations, since graduates of Phase II should have the opportunity to return to communities all over Maine.

STUDY DESIGN AND METHODS

In conducting this study, we analyzed quantitative and qualitative information from existing data sources and reports, and conducted qualitative interviews with representatives from substance abuse service provider agencies, from state agencies, and from the legal and criminal justice systems. We see these respondents as both stakeholders and experts in

[1] Maine does not currently have "therapeutic community" as a residential program type for licensing purposes, so there are no "official" state criteria or requirements for such programs.

Maine's substance abuse treatment and criminal justice systems, providing expert opinion as well as contextual information regarding in-state practices.

Developing a Framework to Measure Need and Demand

The first step in developing a model or framework with which to measure need and demand was to incorporate stakeholder/expert input regarding the best measures available in Maine. Although a number of databases and measures were suggested, respondents in both the treatment community and the criminal justice community noted that there were no direct measures that could be used to document the following:

- the number of clinically and situationally eligible persons in either existing treatment populations or existing criminal justice populations
- the likelihood of potentially eligible persons to enter a 12-month residential program
- the current magnitude of delays in accessing treatment (i.e., "wait times")

Although a few of the larger relevant datasets (such as the state Office of Substance Abuse's Treatment Data System) were known prior to beginning our study, significant information regarding the presence/absence of other data was obtained as a product of our qualitative interview process. Because of the lack of direct measures, we undertook an approach to utilize indirect, or "proxy" data in order to approximate levels of need and access. These include information both from existing databases and from interviews, as outlined below.

Defining the Potentially Eligible Population

Need. In order to assess the level of need for a therapeutic community in Maine, we first had to define and operationalize the characteristics of clients who typically have been found to benefit from treatment in the Daytop-model therapeutic community. The Maine Lighthouse Corporation identified the target population for a TC as those individuals who meet the diagnostic criteria for a substance dependence disorder as defined by the Diagnostic and Statistical Manual of Mental Disorders IV (DSM-IV) of the American Psychiatric Association, with or without physiological dependence. Special emphasis is on individuals meeting Criteria 4-7:

4. persistent desire or unsuccessful efforts to cut down or control substance use;
5. significant time spent in activities necessary to obtain or use the substance, or recover from its effects;
6. social, occupational, or recreational activities are given up or reduced because of substance use;
7. the substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.

This diagnostic characterization was refined through review of materials from Daytop and through discussion with Lighthouse Corporation board members and other key informants in order to produce statements describing "typical" TC clients:

General Description: A person who has failed in previous treatment efforts, recognizes that alcohol and/or drugs control his/her life, and is willing to consider long-term treatment isolated from their current lifestyle.

Criminal Justice Focus: A person who recognizes that alcohol and/or drugs controls his/her life, and is willing to consider long-term treatment isolated from their current

lifestyle in lieu of incarceration, as a step-down from incarceration to independent living, or as part of their probation plan.

In our analysis of existing statistical data sources for Maine, we focused on population characteristics that most closely reflected the diagnostic criteria and description of the "typical" Daytop TC client, and which our key informants identified as being most relevant. In particular, we focused on "high recidivist" clients in the Maine treatment data system (i.e., those who had had three or more prior treatment episodes) as a proxy measure for diagnostic criterion 4 ("persistent desire or unsuccessful efforts to cut down or control substance use"). As proxies for diagnostic criteria 5 and 6, we used employment, marital status, and living arrangements. The Daytop TC program has a large proportion of clients with criminal justice involvement (over two-thirds), and a large proportion with addiction to "hard" drugs (69% reported crack, cocaine, or opiates as their primary drug). We therefore included current legal status, referral source, arrest history, and primary and secondary drugs in our analysis of Maine treatment data. We also looked at gender, whether the client had children and payment source, since these factors were identified by key informants as also being important for program planning and implementation. In Table 2, we present these data in five "profiles" comparing Daytop program clients with high-recidivist clients admitted for residential substance abuse treatment in Maine 2004 and with segments of Maine's criminal justice population (drug court, state correctional system, and community corrections).

Demand. "Demand" for services may be seen as emanating from persons or agencies making referrals for treatment on behalf of a potential client. Or, it can be seen as client requests for (or willingness for) treatment. Assessing demand is more difficult than describing need. There are no comprehensive data with which to estimate the total number of people who would be *willing* to enter long-term residential treatment (i.e., demand from the client point of view). Indicators (as opposed to measures) of demand include: waiting lists of people referred for services in particular programs, and interview data from stakeholder/experts regarding their perceptions of the volume of people appropriate for referral for services, or the volume who are receiving less than optimal services.

Although treatment providers complete and return forms to the Office of Substance Abuse (OSA) regarding their waiting lists, staff at OSA indicated to us that these data are not currently as reliable as they could be, and that it is not possible to track clients to see how long they remain on the lists, or what type of treatment services they are awaiting. Further, OSA requires agencies to have potential clients call in weekly to renew their request to stay on the list, so clients who may still need treatment are dropped from the list if they (or someone on their behalf) do not take the initiative to stay on the list. We utilize qualitative descriptions by residential treatment providers of their agencies' waiting lists as a rough proxy for unmet needs within the treatment population. We also use provider estimates as to the proportion of presenting clients whom they judge may be appropriate for TC referral.

We know from the experience of the Daytop program that a large proportion of clients in their therapeutic community programs enter through persuasion by the criminal justice or child welfare systems, as an alternative to incarceration or as part of a release program from incarceration. We use waiting list data for substance abuse residential services from a five-county pre-trial service agency, extrapolated to the state as a whole.

Data Collection Methods

Interviews. We conducted focused qualitative interviews with representatives of state agencies, substance abuse providers, and the criminal justice and legal systems. With regard to substance abuse treatment services, we concentrated on agencies that provided residential services, since the potential therapeutic community population is likely to share many characteristics with those receiving residential services. Some of these residential providers have non-residential services as well, such as outpatient and intensive outpatient. Altogether, we interviewed 30 representatives from the substance abuse provider community, which included nearly all agencies providing adult substance abuse residential services (9 agencies, 12 staff), a small sample of other providers (3 agencies, 11 staff), staff at two hospitals that offer a range of substance abuse services, including residential (7 staff), and officials and staff from the Office of Substance Abuse and the Maine Association of Substance Abuse Programs.

Within the legal/criminal justice community we interviewed a broad range of respondent types in order to flesh out the context and flow of services and clientele. We interviewed 15 individuals from nine organizations, including judges, state corrections officials and staff, the assistant attorney general in charge of drug case prosecutions, the family treatment drug court coordinator, administrators and staff at the state's two largest county jails (Cumberland and Penobscot), and representatives from organizations that work with corrections clients (Volunteers of America and Maine Pretrial Services).

The interviews were conducted by Ann Acheson of the Margaret Chase Smith Policy Center and consultant Joanne Ogden, formerly manager of the treatment division of the Maine Office of Substance Abuse, some jointly by the two interviewers and others separately. Interviews lasted anywhere from 45 minutes up to two hours, with most being conducted in-person and a few over the phone. Several were group interviews, and included several staff from the agency or organization.

We provided each interviewee with a copy of the descriptor statement for the "typical TC client," an outline of the Lighthouse Corporation's therapeutic community proposal, and a general description from Daytop about the therapeutic community (see Appendix A: Interviewee Handouts). We used these statements so that there would be a common understanding of the population under consideration and the type of program being proposed. These materials were generally mailed out prior to the interview, but in a few instances were provided at the time of the interview. The content of the interview was semi-structured. We utilized a uniform interview process and set of interview questions for all interviewees within the treatment community and a slightly different set of questions for the criminal justice community. In all interviews, we reviewed the "typical TC client" description and the statement describing the therapeutic community. In all interviews we also asked about potential barriers to referral and treatment in the type of therapeutic community described in the interviewee handout materials.

In our interviews with treatment provider representatives, we obtained basic information about their agency: types of programs offered, types of clients served, waiting lists for services, and other relevant information they wished to share. We asked if they received referrals for clients who matched the "typical TC client" description, and explored with them how to estimate the state-wide volume of clients with that level of need.

In our interviews with criminal justice system representatives, we asked for an estimate of how many or what proportion of their population in a given year would fit the "typical TC client" profile, whether they try to make referrals for individuals fitting this kind of profile, and to which agencies or programs they make referrals. If they do not make referrals, we asked what the disposition is for these individuals (e.g., remain in jail without treatment, agency waiting list, probation). We asked them if a therapeutic community program were available that served a state-wide population, about how many they thought might be referred for treatment as an alternative to a jail or prison sentence.

As well as addressing specific questions we asked, most people we interviewed offered a good deal of additional useful information, opinions, and sometimes recommendations about service needs and gaps, the fiscal climate, state policies, and other topics, which we have tried to incorporate in this report, as relevant.

Existing formal databases and reports. The Maine Office of Substance Abuse provided us with a deidentified database of client admission and discharge data for calendar year 2004 from their treatment data system (TDS). While these data reflect only one year's worth of client admissions and discharges, we make the assumption that the "profiles" of clients admitted in one year are generally representative of the population receiving substance abuse services in recent years. From these data, we analyzed only clients over age 18 who had a primary diagnosis of substance abuse and who received treatment. We excluded those who received only "evaluation" (with no resulting treatment) and excluded "affected others" (individuals in the client's family affected by substance abuse of the client). As noted above, our primary focus was on high recidivists, those with three or more prior treatment episodes, since this would be a likely client "pool" from which a therapeutic community would draw.

We used summary data from published and unpublished sources regarding segments of the criminal justice population, including drug court, Maine pre-trial clients, community corrections, and the prison system (Anspach and Ferguson 2005, Graves and Bell 2004, unpublished data provided by Rick Bell, Maine Pre-trail Services Annual Report [unpublished]). We should note that there is overlap in these reports and the TDS database, since anyone in Maine receiving substance abuse services from a licensed provider is recorded in OSA's Treatment Data System. For example, individuals included in drug court figures for 2004, are included also in the TDS. Similarly, those in jails or prison receiving services delivered by licensed providers are recorded in the TDS.

RESIDENTIAL SERVICES IN MAINE

Current Adult Residential Substance Abuse Services

In Maine, as of April, 2005, there are 256 licensed substance abuse residential treatment beds, and 66 licensed (non-treatment) shelter beds, for a total of 322 beds (Table 1).[2] There are also 65 beds licensed for short-term inpatient drug-alcohol detoxification, most of which are located in hospitals, with one free-standing inpatient detox facility run by Milestone. The residential treatment programs vary in terms of treatment intensity, with extended shelter

[2] Efforts are underway between the Department of Behavioral and Developmental Services [now merged into the Department of Health and Human Services] and the Office of Substance Abuse [also now part of DHHS] to develop a licensing scheme with just three "categories" of residential care, simpler than the one currently in effect, but this system has not yet been finalized and approved.

being the least intense. The short-term (overnight) licensed shelters encourage and support clients to enter treatment, but do not themselves provide treatment services.

In 2004 the OSA treatment data system recorded a total of 8,764 unique clients over the age of 18 with a primary diagnosis of substance abuse who received substance abuse treatment. Of these, 1,114 (12.7%) received residential services.

Table 1. Licensed Adult Substance Residential Treatment and Detox Programs, 2004 Admissions and Program Descriptions*

Program Type	*Licensed Beds and 2004 Admissions (duplicated count)**	*Program Description (from Office of Substance Abuse)*
Extended Shelter	Beds: 53 Admissions: 468 (High recidivists: 175)	Offers structured residential treatment for people who are on waiting lists for residential treatment or have completed detoxification and need to develop a social support system to help them remain sober. Clients may remain up to 45 days or longer if awaiting placement in another residential facility.
Extended Care	Beds: 66 Admissions: 158 (High recidivists: 116)	Clients with extensive substance abuse or coexisting disorders of substance abuse and mental illness may enter an extended care residential treatment program. Length of stay is generally more than 6 months (180 days).
Halfway House	Beds: 92 Admissions: 315 (High recidivists: 129)	Three to six-month residential programs that provide support for sobriety, and prepare clients to re-enter the work force and re-establish themselves in the community. The programs help clients develop socialization skills and vocational needs.
Residential Rehab	Beds: 45 Admissions: 402 (High recidivists: 138)	Programs that offer substance abuse treatment in a 24-hour residential setting for 7-21 days. Treatment includes lectures, groups and individual counseling (required minimum of 10 hours per week of individual, group or family counseling).
Total Adult Residential Treatment	**Beds: 256 Admissions: 1,343 (High recidivists: 558)**	
Shelter	Beds: 66 Admissions: 3,835 (High recidivists: 2,223)	Facilities that provide food, clothing, and lodging for up to 12 hours a day. Shelters do not provide 24 hour residence, and do not provide treatment, but do try to motivate people to seek and enter treatment.
Detox	Beds: 65 Admissions: 732 (High recidivists: 328)	Residential program that provides assessment, diagnosis, and medical treatment to stabilize people who are experiencing withdrawal from alcohol or other drugs. Length of stay is short, generally 1-4 days.
Total Adult Shelter and Detox	**Beds: 131 Admissions: 4,567 (High recidivists: 2,551)**	

*"Duplicated count" provides the number of admissions, not the number of clients. An individual may have more than one admission. The totals for high recidivists are a subtotal of all duplicated admissions.

The ease of entry into residential services and the type of referral sources into them vary depending on the type of program:

- *Shelters* licensed by OSA are essentially "open" facilities that have a lot of resident turnover and which can usually accommodate anyone who needs a bed. [In some areas, such as Portland, where there are both licensed shelters and general (non-OSA licensed) homeless shelters, there are cooperative arrangements to allow individuals in need to be served even if a given facility happens to be full on a particular night.]
- Of all residential treatment programs, *extended shelter* is usually the quickest and easiest to get into. Clients will enter from detox programs, by referral from criminal justice and from other substance abuse providers, referrals from other providers, and self or family/friend referral.
- *Extended care* programs are the longest residential programs, and generally have waiting lists. They do not typically have direct referrals from the criminal justice system, but do have referrals from substance abuse and other treatment providers, and sometimes self/family referral.
- *Halfway house* programs are somewhat shorter in duration than extended care, and emphasize re-entry to the community. Halfway houses also typically have waiting lists. Referrals into these programs come from a variety of sources, including criminal justice.
- *Residential Rehabilitation* programs serve a somewhat younger population for whom this may be their first residential treatment episode. They accept referrals from a variety of sources, including criminal justice. While there are waiting lists for these programs, the length of time to get in from the waiting list is reported to be shorter than for the halfway house and extended care programs, in large part because the shorter length of stay means there is more turnover.

High-recidivist Users of Residential Services

Our detailed analysis of residential service use focuses only on high-recidivist adults (over 18) and those with three or more prior lifetime episodes of treatment for substance abuse. The reason for this focus is that this would be a population more likely to be eligible for a therapeutic community residential program. Information presented in this section is based on data from OSA's treatment data system (TDS) for calendar year 2004.

Licensed Shelter and Detox: Licensed shelters are not considered treatment programs, and the shelter/detox population differs in many ways from the population using other residential services.

- Licensed shelter and detox admissions account for the largest number of high-recidivist admissions, with 2,551 admissions in 2004, representing 713 unique clients. Because of the nature of the service, these clients are apt to have multiple admissions per year, averaging 3.6 per person, with some having in excess of 15 admissions per year.
- High recidivist shelter/detox clients overwhelmingly (over 90%) report alcohol as the primary substance abused, and most (86%) reported no secondary substances.
- Over 90% of high recidivist admissions to shelter and detox facilities in 2004 were paid for through direct (grant) funding to the facilities from the Office of Substance Abuse or the Department of Health and Human Services (DHHS).
- A majority of high recidivist shelter/detox users reported being homeless (90%) and unemployed (96%).

- The high recidivist shelter/detox population is predominantly male (over 90%), and not currently married (95%). (Information on children is not recorded for shelter and detox admissions.)
- Only 10% of high recidivist shelter/detox admissions report co-occurring disorders of substance abuse and mental illness.
- In terms of involvement with criminal justice, 36% of high recidivist shelter/detox clients report having had one or more arrests in the previous year, but less than 1% were referred by criminal justice sources. (Information on current legal involvement is not recorded for shelter and detox admissions.)

Other Residential Services:

- There were 558 admissions of high recidivists to residential services other than shelter and detox, which represented 526 unique individuals. Given the nature of the services and the length of time involved, a majority of individuals had only one admission for residential treatment during the year.
- Out of a total of 1,343 non-shelter residential admissions in 2004 (Table 1), less than half (42%) were clients who had had three or more prior episodes of substance abuse treatment.[3]
- Alcohol was reported to be the primary substance by a majority (62%) of these high recidivists, with opiates (heroin, OxyContin, etc.) the next highest (25%). In contrast to high-recidivist shelter clients, high recidivists in other residential services much more frequently reported use of secondary and tertiary substances.
- For non-shelter residential high-recidivist admissions, there was wider mix of funding sources than for those in shelters. OSA/DHHS were the largest source (43%), followed closely by MaineCare (Medicaid) (40%); "other payers" provided funding for 14%, mainly in the residential rehabilitation (under 30 day) and extended care programs.
- 52% of high recidivist residential admissions reported being homeless, and 97% were unemployed or not in the labor force.
- High recidivist residential admissions were 70% male, 30% female, and 92% were not currently married; 37% have children.
- A substantial proportion of high recidivist residential admissions (68%) have co-occurring disorders of mental illness and substance abuse.
- In terms of criminal justice involvement, 46% of high recidivist residential admissions reported having had one or more arrests in the previous year, 48% had current legal involvement (e.g., probation/parole, awaiting sentence), and 12% were referred by criminal justice sources.

ESTIMATING THERAPEUTIC COMMUNITY CLIENTS IN MAINE

Client Profiles

Existing data sources for Maine do not allow us to exactly count individuals who meet diagnostic and other criteria for therapeutic community treatment. However, we are able to look at the general demographic characteristics of adults served in Daytop's New York

[3] Further exploration is needed to identify which kinds of clients are entering residential services without having had much prior substance abuse treatment.

therapeutic community program and compare that profile with information from the Maine Office of Substance Abuse's treatment data system (TDS) on clients receiving services, along with some information from Maine's drug courts, state corrections, and community corrections. Information presented from the treatment data system is for high recidivist adult clients who received residential treatment, since this is the population in treatment that is likely to be the most similar to Daytop TC clients.

We do not have comparable data for all the groups described in these profiles. For example, in Maine, a screening assessment has been implemented in the prison system, and is being phased in within drug courts and community corrections as part of the Differential Substance Abuse Treatment (DSAT) program.[4] Substance abuse severity levels are determined for each person based on this computerized screening assessment, with severity rated on a five point scale ranging from "none" to "severe" (see Graves and Bell 2005). These severity levels, along with a clinical interview, are used to determine the level of treatment needed. There are good data for the prison population, but community corrections and drug courts have not yet fully implemented the screening.

Table 2 shows some highlights of these comparisons.

[4] As described by the Office of Substance Abuse, "DSAT is an evidence-based addiction treatment program developed in partnership with the MDOC [Maine Department of Corrections] for adults involved with community corrections or incarcerated in an adult institutional setting in Maine. DSAT is a differentiated group treatment program, which means men and women [are] separated by gender and then again by severity level of their dependence on alcohol and/or drugs."

Table 2. Profiles: Daytop, Maine Drug Court, Correctional System, Community Corrections, and "High-recidivist" Adult Clients Receiving Residential Substance Abuse Services in 2004*

	DAYTOP (Annual Report, 2001-2002)	**Maine Drug Court (enrolled since 11/30/2003)***	**Maine Correctional System***	**Community Corrections***	**Maine High Recidivist Residential Treatment Admissions***
	n = 2,539 unique indiv.: n/d	n = 111 unique indiv. = 111	n = 1,549 unique indiv. = 1,549	n = 196 unique indiv. = 196	n = 558 unique indiv.= 526
Gender					
Male	83%	77%	88%	77%	70%
Female	17%	23%	12%	23%	30%
Employed Full or part time	12%	64%	n/d	n/d	3%
Criminal Justice Involvement	68%	100%	100%	100%	48%
Criminal Justice Referred	53%	100%	100%	100%	12%
Prior Substance Abuse Admission					
Any treatment	83%	68%	56%	68%	100%
Daytop	32%	n/d	n/d	n/d	n/d
Primary Drug Use					
Alcohol	12%	29%	n/d	n/d	62%
Cannabis	15%		n/d	n/d	5%
Crack	29%		n/d	n/d	3%
Cocaine	13%		n/d	n/d	6%
Heroin/morphine	27%		n/d	n/d	13%
OxyContin			n/d	n/d	7%
Opiates (heroin, OxyContin, etc.)	(27%)	41%	n/d	n/d	(25%)
Other	4%	31%	n/d	n/d	5%
Co-occurring mental illness and substance abuse disorders	n/d	30%	n/d	n/d	68%
Currently married/cohab	n/d	54%	22%	15%	8%
% with children	n/d	50%	n/d	n/d	37%
Homeless	n/d	9%	n/d	n/d	52%
CSA Severity Level "Severe"	n/d	n/d	11%	12%	n/d

*Data on Maine high recidivists are from the OSA treatment data system. High-recidivists are defined as having three or more prior lifetime treatment episodes. Admissions to non-treatment shelters and to detox are not included in these figures. Information on drug court clients is from Anspach and Ferguson (2005). Information on community corrections and the Maine correctional system was provided by Rick Bell, from the computerized screening assessment (CSA) done as part of the DSAT program. The CSA uses separate instruments for alcohol and for other drugs, so determining the primary drug used is not possible. (See also: Graves and Bell 2005.) "n/d" indicates no data are available.

Profile Highlights:

- The Maine high recidivist population receiving residential treatment had a higher proportion of females (30%) than did the Maine drug court (23%), community corrections (23%), the Daytop TC (17%), or the Maine state correctional system (12%).
- A higher proportion of Daytop clients (83%) had prior substance abuse treatment, compared with clients of Maine drug court (68%), community corrections (68%), and the state correctional system (56%).
- Maine "high recidivists" receiving residential treatment were much more likely to report alcohol as the primary substance (62%) than were Daytop clients (12%) or Maine drug court participants (29%). However, many of these high recidivists reported secondary substances as well as alcohol. (Comparable information is not available for the Maine state correctional system or community corrections.)
- A similar proportion of Daytop TC clients (27%) and Maine high recidivists (25%) reported opiates as the primary substance abused. Maine drug court clients were higher in opiate use (41% had opiates as primary). (Comparable information is not available for the Maine state correctional system or community corrections.)
- Almost half (48%) of Maine "high recidivists" had criminal justice involvement, but this was less than at the Daytop TC (68%). Compared to Daytop (53%), Maine "high recidivists" were much less likely (12%) to be referred from criminal justice.
- Maine drug court clients, who must meet stringent screening criteria, were clearly in a different category than the other populations for whom information is available, in terms of social measures: much more likely to be married, employed, and have a stable living situation.
- There was a high rate of co-occurring disorders of mental illness and substance abuse among the "high recidivists" (68%), but the rate was significantly less (30%) for drug court participants. (Comparable information is not available for Daytop, the Maine state correctional system or community corrections.)
- Eleven percent (170 individuals) in Maine's prison population had the highest rating of substance abuse severity, "severe," based on the computerized screening assessment (CSA). The numbers screened in community corrections is still a small proportion of the total, but 12% of those screened fell into the "severe" category.

Waiting Lists for Residential Services

Obtaining exact figures on the number of people needing but not receiving residential treatment is difficult. Waiting list figures as they are currently collected are not systematically available. Although substance abuse service providers are required to mail monthly waiting list reports to the Office of Substance Abuse, those reports do not include the type of service for which the client is waiting. Individuals may be on several waiting lists, and no statistics are available on whether people are admitted, and how many, from those waiting lists. In addition, it is common for people to become discouraged and drop out if a residential bed is not immediately available.

Interviews with substance abuse providers and with representatives from criminal justice suggest that current residential treatment capacity is not adequate to meet treatment needs. Residential programs report being at full capacity most of the time, and all have waiting lists most of the time. Extended shelter is easiest to access, with clients generally getting in from the wait list in two weeks or less. The shorter-term (less than 30-day) residential

rehabilitation programs generally report having wait times of about two weeks up to as long as two months. The longest waiting times to get into residential service currently are for the halfway house and extended care programs. Providers we interviewed reported wait list times for halfway houses ranging from two to three weeks up to eight months. Some halfway house programs report that they try to limit the proportion of clients from the criminal justice system in order to retain slots for admissions from the community. For example, one halfway house program limits criminal justice clients to one-third of the total "mix." They reported that community referrals usually will be admitted from the wait list in about two to three weeks, while inmates may wait up to three months. Another halfway house program reported wait list times of about two months for a community client to as much as eight months for a criminal justice client.

Some criminal justice representatives indicate that "many" people they see should be in residential treatment, not jail. However, providers comment that only clinical assessments can determine how many may be appropriate for such treatment. Incarcerated individuals who are referred for residential placement are normally held in the correctional facility until a slot is available. However, there are few readily available figures on how many such individuals there may be over the course of a given time period for the state as a whole.

The best information we have in terms of criminal justice substance abuse residential need comes from Maine Pretrial Services. This program serves adults, primarily the indigent, as a bail alternative, and currently works with people with more serious or high profile crimes. They assess and refer for treatment using a psychosocial assessment predicated on the jail code, get a bail contract from the client, and stay on the case until it is disposed. In 2004, they served jail and drug court clients in Cumberland, Knox, Washington and York Counties, and just drug court clients in Penobscot County. They reported that in 2004, they had 133 clients on waiting lists for substance abuse residential services, which represented 14% of the total of 978 individuals they served. These 133 clients spent 8,365 "bed days" in jail waiting for a spot in a residential substance abuse treatment program, which is an average of about two months per person. We can extrapolate from the numbers of people waiting in jails in the counties covered by Maine Pretrial Services to the state as a whole, assuming that there is the same rate of people waiting in jail in other counties. For the state as a whole, that would mean that about 247 people in 2004 waited in jail for substance abuse residential placements. Although, not all those people waiting would necessarily be appropriate TC candidates, at least some would be.

For clients in the community who are on residential waiting lists, other treatment (such as intensive outpatient) may be offered as an alternative, even though the alternative may not be an optimal match for the clients' needs. Extended shelter residence is another option for those waiting for residential treatment. Providers point out that since individual motivation and readiness play a crucial role in substance abuse treatment success, not having residential treatment available at the time when someone is "ready" for it can be a serious drawback.

HIGHLIGHTS OF KEY INFORMANT INTERVIEWS

We conducted interviews with treatment providers, as well as a broad range of state agency officials and representatives from the legal and criminal justice community. An analysis of their responses gives additional insights on both the perceived need for additional substance abuse treatment services, and on some of the immediate and longer-term issues involved in initiating and sustaining new services.

There was a wide range of opinions and responses, both regarding estimating the level of need for a therapeutic community and regarding concerns or barriers for successful referral and treatment. These are the views of respondents who are currently working in the treatment and criminal justice systems, within the parameters of the present fiscal and policy environment. The quotations and interview summaries presented here are selected to be illustrative of representative responses and comments of those we interviewed. In a few cases, we present some unique views of only a few respondents that we think may provide useful insights for policy or planning. [5]

Perceived Needs

Residential Services (in general)

There was consensus that more long-term adult substance abuse residential treatment beds are needed in Maine. For example, providers and representatives from criminal justice alike noted that wait lists are common for many current programs. They reported that both they and the people they serve are frustrated by the inability to have quick placements when the client needs and is "ready" to enter a particular type of treatment.

From providers we heard statements such as:

> "There is definitely a need for more residential service for both kids and adults focused on substance abuse."
>
> "Over the years the need for more residential beds is still there. If you could take whatever model, such as the TC, and get people right in—any more residential beds would take the heat off."
>
> "There's an immediate need of around 30-50 long term care beds [programs of one year or more]. Just in our area [eastern Maine] there's a tremendous need."
>
> "We have found that at any point in time, need will be greater than availability."
>
> "There are drug court people that have to go into outpatient because they don't have residential placements available."

From criminal justice representative we heard statements such as:

> "The biggest problem [we] have is finding safe housing and ongoing treatment for their [women criminal justice clients'] issues. Waiting lists cause a good deal of discouragement to the women that badly need the immediate connection to services."
>
> "There's a crying need for a large in-house [residential] treatment facility."
>
> "Treatment people are doing the best they can. I just wish there were larger inpatient [residential] facilities without waiting lists."
>
> "There isn't a lot of treatment currently available to the jailed community. Alternatives are important."

Therapeutic Community Program Support

Many providers felt that there is a subset of the substance abusing population that could use long-term residential treatment alternatives different from those currently available in Maine. Most (over two-thirds) of the providers interviewed were supportive of TC programs in

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[5] We did not use a tape recorder during our interviews, but were able to record some parts of responses verbatim. When verbatim statements are available, we provide them here, but in other instances, we have non-verbatim notes and summaries.

principle, and thought that a therapeutic community could be a good addition in Maine's continuum of care. Some criminal justice representatives mentioned that through diversion projects, some number of people might be eligible to enter a TC, which would provide relief to the growing prison population, as well as a better response to substance abuse issues. Criminal justice representatives indicated a preference for having structured and accountable residential treatment programs. The specifics of the TC model itself were not necessarily familiar to many criminal justice respondents, but when presented with a brief description of the Daytop model and the Lighthouse Corporation proposal, those who were not previously familiar with the specifics of a TC expressed interest and support.

Some provider comments:

[from a respondent who had worked in therapeutic communities out of state in the 1970's] "I'm kind of a believer in TCs for a certain type of the population. …. There's a need for a TC for the right kind of person—willing to go but not motivated. No one wakes up one morning and says 'I'll go to treatment.' Some prodding is needed. If there were a TC, there would be some level of use…. We would make referrals once we saw what was being done. Referrals might not be huge, but for those in need it would be good. I would imagine that a TC might be good for a somewhat younger population that has had repeated failures."

[from a provider whose agency runs a halfway house program] "I truly believe residential care and therapeutic communities really work…. Judges, probation officers and jails love residential care because there are rules, curfews and guidelines."

[from a provider at another halfway house program] "Disregarding financial viability [of a TC], there would be clients who would be well-served by such a program. You always run into people for whom current treatment hasn't worked. A longer-term, well-structured program would be good for some people."

[from a physician] "There's a real hunger and need. It's a level of care that's missing in the state. There is reasonable literature to support TC outcomes….It's an entirely different model of care than what's in Maine, which is an advantage. It's a social-learning model."

Some criminal justice representatives' comments:

"[I] think the Lighthouse project is a positive for people in need of a higher level of services."

"TC 'hierarchy' is a good thing [as it would] help develop leadership qualities…. Community living is a good thing."

[from a judge] "People who bomb out of drug court could have this [TC] as a backup, rather than serving a sentence of 2-3 years…."

"TC utilization would reduce overcrowding in jails/prisons."

Therapeutic Community Program Size and Population Need

We discussed possible program size with providers who were supportive of the therapeutic community model and who felt that a TC could be a good addition to the continuum of care in Maine. We did not routinely ask criminal justice representatives their opinions about TC program size, though some did make comments about the level of client residential needs in general.

Providers' opinions about TC program size were based in part on client needs as they saw them now, and the potential volume of people they estimated who would participate in a therapeutic community. Their opinions about program size also were probably influenced by their experience with the current policy and fiscal climate in Maine's substance abuse and criminal justice systems, and their degree of familiarity with The Maine Lighthouse Corporation's ongoing efforts to develop a therapeutic community. Almost all providers were familiar with the original proposal for 300 beds at Cutler, and some were aware of the current revised proposal for 60 beds at Limestone.[6] During the interviews, we provided information about the current proposal if the respondent was not familiar with it, i.e., the 16-bed facilities for Phase I and Phase III and 60 beds for Phase II. There was universal sentiment among providers that the 300-bed proposal had been "unrealistic," and most who support the concept of a therapeutic community thought that a 30-60 bed facility would be reasonable in terms of size.

> [from a physician] "I'm thoroughly certain that the demand would be very high from drug courts, jails, and corrections…. If you had a 60 bed facility, I would estimate that 98% would come from the correctional/legal system, which would likely be opioid dependent."
>
> "If you have 50 adults that need the program, that's one place, or maybe two places."
>
> "If you could start with a 25-30 bed unit, and could demonstrate that it [TC] is working well, it might be a good place to start. But there might some economics to needing the larger, 60-bed unit."
>
> "About 6% of the [substance abuse] service population is in need of residential care. I would 'guestimate' that 1-3% of people presenting for service would need a strict TC model. I'm talking about people with recurring failure, who have progressed to a certain severity level."

Needs of Sub-populations (in general)

Women: Many respondents from both the provider and criminal justice communities cited women as having different needs than men, noting, for example, that the vast majority of women seen in treatment in the community and those in the criminal justice population have histories of trauma and domestic abuse; some are pregnant (a priority population for treatment); and many also are dealing with the loss of their children. Some examples from our interviews:

> A criminal justice respondent said he felt women were "more difficult to treat because of their numerous trauma issues."
>
> Staff at an agency that focuses on serving women strongly supported having longer term, more in-depth treatment services for women, who, they stated, had needs that were not being met by the current system, particularly women with co-occurring disorders.
>
> A judge reported that he's now seeing a lot more women in drug court and more women up on criminal charges. "You need to design programs so women don't get short shrift. In drug court, we find many women who have been abused and are

[6] The Maine Lighthouse Corporation had originally (2002-2003) proposed a 300-bed facility for Phase II, to be located on the site of the former navy base in Cutler. This met with local community opposition, and there were also more general concerns about having a facility that large which was proposed to treat clients from throughout New England.

controlled by males. Women can't break free of substance abuse until they break free of the abuse cycle."

A halfway house provider indicated that they are seeing more pregnant women than ever before, four in the last year for example, with most being young opiate addicts.

Another halfway house provider observed that women are more involved with hard drugs and drug dealers today than in the past. They also are more desperate for treatment. The number of calls by and for women is at an all time high. He thinks the severity of their addiction "takes them down quicker" so they seek help earlier.

People With Co-occurring Disorders of Mental Illness and Substance Abuse: Another sub-population frequently mentioned by our respondents was those with co-occurring disorders of mental illness and substance abuse. Some criminal justice respondents expressed frustration at being unable to meet the needs of that group or to find appropriate placements for them, noting that the proportion with mental health needs among the incarcerated population is high and growing. Some examples:

[a corrections representative] "The area we have spent the least amount of time thinking about is co-occurring disorders…. [There are] a lot of people with serious mental illness in the corrections system."

[a clinician working in a county jail] "Substance abuse is a big part of the population, and about 75% of them have co-occurring disorders."

[a judge] "The toughest part is those with mental illness and substance abuse. There's a real need for dealing with that population. There's only limited mental health treatment; people end up in corrections."

Representatives of an agency serving women reported that many of the clients they see with co-occurring disorders are poor at taking medications regularly and are highly prone to relapse.

Opioid-replacement clients: A few providers (a minority of our respondents) felt that some clients who are on opioid replacement therapy could use a long-term residential program such as a therapeutic community, or at least needed more residential alternatives than are currently available to them.

[hospital-based respondents--group interview] "Many people being treated now are opioid dependent." "I think the opioid-dependent are the most appropriate for a TC and many are best served by opioid replacement therapy." "It would be an exciting process to have a TC that allowed opioid replacement people." "The number one health problem in the state of Maine is opioid dependency; 500 people are seen in our [opioid-replacement program], most in their 20's, half are positive for Hepatitis C."

"We [halfway house] will take a methadone client. In the past two years, we have had two methadone moms, and this year maybe one…. [We] have evolved [in attitudes about methadone]. Staff has evolved. In the early stages of methadone, people aren't so good for a HWH. It's a catch-22: When they are doing well, they don't need the house. Methadone: tends to be chronic, difficult clients."

Persons coming out of prison: Respondents who worked with individuals coming out of incarceration cited the need for having increased transitional residential options and more effective substance abuse treatment. This population includes both those who have been in the treatment programs in correctional facilities and those with substance abuse problems

who were not in those programs. Several corrections representatives indicated that their current highest priority is having more DSAT-certified providers to provide continuity between prison and community treatment systems.[7]

[corrections respondent] "The challenge is having DSAT providers in the community. The DOC doesn't have much budget to fund this, and is dependent on MaineCare and on having providers with a sliding scale for charges.… There is also the need to build a re-entry plan that builds on each person's high risks, and substance abuse can be one of those risks.… For providers, the DOC is looking for cognitive-behavioral treatment; assessment that separates high and low risk so people can be treated at the appropriate level of intensity; focus on criminogenic risks and take that into account."

[another corrections respondent] "A lot more work needs to be done; DSAT providers are not developed in Somerset, Piscataquis and Aroostook Counties."

A respondent from an organization dealing with female inmates said that what women who had been through the DSAT program really need is a long term transition program, up to two years, much like the one currently available for victims of domestic violence in Maine.

Pre-incarceration Services: There was strong support, especially among criminal justice respondents, for developing additional treatment options and systemic changes that would allow for more diversion of people into treatment in place of incarceration.

[a corrections representative] "Now, [there are] more people [in the prison system] with shorter sentences. There are a couple of reasons for this: there is treatment available in prison, and there is inadequate treatment available in county jails. People have cycled through jail, probation, etc., and prison and the treatment available there is the only thing left. We need to improve the system by having better intervention, earlier, for lower-level offenders…. Prison is getting lot of drug court dropouts. We need more front end treatment done in a way as to not break up whatever fragile support system people have. You can't just fix the person. It's a social context."

[a judge] "I could see a situation where a defense attorney would negotiate the client or enter a plea to allow the person to enter treatment. With changes with regard to diversion that the Legislature passed recently, there are alternatives that can be offered instead of straight jail time. Judges have more discretion. This could take place informally, or through a formal plea. It could be very similar to drug court…. Not all prosecutors would buy into sending people away to a treatment program for 10 months to a year. But most prosecutors will be aware that people will need to do something to break free from their addictions."

[a respondent from the legal community] "The key to providing TC treatment for these people would be getting the prosecutors to buy in to the therapeutic community as an alternative to incarceration." He says it would be good if people who are too high risk for drug court and facing two or more years of incarceration be placed instead in the TC pre-conviction. Another recommendation would be for those with post-conviction/pre-sentencing guilty pleas to have the option of one year in a TC for second degree drug offenses.

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[7] As previously noted, "DSAT" refers to the "Differential Substance Abuse Treatment" system developed by the Office of Substance Abuse in partnership with the Department of Corrections.

Perceived Barriers, Concerns, and Suggestions

Representatives from substance abuse service providers, from the criminal justice community, and from state agencies expressed somewhat different kinds of concerns or suggestions about establishing and sustaining a therapeutic community treatment program, and about potential barriers to successful referral and treatment completion. However, there were also some issues mentioned by representatives of all the respondent groups, particularly with regard to concerns about sub-populations, discussed below.

It needs to be emphasized that some of the issues noted by our interviewees are systemic, policy, and logistic concerns that are not unique to a new program such as the proposed therapeutic community, but are part of the current environment in which all substance abuse providers and the criminal justice system are operating. Other concerns, particularly from providers, were specific to the therapeutic community proposal as currently described by The Maine Lighthouse Corporation. Still other concerns were of a more general nature related to treatment philosophy and practice.

None of the issues discussed here should be construed as insurmountable obstacles to establishing or sustaining a therapeutic community or any other kind of expanded substance abuse treatment service. As previously noted, the views expressed and presented here should be seen as reflecting a range of concerns and opinions expressed by people operating within the current treatment and criminal justice systems, in the current policy environment.

"Environmental" Concerns

Financial sustainability was a universally-cited concern expressed by providers, and was mentioned by some criminal justice system representatives as well. Residential substance abuse services currently are funded primarily from MaineCare (Medicaid) or through direct grants from the Office of Substance Abuse or the Department of Health and Human Services. Providers noted that recent MaineCare changes are likely to have a dramatic impact on funding for current services, as well as on funding to sustain any new service. For MaineCare, there is a cap on extending coverage to any new "noncategoricals" (childless adults who do not have a disability); those found to be financially eligible will have to remain on a waiting list until others drop out of the program. In addition, "personal care services" will no longer be covered under MaineCare for single adults; these kinds of services constitute a fairly high proportion of services in some residential programs.[8]

Respondents also noted that if OSA or DHHS are to provide some of the funding for any new or expanded treatment services, and their budgets are not increased to cover the additional costs, funds would have to be reallocated and shifted away from existing services and providers. Criminal justice representatives noted that the correctional system does not have adequate funds currently to be able to shift resources to fund substance abuse services for their clients who are not incarcerated.

[8] The MaineCare benefits manual describes personal care services in licensed substance abuse facilities to include: personal supervision and monitoring; supervision or assistance with administration of prescribed medications; arranging or providing motivational, diversionary and behavioral activities that focus on social interaction and reduce isolation and to enhance social skills; and psychosocial services to assist people in adjusting to the facility, in accepting and coping with chemical addictions and decreasing unhealthy behaviors, and in accepting and adjusting to their personal life situations.

[a provider] "I would hate to see it [TC] built and not be able to support it after a few years. If the noncategorical changes [MaineCare enrollment cap, etc.] are enacted, [our residential program] would need an additional $100,000. It's a question of state resources--trying to spread available funds over a larger group."

[a provider] "[You] can fundraise until the cows come home, but you need an ongoing revenue stream….. All the Maine residential services are facing demise because of categorical changes in MaineCare…. There may be changes in residency [so people coming in from out of state will not be covered by Medicaid]. In this environment there are going to be concerns about starting a new residential facility. Timing is an issue. Long-term viability [of a residential facility] is dependent on state money. The DOC never comes through. You can't build a facility based on that funding stream…. It is important to have a well-thought out plan for financial sustainability."

[a judge] "I think funding should come from corrections because they have the most to gain. When we started with drug court, they [corrections, criminal justice] didn't realize how useful it would be. There's been a change in philosophy."

[a provider] "If the TC program took a percentage of the prison and jail population and transferred funding from corrections to program funds and program people, perhaps a TC could be funded. Counties aren't going to send money elsewhere, however."

Staffing: Many providers mentioned that recruiting and retaining qualified staff is a problem in the current environment, especially with recent changes in licensing and staff certification requirements. Finding and retaining licensed staff is especially difficult. Respondents mentioned that having an adequate number of licensed staff is crucial if Medicaid or other insurance is to be billed. Since staff recruitment and retention difficulties are reported to be greater in geographically isolated areas, some respondents felt that the Limestone location might be difficult from a staffing perspective.

"Although staff are not so hard to find around here [Portland area] elsewhere is a problem. It depends on where you are in terms of staffing. They had problems staffing at Charleston for the youth drug courts. The farther you are from population centers, the longer positions will remain open."

"Money is the big problem. There is no staff, and no money for staff. Finding qualified staff is a problem. There are two levels of employment in Maine: the haves and the have nots. ….[Some agencies] can't pay the going work rate. They rely heavily on counselor trainees, who need to get two years of supervised experience."

Concerns and Recommendations About Sub-populations and Therapeutic Community Treatment

Gender: Most respondents who discussed gender issues suggested that it is better to treat women in all-female residential settings rather than in co-educational ones, in part because so many women in treatment are victims of trauma or domestic abuse. In addition, there was concern by a few regarding the suitability of the TC treatment model for women, even if women were to be in a separate program from men.

A criminal justice representative said he does not see females as appropriate for a therapeutic community. He feels males benefit from the "behavioral control model" of a TC, whereas females respond best to a "relationship model," which is not part of a therapeutic community.

Another criminal justice representative who was very supportive of long-term residential substance abuse treatment felt very strongly that there should be services for females as well as males, but that they should be totally separated programs.

A physician mentioned that he was familiar with an intensive long-term12 month residential program [not a TC] that has very strict separation of the sexes, with parallel programs. "It works better that way," he said.

One provider who had worked in an out of state TC, and who had developed negative opinions about the model as a result of experiences there, felt that women, in general, are inappropriate candidates for TCs. In this provider's opinion, the normal TC concept of "breaking down egos" is very dangerous. Women entering treatment are already victims of shame and self-hatred. Any reinforcement of these feelings is destructive to the women and deterrents to recovery…. Ninety percent of women that enter treatment have trauma issues along with their substance abuse.

<u>Clients With Co-occurring Disorders of Mental Illness and Substance Abuse:</u> A few providers mentioned that the TC model, because of its "hierarchical" structure, may not be suitable or appropriate for people with certain types of mental illness. A few also discussed how substance abuse facilities are going to handle the increasing numbers of people who are on psychotropic medications.

[a physician] "Co-occurring disorders people would not be well-suited for a TC."

[providers – group interview] "As the field embraces co-occurring disorders, the field will have to reconsider how to deal with medication issues and with opioid maintenance." "I've got concerns about how a TC would deal with co-occurring disorders. Could people with significant mental health issues handle the challenges in a TC?" "The milieu will sometimes drive people out." "Size is a factor in dealing with clients with mental health issues too."

A provider stated that women with co-occurring disorders would be negatively impacted by TC living inasmuch as this environment would readily exacerbate their mental health issues. This provider believes this issue is much worse for women than it is for men.

<u>Opioid Replacement Clients:</u> The majority of both providers and criminal justice representatives we interviewed support abstinence-only programs such as the Daytop model therapeutic community. However, some of the more medically-oriented providers were concerned that most residential programs, including TCs, have not generally been willing to accommodate clients on opioid replacement therapy, a large, and potentially growing, population.

[a hospital-based provider] "TCs are very resistant to changing their model of being against any kind of replacement therapy. It doesn't pass the logic test to have a treatment program that rejects opioid replacement patients on principle."

[a judge] "To me – and many judges – don't believe in methadone. Maybe you could set up a methadone drug court, but you'd need to keep the populations separate. Maybe it could be the same for residential."

Client Motivation ("demand")

Motivation, i.e., willingness of an individual to accept referral for treatment, was mentioned by many people we interviewed as a big potential barrier to successful implementation and

ongoing maintenance of a therapeutic community. Several criminal justice respondents reported that, in their experience, many who are in the criminal justice system (arrestees, those already convicted) are so unmotivated for any kind of substance abuse treatment that they would rather remain in jail or serve a longer prison sentence than accept any kind of treatment, especially one as lengthy and personally demanding as a therapeutic community. Some providers questioned whether a therapeutic community could sustain census over time due to lack of motivation of clients, and the consequent diminution of the prospective client "pool" over time.

[a provider] "Are there enough people committed to going? There are plenty of people who would rather stay in jail than do any kind of treatment.… Motivation to get people in the front door is the big question. Does Maine have a mechanism to drive that? And even if they did, are there the numbers? Convincing someone to take one or more years, when they understand the resocialization model [of the TC], is a big problem.… I do think mandated programs can work, and can serve very reluctant people. Does the state have the political will to do this?"

[a provider] "I'm a believer in the continuum of treatment, so the more options you have for clients the better.… But getting people to go to it [TC] is a problem, even if it is an appropriate level of care for them. Whether there's enough business to keep a TC viable, I'm not sure."

[a judge] "Many defendants do not want to deal with their substance abuse issues and would rather do time. If people are facing a lot of time, they might be more willing."

"Logistics" Concerns Related to the Current Lighthouse Corporation TC Proposal

Integration with provider community and Office of Substance Abuse: Several provider respondents mentioned that any new provider or new program would need to become well-integrated in the current system of care, and to have good relations and good communication within the current system of care. Some of them specifically mentioned the importance of belonging to the Maine Association of Substance Abuse Programs (MASAP), and of how closely MASAP members, as well as other non-member providers, work together with OSA to try to provide adequate and appropriate substance abuse services. A few residential providers gave examples of instances where they themselves had shared policies and procedures, their expertise, etc. with staff from new residential programs starting in their area, as illustrations of the cooperation among substance abuse providers.

[a provider] "In the past, 15 or16 substance abuse programs were axed from Corrections. OSA must be the centerpiece. Other departments won't support substance abuse services. Lighthouse—or anyone else—needs to work with MASAP. Providers' commitment is to services and the community." [This respondent saw "money, staffing, and integration," in that order, as the three biggest obstacles to be faced.]

[a provider] "Agencies need 10 different strategies these days to keep things afloat…. Providers already in the system can give good information about what's in the system and what's happening…. [There's a] need to do groundwork—look at the system. Don't act as though the system of care isn't there…. Some members will say OK and cooperate. Others may stay out. Organizations have learned to depend on each other. There's lots of information sharing, which allows the system to react

to threats, for example, the recent changes proposed for OSA. You need partners… it helps if you have allies and partners."

Criminal Justice System: Drug court judges and a few other respondents noted that if a TC were to be established, district attorneys and defense lawyers would be the likely starting point for referral, especially for those in the pre-trial or pre-sentencing phases. Respondents noted that there would have to be a very careful screening process set up for dangerousness and other risk factors, and to insure appropriateness of the criminal justice client for a TC. If a large proportion of TC clients are to be drawn from those who enter the program as an alternative to sentencing, several respondents mentioned that there would have to be good education and communication between the TC provider and the legal and criminal justice systems.

With regard to drug court, we were told that if a TC or other residential services are to be offered as alternatives for drug court participants, there would need to be follow-up mechanisms that are acceptable to the courts, either by establishing a new drug court in Aroostook County, if a TC were to be established in Limestone, or having very close communication and reporting between the TC and the original drug court judge.

A respondent from the legal community noted that there is political pressure on district attorneys for jail sentences, especially for those with prior convictions. There is currently no way to refer pre-conviction at this time. [Yet, he was very supportive of having this option.]

[a judge] "I could see a situation where a defense attorney would negotiate the client or enter a plea to allow the person to enter treatment. So you really have to educate the defense attorneys as well as the prosecutors about the therapeutic community as an alternative."

[a judge] "Judges are unlikely to sentence people to long term residential substance abuse treatment. Judges might be receptive to it as a plea bargain. It would have to be initiated by the DA and/or defense attorney. Defense is probably primary, plus probation officers. The DA association would have to be made aware of it. Judges would not take the lead. They are very reluctant to order treatment in lieu of incarceration. If someone can convince them that the defendant is ready to change, they might consider sentencing to a long-term residential program. It's such a new procedure it would have to be 'marketed,' that is, explained." He also noted that there would have to be very careful screening for a TC, similar to what they now do in drug court. "They [drug court] don't take early users or hard-core end-stage users. They don't take violent offenders or those with a history as domestic abusers."

Location: There were mixed opinions about locating a TC in Limestone, or in any rural area far from population centers. Concerns about the location for the long-term phase, in general, had more to do with possible problems in staffing a facility than with getting clients motivated to go. While some respondents mentioned that clients would not want to go far away from home, more of them seemed to be of the opinion that would not be a problem. A few providers and criminal justice representatives raised questions about the ability for family involvement during Phase II, given the Limestone location.

From a client perspective, providers expressed more concern about the location of the community reintegration phase (Phase III). A number of providers and a few criminal justice

representatives recommended that the community reintegration and transition facility should not be set up only in the Portland area, but should be available in at least several other locations to serve people from other regions of the state.[9]

[a provider] "Geography plays a role. It's hard to get people from southern Maine to go elsewhere, for example Hearthside in Sidney [extended care program]. People might go from here [Portland area] to Limestone for three weeks, but it's unlikely for a longer program."

[a provider] "There might be some who wouldn't want to go up to Limestone. There are others who want to go somewhere other than their usual stomping ground. Some have lost so much or become so ill that they'll want to go away."

[a provider] "Adding new facilities in rural areas is problematic in general. Have they thought of several smaller facilities scattered in various parts of the state? There are differences for people in rural vs. urban areas.… Can they build onto existing capacity in a collaborative way, where resources already are?"

[a provider] "People sometimes start to get integrated where they are. Would they anticipate having [Phase III] in more than just Portland?... Where will people come from geographically? Are there potential partners for the re-entry phase?"

In a group interview, respondents in one program were unanimous in saying that distance to treatment is not a concern as long as it is instate but that the women should be able to return to their home areas for the community reintegration process (Phase III).

Program size and sustainability: Some providers who were supportive, in principle, of having a TC were uncertain that the current Lighthouse proposal for a 60-bed facility was feasible or sustainable. Their concerns related both to immediate practicalities of funding and staffing, and to the ability to continue to admit enough motivated clients for the program to continue.

[a provider] "I think having a Daytop-type TC available for Maine is a good idea, but numbers is the big issue….You have to have the numbers initially, and you have to have that over time, and you have to have state bureaucracy changes to support this. … A real issue is scale. … Down the road, are you going to exhaust the population that would benefit? I know at Daytop there are people screened out before they even get to intake. It would be interesting to go to corrections in New York and see which are screened out. What I'm saying doesn't negate that there is need, or that there is effectiveness for this kind of treatment."

[a provider] "The question I have [about the Lighthouse TC proposal] is size, scope, and where does it fit in the continuum of care and what people need? … I can see that there has been a honing of numbers … and I would ask if it can be done financially in a prudent manner. If the size has to be larger than Maine's need, I don't have a problem with that if that is what is needed for it to become viable."

Program Start-up Recommendations from Respondents: A number of providers felt that the best strategy would be to start the therapeutic community in Maine and grow it slowly, rather than to start by sending the first clients out of state to Daytop and then bring them back.

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[9] We did explain that the Lighthouse Corporation's intent was to have "reintegration/transition" facilities in several regions, and that a southern Maine location would be just a first step as the program is getting established.

There were major reservations expressed about sending people to start treatment in New York rather than having them remain in Maine for the duration of their treatment.

Provider respondents who were familiar with the Daytop model understood the need for having residents at various "stages" in the therapeutic community so that those who are further along in treatment can serve as mentors for those entering. However, most felt that this could be accomplished entirely within Maine from the start. One person suggested that a Maine start-up could be achieved perhaps by initially staffing the program temporarily with paraprofessional and clinical staff affiliated with Daytop, with Maine staff being brought in and trained to eventually replace the Daytop staff. Several providers recommended starting on a small scale in Maine, and building the program, even if the first clients in the program might not get the full experience they would have had if they had entered a program with a lot of people on the "steps" above them.

TC as an Alternative Early Release Program for People in the Prison System

We specifically asked criminal justice representatives whether they thought a therapeutic community would be a good alternative as part of an early release program for people in the prison system. We were told by one respondent that early release for prisoners to enter a TC would likely not be supported and could be politically unpopular, and that the current community release program in Maine is mainly for people who have already had a lot of substance abuse and mental health treatment while incarcerated. However, one person from the legal community did suggest that one option might be early release from prison for "medical treatment," e.g., serve two years and go to TC for third year. He noted that this arrangement already exists for some medical treatment and would allow for consideration of a TC as medical treatment.

"*Philosophical" Concerns About the Therapeutic Community Treatment Model*

There were a few provider respondents who supported the need for more residential treatment but who were opposed, in principle, to therapeutic community treatment. One felt that the model was overly hierarchical and "not a good match for Maine." In another case, the negative opinion was based on the respondent's fairly recent first-hand experience with a therapeutic community outside of Maine. Another respondent who runs a halfway house program considers it to be a "modified TC," with assessment, treatment, and transition phases. However, this person said that they did away with hierarchical roles some time ago because "they caused more problems than they were worth ... too many egos involved," and later added that the term "TC" has negative connotations.

ANALYSIS AND DISCUSSION

We present here a framework to assess need and demand for a therapeutic community in Maine, including quantitative and qualitative components. This multifaceted approach, while it does not provide precise numeric projections of need and demand, nevertheless presents a realistic picture of the complexities involved in addressing these issues. By analyzing a combination of formal datasets and key informant interview data, we present general parameters of size for the population in need as well as a conceptual map for considering program development, including potential opportunities, barriers, and logistical considerations.

Based on existing data sources, there appears to be a population that matches characteristics for a therapeutic community, and there are an unquantifiable number of people beyond that who are not captured by current statistics. Existing data cannot allow projection of a single, exact "number of beds" for a therapeutic community. However, several ranges are presented below to approximate need and demand.

TC Profile Comparisons

Existing quantitative information gives us some idea of who are possible therapeutic community candidates, based on very broad characteristics. Although there are some similarities with Daytop clients, Maine's potential population "pool" for a therapeutic community appears to have somewhat different characteristics than those in the New York Daytop program. Based on 2004 data describing high-recidivist residential treatment clients, the Maine profile includes nearly twice as many women (30% compared to 17%), fewer who are employed full or part time (3% compared to 12%), fewer with criminal justice involvement (48% compared to 68%), and more who have alcohol as a primary drug (62% compared 12%)

The short-term shelter and detox population in Maine differs even more markedly from the Daytop population, and is predominantly male, older, homeless, unemployed, and overwhelmingly alcoholic, with few reporting secondary or tertiary drugs, and they have a lower level of involvement with criminal justice than do those who are in residential treatment. Shelter is not treatment, and these individuals generally have multiple admissions per year to these shelters. Providers generally expressed the opinion that shelter users are for the most part highly unmotivated for treatment, at least at that point in their lives. Accordingly, most providers did not anticipate that very many potential TC clients would come directly from the shelter population.

Clients currently in Maine's drug court are much "higher functioning" (e.g., employed, married, with stable living situations) than Daytop clients or Maine's high recidivist clients receiving residential treatment. Judges report that drug courts screen to try to accept more "highly motivated" clients. A higher proportion of Maine drug court clients report opiates as their primary drug (41%), compared with Maine high recidivists (25%) or Daytop TC clients (27%). Maine's drug court and community corrections populations have a higher proportion of females (23%) compared with the Daytop TC (17%). Maine's drug court, correctional system, and community corrections clients are somewhat less likely than Daytop clients to have had prior substance abuse treatment. In the computerized screening assessment (CSA) implemented in the prison system, 170 individuals (11% of the prison population) have the highest level of severity, requiring the most intensive level of treatment, and 12% of those screened to date in the community corrections system fall into this category.

Census Projections: Maine Numbers Based on Daytop's Completion Experience

We constructed a spreadsheet formula using Daytop's experience with completion rates at various stages, and using the current Lighthouse Corporation proposal for a 16 bed intake facility (Phase I) and a 60 bed treatment facility (Phase II). The transitional facility of 16 beds (Phase III) was not included in our calculation, as we were only projecting admissions, dropouts, and program completions through Phase II. We found that a census of approximately 25 could be achieved by the 4th month, assuming that each month 16 are assessed, 8 move on into Phase II, and dropouts per month are the same as in the Daytop

program. With the same assumptions, an equilibrium census of close to 60 (56) could be achieved by the 12th month from the start of the program.

Based on Daytop's reported completion rates, 28% of those admitted to Phase II will complete treatment. In other words, for every 100 people who enter Phase I, half (50) will go to Phase II, and 28% of those (14 people) will complete Phase II. What the Daytop-based projections suggest is that 14 of every 100 clients entering the intake/assessment phase will complete treatment. An average rate of 6% of admissions are discharged each month (non-completers). Based on these assumptions and projections, in order to maintain an equilibrium census at close to 60 (56), 196 individuals would need to be admitted to the screening/referral facility (Phase I) the first year and each year thereafter. For an equilibrium census of 60, 210 individuals would need to be admitted yearly.

Maine's Potential Candidates for a Therapeutic Community

We are making the assumption that a Maine TC would draw both from the criminal justice-involved population and from a subset of people in the community similar to those already receiving substance abuse services. We also are making the assumption that a Maine adult therapeutic community would include clients from a range of subpopulations, including both men and women, those with and without co-occurring disorders of substance abuse and mental illness, and people addicted to a variety of substances (either singly or in combination). If the TC program proposed for Maine were to focus on particular sub-populations (e.g., predominantly those with criminal justice involvement, or exclusively men or women, or predominantly those with co-occurring disorders of mental illness and substance abuse) estimates of the level of need would be different.

We have assessed the potential TC population size in several ways, as shown below.

- A hypothetical subset of the population of clients in the Maine treatment data system currently receiving residential treatment: 1,114 out of 8,764 unique adult clients treated in 2004 (12.7%) received residential treatment. A subset of these would be TC candidates.
    - Of those 1,114 clients receiving residential treatment, 526 (47.2%) had three or more prior lifetime treatment admissions ("high recidivist population"). We used these as a proxy to examine TC candidate characteristics, but assume only a subset of these would be TC candidates. 48% (n=252) of this high recidivist group have criminal justice involvement.
- A hypothetical population size based on similar estimates provided by two key informants suggested that a range of 1-5% of all people presenting for substance abuse services are potential TC candidates. Applying this to the total of the 8,764 unique adult Maine clients receiving treatment in 2004, we could project 88-438 individuals. The mid-point of the range is 3.25%, or 306 individuals.
- For the criminal justice population, an indicator of demand can be derived from the number who were wait-listed in Maine Pre-Trial Services for residential treatment (133 waited an average of two months during 2004). Extrapolating from the counties that Maine Pretrial serves to the total state population, there are estimated to be 247 in jails on wait lists for residential treatment. (Note that TDS database total includes those who are referred by criminal justice and admitted in 2004 for residential treatment, so the TDS figures overlap with Maine Pre-Trial figures.) A subset of these would be TC-appropriate.

Discussion: Interview Findings Regarding the Therapeutic Community

Our interviews suggest that there is wide consensus of the need for more adult residential services in Maine. However, there is not consensus that new residential beds should necessarily all be in a therapeutic community. There is variation in perceived need and perceived feasibility, but a range of 30-60 additional adult beds seemed reasonable to most.

A hypothetical, annual TC candidate population size range can be extrapolated from the judgments by some respondents about a possible size for a new TC program, 30-60 beds. Based on our census forecast spreadsheet, and using Daytop's completion rates, in order to maintain an equilibrium census of 60, 210 would be assessed over 12 months, and half (105) would be admitted to the TC. In order to maintain a census of 30, 105 would need to be assessed in Phase I and 52 admitted to Phase II. Thus, if the 30-60 bed size is a reasonable response to need, the TC Phase I admission population size annually would be approximately 105-210.

The strongest level of support for expanded residential programs comes from the criminal justice community, but there is little available hard information to translate that support into actual numbers of potential TC clients. There are good substance abuse severity-level data for the prison population, but community corrections and drug courts have not yet fully implemented the screening assessment. Once they do, we will have a much better idea of the magnitude and type of needs in the criminal justice population more broadly.

Although supportive of additional substance treatment, the corrections/criminal justice system has only limited funding to provide for substance abuse services. Respondents commented that the system is not able to provide more funds or services. Even though it is acknowledged that treatment is more effective—and less expensive—than incarceration for those with mental illness or substance abuse, shifting funds from the corrections system to treatment systems or increasing the level of funding has to date not been done, and would require major policy and legislative initiatives. A number of substance abuse service providers voiced the wish that a shift in funding could happen, while criminal justice respondents stressed that current demands and constraints would allow this to happen.

The two largest funding sources for community-based residential substance abuse services currently are MaineCare and grants from the Office of Substance Abuse. Any substance abuse treatment program that wants to receive MaineCare (Medicaid) funds by statute must be licensed by OSA. MaineCare is facing substantial cutbacks, and all residential programs, existing or new, are likely to see a lesser share of their funding from that source in the future, particularly with the elimination of "personal care services" from reimbursement for single adults and the capping on enrollment of single adults. And, we have seen that the highest need population is predominantly single adults. If OSA were to be given additional state general funds specifically for expanding residential services, the current usual procedure is for service specifications to be spelled out and awarded through a competitive RFP process.

Sustainability of a new program of the size proposed by Lighthouse was a major concern of those interviewed, especially from those associated with substance abuse service provision. Adding 92 beds (16 each for Phases I and III and 60 for Phase II) to the current complement of residential beds represents a major percentage increase in state residential treatment capacity devoted to a single program type—an overall increase of 36%. A few providers

mentioned that additional clients could be brought in from out of state to maintain census at a particular size if there were not enough referrals from within Maine.

Besides funding, respondents mentioned several other areas as being important to the ongoing maintenance of a TC program. First, there would have to be cultivation of referral sources, particularly from the criminal justice system which is seen as one of the primary sources for TC clients. Respondents from the criminal justice system suggested that not only judges, but district attorneys and defense lawyers would need to be well-informed about the nature of a TC program, and convinced that it offered a secure and potentially helpful treatment environment that could prevent present or future incarceration and maintain the public's safety. Second, as a practical matter, several respondents suggested that establishing a system for on-site screening in the jails would be helpful. Third, many provider representatives believe that employing and retaining staff to work in an isolated area such as Limestone could be a major detriment to the ongoing viability of a TC located there. Even in more populated areas, a number of agencies reported having staffing difficulties, in part because of recent changes in licensing and certification requirements, and in some cases because of pay issues.

Other Unmet Needs

Respondents identified a number of unmet needs for substance abuse services:

- For those released from prison, integration into the community and continued treatment using the DSAT model is one such pressing need, as is more transitional housing.
- Developing more capacity in long-term residential programs designed specifically around women's issues is another need mentioned by respondents.
- Having residential programs that accept people who are on opioid replacement therapy, without requiring them to titrate off that therapy as a condition for admission, is a need identified by some.
- Providing services for those with co-occurring disorders of mental health and substance abuse has already been identified as a state priority, and many respondents felt more could be done in that area.

Finally, our interviews and use of existing data resources strongly suggest the need for specific attention to improving long-term policy and planning mechanisms, including further development of existing comprehensive datasets, to more readily identify needs for substance abuse (and mental health) services and to project those needs based on recent trends. People are served by multiple systems (e.g., substance abuse, criminal justice, mental health) and each system, to greater or lesser degrees, maintains separate and unconnected statistics and profiles about who it is serving. In many cases, the service populations are overlapping. The Office of Substance Abuse, through its treatment data system, tracks some of these overlaps already. Regarding the waiting lists for services that substance abuse agencies are required to maintain, data collection routines might be strengthened by updating the form and compiling information from it in ways that could better support planning and policy.

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APPENDIX A: Materials Provided to Interviewees

Handout 1: Information for Respondents
Handout 2: "Typical Client" in a Therapeutic Community
Handout 3: Lighthouse Corporation therapeutic community proposal and background
Handout 4: Daytop therapeutic community description.

Handout 1: Information for Respondents

Margaret Chase Smith Policy Center, University of Maine

Therapeutic Community Needs Assessment Project

Information for Respondents

The Margaret Chase Smith Policy Center (MCSPC) at the University of Maine has been engaged under contract with The Maine Lighthouse Corporation to evaluate and assess the level of need and demand for a therapeutic community (TC) substance abuse treatment program in Maine. Such a program would be modeled after New York's Daytop program. This study aims to give an objective picture from stakeholders – state substance abuse agencies, service providers, criminal justice affiliates – of the appropriate scope for a therapeutic community program within the continuum of care in Maine. Funding for this needs assessment project is provided by a planning grant from the Maine Health Access Foundation (MeHAF) to The Maine Lighthouse Corporation.

The project will use available quantitative data sources (e.g., information from the Office of Substance Abuse's data system, criminal justice and drug court information), combined with qualitative interviews with representatives from treatment provider organizations, law enforcement, criminal justice, and state agencies in order to develop a model of census volume and patient characteristics for a therapeutic community program in Maine. The interview in which you are participating focuses on current substance abuse services being provided, gaps in such services, the demand for therapeutic community residential treatment, how such demand might be measured, and the barriers to successful implementation of a therapeutic community.

All your interview responses will be confidential. Interview notes and identifiable project records will be accessible only to Margaret Chase Smith Center staff and consultants involved with the project, and will be maintained in a secure manner. Preliminary findings may be shared with individuals, agencies and organizations which have participated in providing information in order to seek feedback and to refine the census models and projections. Written reports will identify respondents only by organizational type and geographic region. Final results from the project will be provided to the sponsoring organization, The Maine Lighthouse Corporation, and will be shared with participating organizations, upon request.

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Handout 2: "Typical Client" in a Therapeutic Community

Typical Client in a Therapeutic Community

General Description:

A person who has failed in previous treatment efforts, recognizes that alcohol and/or drugs control his/her life, and is willing to consider long-term treatment isolated from their current lifestyle.

Criminal Justice Focus:

A person who recognizes that alcohol and/or drugs controls his/her life, and is willing to consider long-term treatment isolated from their current lifestyle in lieu of incarceration, as a step-down from incarceration to independent living, or as part of their probation plan.

Handout 3: Lighthouse Corporation proposal and background

THERAPEUTIC COMMUNITY MODEL IN MAINE

- As serious drug abuse has escalated in Maine, there is increased demand for additional residential, intensive levels of treatment. The Therapeutic Community is a treatment model designed to deal with the myriad problems associated with serious substance abuse compounded with mental health disorders and criminal activities and attitudes. The Therapeutic Community has also been shown to be a cost-effective model that offers transition from abuse, incarceration, or homelessness back into independent living.

- The proposed Therapeutic Community model is based on Daytop Village, a program operating in New York and elsewhere in the U.S. and around the world since 1963.

- The premise of the program is to foster in each participant a sense of *right living* – maintaining sobriety; abiding by community rules; participating in groups, meetings, work, education or vocation programs; meeting obligations; acting responsibly and respectfully towards self, others and the community; modeling the TC values of honesty, self-reliance, responsible concern, and a good work ethic.

- The program is designed in three phases:
  --*Entry* – 2-4 weeks of bio-psycho-social assessments, introduction to TC; those deemed to be not ready or not appropriate for the long-term residential phase would be referred for other types of services/treatment.
  --*Long-term residential* – 9-12 months living and working in TC
  --*Re-entry into community, half-way house model* – 3-6 months residential

- Phases I and III will be implemented initially in southern Maine, close to the largest population base, detoxification services, job opportunities, and public transportation. Over time, other sites for Phase III re-entry should be available around the state.

- Phase II is currently planned for the Loring Commerce Centre, with residential and dining facilities in turn-key condition, and surrounding amenities for primary and mental health care, education and vocation programs. Daily transportation between the Loring Commerce Centre and Bangor currently exists via Cyr Bus lines, with connections available from Bangor to all other parts of Maine.

The Therapeutic Community will work within the continuum of care that currently exists in Maine, with close connections for referrals from hospitals, detoxification centers, drug courts, and other outpatient or residential programs for clients who need longer term and more intensive therapy.

Handout 4: Daytop therapeutic community description.

Daytop

What is a Therapeutic Community?

The therapeutic community is a drug-free self help program whose primary goals are the cessation of substance abuse behaviors and the fostering of personal growth. The TC model incorporates nine essential elements. These elements are based on the social learning theory that utilizes the community to foster behavioral and attitudinal change. The elements are: active participation, membership feedback, role modeling, collective formats for guiding individual change, shared norms and values, structure and systems, open communication, individual and group relationships and a unique terminology.

The TC includes both professional and para-professional staff. Graduates of the TC program who have completed classroom and internship training in counseling are an essential part of the program's effectiveness, as is the inclusion of professionals from the fields of medicine, mental health, education, and law.

Community activities help members explore and learn about themselves in the following four distinct yet overlapping areas of personal development: behavior management, emotional/psychological, intellectual and spiritual and vocation/education and survival skills. The TC believes that people can change and that learning occurs through challenge and action, understanding and sharing common human experiences.

Treatment in the TC begins with entry into the community. Here the member learns the values and norms of the community, which are a reflection of those held by society. In the middle phase of treatment, members explore individual histories and experiences, practice new behaviors and begin to gain increased self-esteem and knowledge of themselves. As new attitudes and behaviors are developed so too are individual goals and possibilities for the future, including vocational and educational training. The next phase of treatment involves the important task of re-entry into the larger community. New ways of relating to others are practiced and members gain valuable experience in working or going to school outside the TC while receiving support from the community. Ultimately, the member will be ready to live independently and continue to gain support from an aftercare program.

The TC model is adaptable to different client populations and settings. Adolescent programs include a full educational curriculum and greater family involvement. The model can be adapted to an outpatient setting, long or shorter-term treatment and include specialized groups such as those involving medical regimes or other lifestyle changes. The TC engages the whole person in the recovery process and challenges the individual to have a full, positive life with healthy supportive relationships and satisfying work.
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