Alaska Opioid Policy Task Force
FINAL RECOMMENDATIONS

2017

Alaska Opioid Policy Task Force Members

- Jay Butler, MD, Chief Medical Officer, Alaska Department of Health and Social Services
- Gunnar Ebbesson, LPC, Chairman, Advisory Board on Alcoholism and Drug Abuse
- Jeff Jessee, CEO, Alaska Mental Health Trust Authority
- Byron Maczynski, Bethel City Council
- Shane Coleman, MD, Southcentral Foundation
- Captain Michael Duxbury, Alaska State Troopers
- Randall Burns, State Opioid Treatment Authority, Alaska Division of Behavioral Health
- Christina Love, Person in Recovery
- Nick Kraska, Person in Recovery
- Kerby Kraus, Person in Recovery
- Tina Woods, PhD, Alaska Native Tribal Health Consortium
- Perry Ahsogeak, Fairbanks Native Association
- Erich Scheunemann, Assistant Chief, Emergency Medical Services, Municipality of Anchorage
- Robert Henderson, JD, Chairman of Controlled Substances Advisory Committee/Andrew Peterson, JD, Assistant Attorney General
- Mark Simon, MD, Fairbanks Memorial Hospital
- Erin Narus, PharmD, State Medicaid Pharmacist, Alaska Department of Health and Social Services
- Elizabeth Ripley, Executive Director, Mat-Su Health Foundation
- Anna Nelson, Executive Director, Interior AIDS Association
- Kim Zello, family member
- Raegan Eidsness-Haugse, family member
- Representative Paul Seaton, *ex officio,* Alaska House of Representatives
- Senator Cathy Giessel, *ex officio,* Alaska State Senate
- Sarah Health, *ex officio,* Governor's Office

Staff: Kate Burkhart, Executive Director, Advisory Board on Alcoholism and Drug Abuse
Katie Baldwin-Johnson, Program Officer, Alaska Mental Health Trust Authority
Ray Michaelson, Program Officer, Mat-Su Health Foundation

Introduction

The Alaska Opioid Policy Task Force,* after substantial expert and public input, endorses a public health approach to the prevention and reduction of opioid use, misuse, and abuse in our state. The task force believes that implementing comprehensive prevention strategies will mitigate the harm that heroin and opioids are causing Alaskans and their families and communities.

The National Survey on Drug Use and Health reports that, in 2015, 18.9 million people aged 12 or older (7.1%) misused prescription psychotherapeutic drugs in the past year. This number included 12.5 million people who misused pain relievers in the past year (4.7%). Of people who used heroin in the past year, 72.1% also misused pain relievers. Of people who used alcohol in the past year, 5.9% also misused pain relievers. About 1% percent of people aged 12 or older (2.7 million) had a prescription drug use disorder in the past year; 2 million of those people had a pain reliever misuse disorder. Among people who misused pain relievers in the past year, the most common source of the pain reliever was a friend or relative (53.7%). About 33% misused a prescription from one doctor. Only about 5% reported buying the last pain reliever they misused from a drug dealer or stranger. (*Prescription Drug Use and Misuse in the United States: Results from the 2015 National Survey on Drug Use and Health*, SAMHSA NSDUH Data Review, September 2016.)

The Alaska Epidemiology Section reported in 2015 that the rate of heroin poisoning resulting in hospital admissions doubled between 2008 and 2012 and "during 2008–2013, the number of heroin-associated deaths more than tripled in Alaska, and in 2012, the rate of heroin-associated deaths in Alaska was 42% higher than that for the U.S. overall (2.7 per 100,000 vs. 1.9 per 100,000, respectively)." Admissions to publicly funded substance use disorder treatment for heroin dependence increased 58% between 2009 and 2013. The majority of those individuals seeking treatment were age 21-29. (*Health Impacts of Heroin Use in Alaska,* State of Alaska Epidemiology Bulletin, July 14, 2015)

Primary prevention policies supporting "upstream" efforts to improve the overall health and wellness of individuals across the lifespan can help reduce the risk of opioid use, misuse, and abuse at the population level. Programs that support healthy childhood development, prevent adverse childhood experiences, and promote whole-person health can strengthen protective factors against opioid (and other substance) abuse.

Opioid use disorders, like other substance use disorders, are a disease that responds to treatment. Access to appropriate levels of treatment when a person seeks help, as close to home as possible, is critical to helping Alaskans move from opioid dependence to recovery. Understanding that not every person who needs treatment will seek it out, the task force sees value in harm reduction policies that protect public health and safety and increase individuals' treatment readiness.

Supporting Alaskans in recovery from opioid use disorders reduces the risk of relapse. Ensuring that individuals in recovery have immediate access to services to prevent relapse, or to reduce the harm

* The task force is comprised of twenty volunteer members representing diverse stakeholder groups from across the state. The task force met eleven times to hear presentations from experts in a variety of fields, and to hear public comment. The task force met twice to draft and finalize recommendations. The meeting schedule, presentations, and minutes are available at http://dhss.alaska.gov/AKOpioidTaskForce/Pages/Meetings.aspx.

of relapse, is critical. Likewise, recidivism is reduced when individuals are supported to transition successfully from incarceration to the community.

Only by working together can Alaskans turn the tide on the opioid crisis. The task force appreciates the significant contributions of federal and state agencies, the legislature, community organizations, and individuals that have helped to:

- Increase public awareness and understanding;
- Reduce the stigma associated with opioid dependence and overdose;
- Encourage individuals and families to seek treatment and support;
- Comfort those who have lost someone to an opioid overdose;
- Increase access to naloxone;
- Increase access to opioid use disorder treatment, including withdrawal management and medication assisted treatment; and
- Reinforce that recovery is possible.

Recommendations

These recommendations are derived from information provided to task force members by Alaskan and national experts, public comment at task force meetings and other forums around the state, input from local community heroin/opioid coalitions, research and evidence. They are organized according to a public health framework promoted by the Association of State and Territorial Health Officials.

Environmental Controls and Social Determinants of Health

Reducing and Controlling Access to Opioids

1. Communities statewide provide timely and convenient access to medication take-back and disposal programs.[1]
    - Take-back programs provide a safe, convenient, and responsible means of disposing of prescription drugs, while also educating the general public about the potential for abuse of medications.
    - Reduced access to prescription opioids and other medications will contribute to the outcomes:
        - Reduced number of hospital admissions for prescription overdose;
        - Reduced number of deaths by prescription overdose.

2. Local, state, tribal, and federal authorities work together to increase security measures to prevent importation of opioids (and other drugs) on bush airlines, small planes, ferries, boats, etc.[2]
    - Heroin, prescription opioids, and other drugs make their way to rural Alaska *via* transport that is not subject to the same level of federal security/ inspection as that of major commercial airlines.
    - The Alaska State Troopers (AST) Statewide Drug Enforcement Unit includes 6 investigative teams. The AST and local law enforcement agencies partner with federal authorities, including the U.S. Coast Guard, to prevent drug trafficking. State

and federal constitutional protections limit the ability of law enforcement to seize and/or search baggage or cargo while in transit.
- Increased security measures by commercial carriers at ports, ferry terminals, and rural airports would complement law enforcement efforts to prevent drug trafficking in rural Alaska.
- Increased security measures will contribute to the outcomes:
    - Reduced quantity of heroin, opioids, and other illicit drugs in rural communities;
    - Reduced number of hospital admissions for overdose;
    - Reduced number of deaths by overdose.

3. a. The State of Alaska engages in continuous optimization of the Prescription Drug Monitoring Program to improve ease of use and incentivize participation by prescribers.
   b. All prescribers utilize the Prescription Drug Monitoring Program to the fullest extent possible as provided in SB 74.
   c. The Department of Health and Social Services analyzes data from the Prescription Drug Monitoring Program, as allowed by SB 74, "for the purpose of identifying and monitoring public health issues in the state."[3]
    - Prescription Drug Monitoring Programs (PDMP) are tools for health care providers, used to make prescribing decisions based on patient's histories. They are useful when consulted by health care providers as they make prescribing decisions, pharmacists as they fill prescriptions, and when actively managed by public health officials to monitor and respond to population level trends.
    - Full utilization of the PDMP by health care providers and the State Alaska will contribute to the outcomes:
        - Increased consistency in opioid prescribing practices;
        - Increased utilization of evidence-based non-opioid pain management for acute conditions;
        - Reduced number of hospital admissions for prescription overdose;
        - Reduced number of deaths by prescription overdose.

4. Public and private health plans reimburse alternatives to narcotic pain management.[4]
    - Non-pharmacologic therapies and non-opioid medications are effective options for managing pain in many cases. If patients and prescribers have access to non-narcotic pain management options through their health plans, opioid pain medications will be reserved for treating chronic and the most acute pain.
    - Reimbursement of alternatives to narcotic pain management will contribute to the outcomes:
        - Increased consistency in opioid prescribing practices;
        - Increased utilization of evidence-based non-opioid pain management for acute conditions;
        - Reduced number of hospital admissions for prescription overdose;
        - Reduced number of deaths by prescription overdose.

5. A regulatory body is granted statutory authority to add substances of abuse to the state controlled substances schedule by regulation, including emergency regulation, to allow the State of Alaska to react quickly to public health dangers posed by synthetic and other emerging opioids and substances of abuse.[5] More nimble regulation of opioid substances of

abuse will help law enforcement, public health, and health care organizations prevent trafficking in and misuse/abuse of these substances, and will contribute to the outcome:

- Reduced number of deaths by overdose.

Reducing Risk of Opioid Misuse, Abuse, and Dependence

1. State and local authorities implement evidence and research based policies promoting healthy childhood development.
    - Research shows that strengthening the bond between parents and children, especially soon after birth, reduces the risk of child neglect and improves lifetime health outcomes. Effective programs include (but are not limited to) promoting and supporting breastfeeding and providing new parents with education and in-home parenting supports.[6]
    - Early and Periodic Screening, Diagnostic, and Treatment (EBSDT) services are available to Medicaid-eligible children age 0-21 and can help identify and intervene early to treat delays and disabilities. EPSDT services are not well utilized, especially after early childhood.
    - Healthy childhood development enhances protective factors and reduces risk factors, contributing to the outcomes:
        - Reduced incidence of child neglect and maltreatment (short-term);
        - Reduced incidence of under-age use of alcohol and/or other drugs (long-term);
        - Reduced incidence of adult heroin, opioid, and other drug misuse, abuse, and dependence (long-term).

2. State and local authorities implement evidence and research based policies preventing and mitigating the impacts of adverse childhood experiences.[7]
    - Alaskans report high rates of adverse childhood experiences, particularly parental incarceration and household substance abuse. Nearly 30% of Alaskan adults surveyed in the Behavioral Risk Factor Surveillance System report substance abuse in their household growing up, and 11.3% report having a parent or household member incarcerated during their childhood. Adverse childhood experiences like these can increase an individual's risk of developing mental health and/or substance use disorders, arthritis, and other chronic health problems.
    - Preventing and addressing the trauma of adverse childhood experiences will contribute to the outcomes:
        - Reduced incidence of child neglect and maltreatment (short-term);
        - Reduced incidence of under-age use of alcohol and/or other drugs (long-term);
        - Reduced incidence of adult heroin, opioid, and other drug misuse, abuse, and dependence (long-term).

3. Local, state, tribal, and federal authorities work together to maintain and expand comprehensive school-based prevention programs.
    - Evidence-based comprehensive prevention programs can help reduce youth risk behaviors, including prescription drug abuse.[8] These programs contribute to the outcomes:
        - Reduced incidence of under-age use of alcohol and/or other drugs (long-term);

- Reduced incidence of adult heroin, opioid, and other drug misuse, abuse, and dependence (long-term).

4. Health care professionals have access to information and tools to provide patient education on nutrition, as well as referrals to nurse-family partnerships and nutrition support programs such as WIC, SNAP, and local food pantries.
    - Improved nutrition is a cost-effective way to help Alaskans safeguard their bodies and minds against stress and may reduce the types of physical injuries that can lead Alaskans, especially young athletes, to their first opioid prescription. Research also indicates that proper levels of nutrients such as Omega-3 fatty acids and vitamin D can reduce anxiety, depression, and other mental stresses that can compound existing behavioral health concerns. The northern latitude and transition away from traditional foods increases Alaskans' risk of a nutritional deficiency in vitamin D.[9]
    - Increased patient education and resources related to healthy nutrition can contribute to the outcomes:
        - Reduced rates of vitamin D deficiency and rickets;
        - Reduced number of opioid prescriptions to youth and young adults for sports related injuries;
        - Reduced number of opioid prescriptions to older Alaskans for hip fractures and other bone and joint issues;
        - Reduced rate of depression, anxiety, and other mental health disorders.

Chronic Disease Screening, Treatment, and Management

Screening and Referral

1. a. Public and private health plans promote and reimburse Screening, Brief Intervention, and Referral to Treatment (SBIRT) in all health care settings.[10]
   b. Public and private health plans promote SBIRT and peer-supported referral to substance use disorder treatment after emergency admissions for opioid overdose.
    - SBIRT is an evidence-based model of care that identifies patients at risk of or experiencing substance misuse or abuse, provides brief behavioral interventions, and can connect patients to more intensive substance use disorder treatment. It has been effectively implemented by some Alaska health care providers and Public Health Nursing, but is not available in all health care settings or in all communities.
    - SBIRT is reimbursed by Medicaid. Reimbursement of the model by private health plans will further incentivize health care providers to implement SBIRT.
    - After emergency treatment for an overdose, the patient may experience a desire for treatment. Taking advantage of that period of treatment readiness, and facilitating referral to treatment with peer support services, can increase the likelihood the patient will enter treatment. Reimbursement of the services will incentivize implementation.
    - Implementing SBIRT and peer-supported referrals can contribute to the outcomes:
        - Increased utilization of outpatient substance use disorder treatment;
        - Reduced number of hospital admissions for overdose;
        - Reduced number of deaths by overdose.

2. Public and private health plans reimburse clinical assessment of risk of abuse and overdose whenever opioids prescribed.[11]
    - Assessment of risk of misuse, abuse, and dependence is included in the prescribing guidelines adopted by Alaska's licensing boards, as well as the Centers for Disease Prevention and Control Guidelines. Reimbursement of assessment will incentivize health providers to provide the service and will contribute to the outcomes:
        - Reduced number of hospital admissions for prescription overdose;
        - Reduced number of deaths by prescription overdose.

3. a. The Department of Public Safety implements Mental Health First Aid and Crisis Intervention Team in the Alaska State Trooper Academy curriculum, so that troopers as well as local law enforcement and village public safety officers have access to research-based education and tools. [12]
   b. State and local authorities support effective implementation of public safety assisted addiction and recovery models (also known as the Gloucester Model of responding to individuals experiencing substance use disorders).[13]
    - Law enforcement officers trained to identify when someone is experiencing a substance abuse or mental health related crisis will be better able to connect that person to appropriate community treatment resources in lieu of arrest and incarceration.
    - Implementing training and equipping public safety officers and responders to facilitate a referral to substance use disorder treatment will contribute to the outcomes:
        - Reduced arrests, incarcerations of individuals experiencing behavioral health crises;
        - Increased referrals of individuals to behavioral health treatment by law enforcement agencies.

4. a. The State and its partners ensure that Aging and Disability Resource Centers, care coordination providers, Alaska 211, or other referral resources can provide up-to-date information about local behavioral health treatment services to health care providers.[14]
   b. Pain management specialists have information/tools, and are reimbursed, for screening patients for depression and other mental health disorders that may be contributing to or exacerbating conditions causing pain, and providing "warm hand-off" referrals of patients to appropriate mental health treatment.[15]
    - Health care providers will be more likely to screen for and identify substance use and mental health disorders if they have concrete services to which to refer patients in need of treatment. This will contribute to the outcomes:
        - Increased utilization of outpatient substance use disorder treatment;
        - Reduced number of hospital admissions for overdose;
        - Reduced number of deaths by overdose.

Treatment

1. The State of Alaska adopts a "chronic disease management" framework for substance use disorder treatment policies and system reform.[16]
    - Expressly adopting a chronic disease framework will contribute to the outcomes:
        - Decreased stigma associated with opioid dependence;

- Decreased stigma associated with providing treatment for opioid dependence;
- Increased utilization of outpatient substance use disorder treatment;
- Reduced number of hospital admissions for overdose;
- Reduced number of deaths by overdose.

2. Alaskan medical professional organizations develop and/or deliver education to train and support health care providers in implementing the state prescribing guidelines.
    - The task force appreciates the thoughtful consideration that the Alaska State Medical and Dental Boards, Board of Pharmacy, Board of Nursing, Board of Optometry, and Division of Professional Licensing gave to the issue of establishing prescribing guidelines for Alaska-licensed practitioners. The task force appreciates that, after a thorough public process, these boards have agreed to incorporate the Interagency Guideline on Prescribing Opioids for Pain Developed by the Washington State Agency Medical Directors' Group and stakeholders in 2015 – with the important amendment of a **morphine equivalent dose limit of 90 mg/day**. Washington's comprehensive guidelines (with the amended morphine equivalent dose of 90mg/day) will address many concerns related to prescribing practices.
    - Training and support will be needed for health care providers to effectively implement those guidelines, which will contribute to the outcomes:
        - Reduced number of hospital admissions for prescription overdose;
        - Reduced number of deaths by prescription overdose.

3. a. Encourage all state licensed, registered, and certified health care professionals to have completed addiction medicine continuing education hours prior to each license renewal.
   b. State and health care organizations partner to provide free or low-cost access to approved addiction medicine continuing education.
    - Many changes to prescribing practices; patient screening, assessment, and referral; and provision of substance use disorder treatment in integrated settings are contemplated by national and state prescribing guidelines as well as these recommendations. In order to meet these expectations, health care professionals will need to understand the science of addiction.
    - Encouraging addiction medicine continuing education will contribute to the outcomes:
        - Decreased stigma associated with opioid dependence;
        - Decreased stigma associated with providing treatment for opioid dependence;
        - Increased utilization of outpatient substance use disorder treatment;
        - Reduced number of hospital admissions for overdose;
        - Reduced number of deaths by overdose.

4. The State of Alaska coordinates a comprehensive withdrawal management system (detoxification) in a variety of health care settings, specifically including rural and correctional health care settings.
    - Managing withdrawal symptoms is critical to treating individuals experiencing opioid use disorders. Lack of effective withdrawal management services is a huge barrier to treatment readiness and can pose a grave health risk, given the severity of the symptoms of withdrawal.

- Access to facility-based withdrawal management is severely limited, leaving emergency departments to deal with emergency withdrawal cases in which the person's life is at risk.
- Ensuring a comprehensive withdrawal management system statewide, so that any Alaskan seeking to (or due to circumstances must) withdraw from opioids and enter treatment has timely access will contribute to the outcomes:
    - Increased utilization of outpatient substance use disorder treatment;
    - Reduced number of hospital admissions for overdose;
    - Reduced number of deaths by overdose.

5. a. Public and private health plans reimburse the cost of medications used for medication assisted treatment (MAT), as well as the administration of the medication. [17]
   b. Public and private health plans minimize barriers to access MAT.
   c. Public and private health plans reimburse, and educate providers about reimbursement options for, urine drug testing as part of MAT.
   d. Require substance use disorder treatment providers and programs licensed/certified by the State of Alaska to ensure that patients receive psychosocial treatment along with MAT, if clinically indicated. [18]
    - Lack of or disparate reimbursement for all the costs of MAT (medications, administration, labs, professional services) discourages health care providers from offering the service.
    - While prior authorization requirements can create barriers to treatment by discouraging health care providers from participating in the service, they can also help ensure the quality of MAT services provided to high-risk populations.
    - Access to MAT will contribute to the outcomes:
        - Increased utilization of outpatient substance use disorder treatment;
        - Reduced number of hospital admissions for overdose;
        - Reduced number of deaths by overdose.

6. The Advisory Board on Alcoholism and Drug Abuse and partners convene a working group to review and provide revisions to the statutes for commitment of individuals incapacitated by drug and alcohol intoxication to treatment, with the goal of increasing utilization and access for appropriate patients.
    - Family members, providers, and law enforcement officers all report difficulty in accessing treatment services for individuals incapacitated by their opioid and other drug use disorders, due in part to the legal framework for involuntary commitments to treatment.
    - Review and revision of Title 47 commitment statutes will contribute to the outcomes:
        - Increased utilization of intensive treatment for individuals acutely disabled by chronic substance use disorders;
        - Reduced arrests, incarcerations of individuals experiencing behavioral health crises.

7. State and federal authorities work together to remove barriers to offering clinically appropriate methods of managing withdrawal symptoms, specifically the regulation of which medications can be used (i.e. Tramadol).
    - Federal decisions regarding the scheduling of medications, particularly Tramadol, as a controlled substance significantly reduced the ability of Alaskan withdrawal management providers to provide clinically appropriate services.
    - Removing barriers to offering clinically appropriate methods of managing withdrawal symptoms will contribute to the outcomes:
        - Increased utilization of withdrawal management services;
        - Reduced number of hospital admissions for overdose;
        - Reduced number of deaths by overdose.

8. Public and private health plans provide parity for inpatient and residential substance use disorder treatment.
    - Despite federal parity requirements, many insurers do not cover inpatient and residential substance use disorder treatment the way that hospitalization for other chronic diseases is covered.[19]
    - Federal law prevents large (more than 16 beds) facility-based substance use disorder treatment programs. This makes it difficult for health care organizations to offer/sustain long-term inpatient or residential treatment without state funding.[20]
    - Reimbursement of inpatient and residential substance use disorder treatment will contribute to the outcomes:
        - Increased number of inpatient/residential treatment beds;
        - Increased utilization of inpatient/residential treatment services;
        - Reduced arrests, incarcerations of individuals experiencing substance use disorders;
        - Reduced number of hospital admissions for overdose;
        - Reduced number of deaths by overdose.

9. State and federal authorities work together to expand access to drug courts and therapeutic justice alternatives.
    - Drug courts and therapeutic justice programs reduce recidivism by connecting criminal defendants to appropriate substance use disorder treatment, as well as social supports, in a structured environment of accountability.[21]
    - Increased access to drug courts will contribute to the outcomes:
        - Increased utilization of substance use disorder treatment by justice-involved individuals;
        - Reduced recidivism for drug-related offenses (and related crimes).

Harm Reduction

Overdose Prevention

1. Public and private health plans establish or maintain systems to identify and intervene with high-risk prescriptions (frequent refills, large dosages, etc.).[22]
    - Insurers can implement systems to complement PDMPs, providing tools for health care providers and pharmacists to identify when patients are at risk due to high-dosage or high-volume opioid prescriptions. This will contribute to the outcomes:

- Increased monitoring of prescription histories by public and private health plans;
- Reduced number of hospital admissions for prescription overdose;
- Reduced number of deaths by prescription overdose.

2. a. Public health plans shall reimburse cost-effective naloxone preparations.
   b. Prescriptions and training for naloxone accompany all prescriptions exceeding 90mg/day morphine equivalent dose.
   - Access to affordable naloxone is an essential strategy to reducing opioid overdose deaths. Ensuring that patients with high dosage opioid prescriptions have naloxone available will contribute to the outcomes:
     - Increased access to naloxone through prescription/pharmacy;
     - Reduced number of hospital admissions for prescription overdose;
     - Reduced number of deaths by prescription overdose.

3. a. Local, state, tribal, and federal authorities work together to ensure consistent, affordable access to naloxone and education on its use in the community for family/caregivers of individuals addicted to opioids.
   b. All first responders (EMTs, firefighters, police, etc.) are trained and equipped with naloxone.
   c. Education on administration of naloxone is included in basic CPR and First Aid Training curricula.
   - Access to naloxone immediately upon overdose is an essential strategy to reducing opioid overdose deaths and will contribute to the outcomes:
     - Reduced number of hospital admissions for prescription overdose;
     - Reduced number of deaths by prescription overdose.

Syringe Exchange

1. a. State, tribal, and local authorities work together to reimburse syringe exchange programs that provide disease prevention supplies and exchange, screening/testing for sexually transmitted infections (STI) where appropriate, referral to local resources for treatment, and arrange for safe disposal of used syringes and needles.
   b. State, tribal, and local authorities work together to Incentivize expansion of syringe/needle disposal services.
   - Syringe exchange programs are an effective public health intervention to reduce infections, overdoses, and the transmission of STIs.[23]
   - Lack of local, affordable syringe/needle disposal services creates a barrier to implementing syringe exchange programs.
   - Expanding access to syringe exchange programs will contribute to the outcomes:
     - Increased utilization of syringe exchange services statewide.
     - Increased availability of licensed syringe/needle disposal services.
     - Reduced reports of needle/syringe litter found in the community.
     - Reduced rates of Hepatitis C in communities with syringe exchange programs.
     - Reduced rates of HIV, other STIs in communities with syringe exchange programs.
     - Increased utilization of substance use disorder treatment by syringe exchange participants.

Recovery

1. Public and private health plans reimburse – and support providers to offer – peer support services.[24]
    - According to the Substance Abuse and Mental Health Services Administration, "peer support facilitates recovery and reduces health care costs. Peers also provide assistance that promotes a sense of belonging within the community. The ability to contribute to and enjoy one's community is key to recovery and well-being. Another critical component that peers provide is the development of self-efficacy through role modeling and assisting peers with ongoing recovery through mastery of experiences and finding meaning, purpose, and social connections in their lives."
    - Peer support is an integral part of effective substance use disorder treatment, and contributes to the outcomes:
        - Increased access to peer support services in hospital emergency departments;
        - Increased access to peer support services in community behavioral health centers;
        - Increased access to peer support services in private substance use disorder treatment practices;
        - Reduced number of deaths by overdose.

2. a. Local, state, tribal, and federal authorities work together to incentivize, educate, and support "second chance" employers (employers willing to hire people in recovery from opioid and other substance use disorders).
   b. Local, state, tribal, and federal authorities expand services for individuals in recovery who are re-entering the community from incarceration and residential substance use disorder treatment, to include supportive and transitional housing services.
    - Employers willing to hire people in recovery from opioid and other substance use disorders need tools and resources to effectively support these employees in their work performance and recovery.
    - Individuals re-entering the community, whether from corrections or residential treatment, need support to connect to employment, housing, health care, and healthy social networks.
    - Supportive effective re-entry to the community contributes to the outcomes:
        - Increased rates of employment among Alaskans in substance use disorder treatment or who have completed substance use disorder treatment;
        - Increased rates of housing among Alaskans in substance use disorder treatment or who have completed substance use disorder treatment;
        - Reduced recidivism for opioid, other drug related offenses.

3. a. Support expansion of existing recovery networks to include people in recovery from opioid addiction, including those receiving MAT.
   b. The Department of Corrections increases access to 12-step, other group recovery models in its institutions.
    - Access to recovery supports, such as 12-step programs and culturally-relevant support groups, are essential to preventing relapse. People receiving MAT may not be able to access or comfortable going to traditional 12-step programs.
    - Expanding access to recovery networks will contribute to the outcomes:

- Increased rates of substance use disorder treatment participation;
- Increased length of time of recovery between relapse episodes;
- Reduced number of repeat hospital admissions for overdose.

Collaboration

1. The Department of Health and Social Services and its partners identify and work together to address barriers to integration and coordination of care between prescribers and behavioral health treatment providers.
    - Coordinated and integrated behavioral and primary health care results in improved health outcomes, especially for individuals with chronic and co-morbid conditions and for those who overuse emergency and acute care services. Comprehensive information about integration of care is available from the SAMHA-HRSA Center for Integrated Health Solutions.
    - Expanding access to integrated and coordinated care can contribute to the outcomes:
        - Increased access to substance use disorder treatment;
        - Increased number of primary care practices providing substance use disorder screening, referral, and/or treatment;
        - Increased number of MAT providers.

2. a. Local, state, tribal, and federal authorities strengthen partnerships with public safety in community prevention efforts (prevention coalitions, school-based programs, etc.).
   b. State and tribal authorities partner with community coalitions in evidence-based substance abuse prevention education and awareness efforts.
    - Population health is improved through effective prevention strategies implemented with local support and planning. Increased prevention efforts will contribute to the outcomes:
        - Increased rates of youth not misusing prescription medications;
        - Increased rates of youth not using heroin;
        - Increased rates of youth not using alcohol, marijuana, and other drugs;
        - Reduced number of hospital admissions for overdose;
        - Reduced number of deaths by overdose.

3. State and tribal authorities work together to mitigate the collateral consequences of incarceration for drug-related offences, to increase the likelihood that persons re-entering the community are successful.
    - Effective re-integration into the community will reduce the likelihood that individuals will resume opioid use and associated criminal activities, thereby preventing relapse and recidivism.[25]
    - Supporting successful re-entry to the community will contribute to the outcomes:
        - Increased rates of employment among Alaskans re-entering the community after a period of incarceration for drug-related offenses.
        - Increased rates of housing among Alaskans re-entering the community after a period of incarceration for drug-related offenses.
        - Increased rates of health care insurance among Alaskans re-entering the community after a period of incarceration for drug-related offenses.
        - Reduced recidivism for drug-related offenses.

Conclusion

The recommendations described herein are meant to provide a guide to policymakers, offering a consistent and comprehensive public health framework for addressing Alaska's opioid crisis at all levels. The task force recognizes that the "devil is in the details" when it comes to implementation of these recommendations. Task force members are available to contribute their expertise to support organizational, local, and statewide efforts to implement these recommendations.

We would like to thank the dozens of presenters and members of the public who attended meetings and contributed to task force discussions, as well as every Alaskan who shared their experience and input to tailor these recommendations to the needs of our state and our unique communities.

Endnotes

[1] Congress passed the Secure and Responsible Drug Disposal Act in 2010, amending the Controlled Substances Act to give the U.S. Drug Enforcement Agency (DEA) to regulate safe and effective disposal by public and private entities. Pursuant to this law, the DEA issued regulations in 2014 that expanded the types of entities that can collect and dispose of medications.
"Proper Medication Disposal" is one of four strategies adopted by the Office of National Drug Control Policy in its 2011 strategic plan, Epidemic: Responding to America's Prescription Drug Abuse Crisis. This strategy – reducing access to unwanted and expired medication -- is based on the data that shows that the majority of individuals misusing prescription medications, and specifically pain relievers, get those medications from friends and/or family.
The DEA reported that, between September 2010 and September 2015, National Prescription Drug Take Back Initiative events collected 5,525,021 pounds of drugs nationwide. (DEA Press Release, October 1, 2015.) The DEA reported that the April 30, 2016 Drug Take-Back Day event collected 893,498 pounds of medications at 5,400 collection states nationwide; Alaska's 15 sites collected 4,162 pounds of medications. (DEA Press Release, May 6, 2016.)

[2] The Alaska State Troopers (AST) report that prescription medications are most often "obtained through illicit means, either by theft, prescription fraud, or overseas mail order." AST also reports that "there has been an increase in the availability of heroin throughout the state and it is no longer isolated to the urban areas." Heroin traffickers use "internal body secretion" and "mules" from outside of Alaska to avoid detection. (*2015 Annual Drug Report*, Alaska State Troopers.) Alcohol bootlegging practices have long included use of local air carriers, private aircraft, boat, and snow machine, providing routes for traffickers of heroin and controlled substances. Given the mechanisms of trafficking, and the limitations on when and how law enforcement officers can search or seize baggage/cargo, increasing the role of commercial carriers in screening of the property they transport will reduce the flow of controlled substance into rural communities.

[3] Prescription Drug Monitoring Programs (PDMP) are one of four strategies adopted by the Office of National Drug Control Policy in its 2011 strategic plan, Epidemic: Responding to America's Prescription Drug Abuse Crisis. PDMPs support the identification of and intervention with prescribers who deviate from accepted standards of practice or exhibit prescribing practices not characteristic of their specialty. (*Using PDMP Data to Guide Interventions with Possible At-Risk Prescribers*, PDMP Center of Excellence at Brandeis, October 2014.) Research of states with PDMPs showed that "the presence of a PDMP reduces per capita supply of prescription pain relievers and stimulants," which "reduces the probability of abuse." (*An Evaluation of Prescription Drug Monitoring Programs,* Simeone R, Holland L., funded by the U.S. Department of Justice, Office of Justice Programs, September 1, 2006.)

[4] "Pain is one of the oldest challenges for medicine. Despite advances in evidence and understanding of its pathophysiology, chronic pain continues to burden patients in a medical system that is not designed to care for them effectively. Opioids have been used in the treatment of pain for centuries, despite limited evidence and knowledge about their long-term benefits, but there is a growing body of clear evidence regarding their risks." *Chronic Pain Management and Opioid Misuse: A Public Health Concern*, American Academy of Family Physicians
When considering treatment options for pain, physicians and patients look to the options that are most effective **and** most affordable. Health plans often limit pain management/ treatment to pharmacological options. However, the CDC cites research that "several nonpharmacologic and

nonopioid pharmacologic treatments have been shown to be effective in managing chronic pain in studies ranging in duration from 2 weeks to 6 months." CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016
The National Pain Strategy Final Report, issued by the Interagency Pain Research Coordinating Committee of the National Institutes of Health in 2016, includes strategies for multidisciplinary and "multimodal pain treatment" that includes medical, surgical, psychological, behavioral, and rehabilitative services.

[5] The US DEA reports that proliferation of synthetic (also known as designer) drugs has grown significantly since 2008. These substances are made without regulation, often outside the United States. The effects of synthetic drugs vary, depending on the chemicals used, and can be life-threatening. Deaths due to misuse of synthetic opioids, "likely driven primarily by illicitly manufactured fentanyl," increased 72.2% between 2014 and 2015. *Increases in Drug and Opioid-Involved Overdose Deaths — United States, 2010–2015*, Centers for Disease Control and Prevention (December 30, 2016).
The State of Alaska Epidemiology Bulletin, *Overview of Recent Synthetic Opioid Overdose Deaths* (November 7, 2016) provides information about the rise of overdoses related to synthetic opioids since 2014.
Controlling access to synthetic drugs is difficult, as statutes must be specific in order to be enforceable. However, the need for specificity results in legislative processes which are not always able to respond immediately to emerging public health risks. Creating a nimble regulatory process that provides authority to a state agency to administratively schedule synthetic drugs for a limited amount of time until lawmakers can decide whether to permanently control access to the substances (similar to the emergency scheduling authority provided under the Controlled Substances Act, 21 USC 811(h)) will help prevent harm caused by synthetic opioids/drugs.

[6] An overview of the biology of kinship and its relationship to health outcomes is available from Dr. Mark Erickson, MD: *Preventing Opioid Dependency Across Generations (September 16, 2016).*

[7] "A scientific consensus is emerging that the origins of adult disease are often found among developmental and biological disruptions occurring in the early years of life. . . there can be a lag of many years, even decades, before adverse experiences are expressed in the form of disease." Shonkoff, J. et al. (2009) JAMA 301:2252-2259.

[8] The National Institute on Drug Abuse has compiled "Lessons from Prevention Research" in the form of 12 principles derived from extensive research on the origins of drug use/abuse and effective prevention programs. NIDA's research program focuses on risks for drug abuse and other risky behaviors that can occur during a child's development, from pregnancy through young adulthood. Federally-funded research shows that early intervention can prevent many adolescent risk behaviors. The National Registry of Evidence-based Programs and Practices provides a catalog of behavioral health prevention (and other) programs that have been found, after third party evaluation, to be effective means of achieving various prevention outcomes.

[9] There is a large body of research related to nutrition and Vitamin D and how they affect a person's physical and behavioral health. The Harvard School of Public Health provides an overview of some research related to Vitamin D, including research on Vitamin D's impact on the incidence of bone fracture (an injury that can lead to pain that is then treated with opioids). See also

"Recommendations Abstracted from the American Geriatrics Society Consensus Statement on Vitamin D for Prevention of Falls and Their Consequences," *American Geriatrics Society Workgroup on Vitamin D supplementation for Older Adults* (December 18, 2013).

[10] Screening, Brief Intervention, and Referral to Treatment (SBIRT) has been endorsed by the Substance Abuse and Mental Health Services Administration and Veterans Administration as an effective evidence-based practice. While primarily focused on alcohol abuse, SBIRT has shown to be an effective tool for helping patients identify and address problem drug use. A comprehensive SBIRT approach was found to be effective in reducing risky drug use, including cocaine and heroin use (*SBIRT for Illicit Drug and Alcohol Use at Multiple Healthcare Sites: Comparison at Intake and 6 Months*, Madras, B.K. et al. *Drug and Alcohol Dependence*, 99(1–3), 280–295 (2009); *A Randomized Controlled Trial of Brief Cognitive-Behavioral Interventions for Cannabis Use Disorder*, Copeland, J. et al. *Journal of Substance Abuse Treatment*, 21(2), 55–64 (2001). Screening and brief interventions have been linked to reduced use of heroin, stimulants, marijuana, and other drugs (*The Effectiveness of a Brief Intervention for Illicit Drugs Linked to the Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) in Primary Health Care Settings,* Humeniuk et al. World Health Organization, 2008).

[11] An overview of evidence supporting the need for patient risk assessments is provided in the CDC Morbidity and Mortality Weekly report, *CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016* (March 18, 2016 / 65(1);1–49).

[12] Crisis Intervention Teams (CIT) were developed by the Memphis Police Department in partnership with the University of Memphis (Tennessee). CIT is based on community partnerships between law enforcement, mental health, and consumer organizations. Officers are trained to de-escalate crisis situations involving individuals experiencing a behavioral health crisis, and then directly connect the individual to appropriate treatment rather than jail. CIT training has been made available to law enforcement officers through support from the Alaska Mental Health Trust Authority and NAMI since 2001. Police departments in Anchorage, Juneau, and Fairbanks all have CIT-trained officers on duty. CIT can transform a community's response to day-to-day crises. It is most effective when officers participate voluntarily, and then are embedded in the patrol operations of the law enforcement agency. A comprehensive review of research into the effectiveness of CIT programs was published in 2008, and reported generally positive outcomes for officers and individuals. (*A Comprehensive Review of Extant Research on Crisis Intervention Team Programs*, Compton, M. et al. *Journal of the American Academy of Psychiatry Law*, 36:47-55 (2008).
Mental Health First Aid (MHFA) complements the more intensive CIT training by providing all officers and staff with a basic level of mental health awareness and understanding. CIT International and the National Council for Behavioral Health provide an overview of how MHFA and CIT can work together.

[13] Public Safety Assisted Addiction and Recovery Models are a relatively new endeavor, brought to national attention in 2015 by the Gloucester, Massachusetts police department. However, they are built upon the same community partnerships and principles proven effective by CIT models nationwide – training and equipping officers to divert people in need of treatment (in this case opioid use disorder treatment) to community resources rather than arresting them. The Police Assisted Addiction and Recovery Initiative, which includes more than 160 law enforcement agencies nationwide, coordinates information and resources related to these programs. They report a 25% reduction in addiction-related crimes in communities implementing this model. (PAARI Annual Report, June 2015- June 2016)

[14] Primary care providers are less able to coordinate care for patients with complex needs, including substance use disorders, if there is a lack of communication with specialist providers, hospitals, and social services organizations. (*Primary Care Physicians in Ten Countries Report Challenges Caring for Patients with Complex Health Needs,* Osborn, R. et al. *Health Affairs* (December 2015)). If primary care providers can easily connect with an up-to-date clearinghouse of information and referral supports from existing services, like Alaska 211 and Aging and Disability Resource Centers, that will facilitate the screening and referral of patients to treatment.

[15] Individuals experiencing chronic pain are also likely to experience mental health and substance use disorders. Chronic pain and addiction have many shared neurophysiological characteristics, and have similar physical, emotional, social, and economic effects on a person. Depression is also frequently found in patients with chronic pain. (*TIP54: Managing Chronic Pain in Adults with or in Recovery from Substance Use Disorders,* SAMHSA (2012)) The National Pain Strategy includes access to a "well trained behavioral health work force . . . to support the needs of patients who suffer from chronic pain, including those at risk who need mental health care and substance abuse prevention and recovery treatment." (National Pain Strategy Final Report, Interagency Pain Research Coordinating Committee, National Institutes of Health (March 18, 2016))

[16] "Substance use has complex biological and social determinants, and substance use disorders are medical conditions involving disruption of key brain circuits." *Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health* at 7-1 (2016). The American Society of Addiction defines addiction as "a primary, chronic disease of brain reward, motivation, memory and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social and spiritual manifestations. This is reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviors. . . Like other chronic diseases, addiction often involves cycles of relapse and remission. Without treatment or engagement in recovery activities, addiction is progressive and can result in disability or premature death."

[17] Medication assisted treatment (MAT) is promoted by the Substance Abuse and Mental Health Services Administration for the treatment of opioid and other substance use disorders. MAT combines medications and behavioral health treatment to help individuals achieve recovery. MAT is considered to be a highly effective treatment for opioid use disorders, given the impact opioids have on the human brain. Methadone, buprenorphine, and naltrexone are the approved medications for opioid use disorder treatment. These medications can help mitigate initial withdrawal symptoms and support abstinence over the long-term.

[18] An estimated 80% of individuals experiencing a substance use disorder also experience a mental health disorder (and vice versa). It is appropriate to assess patients to determine whether psychosocial treatment is indicated, and then coordinate with behavioral health providers to ensure the patient has access to appropriate clinical services.

[19] Health plans are required to provide parity in coverage of services for behavioral health under the Mental Health Parity and Addiction Equity Act of 2008.

[20] "Institutions of mental disease" (IMD) are defined as "a hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnoses, treatment, or care

of persons with mental diseases, including medical attention, nursing care, and related services." (42 USC §1396d(i)). IMDs serving adults age 21-64 are excluded from Medicaid reimbursement. (42 USC §1396d).

[21] An overview of the evidence and research on drug courts is available from the U.S. Department of Justice Office of Justice Programs (May 2016).

[22] Alaska Medicaid implemented prior authorization processes for extended release opioids in 2015 to help reduce the risk of patient dependence, overdose and death. Alaska Medicaid also has established therapeutic duplication measures, dosage and unit limits for opioid analgesics.

[23] Preventing HIV Infection Among Injecting Drug Users in High Risk Countries: An Assessment of the Evidence, Institute of Medicine (2006)
Evidence for the effectiveness of sterile injecting equipment provision in preventing hepatitis C and human immunodeficiency virus transmission among injecting drug users: a review of reviews, Palmateer, N. et al. *Addiction* (May, 2010)

[24] Benefits of peer support can include reduced substance use, increased treatment engagement, reduced risk behaviors, and improved maintenance of recovery. *Benefits of Peer Support Groups in the Treatment of Addiction,* Tracy, K. and Wallace, S. *Journal of Substance Abuse and Rehabilitation* (September 29, 2016).

[25] The Council of State Governments Justice Center National Reentry Resource Center provides an overview of research and evaluation of "what works" in re-entry programs.