ALASKA STATE LEGISLATURE
HOUSE HEALTH AND SOCIAL SERVICES STANDING COMMITTEE
May 9, 2019
3:06 p.m.

MEMBERS PRESENT

Representative Ivy Spohnholz, Co-Chair
Representative Tiffany Zulkosky, Co-Chair
Representative Matt Claman
Representative Harriet Drummond
Representative Geran Tarr

MEMBERS ABSENT

Representative Sharon Jackson
Representative Lance Pruitt

OTHER LEGISLATORS PRESENT

Representative Bryce Edgmon

COMMITTEE CALENDAR

PRESENTATION(S): SUBSTANCE ABUSE TREATMENT SYSTEM

- HEARD

PREVIOUS COMMITTEE ACTION

No previous action to record

WITNESS REGISTER

ANDY JONES, Director
Office of Substance Misuse and Addiction Prevention (OSMAP)
Office of the Commissioner
Department of Health and Social Services (DHSS)
Anchorage, Alaska
POSITION STATEMENT: As part of the presentations on the substance abuse treatment system, provided a PowerPoint slideshow titled "Addressing Alaska's Poly-Substance Epidemic."

GENNIFER MOREAU-JOHNSON, Acting Director
Division of Behavioral Health
Department of Health and Social Services (DHSS)
Anchorage, Alaska

POSITION STATEMENT: As part of the presentations on the substance abuse treatment system, provided a PowerPoint slideshow titled "Division of Behavioral Health."

BRADLEY GRIGG, Chief Behavioral Health Officer
Bartlett Regional Hospital
Juneau, Alaska
POSITION STATEMENT: As part of the presentations on the substance abuse treatment system, described what Bartlett Regional Hospital is seeing in the patients it is serving.

SHERRIE WILSON HINSHAW, President & CEO
Volunteers of America-Alaska (VOA)
Anchorage, Alaska
POSITION STATEMENT: As part of the presentations on the substance abuse treatment system, described what VOA is doing.

LANCE JOHNSON, Director
Behavioral Health Services (BHS)
Norton Sound Health Corporation (NSHC)
Nome, Alaska
POSITION STATEMENT: As part of the presentations on the substance abuse treatment system, described what NSHC is doing.

ADELE LANDROCHE, Advocate
Anchorage, Alaska
POSITION STATEMENT: As part of the presentations on the substance abuse treatment system, provided the perspective of being the mother of children with additions.

DOUG WOOLIVER, Deputy Administrative Director
Alaska Court System
Juneau, Alaska
POSITION STATEMENT: As part of the presentations on the substance abuse treatment system, discussed the role of the therapeutic courts.

ACTION NARRATIVE

3:06:01 PM

CO-CHAIR IVY SPOHNHOLZ called the House Health and Social Services Standing Committee meeting to order at 3:06 p.m. Representatives Claman, Drummond, Zulkosky, and Spohnholz were present at the call to order. Representative Tarr arrived as the meeting was in progress. Representative Edgmon was also present.

PRESENTATION(S): SUBSTANCE ABUSE TREATMENT SYSTEM

3:06:37 PM

CO-CHAIR SPOHNHOLZ announced that the only order of business would be a presentation on the Substance Abuse Treatment System.

CO-CHAIR SPOHNHOLZ noted the committee has been working on a series of crime bills for much of the last month. She said she feels that any conversation about crime is incomplete without a discussion about the need to address addiction, which drives most of the crime in the state of Alaska.

3:07:35 PM

ANDY JONES, Director, Office of Substance Misuse and Addiction Prevention (OSMAP), Office of the Commissioner, Department of Health and Social Services (DHSS), provided a PowerPoint slideshow titled "Addressing Alaska's Poly-Substance Epidemic." Displaying slide 2, he described the magnitude of the problem. He said drug overdoses are now the leading cause of accidental death in the U.S., exceeding automobile deaths. In 2016, drug overdoses killed 65,000 Americans - more in a years' time than were killed in the Vietnam, Iraq, and Afghanistan wars combined. In 2017, the number increased to 70,237. In 1999, the rate was about 6.1 deaths per 100,000 in population and in 2018 it skyrocketed to 21.7 per 100,000.

3:09:58 PM

MR. JONES moved to slide [3] and explained that epidemics come in waves and this epidemic is probably the third wave to happen. He said driving factors in this epidemic include medical fallacies that resulted in over prescribing, such as being able to measure pain objectively and the mentality that tolerance is just under-dosing. Another fallacy is pseudo-addiction, the thought that persons who display drug-seeking behavior are simply in pain and need more opioids. These types of thought come from inadequate training in pain management for doctors.

MR. JONES displayed slide 4 and said scaring him the most is the transition from the prescribed opioid problem to the illicit street drug problem of heroin, fentanyl, and carfentanil; three out of four new heroin users report having misused prescription opioids. Too often people with a sports or other injury are prescribed opioids and then become addicted to the substance.

Heroin doesn't require a prescription and the street price of heroin is much cheaper than prescription opioids. The danger is a higher risk of overdose from street drugs because they can have unknown ingredients. For example, recently law enforcement officials seized fentanyl that was pill pressed in "Mallinckrodt 30s." A pain patient unable to get a prescription anymore, and who bought this pill on the street thinking it was a Mallinckrodt 30, would face almost instant death because this pill was pure fentanyl. Dealers do this because it is cheaper for fentanyl and lots of money can be made by pill pressing it. He pointed out that morphine is dangerous, heroin very dangerous [50 times], and fentanyl even more dangerous [100 times].

3:13:32 PM

MR. JONES turned to slide 5, a graph of drug incidents for opioids and methamphetamine provided by the Department of Public Safety. The numbers for incidences in 2018 are down, but he explained, current cases are still open, so by the time they are closed the numbers will remain close. Methamphetamine is one of Alaska's biggest problems today. It is no longer local cooking in labs - it is coming from Mexico in very high potency and purity rates. "We're moving towards more of a poly-substance approach when it comes to our response," he continued. "Yes, we focused a lot on opioids and yes we still do, and the money is there; whenever we secure money, we're looking at trying to make our resources, our capabilities, our capacities, as broad as possible."

MR. JONES showed slide 6 and said alcohol is still Alaska's biggest problem. Methamphetamine is big, heroin is still big, and cocaine is starting to come back.

MR. JONES addressed slide 7. He explained it is a poly-substance misuse epidemic. Agencies are now focusing on what methamphetamine treatment looks like and what the interdiction processes look like as an attempt to get ahead of the game. About 95 percent of the individuals in Alaska who die from a drug overdose have multiple substances in their bodies.

3:15:35 PM

MR. JONES displayed slide 8 and explained that the depicted response structure to the opioid epidemic is Alaska's incident command system and it takes all state agencies. He said a state disaster was declared in [2017] because people had died, there was crime and property destruction in relation to the epidemic,

and communities were asking for help. To this day Alaska is pushing more naloxone than any other state in the U.S. and is saving many lives. Alaska's system includes locals, tribal, federal, and [non-governmental] state partners to ensure communication and inclusion of the people who are doing the work on the ground. Approaches within the system include a multi-agency approach, a multi-agency coordination (MAC) group where the commissioners come together for monthly briefings, joint information systems to help with coordination, and utilization of the Alaska Criminal Information and Analysis Center which is with the troopers and that is fed to the incident commander and deputy incident commander. Mr. Jones said this provides information on the drug trends that are going on and helps him as an individual to focus his prevention treatment efforts and where to put resources.

MR. JONES spoke to slide 9. Cross-sector collaboration, he said, is extremely important because without all the pieces and the players together there will be duplicative efforts.

3:18:35 PM

MR. JONES moved to slide 10 and elaborated on the response framework. When Alaska's response was started in 2007, he said, only a few states had declared disasters. In 2016 the Alaska Opioid Policy Task Force was formed and its [recommendations] were released in [January 2017]. However, locals informed him that it was a policy document meant for people like himself and legislators, not communities. Something needed to be changed to make it work for communities, but there needed to be a response framework. The question was whether DHSS should work on a plan right away or save lives. The decision was to save lives and it began by saturating the market with Narcan kits [medication that temporarily blocks or reverses the effects of opioids]. [Addiction] is a chronic condition of the brain, not a moral failing, and people need help and often more than one chance. Drug disposal bags were distributed to reduce prescription drugs in houses; these bags contain activated charcoal to which water and the substance are added and the substance is then destroyed.

MR. JONES continued and drew attention to the graphic on slide 10. He explained that tertiary prevention [acute health event control and prevention] is naloxone and working with syringe and needle exchanges. He said these exchanges have been extremely helpful because Alaska doesn't have drug paraphernalia laws. The choice is to either have these exchange sites or have needles everywhere, which can cause hepatitis outbreaks. The

exchange sites also help to connect with the individual who is suffering. The secondary prevention [chronic disease screening and management] is increasing screening, reducing the stigma, and understanding that addiction is a chronic disease. Primary prevention [environmental controls and social determinants] includes things like adverse childhood experience, judicious prescribing, and doing upstream prevention that is being talked about and worked on right now.

3:21:29 PM

MR. JONES discussed the prevention resources listed on slide 11. He said DHSS has secured quite a bit of funding for prevention. The Alaska Partnerships for Success is a coalition across the state that comes together to focus on substance use disorders and misuse. The Community Substance Misuse and Abuse Task Forces are local citizens who come together, and they have been phenomenal is making changes. The Office of Substance Misuse and Addiction Prevention (OSMAP) was created, which focuses solely on integrating public health approaches to reduce or minimize subsistence use disorders. Other resources are Data Dashboards and the department's Opioids in Alaska website.

MR. JONES spoke to slide 12 regarding the Alaska State Troopers and the Statewide Drug Enforcement Units. He said this is important because while talking about treatment there must also be talk about enforcement and the criminal. Alaska cannot just arrest its way out, but the state can't just treat its way out of this either, it's a balanced approach. He advised that drug trafficking organizations (DTOs) and cartels are coming into Alaska. Enforcement units need to be focusing on those individuals who are feeding on the misery of Alaskans and hooking Alaskans to these substances, while DHSS in partnership with the troopers and other agencies works on enhancing and building the capacities of treatment capability. In addition to the troopers there are narcotics interdiction teams. These teams are made up of local, tribal, state, and federal agencies.

3:23:45 PM

MR. JONES displayed slide 13 and noted that about 80 percent of the offenders in custody with the Department of Corrections (DOC) struggle with substance abuse. Thirty percent of the offenders who are assessed report abuse of opioids, probably one of the state's biggest populations when it comes to substance use disorders. The Department of Corrections has been building a comprehensive substance abuse program. Currently, vivitrol is

used for medication-assisted treatments (MATs) in DOC's programs. Upon re-entry or release, an offender will receive this shot if he or she qualifies, and then the offender goes through the re-entry service programs and is connected to the community. The DOC is looking at increasing the footprint of MAT, which could include things like bridging with methadone or integration of suboxone. Getting offenders treatment and care from day one is much better than giving them treatment and care a month before release.

MR. JONES turned to slide 14 and discussed policy, partnerships, outcomes, and results. Regarding partnerships he said DHSS is currently working to implement the patient Voluntary Non-opioid Directive that was signed into law by a previous governor. The department now has the authority to emergency schedule a substance if it's on the federal list, allowing DHSS to take immediate action if a trend is being seen in a certain substance coming through a community. First-time opioid prescriptions are limited to no more than a seven-day supply with exceptions; the exceptions help with rural Alaska. As of 7/1/18, the controlled substance prescription database was required to be updated daily, which has been instrumental.

3:26:05 PM

MR. JONES addressed slide 15 regarding community coalitions. He said isolation fuels addiction and community provides the cure and the groups listed on the slide are the true boots-on-the ground individuals. [Mat Su Opioid Task Force, Anchorage Opioid Task Force, Juneau Opioid Work Group, Fairbanks Opioid Work Group, Southern Kenai Peninsula, Change 4 Kenai Coalition, Aleutian Pribilof Islands Opioid and Substance Misuse Task Force, Ketchikan Substance Abuse Task Force, Bristol Bay Opioid Task Force, THRIVE Mat Su.]

MR. JONES moved to slide 16 and discussed prevention with partnerships. He reported that Project HOPE (HOPE stands for Harm reduction, Overdose Prevention, Education) currently has 102 overdose response programs; has distributed 18,000 overdose rescue kits; and has saved over 260 lives. He explained that the number of lives saved is much higher than 260, but 260 is the documented number. Regarding the medication deactivation disposal bags, he reported that 46,000 bags have been distributed since 2017, which represents a potential reduction of over 2 million pills in the state. In addition, DHSS and the Department of Education and Early Development developed a teaching module called Opioids and Opioids Epidemic 101 that is

available to teachers and parents. There is also first responder training, which is a compassion fatigue training because first responders get exhausted from seeing this every day and often seeing the same individual. As well, consideration is being given to implementing a Fatal Overdose Death Review Committee that would look at the cases to see if policy and prevention are working.

3:28:26 PM

MR. JONES spoke to slide 17 regarding partnerships, outcomes, and results of enforcement. He explained that the designation of a High Intensity Drug Trafficking Area (HIDTA) has been received, which is important and can be equated to the special operations of narcotics. This designation brings in about $2.5 million annually from the U.S. Office of National Drug Control Policy. This funding goes to the various task forces outlined on [slide 15], thereby increasing the footprint to do things like better interdiction and information sharing so it can be understood what is being seized throughout the entire state. Better private sector partnerships are also being developed and paying for overtime for officers. A director has been hired to build the system in partnership with DHSS's local, state, and federal partners.

MR. JONES displayed side 18 and elaborated about the partnerships, outcomes, and results of strategic direction. He said DHSS traveled to 15 communities in 2018 to conduct Community Café events to build a Statewide Opioid Action Plan. The department also went to other communities and held townhall events. In the Community Café events DHSS spent one day meeting with the medical community to understand what the barriers and gaps are and another day meeting with community members about prevention, treatment, re-entry, criminal justice population, what is currently in the community, what's not working, what are the barriers to change, and what is needed. The University of Alaska Anchorage (UAA) and DHSS compiled this data and then DHSS brought in 100 experts from across the state to spend two and half days building a plan. The plan is a long-term approach and will be used to help fund future coalition activities through federal grants.

3:31:00 PM

MR. JONES turned to slide 19 regarding the preliminary results of the number of opioid-related overdose deaths in the U.S. He reported that the percent-age-adjusted rate in deaths increased

from 6.1 in 1991 to 21.7 in 2017. In 2018, Alaska saw downward trends across the board. For example, in drug overdose deaths in 2015, Alaska had an age-adjusted rate of 16 percent, which increased to 17 percent in 2016, then increased again to 19.3 percent in 2017, and in 2018 it decreased to 11.9 percent. While the rest of the U.S. is battling fentanyl, Alaska went from 28 fentanyl deaths in 2017 to 7 deaths in 2018. However, Alaska still has lots of people who need to get into treatment and many people are still dying. He attributed the decline to the combination of hard work and sense of community in Alaska, the partnerships helping to remove the stigma of use, and the use of naloxone. The downward trend, he said, doesn't mean Alaska can sit back and think the job is done, it means Alaska needs to remain diligent.

MR. JONES discussed the next steps outlined on slide 20. He said these next steps include a transition out of the Incident Command System (ICS) and going more towards the long-term recovery approach. Execution of the Statewide Opioid Action Plan needs to be continued as part of the next steps. Other steps include implementation and building of the Alaska High Intensity Drug Trafficking Area. As well, the next steps include continuing to secure more federal funding to build capability and capacity.

3:33:25 PM

REPRESENTATIVE TARR drew attention to slide 7 regarding poly-substance misuse and noted that in her work in Anchorage she has heard the term "garbage addict" for people who will use any kind of substance that they can obtain. She asked how a person addicted to alcohol is defined and what "addicted to" means in that context.

MR. JONES replied that a person using multiple substances might get counted more than once. He said he would consult with the state medical officer and get back with an answer as to how the medical officer picks a substance and defines it. When multiple substances are found in the body it often will be attributed to poly-substance. Regarding "garbage addict," he said he personal believes that this term would put more of a stigma on an individual. He said he doesn't even like the term "addict" and would prefer it be called "somebody who is struggling with substances" to reduce stigma and prevent these people from being returned to the shadows.

REPRESENTATIVE TARR pointed out that people who are compromised by their health conditions might be willing to use substances that are typically considered recreational drugs, for example anti-anxiety medication, as opposed to substances that are considered recreational drugs.

MR. JONES concurred. A problem is being seen with stimulants, he said. People don't understand what a stimulant can do if misused and what a stimulant can do if misused with an opioid. That is some of the messaging that DHSS wants to get out. Through partnering with methadone clinics and drug testing companies, things like gabapentin are coming up on the radar. Through this public health work, radar is being kept on all the different systems to see what the trends are and to then begin messaging and education prior to enforcement.

3:36:57 PM

CO-CHAIR SPOHNHOLZ said one of the things she learned from Dr. Butler was the value of medication-assisted treatment (MAT), particularly for opioid addition. She inquired about the barriers to accessing medication-assisted treatment.

MR. JONES responded that there is a definite stigma associated with treatments. There has been a movement from substance use as a stigma to the treatment use and that feels like more of a battle in the communities. What he means by that is suboxone versus vivitrol, abstinence versus MAT, and he sees that as one of the biggest barriers other than building capacity and capabilities on services across the state and doing it appropriately with the medication aspect of it as well as assisted therapy. It must be ensured that the providers who are popping up are providing a complementary service. Getting past the stigma of MAT is needed.

3:38:33 PM

CO-CHAIR SPOHNHOLZ noted that the history of the recovery community is an abstinence-only model, which doesn't work for everyone because moving away from dependence is a physiological process that takes a lot of time. Dr. Butler related to her that diabetics wouldn't be told they didn't need insulin and they should just muscle through it. The same is true for people who are experiencing withdrawal from opioids; the person's body must change significantly and access to medication can be access to a normal productive healthy life. She asked whether there is anything beyond vivitrol for MAT in Alaska's prisons.

MR. JONES answered that vivitrol is currently the only thing and he would love to see this changed in Alaska's prisons; other states have been introducing suboxone. He related that he shadowed someone who was released from jail and this person struggled with going to treatment and having a job because it was very difficult. He said he thinks that if MAT and other treatment were begun as soon as a person entered jail, rather than a month before release, the recidivism rate would drop.

3:40:49 PM

REPRESENTATIVE DRUMMOND requested that an easier-to-read copy of the response structure on slide 8 be provided to the committee. She said numerous constituents have contacted her because drug takeback doesn't happen every day and she has distributed drug disposal bags to these constituents. She asked how to get the word out about the drug disposal bags and where to obtain them. She further asked where the disposal bags should be disposed of once they have been filled with medications.

MR. JONES agreed to provide the committee with copies of the appropriate slides on response structure. He said he would provide drug disposal bags to those committee members who send him their email addresses.

REPRESENTATIVE DRUMMOND asked whether drug disposal bags could be made available at all pharmacies in the state.

MR JONES replied that there is no sustainable long-term funding source for this. He said he would like for pharmacies to purchase the bags and provide them for discount or free, but it may not make sense for a business model. However, it would make sense for community-based models. He said DHSS is having the different coalitions distribute the bags because it is a great way for them to connect with individuals who are struggling and with individuals who don't understand the opioid epidemic or addiction. If he had unlimited funding and an unlimited supply of the bags, he would have them everywhere.

3:44:17 PM

REPRESENTATIVE TARR expressed her surprise at hearing there is a stigma around going to treatment. She requested Mr. Jones to elaborate further.

MR. JONES responded that the recovery community was very abstinence based and everyone is learning as they go along. He said treatment plans are extremely important in this epidemic. Somebody who has been using for 30 years may be on suboxone for forever, but maybe somebody who has used for 15-20 years could be on suboxone under a step-down plan. The recovery community has been asking for that. In the criminal justice world, abstinence based is a lot more eye opening and probably more appropriate than a non-abstinence based. When courts across the country tell someone on suboxone to taper off and get on vivitrol it puts a stigma on people and doesn't work and is why there is a high failure rate. He noted that DHSS has been working on use and now it is working on treatment.

3:46:27 PM

GENNIFER MOREAU-JOHNSON, Acting Director, Division of Behavioral Health, Department of Health and Social Services (DHSS), provided a PowerPoint slideshow titled "Division of Behavioral Health." Displaying slide 1, she explained she will describe how the division oversees services, how it is currently delivering services across Alaska, how it got here, what the challenges are, and where the division is looking to go. Addressing slide 2, she said the programs and services overseen by the division include: Prevention and Early Intervention, Alcohol Safety Action Program, Tobacco Compliance Unit, Treatment and Recovery Grants Services, and Behavioral Health Medicaid Services. She noted that, for the division, the use of the word "prevention" is a specific reference to preventing these conditions before the behavior starts.

3:48:20 PM

MS. MOREAU-JOHNSON showed slide 3 regarding Prevention and Early Intervention. She said the division engages with communities to determine community needs and form coalitions. These coalitions and grantees use the Strategic Prevention Framework (SPF), which is from the federal Substance Abuse and Mental Health Services Administration (SAMHSA). Through these SPFs, coalitions assess, plan, strategize, implement, and evaluate community-based services. Every community and coalition is different, but one example is the positive messaging of the Be(You) Initiative that is aimed at preventing underage drinking by challenging the misconception that most teens drink. She said 78 percent of Alaskan teens do not drink alcohol and noted that Be(You) campaigns are active in ten locations throughout Alaska. Moving to slide 3, she played a video from the Be(You) Initiative.

3:50:30 PM

MS. MOREAU-JOHNSON noted the Be(You) Initiative is funded by state dollars through the Division of Behavioral Health. These state dollars leverage other funders of the initiative, which are: Alaska Native Tribal Health Consortium, the Mat-Su Health Foundation, Rasmuson Foundation, Alaska Wellness Coalition, and the Mental Health Trust Authority. With all those funders there is a keen interest in knowing how well it's doing and the Youth Risk Behavior Survey (YRBS) assesses how well it is working. This survey, done every two years, asks specific questions about teen drinking.

MS. MOREAU-JOHNSON said that during fiscal year (FY) 2020, statewide and local community partners will assemble a statewide alcohol prevention alliance to revise and to implement the moving of prevention upstream. That is the strategic plan for underage drinking and adult binge and heaving drinking in Alaska. It is anticipated that the plan will include community-based intervention, statewide intervention, mass-reach health communications, surveillance and evaluation infrastructure, administration and management, and will promote screening, brief intervention, and referral to treatment.

3:52:12 PM

MS. MOREAU-JOHNSON stated that the graphic on slide 5 shows the intersection and efforts around substance use disorder (SUD) treatment, which is when the problem appears. She explained that primary prevention is the effort to prevent these conditions from ever happening and SUD is the early intervention of the continuum. The graphic depicts the intersection and efforts across various components that are all part of the system. These components are made up of services that an individual may have contact with and that identify the person as someone who needs help. They are the treatment and recovery providers and services, the agencies that provide the grant funding, agencies that receive the grant funding, data sources, and data sets. The graphic identifies these at the community, state, and federal levels - the components interact with each other within a ring and flow both inward and outward within the circle. For example, data about an individual may end up at the federal level in the Treatment Episode Data Set (TEDS), while funding from the federal level gets funneled through the state down to the individual.

3:53:46 PM

MS. MOREAU-JOHNSON requested committee members to keep the image of this graphic in mind as they look at slide 6, which depicts the distribution of SUD funding by service area and program type across Alaska. She said slide 6 illustrates much effort and great achievement on the part of the state, federal government, and provider agencies in piecing together a system. But, she noted, it also represents a system that is pieced together. Using state general funds, a myriad of federal grants, and Medicaid - each with its own reporting and management requirements and each with its own set of unique regulations - the result is that there are these services, which is good, but service providers are struggling to keep on top of the administration and yet still provide the service. It also ends up with an uneven distribution based on a variety of influences for how these how these services are available across the state.

MS. MOREAU-JOHNSON continued discussing slide 6, pointing out that Alaska has 26 outpatient programs specifically funded by the Division of Behavioral Health for SUD treatment, including youth. The state also has four methadone clinics - one in Wasilla, two in Anchorage, and one in Fairbanks. Alaska has 366 medical professionals certified to treat addiction using buprenorphine and 22 residential treatment programs which is 300 beds, four women and children's programs, and three youth programs. While the graphic shows that Alaska has a lot, it also represents the fragmentation. She said she will be discussing some of the division's solutions, which includes reducing the administrative burden to providers by onboarding the administrative services organization with a performance measure of reducing the administrative burden on providers providing these services.

3:56:10 PM

CO-CHAIR SPOHNHOLZ observed the chart on slide 6 shows that for 2019 Alaska will spend $26.8 million in addition treatment. That is just in the grants, she pointed out; missing from the chart are the Medicaid payments for substance abuse treatment. She cited another chart that was provided to her earlier by DHSS, which showed that in 2015 Alaska spent about $38.5 million on addiction treatment through Medicaid billing and by 2018 that number was up to almost $151 million. Co-Chair Spohnholz said this other chart further showed that Alaska went from about 13,000 people getting addiction treatment through Medicaid billing in 2015 to about 30,734 in 2018. This big piece of

Alaska's addiction treatment system isn't shown in the chart on slide 6. She said she will provide committee members with this chart because it is important to know that most addiction treatment in the state of Alaska is being paid for by Medicaid.

3:57:44 PM

MS. MOREAU-JOHNSON moved to slide 7 and said Medicaid coverage for SUD treatment is essential funding to the state for treatment and is also how [the state] looks forward to developing a more robust continuum of care. It is anticipated that implementation of Alaska's Section 1115 Behavioral Health Waiver ("Section 1115 Waiver") will expand funding to include federal match, which will be a more sustainable source and the continuum will be equally distributed regionally across the state. The Mental Health Trust Authority has funded an infrastructure analysis study by the division that is nearing completion. Given these new federal funding opportunities for the Section 1115 Waiver and the new federal funding opportunity through the Family First Prevention and Services Act, this gap analysis explored the capacity of existing service providers to leverage these new funding sources, including Medicaid, in order to expand existing services or onboard new services. The division and the Office of Children's Services (OCS) visited 14 communities [Anchorage, Mat-Su, Fairbanks, Soldotna, Homer, Nome, Kotzebue, Utqiavik, Bethel, Juneau, Sitka, Ketchikan, Kodiak, Dillingham]. At this point the division has met face-to-face in these communities with 68 agencies across Alaska and has about 6 left to go. The visits allowed candid and deep conversations with providers about what it means to them to bring on the Section 1115 Waiver. Specific data is being collected related to the volume of screens in and out, child protective service reports, and the number of children in custody. The report will include recommended actions and will be complete and available to the public by summer's end.

4:00:05 PM

MS. MOREAU-JOHNSON concluded with slide 8 regarding the Section 1115 Waiver demonstration project, which was required of the department in 2016 through Senate Bill 74. She related that the state submitted its application in 2018 and received its first approval from the Centers for Medicare and Medicare Services (CMS) in November 2018. Alaska received approval from CMS to fast track its substance use disorder components of the Section 1115 Waiver and has negotiated an implementation plan with CMS. The approved implementation plan is available to the public on

the division's website. The division is now getting regulations in place and is targeting July 1 implementation of the SUD services through the Section 1115 Waiver. She noted she has distributed the list of services that are approved, and it is the full continuum from community-based services all the way up to exemption from the Institutions for Mental Diseases (IMD) exclusion for facilities of 16 beds or more.

4:02:11 PM

CO-CHAIR SPOHNHOLZ stated she is thrilled that the Section 1115 Waiver includes allowing for larger facilities because a 16-bed facility is a financial strain. She requested Ms. Moreau-Johnson to elaborate about the community-based services.

MS. MOREAU-JOHNSON replied that "a bucket of services" is being offered through Community Recovery and Support Services. She said she calls it a "bucket" because it includes component services. These component services include peer support; assistance navigating social services, including housing assistance and transportation; support in employment, which is essential for the recovery model of care; and case management. These multiple component services are delivered to the individual in the community setting to help people recover fully and become contributing members of their community.

CO-CHAIR SPOHNHOLZ requested Ms. Moreau-Johnson to explain how people will be identified as eligible for these services.

MS. MOREAU-JOHNSON responded that anyone with a substance use disorder diagnosis would be eligible for this full array of services. People will be identified as the Section 1115 Waiver demonstration project promotes universal screening. Screening, brief intervention, referral, and treatment are being implemented in every setting from hospitals to primary doctor offices. Provider roundtables are being used to identify the best screening tools, practices, and assessments for universal screening.

4:04:36 PM

MS. MOREAU-JOHNSON returned to slide 8 and added that [the division] is continuing to negotiate for the services in the remaining sections of the Section 1115 Waiver. Relevant to what the committee is looking at is the target population of at-risk family and youth. Addressing adverse childhood experiences is a way to bend the curve. At-risk families and youth population

will be identified through screening for indicators of adverse childhood experiences, one of which is substance use in the home. If at a well-child check a child is identified as living in a substance use home, the child would be eligible to receive in-home support to help the family remain whole and healthy.

4:05:54 PM

BRADLEY GRIGG, Chief Behavioral Health Officer, Bartlett Regional Hospital, stated he will describe what the hospital is seeing in the patients it is serving. He said Bartlett Regional Hospital has a broad addictions program on its campus that includes a co-ed adult residential treatment facility of 16 beds. Mainly because of the IMD exclusion, Bartlett has had to attend to this business model in order to bill Medicaid for its services, which is about 95 percent of its population both pre- and post- Medicaid expansion. Bartlett is therefore excited about the possibility of the Section 1115 Waiver helping the hospital to expand its [residential treatment facility]. Through funding by the City and Borough of Juneau and Bartlett general funds, the number of residential treatment beds is being expanded. As well, four specific withdrawal management, or detox, beds are being added to the Rainforest Recovery Center facility, which will provide detox for alcohol and opioid withdrawal. The bid has been awarded for the project and construction will begin in about two months.

4:07:58 PM

MR. GRIGG stated that Bartlett wasn't waiting for its referrals and numbers to increase in order to expand; rather, it was waiting on an opportunity for the IMD waiver so Medicaid could be billed. He explained that if Bartlett had had more than 16 beds, it wouldn't have been able to bill for the patients on Medicaid, but now it will be able to do so. Bartlett is looking at a minimum of 20 beds total to help serve these patients and is also looking at as many as 24 total and that would include the detox patients. Given Bartlett is a hospital, it has been able to provide detox services for years, which is done on its medical floor as a medical service. The challenge has been with the opiate piece because it is a very different level of withdrawal - the medical concerns and the risk associated with opiate withdrawal as opposed to alcohol withdrawal is very different. Bartlett is grateful for the opportunity to build these beds that will address its ongoing needs for alcohol detox as well as opioid detox.

MR. GRIGG related that Bartlett-specific data reports show that over the last three years alcohol has been the number one drug of choice on patients' self-reports. In FY 2018, four out of five of Bartlett's patients, 80 percent, reported that alcohol was either their number one drug of choice or their only drug abuse. Over the last three years the hospital has learned that drug abuse is not a monogamous relationship when it comes to individuals struggling, so a poly-substance approach is being taken. Ironically, compared to three years ago, Bartlett has seen a distinct shift in the patient populations it is serving. Alcohol has now gone from 80 percent to below 55 percent as the drug of choice on the self-reports, with the other 45 percent split evenly between methamphetamines and opiates. It doesn't mean those individuals aren't using alcohol, it means that their self-reported drug of choice is now opiates and methamphetamines over alcohol.

4:10:41 PM

MR. GRIGG said that in addition to its residential treatment and detox, Bartlett also provides outpatient substance use services to kids and adults. The Division of Behavioral Health recently awarded Bartlett a combination capital and operational grant to build a crisis stabilization program for adults and kids ages 10 and up. Two separate programs will be housed in the same facility that will serve behavioral health needs as it comes to mental health crisis stabilization, but also substance use stabilization that could be in the form of 23.5 hour observation for a person who is intoxicated and possibly suicidal at the same time. But it does not have the capacity for Bartlett to be able to put them in its inpatient mental health unit.

MR. GRIGG noted that Rainforest Recovery Center, like many others, is serving individuals statewide. On any given day 16 patients are in the 16-bed facility. Over the past 6 months, a bed is only empty when someone has had to be discharged and the center is waiting on the arrival of the patient that the bed has been obligated to. As of today, 12 of the 16 patients are not from Southeast Alaska. A challenge is that as soon as people are moved in and the beds full, there are also people on the waitlist. Today, 13 people from all over the state are on the waitlist to get into treatment. The average length of stay in the program is about 24 days, so a three-week period is used to say how quickly someone can get in. This bottleneck effect at Rainforest has a statewide impact because the center takes individuals from across the state. Juneau and Southeast Alaska individuals are treated, but the waitlist is prioritized based

on who has come to the table for acceptance first and possibly who has the most complex needs.

4:13:31 PM

MR. GRIGG said a challenge seen every day with patients is that along with addictions, patients are also struggling with co-morbidities around medical conditions, such as diabetes and hypertension. Twenty beds are not going to meet the need, but Bartlett believes these [four] additional beds can be added without putting extra pressure on its staffing outside of adding additional psychiatric and medical coverage, which is critical to the service it delivers. Adding these beds will help be a part of the solution even though Bartlett is only one agency of many doing that.

MR. GRIGG noted that Bartlett also provides medication-assisted treatment, both in its residential and its outpatient programs, in the form of suboxone and vivitrol. There are no methadone services per se in Juneau or Southeast Alaska.

4:14:52 PM

CO-CHAIR SPOHNHOLZ asked about the number of people that can be served in Bartlett's outpatient program for addiction treatment.

MR. GRIGG replied that Bartlett currently has just under 100 individuals in outpatient treatment for addictions. Bartlett's outpatient program serves both mental health and substance abuse and co-occurring disorders. The caveat is that the number 100 is where substance abuse is primary over mental health. Bartlett has 200 active patients in its outpatient program. Of those other 100, the majority also have addiction history or current experiences with addictions, but mental health seems to be their driver at the point in time when it gets to why Bartlett is serving them.

4:15:50 PM

REPRESENTATIVE DRUMMOND inquired whether the Section 1115 Waiver limitations are what kept Bartlett from growing beyond 16 beds.

MR. GRIGG answered that that was a major driver; it definitely wasn't meeting the need. Sixteen was the maximum we've done for over two decades now mainly because of the IMD exclusion.

REPRESENTATIVE DRUMMOND observed from a list of facilities provided by the co-chair that most are 16 beds or under.

CO-CHAIR SPOHNHOLZ responded that this is because of the Institutes for Mental Disease limitation on billing at the federal level, a federal regulation that was passed a long time ago. That rule was put into place because in the Lower 48 there was a problem where people who experienced mental illness were often housed in large institutions that operated more like prisons than health care facilities. It had good intentions and resulted in the de-institutionalization of people that had primarily really been warehoused for mental health issues or developmental disabilities. An unintended consequence was to not be able to have mental health care facilities and substance abuse treatment facilities that were economic to operate. Many states are applying for waivers that will allow them to have larger facilities given there is now a more patient-centered model for doing things rather than warehousing people.

4:17:57 PM

MR. GRIGG returned to his testimony, stating that since Senate Bill 91, the criminal justice reform bill, went into effect two fiscal years ago, a growing number of referrals are coming from the Department of Corrections (DOC) for individuals re-entering the community. So, a new dynamic is the challenge of what is called a bed-to-bed transfer. Having an available bed when an individual is discharged from corrections and getting that person from bed to bed is critical because a lot can happen in the time from discharge to the time to the hospital. With these additional beds, Bartlett is trying to increase that access for bed-to-bed transfers because it will give these individuals a better chance of being successful as they exit.

4:19:02 PM

CO-CHAIR ZULKOSKY asked whether Bartlett has a prioritization process for the wait list; for example, pregnant women or people who have had close encounters with overdoses.

MR. GRIGG replied that federal regulations guide part of the hospital's practice around priority populations and includes pregnant women and intravenous (IV) drug users. When looking at the wait lists, those rise to the top no matter where they are coming from in the state. Those two priority populations are actively served in Bartlett's program.

4:20:07 PM

SHERRIE WILSON HINSHAW, President & CEO, Volunteers of America-Alaska (VOA), explained VOA is an Alaska-based company providing behavioral health services to youth since 1981. She said VOA has a residential substance abuse treatment program, a 24-bed facility, in Eagle River; outpatient and intensive outpatient programs in Anchorage; and prevention and early intervention services in Anchorage and other areas. The VOA serves youth all over the state, the primary ages served being 13-24. With that, VOA has affordable housing, family and senior housing, a youth-supportive housing program for homeless youth, and a kinship care program for families who are the primary caregiver of related children due to parental substance abuse in the house.

MS. WILSON HINSHAW explained that the youth seen at VOA are trying to fill a void. They feel lonely, scared, pushed aside, and are often self-medicating. There are impulsive behaviors given where they are in life and they don't have a fully developed pre-frontal cortex. When a chaotic home life and trauma are added in, they face multiple barriers. In working with them, VOA's goal is to help them grow, change, and overcome the obstacles. The journey of recovery looks different for different people and VOA is helping them find meaning and purpose in their life beyond just what their substance use profile says. The impact of trauma and addiction in communities is seen by VOA daily and VOA sees the state as a partner in this work. Having served families in Alaska for decades, VOA has been through times of instability and fiscal challenges, but these last few years have been unusually difficult for VOA and many other organizations.

4:22:36 PM

MS. WILSON HINSHAW related that the Anchorage Health Department undertook a comprehensive community assessment around substance misuse, which it recently presented to an assembly committee. That assessment echoes what VOA sees in its work on a daily basis, which is: alcohol remains the most misused substance, stigma around behavioral health treatment remains a barrier even though gains have made, lack of treatment options and realities prevent access to care, methamphetamine use and vaping are increasing, and the effect of adverse childhood experiences and inter-generational trauma are all factors that need to be focused on. Substance use disorder (SUD) rates of Anchorage youth are among the highest in the nation - 6.54 percent compared to the U.S. rate of 4.13. The teens and high school

students seen by VOA is around the misuse of alcohol, vaping, marijuana, tobacco, and prescription medications.

MS. WILSON HINSHAW said she will discuss the three major areas that constitute the reality of life as a provider in trying to deliver these services: 1) the mission and reasons why VOA is doing this work; 2) gaps in the system; and 3) stability of the system. The reality of being a treatment provider, she explained, is operating in a business environment - VOA must run a business that is consistent and available for those who are seeking care; funding and system decisions affect VOA's ability to consistently deliver those services and grow to meet the needs of the community. There is a high level of uncertainty with funding. It is hard to imagine another system where the expectation is to grow to meet demand and live in an uncertain funding system when lives are really on the line. This means that families seeking services don't know where to go, they can't get the care they need at the right level, or they can't get the full continuum of services that they need. Funding availability directly ties into VOA's ability as a provider to hire clinical staff to deliver those services, which ties directly into VOA's ability to serve the number of individuals that need VOA's services.

4:25:10 PM

MS. WILSON HINSHAW advised that VOA sees gaps in the system around work with parents - working with the whole family is not currently a reimbursable service. She said the Section 1115 Waiver does address some of the gaps, but there are concerns. Partial hospitalization is a gap in the system, especially for youth, where they can access the same level of clinical intensity of services that they would in residential except go home at night. Some states are using this model to do recovery high schools where it is really centered around recovery and trauma-informed care while [the youth] are addressing deficits in education and continuing in their high school. She pointed out that peer mentoring and support is another gap that is included in the Section 1115 Waiver, which VOA is happy to see. Prevention, she continued, is also a gap in the system. As seen on the chart shown earlier, about $2 million is provided for prevention. Clearly not enough is being invested in prevention in a way that is needed going upstream. Some amazing professionals across Alaska are taking that investment in prevention and turning it into meaningful things, such as the community coalitions of which VOA is a participant. Those coalitions are a part of distributing naloxone kits, but more

must be done in prevention so there can be a shift away from being a crisis response system.

4:27:10 PM

MS. WILSON HINSHAW addressed the level of uncertainty and a well-functioning system. She noted that a system itself is an interconnected set of elements that are organized in a way that achieves something. The Alaska behavioral health system is often focused on crisis management versus prevention or being a responsive system that changes as the environment changes and as community needs change. On the continuum of health promotion, prevention, early intervention, treatment and recovery, the state must look at how to adequately address all those areas.

MS. WILSON HINSHAW explained that VOA teaches its clients to not be reactive, to respond in the moment, and to regulate emotion so they can make the best possible choice. That parallels the many wonderful things in the Section 1115 Waiver, which addresses so many gaps in the system. But, she cautioned, the devil is in the details because VOA's current reality as a provider is that rates do not cover the cost of care. It has been a great expense to VOA to continue to provide services that it knows are needed and to meet VOA's mission. Even the recent Medicaid rate increases in January [2019], which VOA is thankful for, do not cover the cost of care and limit an organization's ability to grow to meet the need of the community.

4:28:52 PM

MS. WILSON HINSHAW noted there are a high number of unknowns in the timeline of implementing the Section 1115 Waiver - what that will look like and how that will change services on the street for those seeking the services and those families in care. She urged that thought be given to rolling out change in manageable steps so that the system isn't destabilized by trying to change too much too quickly. She offered her hope that committee members will come away from today's presentations with an understanding of the reality of trying to offer these services and that without the certainty of stable and consistent funding, it is difficult for providers to confidently deliver and grow those services that they know are needed. There must be a shift away from being a reactive system and being crisis driven. This means looking at the whole continuum of care and then rolling out changes in manageable steps that don't destabilize what is already had. She thanked the committee members for what they do to address community needs and substance misuse.

4:30:44 PM

CO-CHAIR ZULKOSKY addressed Ms. Wilson Hinshaw's comments about not destabilizing the system and the need for stable resources to provide reliable treatment support for those individuals needing it and providing opportunities for providers to grow their programs. She said this really resonates, especially with the backdrop of all the financial decisions and challenges that the legislature is currently grappling with. She requested identification of the specific revenues coming into programs.

MS. WILSON HINSHAW replied that the $26 million in comprehensive behavioral health treatment and recovery grants is the gap filler that funds everything Medicaid won't. So, any cuts to that -- she offered her belief that cuts are proposed right now. She said the purpose for bringing the Section 1115 Waiver online on [7/1/19] would correspond with grant cuts, so having grant cuts at the same time as adapting to a new system with many things yet undefined is very concerning for providers. In particular, she was referring to those cuts.

4:32:33 PM

CO-CHAIR ZULKOSKY surmised Ms. Wilson Hinshaw was online when Co-Chair Spohnholz talked about the significant amount of investment Medicaid has made in treatment services. She surmised Medicaid treatment funds are critical to maintaining moving forward.

MS. WILSON HINSHAW responded that Medicaid rates for behavioral health were not adjusted for over 10 years and do not cover the cost of care even with the [recent] increases. Any cuts to Medicaid directly impact VOA's ability to deliver services.

CO-CHAIR ZULKOSKY asked about the impact that would be seen at the community level if cuts were made to Medicaid funding or to the aforementioned grants.

MS. WILSON HINSHAW replied the impact would be a lessening of what availability the system does have right now. For example, VOA would have to lower staffing in its outpatient, intensive outpatient, and residential treatment programs to a level that VOA could sustain. This would mean VOA serving less youth who are coming in for services.

4:34:40 PM

LANCE JOHNSON, Director, Behavioral Health Services (BHS), Norton Sound Health Corporation (NSHC), offered his appreciation for the comments of his colleagues, stating they highlight the issue that is being addressed, which is the rampant substance misuse concerns that are had throughout the state. He said he will provide a rural perspective and highlight some positive developments in Nome that can also benefit the state as well, namely the wellness center that is being built and a day shelter that has been opened.

MR. JOHNSON stated Norton Sound Health Corporation operates the only hospital and behavioral health services in the entire Bering Strait region, which includes 15 remote villages and the home community of Nome. The region is 24,000 square miles with 9,869 people and is only accessible by airplane. He has been the director for behavioral health since 2012, he continued, and the needs are high and are visible. Committed partners in the region collaborate around common concerns that impact the wellbeing of residents. For example, in recognition of public concern about substance misuse in the region, a public safety coalition was put together in the last month to examine basic needs, wellness, and substance misuse, and to develop strategies working outside of the silos with a goal of achieving measurable and sustainable change. These partnerships are wholly important to the region where localized care and treatment can have most effective change. The State of Alaska has been a committed partner in many of these efforts through grants, collaboration with tribes and tribal entities, and to do expansion efforts.

4:37:10 PM

MR. JOHNSON said the negative is that there are glaring needs and the issue is recognized throughout the state, but the positive is that Norton Sound Health Corporation has devoted staff and resources to projects that help with that substance misuse. The significant contribution of historical, inter-generational, and other trauma cannot be overlooked, he advised; it is often masked through substance misuse by the people of the region. The corporation opened a day shelter on 12/29/18 to offer a warm weather and safe place for the several people seen on the streets who were chronically homeless and at varying levels of intoxication. The idea was to keep them safe but to meet them where they are. It is foolish to think that everyone who has a need is going to walk through the doors of behavior health ready for treatment. Change and recovery will not always occur within the four walls of a clinic. People need to be met

where they are, and trust and rapport need to be built. The day shelter operates seven days a week 8:30 a.m. to 7:30 p.m. Since opening it has served 122 unique individuals. Nearly 100 percent of the individuals have claimed homelessness and are misusing substances. On triage forms all of them have said that their top priorities are housing, employment, and treatment. The day shelter is very grassroots. It's small and is not the greatest setup physically in comparison to more established shelters throughout the state, but it is an important need in the continuum of care in this region.

MR. JOHNSON stated that BHS currently offers outpatient mental health and substance misuse services. While wholly important treatment options, they are not enough. A whole continuum of care is necessary anywhere to address the multitude of needs any one group of people may have. Because of this, NSHC has worked on developing a wellness center that will offer a full continuum of outpatient, intensive outpatient, day treatment, and a sober housing that will replicate residential treatment. This means people will be able to come in from the region's villages and have a place to stay while receiving treatment for however long that may take. A sobering center within the wellness complex will serve as an entry point for many people into the other services. It has been a nine-year project with planning support from the Alaska Mental Health Trust Authority. So far, NSHC has secured $7.1 million towards the project, with much of that invested by the corporation. Another $8.3 million is needed. Pylons were put in the ground this past year.

4:40:04 PM

MR. JOHNSON pointed out that these are important efforts in the region because localized care is the most effective care and right now the region is grossly limited. Building and operating the wellness center will allow people to stay in the region surrounded by familial and social supports, which are imperative to successful recovery. As importantly, treatment will be culturally reflected and familiar to people because it is in their own region. When people are sent outside for substance misuse treatment they are most often isolated from their supports and their culture. The family component to treatment where people learn and recover together is often lost. Mr. Johnson said he is grateful for the services that are out there because recovery can have many hills and many valleys and is a lifelong journey. Staying home wrapped in supports and resources offers the better and more sustainable outcomes.

MR. JOHNSON shared the example of "Kenny," who BHS has been working with for the last two years. Over the years Kenny has had more days of intoxication than sobriety. In the last two months Kenny has been to the NSHC emergency room over 30 times, admitted to the inpatient unit three times, and arrested three times. He said Kenny's needs will only be met through high levels of care that are not had in the region. Through the first seven months of the relationship, Kenny would did not want to engage BHS services. But, through BHS's commitment to work with Kenny where he was at in his life and to offer support, a trusting relationship was built where NSHC was able to scrape beneath the masking substances and address those underlying co-occurring issues. The point, Mr. Johnson advised, is that it doesn't happen in a day, trust must be built to get to the core of the problem. Right now, Kenny can go to a 35-day program or he can wait for five or six months for a bed in one of the state's long-term residential facilities. A 35-day program has its place, but it took BHS seven months to build trust with Kenny and to gain daylight into his severe trauma history, the catalyst for his addiction. So, if Kenny could stay home and in the place where he has said he would feel safest getting treatment, and do that surrounded by his supports in his culture and in a care environment he trusts and opens up to, Kenny would spend a lot more time on the hills than down in the valleys.

4:42:37 PM

MR. JOHNSON expressed his appreciation for the committee's interest in looking at ways to partner with agencies that might have these capabilities. He said he is interested in having the opportunity to partner. A lot of infrastructure has been built in the urban areas, he noted, but there needs to be a new energy in building infrastructure in rural Alaska. The more that can be provided locally, the less strain will be put on an already overburdened and under-resourced system. The less he has to send people out of region for services and tie up those beds that Mr. Grigg has, the less it overwhelms the system, the less it costs in emergency room care, incarceration, and police resources because people would be getting the right care in the right place leading to recovery.

MR. JOHNSON explained that this happens best when rural communities have the same or similar opportunities as nonrural communities. For example, the State of Alaska released a Request for Proposals (RFP) for state opioid response peer support services on [11/21/18], but the opportunity was restricted to communities in urban areas. Further disheartening

was that one month later there was another opportunity that would have worked perfectly for NSHC that was only available in urban areas. While the needs of urban areas are just as real as those of rural areas, he said, the danger is that if investment continues only in the infrastructure of urban communities then rural communities will continue to depend on those out-of-region services, leading to more cost, more strain, and more people struggling to achieve recovery in the continuum.

4:44:52 PM

The committee took a brief at-ease.

4:45:18 PM

ADELE LANDROCHE, Advocate, stated she is a mother, grandmother, and a retired teacher. She spoke as follows:

> It is my hope that by coming before you I will leave you with some additional knowledge and insight into the world of addiction. ... Addiction is not just a disease of an individual, it affects family and friends of the addict as well. I am living proof of that. While my experiences have been difficult and sometimes tragic, I'm not all that different from any other parent of an addict.
>
> My three adult children have all struggled with substance abuse. My oldest son died of an overdose administered by his girlfriend who left him to die alone. My daughter struggled through two pregnancies fighting her heroine addiction and has emerged on the other side as a happy successful adult. My other son abused drugs as a teenager, went to treatment twice, and was clean for seven years until his brother died. He struggles with this and has been actively using for several years. He's been in and out of jail and was recently remanded in January. He wants to be clean; he wants to be happy and successful; he wants to be a good dad, son, and brother.
>
> However, he can't do it alone. It is not enough that his friends and family are there for him and that we support his sobriety. What matters is the resources that are available to him when he feels weak and lost. And when you have to navigate the system of assessments and admission paperwork in filling out

forms, et cetera, doing it on your own as an addict must be an insurmountable task. I'm hoping that by sharing my story with you and making the world of addiction a little more personal, will help you to understand, to have some insights into the challenges that the addict and his or her family faces.

4:47:47 PM

My son was remanded to jail in January and immediately started the process for admission into a residential treatment facility. His requests went unanswered or were rejected by corrections staff. In an attempt to facilitate his admission to treatment, I sent dozens of emails and made multiple phone calls with little success. Over the next couple of months, he was sent back and forth between Anchorage jail, Cook Inlet, and Goose Creek. It seemed like every time he started to make some headway they would transfer him. He continued his efforts to get on the list for an assessment and I continued sending emails and making phone calls, most of them went unanswered.

One [corrections officer (CO)] at Goose Creek, Kyle Thompson, took an interest in actually helping my son and facilitating this process and he finally got on the list for an assessment. ... Paperwork didn't get to the treatment facility's intake and so it was another series of emails and phone calls and help from the same CO at Goose Creek until the necessary documents were received by the facility. Then it was a waiting game until the bed was open for him. I'm happy to say that he's finally in treatment and is doing well.

Sadly, though, my son's story is typical of what happens within [the Department of Corrections (DOC)]. Lots of waiting, unanswered requests, and resistance. My son had the benefit of having me outside the system and fortunately for him I am someone who persevered until his assessment and admission were completed. Many inmates don't have this support.

I have also seen the same kind of process that other addicts have tried to work through outside of DOC to get into some kind of treatment program. There are very few detox beds in Anchorage and in the state of

Alaska, and if any of you know anything about addicts, if they're asking for help right now, it needs to happen right now. Addicts are known for their lack of persistence and follow through. Expecting someone who is actively using to make a phone call every morning to see if a bed is open and available is not realistic. The process of being admitted into a treatment facility is so cumbersome that many addicts either never begin the process or give up.

4:49:53 PM

Once a person is fortunate enough to go through detox, then it's a waiting game to get into treatment. I spent some time looking at the real-time chart of beds available and open beds in the state and much of it doesn't make sense to me. There are facilities that listed a number of open beds yet had a waiting list which went from a few days to more than a month. For instance, on May 3 the men's treatment program at Clitheroe has a total of 42 beds, 37 of them occupied, with 5 open beds, there are 24 people on the wait list, and the estimated days wait time for the next available bed is 45. If you were the addict waiting for your chance for an open bed, would that sound promising to you.

I have seen all kinds of wonderful plans in writing from different task forces and committees within the state, as well as the mission statements that DOC has published. This all sounds really good on paper; however, I see very little evidence of any of these great ideas being put into practice. We talk about crime in our state and I'm not an expert. However, I have done my fair share of research and a common theme that runs through many of the people who are committing crimes and are incarcerated is substance abuse.

We seem to be attacking this problem from many angles that don't seem to have a direct effect on reducing crime in our communities. I have listened to debate after debate and complaints from many people in the state talking about [Senate Bill] 91 and the problems that are inherent in it. I have heard very little focus on the causative issues such as substance abuse and support for people following incarceration.

Again, I'm not an expert, but I know how it goes. The person is released from jail, has no money, no job, no place to live, and very little support in the community, and they're back on the streets. They seek out the people that they previously have associated with in the community and return to the lifestyle that they were living prior to being in jail. This is a catch-22 for most of them.

4:51:50 PM

And even for those recovering addicts who truly want a better life and are making the effort to be a positive contributing productive member of society, it is truly an uphill battle. I don't wonder why most of these people don't succeed at staying clean and sober and being gainfully employed. I am amazed that some of them actually make it.

It is imperative that after identifying the underlying causative factors for addiction and crime in our state we actually develop a plan to address these issues that is reasonable, practical, and doable. We can't keep talking about it and doing nothing and expect things to get better.

4:52:36 PM

CO-CHAIR SPOHNHOLZ said she respectfully disagrees that Ms. Landroche is not an expert and offered her appreciation for Ms. Landroche's testimony.

CO-CHAIR ZULKOSKY commented that for someone who has endured such heartache, Ms. Landroche has provided a very concise, clear description of the need for treatment in Alaska. She thanked Ms. Landroche for courageously sharing what must be a very difficult story to share.

CO-CHAIR SPOHNHOLZ thanked Ms. Landroche for her courage and vulnerability in sharing her family story.

4:53:28 PM

DOUG WOOLIVER, Deputy Administrative Director, Alaska Court System, stated that Ms. Landroche's testimony highlights the great benefits of therapeutic courts, which remove the confusion and delay associated with trying to find a way into treatment.

He agreed it seems almost impossible to deal with all the things that must be dealt with, to find treatment, and to get into treatment. Therapeutic courts have contracts with treatment providers in locations around the state. Under that contract, once the person has shown an interest and looks like a good candidate, the person is assessed within five days for his or her needs. There is a bit of delay while the attorneys work out a plea agreement and ensure the assessment is appropriate and the person is a good candidate for the court. Under contract, once accepted, that person is in treatment within five days.

MR. WOOLIVER said the therapeutic courts provide help with housing, both finding it and through grants, particularly through Partners for Progress, which has been a tremendous champion for the therapeutic courts. It is a state funded grant and they provide emergent funds for people to help cover the first and last months' rent, a bus pass, and those types of things that could otherwise make trying to get into a treatment program or be successful in treatment all but impossible. Those types of programs are very helpful.

4:55:30 PM

MR. WOOLIVER reported that at any given time the therapeutic courts have about 280 people. More than 1,300 people have graduated over the years from therapeutic courts. Like corrections, the court system is a direct bridge between treatment and the criminal justice system. Corrections has treatment programs within its facilities and the court system has the therapeutic courts to provide treatment as means to keep people out of those facilities.

MR. WOOLIVER pointed out that one benefit of the therapeutic court program is the number of healthy babies that are born to someone who went through or is in the program. He related that between 15 and 20 women going through the therapeutic court programs became pregnant and gave birth to healthy babies. For example, a fetal alcohol spectrum disorder (FASD) child ends up costing the state in the long run. That doesn't count for the human tragedy of the syndrome itself. But it is also a crime reduction tool. The birth of a healthy baby is prevention, it is keeping an FASD baby from coming down the pipeline who is more likely to be in the juvenile justice and more likely to be in the adult correctional facilities. So, while the people in the therapeutic court are already in the system, the healthy babies are a piece of the prevention angle that comes out of the therapeutic courts.

4:57:40 PM

CO-CHAIR SPOHNHOLZ asked what percentage of the people working their way through the court system every year participate in therapeutic courts.

MR. WOOLIVER replied that it is a very small percentage. The therapeutic court has about 280 people at any given time, about 400 people over the course of a year, and there are thousands and thousands of people in the criminal justice system. It is a challenge getting people into therapeutic courts.

CO-CHAIR SPOHNHOLZ inquired how people get identified to participate in therapeutic courts.

MR. WOOLIVER responded that frequently people's attorneys or other people in jail will tell them about therapeutic courts. He noted that it's hard because the substance abuse courts are about 18 months long. Many of the people going into therapeutic courts have been to jail many times already and going to jail for 90 days isn't that big of a deal, but 18 months of intensive outpatient treatment is a big deal and people must be ready to do it before they will start down that path. That is why a lot of the therapeutic court's defendants are felons - there is more time hanging over their heads, more to avoid. He added that therapeutic courts are good programs, and more are wanted, but there are as many as possible for right now.

CO-CHAIR SPOHNHOLZ remarked that Mr. Wooliver has given the committee something to be hopeful about, although she hesitates to get hopeful about something that serves such a small number of people. She said she wishes that more therapeutic courts could be done in Alaska because she thinks they are great.

4:59:52 PM

ADJOURNMENT

There being no further business before the committee, the House Health and Social Services Standing Committee meeting was adjourned at 4:59 p.m.