**ALASKA STATE LEGISLATURE**
**SENATE JUDICIARY STANDING COMMITTEE**
February 4, 2015
1:37 p.m.

**MEMBERS PRESENT**

Senator Lesil McGuire, Chair
Senator John Coghill, Vice Chair
Senator Mia Costello
Senator Peter Micciche
Senator Bill Wielechowski

**MEMBERS ABSENT**

All members present

**COMMITTEE CALENDAR**

PRESENTATION ON MEDICATION ASSISTED TREATMENT (MAT)

- HEARD

**PREVIOUS COMMITTEE ACTION**

No previous action to record

**WITNESS REGISTER**

MARK BOESEN, Pharmaceutical Doctor and Juris Doctorate
Policy Manager
Alkermes
**POSITION STATEMENT**: Presented information on medication assisted treatment.

PAULA COLESCOTT, MD
Providence Breakthrough
Physician Health Program and
Highland Mountain Correctional Facility
Anchorage, Alaska
**POSITION STATEMENT**: Presented her experience and perspective on medication assisted treatment.

REBECCA YOUNG, ANP
Valley Medical Family Practice

Lemon Creek Correctional Facility
Juneau, Alaska
**POSITION STATEMENT**: Presented her experience and perspective on medication assisted treatment.

WENDY SMITH, PA-C
Family Practice Physicians
Juneau, Alaska
**POSITION STATEMENT**: Presented her experience and perspective on medication assisted treatment.

LISA REYNOLDS
**POSITION STATEMENT**: Shared her story as the mother of an addict who has relapsed several times.

PAUL FINCH, PA-C
Gateway to Recovery Detox
Turning Points Counseling
Fairbanks, Alaska
**POSITION STATEMENT**: Presented his experience and perspective on medication assisted treatment.

**ACTION NARRATIVE**

1:37:52 PM
**CHAIR LESIL MCGUIRE** called the Senate Judiciary Standing Committee meeting to order at 1:37 p.m. Present at the call to order were Senators Wielechowski, Costello, Micciche, Coghill, and Chair McGuire.

## Presentation on Medication Assisted Treatment (MAT)

1:38:12 PM
CHAIR MCGUIRE announced the business before the committee would be a presentation on Medication Assisted Treatment (MAT).

1:38:25 PM
MARK BOESEN, Pharmaceutical Doctor and Juris Doctorate, Policy Manager, Alkermes, introduced himself and stated that he works for the company that manufactures Vivitrol.

PAULA COLESCOTT, MD, Providence Breakthrough, Physician Health Program, and Highland Mountain Correctional Facility, introduced herself and told the committee she works in a methadone clinic and urgent care. Her specialty is internal medicine and she is board certified in addiction medicine.

DR. BOESEN explained that he started these presentations in an effort to educate legislators on underutilized treatment opportunities and to talk about medication assisted treatment (MAT) in general. Vivitrol is one drug that is used for treating both alcoholism and opioid dependency. He explained that opioids are pain relievers and include prescription drugs like Vicodin, Percocet, Morphine, and Dilaudid. Heroin is a widely recognized and potent street version of an opioid. Opioids are all derivatives of morphine derived from the poppy plant.

CHAIR MCGUIRE asked how Americans are gaining access to these drugs.

DR. BOESEN replied there are a number of pathways, one of which is people who are treated with legitimate pain. They are treated appropriately for their acute or chronic injury, but they develop a physical dependence to the dopamine surge that comes with taking opioids. They continue to use or use more and more until it becomes inappropriate. Once they are cut off from legitimate access, they do not seek appropriate treatment and instead seek prescription medications that have been diverted and sold on the street. Heroin is an inexpensive recreational medication commonly found on the street and some people turn to that instead of the more expensive diverted brand-name medications.

SENATOR MICCICHE asked why the price of heroin has come down and why is it so affordable.

DR. BOESEN replied it has always been relatively inexpensive. It isn't difficult or expensive to manufacture, the market demand is high, and there is a lot of competition to sell it on the street. He explained that heroin was brought to the commercial market in the late 1800s as a pain reliever and cough suppressant. It was also used to wean people off of morphine before the dangers were recognized.

SENATOR COGHILL commented on the abuse of methamphetamine in his area and his understanding that heroin is less damaging. He asked Dr. Colescott to comment.

DR. COLESCOTT said methamphetamine is directly neurotoxic to the brain and there is no effective treatment for dependency. The opioids also change the brain but there is effective, brain stabilizing treatment for dependency. She noted that on a per dose basis the most addictive drug is nicotine, followed by

heroin, then the stimulants like methamphetamine and coke, then alcohol, and finally cannabis.

SENATOR COGHILL vouched for the addictive qualities of nicotine.

1:47:56 PM
DR. BOESEN added that regardless of the substance, there is a growing problem and a need for effective treatment. He directed attention to a quote from the National Institute on Drug Abuse to stress the point that addiction treatment is not one size fits all. It is important to match treatment settings, interventions and services to a person's particular problems. He said the clinicians will discuss how to do a proper assessment, the challenges to identifying treatment modalities, where treatment is delivered, and the gaps in care in Alaska.

He advised that recovery is a lifelong process; addiction is a chronic disease and absolutely not a matter of poor willpower. Treatment needs to include a combination of medical and psychosocial interventions along with family and peer support. "Wrap-around services are critical and is a process that is going to last someone their entire life."

SENATOR COGHILL admitted that he struggled with calling addiction a disease because it is not something you catch. He suggested that pushback from legislators may stem from this perception.

DR. BOESEN replied it is a different disease model than the infectious disease model and some people who are addicted arguably made poor choices. However, it does not negate the fact that it is a disease. Some evidence shows that there may be a genetic predisposition to addiction and other evidence shows that once the neurotransmitter pathways are significantly altered, the surge that comes with injecting or taking opioids or consuming alcohol is something that the brain continues to crave. This cannot be overcome with willpower. It requires medical and psychosocial intervention.

SENATOR COGHILL reiterated his perspective.

CHAIR MCGUIRE added that part of the point of the presentation to learn about the disease model and the cost of addiction to the state.

1:52:40 PM

DR. BOESEN said it supports the disease model that some people abuse substances and never get addicted, while others use a substance and get addicted. It is not clear how to differentiate those two populations, he said.

DR. BOESEN displayed a picture depicting the two regions of the brain affected by dependence: the limbic region whose role is the primal drives such as fight or flight, cravings, rewards, and pleasure; and the cerebral cortex whose role is reasoning, thinking, learning, and decision making. The problem when it comes to addiction is that the limbic region is such a powerful driver that it can override the cerebral cortex. Despite an addict's best thinking, he/she will still drink that next drink, inject that next heroin, take that next morphine tablet or whatever it is.

He said what is remarkable about Vivitrol is that it works on the limbic region of the brain to normalize the neurotransmitters so that the cravings are dissipated. It is particularly effective for patients who take opioids. It decreases the cravings so the noise from the limbic region doesn't overpower the cerebral cortex so counseling can work better. He stressed the point that medication alone is not the answer; it has to be combined with counseling and psychosocial support.

SENATOR COSTELLO asked what the side effects are for Vivitrol.

DR. BOESEN explained that 4 ccs of the medication is injected into the buttock every 30 days. Soreness and reaction at the injection site is the most commonly reported side effect, but they also monitor for adverse effects on the liver, for pneumonia, and for allergic reaction. They have found that fewer than 2 percent of the people who receive Vivitrol have to drop out of the program because of an adverse reaction. The people who drop out tend to do so for reasons other than experiencing an adverse effect.

1:57:09 PM
SENATOR WIELECHOWSKI asked what Vivitrol costs.

DR. BOESEN replied it ranges between $600 and $1,300 per month depending on the kind of patient, the kind of insurance, and the kind of payer. A state pays much less than commercial payers.

SENATOR WIELECHOWSKI asked if he expects that Vivitrol would be available to many more people in the state of Alaska if Medicaid were expanded.

DR. BOESEN replied the Medicaid authority in Alaska recognizes the value, but the medication is only as good as the number of clinicians who are available to treat and care for people affected by dependence.

He then discussed the three types of opioids that are classified by the effect that they have on the mu receptors. They are full agonists, partial agonists, and antagonists. An agonist stimulates the neurotransmitter to produces a dopamine surge. An antagonist blocks an effect.

Methadone is an example of a full agonist. It binds to the mu receptor in the brain and produces the dopamine surge. It produces that same lightning storm benefit as the recreational drug, but it is administered in a controlled, safer environment under the monitor of nurses, physicians, and counselors. Full agonists are useful for certain people who still need that dopamine surge in order to help with their therapy.

Buprenorphine-type medications are examples of partial agonists. They bind primarily to mu receptors and cause them to produce endorphins. Although the dopamine surge is less pronounced, there is still a stimulation of the dopamine reward system that calms the limbic center of the brain so the cerebral cortex is not overpowered so counseling works.

Vivitrol is an example of a full opioid antagonist. It binds to the opioid receptors but does not stimulate or produce endorphins. It does not completely stop the dopamine reward system, but it does not activate it so there are more normal levels of dopamine in the brain. During the 30-day period when Vivitrol is in the brain, getting high will not produce the desired effect.

CHAIR MCGUIRE asked if Vivitrol is analogous to Wellbutrin to treat nicotine addiction.

DR. BOESEN said no; the medications work in completely different ways.

Turning to the safety information, he stated that a benefit to using Vivitrol when treating alcoholics is that it can be used in the outpatient setting, it does not require detoxification,

and it can be administered fairly early in the treatment cycle. One of the barriers to using a drug like Vivitrol on opioid dependent people and why sometimes Methadone and Buprenorphine are better choices is that the medication works so well at blocking the receptor, that if there is any sort of opioid in the system the medication will bump off the receptor and put the person into the life-threatening condition called precipitative withdrawal. He noted that Mr. Finch would talk about the importance of detox and the shortage of resources. He called it the critical message of the day.

CHAIR MCGUIRE asked if there is any worry about depression or suicide for an alcoholic or opioid addict who is being treated with Vivitrol and they are unable to get a dopamine surge.

DR. BOESEN deferred to Dr. Colescott.

DR. COLESCOTT said some people who have been opioid or alcohol dependent do extremely well on Vivitrol, but there is also a population that does not. The post-acute withdrawal syndrome (PAWS) phase can last for months and her experience is that the opioid addict finds this phase extremely intolerable. Their world is gray; they are hard to motivate, they sleep poorly, they're emotionally unstable and they react poorly to stress. This can improve if the addict is able to remain sober, but this population has difficulty getting to that point. It is particularly difficult for individuals who have a preexisting emotional or psychiatric problem that may not have been diagnosed or effectively treated because of their drug use.

She advised that a person can release their own dopamine, but they have to learn how. That is where a treatment team is so essential.

2:09:01 PM
DR. BOESEN reviewed the contraindications of Vivitrol. It should not be used for people: receiving opioids analgesics; with current physiologic opioid dependence; in acute opioid withdrawal; who have failed the naloxone challenge test or have a positive urine screen for opioids; and who have exhibited hypersensitivity to naltrexone, polylactide-co-glycolid carboxymethylcellulose, or any other compounds of the diluent.

He reviewed the attributes of Vivitrol. It is: a monthly extended-release injectable formulation of naltrexone; administered by a healthcare professional; an effective complement to psychosocial treatment; and a competitive opioid

blocker. It is not a narcotic, pleasure producing, addictive, or associated with abuse. It is not a drug that is diverted to the street.

DR. BOESEN warned that because Vivitrol blocks the effects of exogenous opioids for approximately 28 days after administration, patients are more likely to have reduced tolerance to opioids after detoxification. As the block dissipates, use of previously tolerated doses of opioids could result in potentially life-threatening opioid intoxication.

2:12:14 PM
DR. COLESCOTT explained that when someone uses an opioid repeatedly, it changes the sensitivity of the receptors covering the brain over the long term. Once the receptors are stimulated, it creates a cascade within the nerve that affects the way the nerve functions down to the nucleus and how it expresses itself genetically. She cited a study that followed 900 IV heroin users for 40 years that found that less than 22 percent were able to remain sober. She opined that the statistics for oral opioids is probably less than that. The brain knows it can release dopamine by using the drug so when the person is depressed, angry, disappointed, or worried the survival area of the brain will sense the need for dopamine and look for ways to get it. She said she lays out the treatment options for her clients and warns that they are in a marathon. Their treatment may include methadone, Vivitrol, or Buprenorphine but the constant is to have a team to help navigate through the process.

CHAIR MCGUIRE directed attention to her website for resources to further the discussion about addiction.

SENATOR WIELECHOWSKI asked how receptive addicts are to treatment and what legislators can do to encourage people to take advantage of treatment.

DR. COLESCOTT said her experience is that people enter treatment when their back is against the wall and something salient is at stake. With regard to the second question, she proposed a pilot project to give Vivitrol to the women coming out of Highland Correction Center who are detoxed but still dependent on opioids or alcohol. It would save money and provide a meaningful reintegration.

DR. BOESEN suggested expanding the treatment and wellness courts and offering treatment alternatives to any municipal or state court. He offered to share the results from other states.

SENATOR MICCICHE asked which states have successful treatment programs.

DR. BOESEN named Colorado, Missouri, Ohio, Massachusetts, Maryland, California, and Illinois. The programs usually start with pilot projects and it's easy to see whether or not it's working within 3-6 months. Colorado, for example, did a pilot program that focused on parolees and they saw a 45 percent reduction in recidivism for parolees treated with Vivitrol as opposed to parolees who were not. He noted that the medication is not administered prior to release. Rather, a parolee who has a technical violation is given the option to enroll in the program. Those who have elected to do so are doing very well.

CHAIR MCGUIRE suggested it would be advantageous to offer the treatment prior to release.

DR. BOESEN agreed that would be optimal and that is happening in Massachusetts and Maryland.

SENATOR COGHILL offered his belief that jails have done inadequate risk assessments for behavioral health issues. The second point is to look at how to administer new programs.

DR. BOESEN said elected officials, governors, and governor's staff in states with these programs are more than willing to share their experience and how to identify the low hanging fruit that may already exist in the system.

2:26:50 PM
SENATOR MICCICHE commented that people who have addiction problems probably get less of a dopamine reward from life experiences and more reward from the drug.

DR. COLESCOTT agreed. She said that people with opioid and alcohol addiction know how to modulate their affect and instead of developing normal coping mechanisms, they have reverted to a drug to deal with any kind of distress. These people may have been abused, raped, and poorly nurtured, but on top of that their mu opioid receptors may not be normal.

SENATOR MICCICHE asked if treatment can normalize the brain.

DR. COLESCOTT replied her impression is that some people are able to get off the medication, but not without developing a robust dopamine network and having a support system.

SENATOR COGHILL offered his experience that young brains are more easily affected.

DR. COLESCOTT agreed, and added that she did not know if the system could be changed back or if the brain is simply overlaid with other dopamine receivers.

CHAIR MCGUIRE said this hearing opens the dialog.

2:32:20 PM
REBECCA YOUNG, ANP, Valley Medical Family Practice, Lemon Creek Correctional Facility introduced herself and explained that weekdays she does contract work at the prison and family practice work at Valley Medical. On weekends she is either in the emergency room (ER) at Bartlett Regional Hospital or she's with the National Guard. In the course of a week she sees about 200 people, many of whom are addicted to opioids or alcohol.

WENDY SMITH, PA-C, Family Practice Physicians, introduced herself and related that she is a primary care provider in Juneau. She is the "go to" for opioid abuse in the clinic.

MS. YOUNG provided her perspective for some of the questions posed earlier. She said that in Juneau heroin is coming into the community primarily by airplane and inside the bodies of females who are serving as mules. If they are caught and arrested, she sees them either at Lemon Creek before they're taken to federal prison or in the ER when she removes the heroin from their bodies. She noted that some men are mules and the drug sometimes comes in by ferry but both are less common. As to why heroin is affordable, she explained that it is a less expensive alternative to diverted prescription medications. Several years ago, OxyContin was a big street drug in Juneau and a number of people became addicted. They switched to heroin when they could no longer afford OxyContin or there wasn't a supply on the street. She noted that in an effort to keep prescription drugs off the street, the medical community cross checks with different pharmacies and has put in place pain contracts. There is also a state-sponsored drug monitoring program. As yet there isn't a good procedure to get heroin off the street or a way to monitor it, she said.

SENATOR COSTELLO asked if she is familiar with the Medi-Set program, because it seems that it would reduce the opportunity for abuse if a patient could only get medications for a week at a time.

MS. YOUNG explained that a prescription can't be written short term if the insurance pays for a 30-day supply. Also, people who are looking for street drugs aren't necessarily looking for a large volume. They're happy to find "left over" medications in a home medicine cabinet. She cited a personal example and cautioned that the heroin addict or alcoholic in the community doesn't always fit the preconceived stereotype. A few of the addicts she has treated have worked in a bank, the post office, a beauty salon, a state office, on a road crew, on electric lines, and in high school. You don't know who it is, she said.

2:39:00 PM
SENATOR MICCICHE asked if people regularly try to get the same prescription from more than one pharmacy and what happens if that happens.

MS. YOUNG said that when she knows the patient recently filled a prescription from another source she tells him or her that she is uncomfortable prescribing the medication. Generally they respond to honest communication, but once in a while the reaction is violent, she said.

2:39:58 PM
SENATOR WIELECHOWSKI asked if Alaska has adequate treatment centers.

MS. YOUNG answered no. She described the limited and expensive options available in Juneau.

SENATOR WIELECHOWSKI asked if Medicaid covers treatment.

MS. SMITH replied she doesn't know of any adults who have used Medicaid for treatment.

MS. YOUNG added that Medicaid only pays if the person goes to a state facility and there are few treatment facilities for children under age 18 in Alaska.

2:42:15 PM
MS. SMITH said it's disturbing that so few providers are willing to treat substance abusers, but it takes a lot of time and energy to deal with all the barriers that come with substance abuse including no shows, late arrivals and non-payers. It's a problem in her own clinic.

MS. YOUNG said that she and one other practitioner see the bulk of the substance abusers at her clinic. She observed that a person who has uncontrolled diabetes may be just as non-compliant as a substance abuser but they don't have trouble being seen because they don't have the onerous addict label.

CHAIR MCGUIRE asked how the healthcare community would describe the difference because they're both diseases.

MS. YOUNG opined that addicts are perceived to be liars. She said that providers believe a heroin addict will lie just to get treatment. They commonly do lie, she said, but she's also had diabetics and breast feeding mothers lie about their behavior. The difference is they don't get the same stigma as the heroin addict

CHAIR MCGUIRE asked for a few thoughts that the committee as policymakers should know.

MS. SMITH stated that she would like every heroin abuser to have health insurance so that isn't a barrier to seeking treatment.

SENATOR MICCICHE questioned how to get ahead of the burgeoning drug problems in the state and whether law enforcement should be part of the discussion to improve the process for intersecting the supply of drugs.

MS. SMITH said she believes the focus should be on getting people to choose not to use drugs.

CHAIR MCGUIRE recognized the next presenters, Lisa Reynolds and Paul Finch.

2:51:15 PM
LISA REYNOLDS said she is speaking as a concerned Mom who has struggled to find help for her 20-year-old son who is a drug addict and alcoholic. She is telling her story in hopes that it will help to get funding for treatment facilities, recovery facilities, medical treatment, and sober living. These are things she has struggled to find since she learned that her son is an addict. It has been a long and difficult journey for the family.

Because of the lack of programs and facilities in Alaska, she had no alternative but to engage an interventionist from Washington to help get her son into rehab in Utah. The facility was top notch and admitted her son with just insurance and no

upfront costs. Her son was in rehab for 92 days and she traveled there every other week to attend family group therapy and counseling. When her son came home, he did not get the treatment he needed and relapsed shortly thereafter. He was readmitted to the program for 30 days and when he returned to Alaska it was a struggle to find a doctor to help with his medical treatment, counseling and other things that must be in place to help with treatment.

MS. REYNOLDS said that when her son relapsed a second time she was able to get him to Gateway to Recovery Detox in Fairbanks. Before he left Gateway he got a Vivitrol shot and Neurontin to help with anxiety. The medications as well as counseling and meetings saved him from relapse upon returning home. She said it is one day at a time, but she hasn't seen her son this clear-minded in years. The current struggle is to find him sober living in Anchorage where he can be close to family. This is a challenge because drugs make their way into sober-living facilities.

She said it is astonishing that resources are so scarce, particularly in light of the fact that Alaska ranks among the ten highest of all the states for drug and alcohol abuse. Addicts and alcoholics can go on to live happy, sober lives, but they can't do it alone. She expressed hope that telling her story will help get the funding, programs, and medical treatment that Alaska desperately needs.

2:59:02 PM
PAUL FINCH, PA-C, Gateway to Recovery Detox, Turning Points Counseling, said he does detox and medication assisted treatment and he believes that one of the biggest barriers to treatment is the fear of withdrawal. He appreciates the comments about the reluctance to treat addicts, but his perspective is that it should be mainstreamed in family practice clinics.

MR. FINCH explained that Gateway is a 16-bed inpatient facility that is administered by the Fairbanks Native Association. Two of the beds are designated to opioids and they are always full. There is a critical need for more beds, but there isn't staffing or resources for that at this time.

CHAIR MCGUIRE asked if there is anything the state can do to increase the number of beds.

MR. FINCH replied he can't speak for FNA leadership, but he doesn't think the answer should always come from government. He

instead suggested trying to attract a leader in the industry to establish a state of the art facility in Alaska.

CHAIR MCGUIRE commented on the alarming cost of treatment.

MR. FINCH stated that the business model at Turning Point is fee for service. The treatment is very good, but it's expensive.

CHAIR MCGUIRE thanked the presenters.

3:04:07 PM
There being no further business to come before the committee, Chair McGuire adjourned the Senate Judiciary Standing Committee meeting at 3:04 p.m.