HB

53

<TARGET><BILL>HB 53</BILL><SUBJECT>HB
53</SUBJECT><COMM>HHSS28</COMM></TARGET>

ALASKA STATE LEGISLATURE

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REPRESENTATIVE WES KELLER
DISTRICT 7

Sponsor Statement
HB 53

"An Act establishing a consultation requirement with respect to the prescription of opiates under certain circumstances.".

Today medical professionals have a long list and growing of medications to choose from to help their patients with pain, be it real or imagined. The level of pain relief medications being prescribed today and some of the reported unintended negative results is alarming. These opiate drugs are additive, and in the long term require larger and larger doses to provide that relief. Opiate drugs also have another more sinister reputation, illegal resale.

HB 53 addresses the issues of opiate prescription drugs head on by establishing a process for the patient and medical professional to work with a pain relief specialist on the actual drug needs. Medical Doctors, Dentists, Physician Assistants, and Nurse Practitioners will work together with pain specialists and patients to determine if the patient needs to increase the dosage above 120 milligrams the consultation process kicks in.

Pain verses addiction. Most patients may not know or realize the difference. Many doctors may not see their patients often enough or they have such a huge caseload that they miss the difference as well. HB 53 is a way to slow the process down by addressing the medications and the potential addiction factor with a goal of options.

HB 53 is an important step in identifying and helping reduce dependency on addictive drugs. It also provides a potential decrease in availability keeping those drugs off the illegal distribution system.

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28-LS0177\C
Martin
1/30/13

CS FOR HOUSE BILL NO. 53( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-EIGHTH LEGISLATURE - FIRST SESSION

BY

Offered:
Referred:

Sponsor(s): REPRESENTATIVE KELLER

A BILL

FOR AN ACT ENTITLED

"An Act establishing a consultation requirement with respect to the prescription of opiates under certain circumstances; relating to pain management specialists; relating to disciplinary sanctions for dentists, prescribers, and persons administering opiates; relating to the controlled substance prescription database; relating to the administration of opiates for treatment of drug abuse; and providing for an effective date."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

*** Section 1.** AS 08.36.315 is amended to read:

Sec. 08.36.315. Grounds for discipline, suspension, or revocation of license. The board may revoke or suspend the license of a dentist, or may reprimand, censure, or discipline a dentist, or both, if the board finds after a hearing that the dentist

(1) used or knowingly cooperated in deceit, fraud, or intentional misrepresentation to obtain a license;

(2) engaged in deceit, fraud, or intentional misrepresentation in the

course of providing or billing for professional dental services or engaging in professional activities;

(3) advertised professional dental services in a false or misleading manner;

(4) received compensation for referring a person to another dentist or dental practice;

(5) has been convicted of a felony or other crime that affects the dentist's ability to continue to practice dentistry competently and safely;

(6) engaged in the performance of patient care, or permitted the performance of patient care by persons under the dentist's supervision, regardless of whether actual injury to the patient occurred,

(A) that did not conform to minimum professional standards of dentistry; or

(B) when the dentist, or a person under the supervision of the dentist, did not have the permit, registration, or certificate required under AS 08.32 or this chapter;

(7) failed to comply with this chapter, with a regulation adopted under this chapter, or with an order of the board;

(8) continued to practice after becoming unfit due to

(A) professional incompetence;

(B) addiction or dependence on alcohol or other drugs that impair the dentist's ability to practice safely;

(C) physical or mental disability;

(9) engaged in lewd or immoral conduct in connection with the delivery of professional service to patients;

(10) permitted a dental hygienist or dental assistant who is employed by the dentist or working under the dentist's supervision to perform a dental procedure in violation of AS 08.32.110 or AS 08.36.346;

(11) failed to report to the board a death that occurred on the premises used for the practice of dentistry within 48 hours;

(12) falsified or destroyed patient or facility records or failed to

maintain a patient or facility record for at least seven years after the date the record was created;

(13) failed to check the controlled substance prescription database created under AS 17.30.200 before prescribing an opiate.

* Sec. 2. AS 08.36 is amended by adding a new section to read:

Sec. 08.36.368. Prescription of opiates; consultation requirement. (a) Except as provided in (c) of this section, a licensed dentist who prescribes 120 milligrams morphine equivalent or more a day of an opiate to a patient shall consult with a pain management specialist if the patient is still taking 120 milligrams morphine equivalent or more a day of an opiate after four weeks.

(b) The consultation required under (a) of this section must consist of at least one of the following:

(1) an office visit with the patient and the pain management specialist;

(2) a telephone or electronic consultation between the pain management specialist and the licensed dentist; or

(3) an audio-visual evaluation conducted remotely by the pain management specialist, at which the patient is present with either

(A) the licensed dentist; or

(B) a licensed health care practitioner designated by the licensed dentist or pain management specialist.

(c) The consultation requirement under (a) of this section does not apply to

(1) the management of acute pain caused by a dental injury or a dental surgical procedure;

(2) a patient who is following a tapering schedule;

(3) a patient who requires treatment for acute pain that necessitates a temporary escalation in opiate dosage before an expected return to or below the patient's baseline dosage;

(4) a situation in which the licensed dentist documents reasonable attempts to obtain a consultation with a pain management specialist, and the circumstances justify prescribing 120 milligrams morphine equivalent or more a day of an opiate without obtaining a consultation; or

(5) a patient whose pain and function are stable and who is on a nonescalating dose of an opiate.

(d) In this section,

(1) "advanced nurse practitioner" has the meaning given in AS 08.68.850;

(2) "osteopath" means a person licensed to practice osteopathy under AS 08.64;

(3) "pain management specialist" means

(A) a physician, osteopath, podiatrist, or physician assistant approved as a pain management specialist by the State Medical Board under AS 08.64.314; or

(B) an advanced nurse practitioner approved as a pain management specialist by the Board of Nursing under AS 08.68.100(a)(11);

(4) "physician" means a person licensed to practice medicine under AS 08.64;

(5) "physician assistant" means a person licensed to perform medical services under AS 08.64.107;

(6) "podiatrist" means a person licensed to practice podiatry under AS 08.64.

* Sec. 3. AS 08.36.370 is amended by adding a new paragraph to read:

(10) "opiate" has the meaning given in AS 11.71.900.

* Sec. 4. AS 08.64 is amended by adding a new section to read:

Sec. 08.64.314. Pain management specialist. The board shall adopt regulations that define the procedure for the board to approve a physician, osteopath, podiatrist, or physician assistant as a pain management specialist. The regulations must require the physician, osteopath, podiatrist, or physician assistant to have a

(1) certification in pain management care by a credentialing agency or organization acceptable to the board;

(2) minimum of three years of clinical experience acceptable to the board in a pain management care setting; or

(3) current practice at least 30 percent of which consists of the direct

provision of pain management care.

* Sec. 5. AS 08.64.326(a) is amended to read:

(a) The board may impose a sanction if the board finds after a hearing that a licensee

(1) secured a license through deceit, fraud, or intentional misrepresentation;

(2) engaged in deceit, fraud, or intentional misrepresentation while providing professional services or engaging in professional activities;

(3) advertised professional services in a false or misleading manner;

(4) has been convicted, including conviction based on a guilty plea or plea of nolo contendere, of

(A) a class A or unclassified felony or a crime in another jurisdiction with elements similar to a class A or unclassified felony in this jurisdiction;

(B) a class B or class C felony or a crime in another jurisdiction with elements similar to a class B or class C felony in this jurisdiction if the felony or other crime is substantially related to the qualifications, functions, or duties of the licensee; or

(C) a crime involving the unlawful procurement, sale, prescription, or dispensing of drugs;

(5) has procured, sold, prescribed, or dispensed drugs in violation of a law regardless of whether there has been a criminal action;

(6) intentionally or negligently permitted the performance of patient care by persons under the licensee's supervision that does not conform to minimum professional standards even if the patient was not injured;

(7) failed to comply with this chapter, a regulation adopted under this chapter, or an order of the board;

(8) has demonstrated

(A) professional incompetence, gross negligence, or repeated negligent conduct; the board may not base a finding of professional incompetence solely on the basis that a licensee's practice is unconventional or

experimental in the absence of demonstrable physical harm to a patient;

(B) addiction to, severe dependency on, or habitual overuse of alcohol or other drugs that impairs the licensee's ability to practice safely;

(C) unfitness because of physical or mental disability;

(9) engaged in unprofessional conduct, in sexual misconduct, or in lewd or immoral conduct in connection with the delivery of professional services to patients; in this paragraph, "sexual misconduct" includes sexual contact, as defined by the board in regulations adopted under this chapter, or attempted sexual contact with a patient outside the scope of generally accepted methods of examination or treatment of the patient, regardless of the patient's consent or lack of consent, during the term of the physician-patient relationship, as defined by the board in regulations adopted under this chapter, unless the patient was the licensee's spouse at the time of the contact or, immediately preceding the physician-patient relationship, was in a dating, courtship, or engagement relationship with the licensee;

(10) has violated AS 18.16.010;

(11) has violated any code of ethics adopted by regulation by the board;

(12) has denied care or treatment to a patient or person seeking assistance from the physician if the only reason for the denial is the failure or refusal of the patient to agree to arbitrate as provided in AS 09.55.535(a); [OR]

(13) has had a license or certificate to practice medicine in another state or territory of the United States, or a province or territory of Canada, denied, suspended, revoked, surrendered while under investigation for an alleged violation, restricted, limited, conditioned, or placed on probation unless the denial, suspension, revocation, or other action was caused by the failure of the licensee to pay fees to that state, territory, or province; or

(14) failed to check the controlled substance prescription database created under AS 17.30.200 before prescribing an opiate.

* Sec. 6. AS 08.64 is amended by adding a new section to article 3 to read:

Sec. 08.64.364. Prescription of opiates; consultation requirement. (a) Except as provided in (c) of this section, a physician, osteopath, podiatrist, or

physician assistant who prescribes 120 milligrams morphine equivalent or more a day of an opiate to a patient shall consult with a pain management specialist if the patient is still taking 120 milligrams morphine equivalent or more a day of an opiate after four weeks.

(b) The consultation required under (a) of this section must consist of at least one of the following:

(1) an office visit with the patient and the pain management specialist;

(2) a telephone or electronic consultation between the pain management specialist and the physician, osteopath, podiatrist, or physician assistant; or

(3) an audio-visual evaluation conducted remotely by the pain management specialist, at which the patient is present with either

(A) the physician, osteopath, podiatrist, or physician assistant; or

(B) a licensed health care practitioner designated by the physician, osteopath, podiatrist, physician assistant, or pain management specialist.

(c) The consultation requirement under (a) of this section does not apply to

(1) the provision of palliative, hospice, or other end-of-life care;

(2) the management of acute pain caused by an injury or a surgical procedure;

(3) a patient who is following a tapering schedule;

(4) a patient who requires treatment for acute pain that necessitates a temporary escalation in opiate dosage before an expected return to or below the patient's baseline dosage;

(5) a situation in which the physician, osteopath, podiatrist, or physician assistant documents reasonable attempts to obtain a consultation with a pain management specialist, and the circumstances justify prescribing 120 milligrams morphine equivalent or more a day of an opiate without obtaining a consultation;

(6) a patient whose pain and function are stable and who is on a nonescalating dose of an opiate; or

(7) the practice of a physician, osteopath, podiatrist, or physician assistant who is a pain management specialist.

(d) In this section,

(1) "advanced nurse practitioner" has the meaning given in AS 08.68.850;

(2) "pain management specialist" means

(A) a physician, osteopath, podiatrist, or physician assistant approved by the board as a pain management specialist under AS 08.64.314; or

(B) an advanced nurse practitioner approved as a pain management specialist by the Board of Nursing under AS 08.68.100(a)(11).

* Sec. 7. AS 08.64.380 is amended by adding a new paragraph to read:

(7) "opiate" has the meaning given in AS 11.71.900.

* Sec. 8. AS 08.68.100(a) is amended to read:

(a) The board shall

(1) adopt regulations necessary to implement this chapter, including regulations pertaining to practice as an advanced nurse practitioner and a nurse anesthetist, and regulations necessary to implement AS 08.68.331 - 08.68.336 relating to certified nurse aides in order to protect the health, safety, and welfare of clients served by nurse aides;

(2) approve curricula and adopt standards for basic education programs that prepare persons for licensing under AS 08.68.190;

(3) provide for surveys of the basic nursing education programs in the state at the times it considers necessary;

(4) approve education programs that meet the requirements of this chapter and of the board, and deny, revoke, or suspend approval of education programs for failure to meet the requirements;

(5) examine, license, and renew the licenses of qualified applicants;

(6) prescribe requirements for competence before a former nurse may resume the practice of nursing under this chapter;

(7) define by regulation the qualifications and duties of the executive secretary and delegate authority to the executive secretary that is necessary to conduct

board business;

(8) develop reasonable and uniform standards for nursing practice;

(9) publish advisory opinions regarding whether nursing practice procedures or policies comply with acceptable standards of nursing practice as defined under this chapter;

(10) require applicants under this chapter to submit fingerprints and the fees required by the Department of Public Safety under AS 12.62.160 for criminal justice information and a national criminal history record check; the department shall submit the fingerprints and fees to the Department of Public Safety for a report of criminal justice information under AS 12.62 and a national criminal history record check under AS 12.62.400;

(11) adopt regulations that define the procedure for the board to approve an advanced nurse practitioner as a pain management specialist; the regulations must require the advanced nurse practitioner to have a

(A) certification in pain management care by a credentialing agency or organization acceptable to the board;

(B) minimum of three years of clinical experience acceptable to the board in a pain management care setting; or

(C) current practice at least 30 percent of which consists of the direct provision of pain management care.

* Sec. 9. AS 08.68.270 is amended to read:

Sec. 08.68.270. Grounds for denial, suspension, or revocation. The board may deny, suspend, or revoke the license of a person who

(1) has obtained or attempted to obtain a license to practice nursing by fraud or deceit;

(2) has been convicted of a felony or other crime if the felony or other crime is substantially related to the qualifications, functions, or duties of the licensee;

(3) habitually abuses alcoholic beverages, or illegally uses controlled substances;

(4) has impersonated a registered or practical nurse;

(5) has intentionally or negligently engaged in conduct that has

resulted in a significant risk to the health or safety of a client or in injury to a client;

(6) practices or attempts to practice nursing while afflicted with physical or mental illness, deterioration, or disability that interferes with the individual's performance of nursing functions;

(7) is guilty of unprofessional conduct as defined by regulations adopted by the board;

(8) has wilfully or repeatedly violated a provision of this chapter or regulations adopted under it;

(9) is professionally incompetent;

(10) denies care or treatment to a patient or person seeking assistance if the sole reason for the denial is the failure or refusal of the patient or person seeking assistance to agree to arbitrate as provided in AS 09.55.535(a);

(11) has failed to check the controlled substance prescription database created under AS 17.30.200 before prescribing an opiate.

* **Sec. 10.** AS 08.68 is amended by adding a new section to article 6 to read:

Sec. 08.68.701. Prescription of opiates; consultation requirement. (a) Except as provided in (c) of this section, an advanced nurse practitioner who prescribes 120 milligrams morphine equivalent or more a day of an opiate to a patient shall consult with a pain management specialist if the patient is still taking 120 milligrams morphine equivalent or more a day of an opiate after four weeks.

(b) The consultation required under (a) of this section must consist of at least one of the following:

(1) an office visit with the patient and the pain management specialist;

(2) a telephone or electronic consultation between the pain management specialist and the advanced nurse practitioner; or

(3) an audio-visual evaluation conducted remotely by the pain management specialist, at which the patient is present with either

(A) the advanced nurse practitioner; or

(B) a licensed health care practitioner designated by the advanced nurse practitioner or pain management specialist.

(c) The consultation requirement under (a) of this section does not apply to

(1) the provision of palliative, hospice, or other end-of-life care;

(2) the management of acute pain caused by an injury or surgical procedure;

(3) a patient who is following a tapering schedule;

(4) a patient who requires treatment for acute pain that necessitates a temporary escalation in opiate dosage before an expected return to or below the patient's baseline dosage;

(5) a situation in which the advanced nurse practitioner documents reasonable attempts to obtain a consultation with a pain management specialist, and the circumstances justify prescribing 120 milligrams morphine equivalent or more a day of an opiate without obtaining a consultation;

(6) a patient whose pain and function are stable and who is on a nonescalating dose of an opiate; or

(7) the practice of an advanced nurse practitioner who is a pain management specialist.

(d) In this section,

(1) "osteopath" means a person licensed to practice osteopathy under AS 08.64;

(2) "pain management specialist" means

(A) a physician, osteopath, podiatrist, or physician assistant approved as a pain management specialist by the State Medical Board under AS 08.64.314; or

(B) an advanced nurse practitioner approved by the board as a pain management specialist under AS 08.68.100(a)(11);

(3) "physician" means a person licensed to practice medicine under AS 08.64;

(4) "physician assistant" means a person licensed to perform medical services under AS 08.64.107;

(5) "podiatrist" means a person licensed to practice podiatry under AS 08.64.

* Sec. 11. AS 08.68.850 is amended by adding a new paragraph to read:

(11) "opiate" has the meaning given in AS 11.71.900.

* Sec. 12. AS 08.80.261(a) is amended to read:

(a) The board may deny a license to an applicant or, after a hearing, impose a disciplinary sanction authorized under AS 08.01.075 on a person licensed under this chapter when the board finds that the applicant or licensee, as applicable,

(1) secured or attempted to secure a license through deceit, fraud, or intentional misrepresentation;

(2) engaged in deceit, fraud, or intentional misrepresentation in the course of providing professional services or engaging in professional activities;

(3) advertised professional services in a false or misleading manner;

(4) has been convicted of a felony or has been convicted of another crime that affects the applicant's or licensee's ability to practice competently and safely;

(5) intentionally or negligently engaged in or permitted the performance of patient care by persons under the applicant's or licensee's supervision that does not conform to minimum professional standards regardless of whether actual injury to the patient occurred;

(6) failed to comply with this chapter, with a regulation adopted under this chapter, or with an order of the board;

(7) is incapable of engaging in the practice of pharmacy with reasonable skill, competence, and safety for the public because of

(A) professional incompetence;

(B) failure to keep informed of or use current professional theories or practices;

(C) addiction or severe dependency on alcohol or a drug that impairs the applicant's or licensee's ability to practice safely;

(D) physical or mental disability; or

(E) other factors determined by the board;

(8) engaged in conduct involving moral turpitude or gross immorality;

(9) made a controlled substance available to a person except upon prescription issued by a person licensed to prescribe controlled substances;

(10) was convicted of selling federal legend drugs without the prescription of a person licensed to prescribe federal legend drugs;

(11) violated state or federal laws or regulations pertaining to drugs or pharmacies;

(12) failed to report relevant information to the board about a pharmacist or pharmacy intern that the applicant or licensee knew or suspected was incapable of engaging in the practice of pharmacy with reasonable skill, competence, and safety to the public;

(13) aided another person to engage in the practice of pharmacy or to use the title of "pharmacist" or "pharmacy intern" without a license; [OR]

(14) engaged in unprofessional conduct, as defined in regulations of the board; or

(15) failed to check the controlled substance prescription database created under AS 17.30.200 before dispensing an opiate.

*** Sec. 13.** AS 17.30.200(e) is amended to read:

(e) The failure of a pharmacist-in-charge, pharmacist, or practitioner to submit information to the database, **or check the database before dispensing, prescribing, or administering an opiate,** as required under this section is grounds for the board to take disciplinary action against the license or registration of the pharmacy or pharmacist or for another licensing board to take disciplinary action against a practitioner.

*** Sec. 14.** AS 17.30.200(h) is amended to read:

(h) An individual who has submitted information to the database in accordance with this section may not be held civilly liable for having submitted the information. [NOTHING IN THIS SECTION REQUIRES OR OBLIGATES A DISPENSER OR PRACTITIONER TO ACCESS OR CHECK THE DATABASE BEFORE DISPENSING, PRESCRIBING, OR ADMINISTERING A MEDICATION, OR PROVIDING MEDICAL CARE TO A PERSON.] Dispensers or practitioners may not be held civilly liable for damages for accessing or failing to access the information in the database.

*** Sec. 15.** AS 17.30.200 is amended by adding new subsections to read:

(o) A dispenser or practitioner shall access or check the database before dispensing, prescribing, or administering an opiate.

(p) In this section, "opiate" has the meaning given in AS 11.71.900.

* Sec. 16. AS 47.37 is amended by adding a new section to read:

Sec. 47.37.175. Administration of opiates; consultation requirement. (a) A health care professional who oversees the administration of an opiate for treatment of drug abuse shall hold a telephonic or electronic consultation with the patient's primary care provider to establish a baseline dosage of the opiate before treatment begins.

(b) The patient's primary care physician shall screen the patient and clear the patient for treatment before the administration of an opiate for treatment of drug abuse.

(c) The patient's primary care provider or health care professional who oversees the administration of an opiate for treatment of drug abuse shall monitor the patient's cardiac stability when the opiate dosage is increased by 30 milligram morphine equivalent or more from the patient's baseline dosage.

(d) If the health care professional who oversees the administration of an opiate for treatment of drug abuse prescribes more than 120 milligrams morphine equivalent a day of an opiate, the health care professional shall monitor the patient's cardiac and pulmonary stability and consult with the patient's primary care provider.

(e) A health care professional who oversees the treatment of drug abuse shall refer a patient who demonstrates intolerance to an escalating dose of an opiate to the patient's primary care provider for screening.

(f) A health care professional who oversees the administration of an opiate to a patient for treatment of drug abuse shall conduct an in-person consultation with the patient's primary care provider six months after the start of treatment with the opiate and every six months thereafter until the patient's treatment with an opiate is discontinued.

(g) A health care professional who oversees the administration of an opiate to a patient for treatment of drug abuse and the patient's primary care provider shall determine a reasonable tapering schedule for the patient.

(h) In this section,

(1) "health care professional" means a physician, nurse, and physician assistant, but does not include a practitioner of religious healing;

(2) "opiate" has the meaning given in AS 11.71.900;

(3) "primary care provider" has the meaning given in AS 21.07.250.

* Sec. 17. Sections 4 and 8 of this Act take effect immediately under AS 01.10.070(c).

* Sec. 18. Except as provided in sec. 17 of this Act, this Act takes effect 180 days after the effective date in sec. 17 of this Act.

ALASKA STATE LEGISLATURE

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REPRESENTATIVE WES KELLER
DISTRICT 7

MEMO

To: Members of the Alaska Legislature

Fm: Rep. Wes Keller

Date: January 30, 2013

Re: Sectional for CS HB 53 (28-LS0177\C)

Section 1: Adds language to discipline for Dentists who fail to check the controlled substance prescription database prior to prescribing an opiate.

Section 2: Adds a new section to AS 08.36.that requires a licensed dentist who Prescribes120 milligrams morphine equivalent or more per day of an opiate to a patient for more than four weeks to consult with a pain management specialist. The section describes the ways to satisfy the consultation requirement and exemptions to the consultation requirement.

Section 3: references AS 11.71.900 for the definition of an opiate.

Section 4: The section requires the State Medical Board to adopt regulations to approve a physician, osteopath, podiatrist, or physician's assistant as a pain management specialist.

Section 5: Adds to the list of sanction violations for Board Consideration failure to check the controlled substance prescription database prior to prescribing an opiate.

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Section 6: Adds a new section to AS 08.64. This section requires a physician, osteopath, podiatrist, or physician's assistant who prescribes 120 milligrams morphine equivalent or more per day of an opiate to a patient for more than four weeks to consult with a pain management specialist. The section describes the ways to satisfy the consultation requirement and exemptions to the consultation requirement.

Section 7: references AS 11.71.900 for the definition of an opiate.

Section 8: The section requires the Board of Nursing to adopt regulations to approve an advanced nurse practitioner as a pain management specialist.

Section 9: Adds to the list of sanction violations for board consideration failure to check the controlled substance prescription database prior to prescribing an opiate.

Section 10: Adds a new section to AS 08.68. This section requires an advanced nurse Practitioner who prescribes 120 milligrams morphine equivalent or more per day of an opiate to a patient for more than four weeks to consult with a pain management specialist. The section describes the ways to satisfy the consultation requirement and exemptions to the consultation requirement.

Section 11: references AS 11.71.900 for the definition of an opiate.

Section 12: Adds to the list of sanction violations for board consideration failure to check the controlled substance prescription database prior to prescribing an opiate.

Section 13: Requires pharmacist to submit and check the substance prescription databases before filling a prescription for an opiate. Failure can result in Board action.

Section 14: Provides liability protection for individuals submitting to and those accessing information in the database.

Section 15: Requires the dispenser or Practioners to access the database before administering an opiate.

Section 16: Requires Practioners working in the drug rehabilitative service that uses methadone to consult with the patient primary care physician. Additionally it requires certain test take place if doses of methadone are increased.

Section 17: Is a section 4 and 8 effective date clause

Section 18: Is the effective date clause which allows six months to put the programs in place.

A sectional summary of a bill should not be considered an authoritative interpretation of the bill and the bill itself is the best statement of its contents.

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Fiscal Note

State of Alaska
2013 Legislative Session

Bill Version: HB 53 (A)
Fiscal Note Number:
() Publish Date:

Identifier: HB053-DHSS-MAA-1-25-13
Title: CONSULTATION FOR OPIATE PRESCRIPTION
Sponsor: KELLER
Requester: House HSS Committee

Department: Department of Health and Social Services
Appropriation: Health Care Services
Allocation: Medical Assistance Administration
OMB Component Number: 242

Expenditures/Revenues

Note: Amounts do not include inflation unless otherwise noted below. (Thousands of Dollars)

	FY2014 Appropriation Requested	Included in Governor's FY2014 Request	Out-Year Cost Estimates				
OPERATING EXPENDITURES	**FY 2014**	**FY 2014**	**FY 2015**	**FY 2016**	**FY 2017**	**FY 2018**	**FY 2019**
Personal Services							
Travel							
Services	48.0		48.0	48.0	48.0	48.0	48.0
Commodities							
Capital Outlay							
Grants & Benefits							
Miscellaneous							
Total Operating	**48.0**	**0.0**	**48.0**	**48.0**	**48.0**	**48.0**	**48.0**
Fund Source (Operating Only)							
1002 Fed Rcpts	24.0		24.0	24.0	24.0	24.0	24.0
1003 G/F Match	24.0		24.0	24.0	24.0	24.0	24.0
Total	**48.0**	**0.0**	**48.0**	**48.0**	**48.0**	**48.0**	**48.0**
Positions							
Full-time							
Part-time							
Temporary							
Change in Revenues							

Estimated SUPPLEMENTAL (FY2013) cost: 0.0

Estimated CAPITAL (FY2014) cost: 0.0

ASSOCIATED REGULATIONS

Does the bill direct, or will the bill result in, regulation changes adopted by your agency? No
If yes, by what date are the regulations to be adopted, amended or repealed?

Why this fiscal note differs from previous version:

Not applicable, initial version.

Prepared By:	Margaret Brodie, Director	Phone:	(907)334-2520
Division	Health Care Services	Date:	01/25/2013 12:16 AM
Approved By:	Sarah Woods, Deputy Director	Date:	01/25/13
	Finance & Management Services		

FISCAL NOTE ANALYSIS

STATE OF ALASKA
2013 LEGISLATIVE SESSION

BILL NO. HB053

Analysis

This bill would require that physicians, osteopaths, podiatrists, or advanced nurse practitioners who prescribe 120 milligrams or more a day of an opiate to a patient in certain situations consult with a pain management specialist. A face-to-face visit between the patient and the pain management specialist is not required.

Medicaid does not pay for provider-to-provider consultations. It currently has pain management specialists on contract to consult on opiate prescriptions. To meet the increased demand for consultation, we anticipate we would need to increase our contract by $48.0 annually. Based on current claim volume, we estimate that we would increase our consultations by 500 per year at $96 per consultation.

The Department does not anticipate that the pain management consultation process will increase the number of office visits. This bill may reduce the amount of opiates prescribed to Medicaid recipients. However, we anticipate that reductions in opiate prescriptions would be offset by increases in non-opiate pain management medication.

Fiscal Note

State of Alaska
2013 Legislative Session

Bill Version: HB 53 (A)
Fiscal Note Number:
() Publish Date:

Identifier: HB053-DCCED-CBPL-01-24-13
Title: CONSULTATION FOR OPIATE PRESCRIPTION
Sponsor: KELLER
Requester: House Health and Social Services

Department: Department of Commerce, Community and Economic Development
Appropriation: Corporations, Business and Professional Licensing
Allocation: Corporations, Business and Professional Licensing
OMB Component Number: 2360

Expenditures/Revenues

Note: Amounts do not include inflation unless otherwise noted below. (Thousands of Dollars)

	FY2014 Appropriation Requested	Included in Governor's FY2014 Request	Out-Year Cost Estimates				
OPERATING EXPENDITURES	**FY 2014**	**FY 2014**	**FY 2015**	**FY 2016**	**FY 2017**	**FY 2018**	**FY 2019**
Personal Services							
Travel							
Services							
Commodities							
Capital Outlay							
Grants & Benefits							
Miscellaneous							
Total Operating	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Fund Source (Operating Only)

None							
Total	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Positions

Full-time							
Part-time							
Temporary							

Change in Revenues							

Estimated SUPPLEMENTAL (FY2013) cost: 0.0

Estimated CAPITAL (FY2014) cost: 0.0

ASSOCIATED REGULATIONS

Does the bill direct, or will the bill result in, regulation changes adopted by your agency? No
If yes, by what date are the regulations to be adopted, amended or repealed?

Why this fiscal note differs from previous version:

Not applicable, Initial version.

Prepared By:	Don Habeger, Director	Phone:	(907)465-2536
Division	Corporations, Business and Professional Licensing	Date:	01/24/2013 09:45 PM
Approved By:	JoEllen Hanrahan, Director	Date:	01/25/13
	Administrative Services Division		

FISCAL NOTE ANALYSIS

STATE OF ALASKA **BILL NO.** HB 53
2013 LEGISLATIVE SESSION

Analysis

HB 53 would require physicians, osteopaths, podiatrist, or advanced nurse practitioners to consult a "pain management specialist" prior to prescribing 120 milligrams or more a day of an opiate to a patient.

The division does not anticipate a fiscal impact from this legislation.

A Guide to State Opioid Prescribing Policies

State Opioid Prescribing Policy: Alaska

Jennifer Bolen, JD

Pain Policy and Regulation: Alaska

Summary

Alaska is one of just a couple of states that lacks a formal medical board position statement on the use of controlled medications to treat pain. As demonstrated below, however, Alaska's Board of Nursing has adopted a guideline on the use of controlled medications to treat pain, and that guideline is modeled after the Federation of State Medical Boards' Model Policy Statement.

Record-Keeping Requirements

The Alaska Medical Board's rules require physicians to maintain adequate records for each patient for whom the physician performs a professional service. The physician is required to meet the following minimum requirements for each patient record: The record must:

1. Be legible;
2. Contain only those terms and abbreviations that are or should be comprehensible to similar licensees;
3. Contain adequate patient identification;
4. Indicate the dates that professional services were provided to the patient;
5. Reflect what examinations, vital signs, and tests were obtained, performed, or ordered concerning the patient and the findings and results of each;
6. Indicate the chief complaint of the patient;
7. Indicate the licensee's diagnostic impressions of the patient;
8. *Indicate the medications prescribed for, dispensed to, or administered to the patient and the quantity and strength of each medication;*
9. Reflect the treatment provided to or recommended for the patient; and
10. Document the patient's progress during the course of treatment provided by the licensee.

Code of Ethics

The Alaska Medical Board has a rule that adopts the Principles of Medical Ethics of the American Medical Association.

Definition of Unprofessional Conduct

"Unprofessional conduct," as defined by the Alaska Medical Board in its Rules, includes:

...(8) delegating professional practice responsibilities that require a license or permit under AS 08.64 to a person who does not possess the appropriate education, training, or licensure to perform the responsibilities; (9) failing to prepare and maintain accurate, complete, and legible records in accordance with generally accepted standards of practice for each patient and to make those records available to the board and the board's representatives for inspection for investigation purposes; ... (12) intentionally or negligently releasing or disclosing confidential patient information; this paragraph does not apply to disclosures required under state or federal law or when disclosure is necessary to prevent an imminent risk of harm to the patient or others; (13) offering, giving, soliciting, or receiving fees or other benefits, in whole or in part, to a person for bringing in or referring a patient; ... (17J) unlawful distribution or possession for distribution of a controlled substance; for purposes of this subparagraph, "controlled substance" has the meaning given in AS 11.71.900; (18) using alcohol or other drugs (A) to the extent that the use interferes with professional practice functions of the licensee or endangers the safety of patients; or (B) that is illegal under state or federal law; ... (27) providing treatment, rendering a diagnosis, or prescribing medications based solely on a patient-supplied history that a physician licensed in this state received by telephone, facsimile, or electronic format; ...

Alaska's Medical Board Rules include a specific provision relating to the prescribing of controlled substances, which requires a physician to create and maintain a complete, clear, and legible written record of care that includes -- at a minimum -- (1) a patient history and evaluation sufficient to support a diagnosis; (2) a diagnosis and treatment plan for the diagnosis; (3) monitoring the patient for the primary condition that necessitates the drug, side effects of the drug, and results of the drug, as appropriate; and (4) a record of drugs prescribed, administered, or dispensed, including the type of drug, dose, and any authorized refills.

Nursing Board Pain Management Guideline

In 1996, the Alaska Board of Nursing published an Advisory Opinion adopting a Guideline on the Use of Controlled Medications to Treat Pain, which applies to advanced nurse practitioners. This guideline is based on the Federation of State Medical Boards' Model Guideline and those adopted by other boards. The main provisions of the Alaska Nursing Board Guideline are as follows.

Evaluation of the Patient

A medical history and physical examination must be obtained, evaluated, and documented in the medical record. The medical record should document the nature and intensity of the pain, current and past treatments for pain, underlying or coexisting diseases or conditions, the effect of the pain on physical and psychological function, and history of substance abuse. The medical record also should document the presence of 1 or more recognized medical indications for the use of a controlled substance.

Treatment Plan

The written treatment plan should state objectives that will be used to determine treatment success, such as pain relief and improved physical and psychosocial function, and should indicate whether any further diagnostic evaluations or other treatments are planned. After treatment begins, the healthcare practitioner should adjust drug therapy to the individual medical needs of each patient. Other treatment modalities or a rehabilitation program may be necessary depending on the etiology of the pain and the extent to which the pain is associated with physical and psychosocial impairment.

Informed Consent and Agreement for Treatment

The advanced nurse practitioner should discuss the risks and benefits of the use of controlled substances with the patient, persons designated by the patient, or with the patient's surrogate or guardian if the patient is without medical decision-making capacity. The patient should receive prescriptions from 1 advanced nurse practitioner and 1 pharmacy whenever possible. If the patient is at high risk for medication abuse or has a history of substance abuse, the advanced nurse practitioner should consider the use of a written agreement between provider and patient outlining patient responsibilities, including urine/serum medication levels screening when requested, number and frequency of all prescription refills, and reasons for which drug therapy may be discontinued (eg, violation of agreement).

Periodic Review

The advanced nurse practitioner should periodically review the course of pain treatment and any new information about the etiology of the pain or the patient's state of health. Continuation or modification of controlled substances for pain management therapy depends on the practitioner's evaluation of progress toward treatment objectives. Satisfactory response to treatment may be indicated by the patient's reduced pain, increased level of function, or improved quality of life. Objective evidence of improved or diminished function should be monitored, and information from family members or other caregivers should be considered in determining the patient's response to treatment. If the patient's progress is unsatisfactory, the practitioner should assess the appropriateness of continued use of the current treatment plan and consider the use of other therapeutic modalities.

Consultation

The advanced nurse practitioner should be willing to refer the patient as necessary for additional evaluation and treatment in order to achieve treatment objectives. Special attention should be given to those patients with pain who are at risk for medication misuse, abuse, or diversion. The management of pain in patients with a history of substance abuse or with a comorbid psychiatric disorder may require extra care, monitoring, documentation, and consultation with or referral to an expert in the management of such patients.

Medical Records

The advanced nurse practitioner should keep accurate and complete records to include:

1. The medical history and physical examination;
2. Diagnostic, therapeutic, and laboratory results;
3. Evaluations and consultations;
4. Treatment objectives;
5. Discussion of risks and benefits;
6. Informed consent;
7. Treatments;
8. Medications, including date, type, dosage, and quantity prescribed;
9. Instructions and agreements; and
10. Periodic reviews.

Adequate records are legible and contain, at a minimum, sufficient information to identify the patient, support the diagnosis, justify the treatment, adequately document the results, indicate advice and cautionary warnings provided to the patient, and provide sufficient information for another practitioner to assume continuity of the patient's care at any point in the treatment. Records should remain current and be maintained in an accessible manner and readily available for review. "Coded" information, without definitions, does not constitute an acceptable record.

Compliance With Controlled Substances Laws and Regulations

To prescribe, dispense, or administer controlled substances, the advanced nurse practitioner must be licensed in the state and comply with applicable federal and state regulations. Practitioners are referred to the *Physicians Manual* of the US Drug Enforcement Administration for specific rules governing controlled substances as well as applicable state regulations.

The Alaska Board of Nursing's Advisory Opinion on the Pain Management Guideline includes the following definitions.

Acute pain. Acute pain is the normal, predicted physiologic response to a noxious chemical, thermal, or mechanical stimulus and typically is associated with invasive procedures, trauma, and disease. It is generally time-limited.

Addiction. Addiction is a primary, chronic, neurobiological disease, with genetic, psychosocial, and environmental factors influencing its development and manifestations. It is characterized by behaviors that include the following: impaired control over drug use, craving, compulsive use, and continued use despite harm. Physical dependence and tolerance are normal physiologic consequences of extended opioid therapy for pain and are not the same as addiction.

Chronic pain. Chronic pain is a state in which pain persists beyond the usual course of an acute disease or healing of an injury, or that may or may not be associated with an acute or chronic pathologic process that causes continuous or intermittent pain over months or years.

Pain. Pain is an unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage.

Physical dependence. Physical dependence is a state of adaptation that is manifested by drug class-specific signs and symptoms that can be produced by abrupt cessation, rapid dose reduction, decreasing blood level of the drug, and/or administration of an antagonist. Physical dependence, by itself, does not equate with addiction.

Pseudoaddiction. Pseudoaddiction is a iatrogenic syndrome resulting from the misinterpretation of relief-seeking behaviors as though they are drug-seeking behaviors that are commonly seen with addiction. The relief-seeking behaviors resolve upon institution of effective analgesic therapy.

Substance abuse. Substance abuse is the use of any substance(s) for nontherapeutic purposes or use of medication for purposes other than those for which it is prescribed.

Tolerance. Tolerance is a physiologic state resulting from regular use of a drug in which an increased dosage is needed to produce a specific effect, or a reduced effect is observed with a constant dose over time. Tolerance may or may not be evident during opioid treatment and does not equate with addiction.

Relevant Basic Provisions of the Alaska Controlled Substances Act Include the Following

Controlled substances may only be prescribed, administered, dispensed, or distributed for a medical purpose. (The Alaska statute omits the word "legitimate" from the "medical purpose" requirement.)

Alaska Prescription Drug Monitoring Database

The Alaska Board of Pharmacy monitors the state's controlled substance prescription database. The purpose of the database is to contain data with regard to every prescription for a schedule IA, IIA, IIIA, IVA, or VA controlled substance under state law or a schedule I, II, III, IV, or V controlled substance under federal law dispensed in the state to a person other than those administered to a patient at a healthcare facility.

The database and the information contained within the database are confidential, are not public records, and are not subject to public disclosure. The Board may allow access to the database only to the following persons, and in accordance with the limitations provided and regulations of the board:

...(3) a licensed practitioner having authority to prescribe controlled substances, to the extent the information relates specifically to a current patient of the practitioner to whom the practitioner is prescribing or considering prescribing a controlled substance; (4) a licensed or registered pharmacist having authority to dispense controlled substances, to the extent the information relates specifically to a current patient to whom the pharmacist is dispensing or considering dispensing a controlled substance; (5) federal, state, and local law enforcement authorities may receive printouts of information contained in the database under a search warrant, subpoena, or order issued by a court establishing probable cause for the access and use of the information; and (6) an individual who is the recipient of a controlled substance prescription entered into the database may receive information contained in the database concerning the individual on providing evidence satisfactory to the board that the individual requesting the information is in fact the person about whom the data entry was made and on payment of a fee set by the board under AS 37.10.050 that does not exceed $10.

National Institute on Drug Abuse

The Science of Drug Abuse & Addiction

What is Prescription Drug Abuse:

Prescription drug abuse means taking a prescription drug that is not prescribed for you, or taking it for reasons or in dosages other than as prescribed. Abuse of prescription drugs can produce serious health effects, including addiction.

Commonly Abused Drugs:

Commonly abused classes of prescription drugs include opioids (for pain), central nervous system (CNS) depressants (for anxiety and sleep disorders), and stimulants (for ADHD and narcolepsy).

Opioids include:

- Hydrocodone (Vicodin®)
- Oxycodone (OxyContin®)
- Oxymorphone (Opana®)
- Propoxyphene (Darvon®)
- Hydromorphone (Dilaudid®)
- Meperidine (Demerol®)
- Diphenoxylate (Lomotil®)

Central nervous system depressants include:

- Pentobarbital sodium (Nembutal®)
- Diazepam (Valium®)
- Alprazolam (Xanax®)

Stimulants include:

- Dextroamphetamine (Dexedrine®)
- Methylphenidate (Ritalin® and Concerta®)
- Amphetamines (Adderall®)

Street Names

oxy, cotton, blue, 40, 80 (OxyContin®)

Effects

Long-term use of opioids or central nervous system depressants can lead to physical dependence and addiction. Opioids can produce drowsiness, constipation and, depending on amount taken, can depress breathing. Central nervous system depressants slow down brain function; if combined with other medications that cause drowsiness or with alcohol, heart rate and respiration can slow down dangerously. Taken repeatedly or in high doses, stimulants can cause anxiety, paranoia, dangerously high body temperatures, irregular heartbeat, or seizures.

Statistics and Trends

In 2009, 16 million Americans age 12 and older had taken a prescription pain reliever, tranquilizer, stimulant, or sedative for nonmedical purposes at least once in the year prior to being surveyed. *Source: National Survey on Drug Use and Health (Substance Abuse and Mental Health Administration Web Site).* The NIDA-funded 2010 Monitoring the Future Study showed that 2.7% of 8th graders, 7.7% of 10th graders, and 8.0% of 12th graders had abused Vicodin and 2.1% of 8th graders, 4.6% of 10th graders, and 5.1% of 12th graders had abused OxyContin for nonmedical purposes at least once in the year prior to being surveyed. *Source: Monitoring the Future (University of Michigan Web Site).*

Opiate addiction: How prescription painkillers pave the way to heroin

Stacey Naggiar, NBC News June 7, 2012

The use of prescription painkillers recreationally is at epidemic levels, according to the Centers for Disease Control and Prevention. What is it about the pills that makes them so dangerously addictive and a potential gateway for heroin?

The surprising answer, at least to many non-medical professionals, is that the common painkillers that doctors and dentists prescribe to patients after injuries and surgeries have the same active ingredient as the drug that alleyway users inject into their arms. And both act in similar ways on the human brain to produce a sense of pleasure that can overwhelm its reasoning functions.

While many who abuse prescription painkillers think of heroin as a low-class drug that will never make its way into their lives, they don't realize, they're already addicted to a form of it.

Prescription painkillers of the sort that 12 million Americans used non-medically in 2010, according to the CDC, are narcotic opioid drugs, more commonly referred to as opiates. They include hydrocodone and oxycodone, also known by the brand names Vicodin and Oxycontin, respectively.

Reward system

According to the National Institute on Drug Abuse, when opiates are consumed, they enter the bloodstream and activate neurotransmitter receptors in the brain's reward system. Scientists call the link between the drug and the receptor a lock and key relationship, because one specific neurotransmitter activates specific receptor molecules, the same way only one key fits a particular lock.

When the opiates reach the opiate receptors, the latter release the hormone dopamine. The dopamine – which acts as an "excitatory neurotransmitter" – produces feelings of pleasure and satisfaction. It's this action at the most basic cellular level that provides the foundation for drug addiction.

Crackdown on painkiller abuse fuels new wave of heroin addiction

By Lisa Riordan Seville and Hannah Rappleye NBC News June 7, 2012

LANCASTER, Ohio -- Holly Yates started using painkillers in the ninth grade, at parties and hanging out with friends. The pills were everywhere, easy to get and cheap. By the time she was 18, she was abusing oxycodone, Percocet and other pills every day.

Then they stopped being enough.

"My cousin, she was into heroin and I started hanging out with her," said Yates, a hazel-eyed 20-year-old. "She told me about it, and I was like, 'I want to try it.' The first time that I shot it up, it was like, 'Where has this been all my life?'"

Experts say Yates and others in this town of about 38,000 southeast of Columbus are on the leading edge of a frightening new drug abuse trend – one that is ironically being fueled by a national crackdown on prescription painkillers. While new regulations and law enforcement efforts have significantly reduced the supply of these drugs, they say, those efforts have inadvertently driven many users to another type of opiate that is cheap, powerful and perhaps even more destructive – heroin.

"It's an epidemic," said Dr. Joe Gay, director of the regional addiction and mental health clinic Health Recovery Services, who has studied patterns of drug use in the state.

A flood of cheap heroin from Mexico, which is now one of the leading sources of the drug to the United States, is one reason for the return of the scourge. According to the Justice Department, the drug is showing up in new areas, including upscale suburban towns where heroin was once rare.

In Illinois, for example, researchers at Roosevelt University have found a spike in young suburban heroin abusers. Long Island, New York, has in recent years seen a rash of addiction among the young. A spike in heroin use and related crime has Dane County, Wis., reeling. Even states like Washington, where heroin has a longtime presence, have seen a sharp increase among young users. In King County, home to Seattle, nearly a third of those entering treatment for heroin abuse in 2009 were between ages 18 and 29 -- a sharp increase from a decade before.

With increased availability has come a spike in the number of visits to emergency room visits for issues related to heroin use, including a 13 percent increase from 2005 through 2009, according to the national Drug Abuse Warning Network. The highest rates of admission were for young adults, 21 to 24 years old.

"Twenty years ago, half of the heroin addicts in treatment lived in two states — New York and California," said Gay. "(Now, in Ohio) we're seeing it spread out of the cities, into the suburbs and into the rural areas." The demographics of heroin addiction are also shifting, he said.

'It's not going away'
Until a few years ago, addicts were overwhelmingly men who lived in urban areas, many of them from racial minorities. An alarming number of those entering treatment programs in Ohio -- a good measure of addiction -- are young, he said. Most are white. They are from poor rural counties and wealthy suburbs. Many are girls and women.

In Ohio, the new face of heroin addiction could be the girl or boy next door. "Everybody does it," Yates said. "It's just here, and it's not going away."

Sarah Mayer, 27, was an early traveler on the path from dabbling in prescription pills to putting a needle in her arm.

Born and raised in Hilliard, a tree-lined suburb of Columbus, she grew up in what is, by all accounts, a loving home. Her father works at the local bank. Her mother is a nurse.

Derailed plans
In high school, Mayer went to parties and drank occasionally, but she kept her grades up. During her last year in high school, in 2002, she took college classes. After graduation, she started a fully-paid-for nursing program. But her plans were derailed by addiction to oxycodone, an opiate-based painkiller found in many medicine cabinets across the country.

"I really didn't know what I was getting myself into," Mayer said. By 2005, she and her boyfriend were taking the pills regularly to get high. But over time, the effects diminished.

One day in early 2006, Sarah and her boyfriend found themselves nearly broke and without the pills they needed. Desperate and sick with withdrawals from the opiates, her boyfriend left the house to try to find pills.

He came back with a bag of powder heroin.

"He knew how I felt about heroin," Mayer said. "That was the one thing I said I would never do."

Despite her conviction, within 24 hours, she had snorted it. She would spend another three years chasing that first high. "It was almost like all of the wind was knocked out of my chest, I could barely hold my head anymore," said Mayer. "It was like my whole body just exhaled."

Soon, she began injecting it. It would take her years, and at least six trips to recovery programs, before she successfully got clean in October 2009. She's now working toward a degree in nursing, and recently made the dean's list.

The addiction was something the Mayer family never saw coming. "There was never a thought that ever entered my mind that I would ever lose a child through addiction," said

Randy Mayer, Sarah's father. "Watching this thing grab her and not let go, I mean, it was a horrible time."

But in Hilliard, where he also grew up, Randy Mayer said he is seeing this happen to others.

"I've met some other families, locally here -- they're dealing with the same kind of situation," he said. "The fact of the matter is, these towns like this are fertile for this to spread."

Paul Coleman, director at the Maryhaven clinic near Columbus, where Mayer sought treatment, said about a quarter of the nearly 130 adolescents currently getting treatment there have used opiates -- something he's never seen in his 22 years at the center.

"A few years ago if you would have asked me how many young patients I would have using opiates I wouldn't have said 25 percent," Coleman said. "I would have said none."

The White House has called prescription drug abuse the nation's fastest-growing drug problem. The Centers for Disease Control and Prevention has officially dubbed it an epidemic.

'Crisis'

In Ohio and elsewhere, however, the beast has two heads. Opiate abuse, which includes both prescription painkillers and heroin, has become a "crisis of unparalleled proportions," according to Ohio's Department of Alcohol and Drug Addiction Services. In 2001, just eight of Ohio's 88 counties reported a significant number of patients were entering substance abuse treatment for opiate addiction. By the same measure, 85 of Ohio's 88 counties reported an opiate problem in 2010.

The state has taken action. In 2006, it implemented a system to track prescriptions to help prevent so called "doctor shopping," where addicts move from one physician to the next looking for prescriptions. Last year, it also passed a law to help fight "pill mills," unscrupulous storefront clinics known for readily dispensing prescriptions.

Similar measures have been taken across the nation. Combined with new pill formulations that make the medication harder to crush up to snort or shoot, the efforts have curbed supply and abuse. Experts agree this is a positive step. But in Ohio, the crackdown has had unexpected consequences.

The pills have become expensive, and often hard to obtain. Prescription opiates now sell for anywhere from $30 to $80 dollars a pill. A $10 bag of heroin offers a similar or better high. Unable to find pills, or afford them, addicts go looking for something else to feed the craving. Heroin is cheap, plentiful and potent.

It is also deadly. In fact, the state saw a record number of heroin-related deaths in 2010, which now account for one in every five overdose deaths in the state. Cuyahoga

County, home to Cleveland, recorded 106 heroin-related deaths in 2011 -- an increase of nearly 180 percent since 2003, according to the Cuyahoga County Medical Examiner's Office. In early May, Loraine County, Ohio, saw five fatal overdoses in 10 days due to a batch of highly potent, or badly cut, heroin. Experts worry other counties may soon follow suit, and that those dying might be among what the Ohio Department of Alcohol & Drug Addiction Services reports show is the fastest growing demographic of heroin users -- young people between ages 20 and 35.

It's an addiction that surprises even those who find themselves in its grip.

"If you were to tell me that I was going to use heroin ... the same week in which I used it, I probably would have laughed in your face," said Tej Yaich, a 20-year-old from Pickerington, Ohio. "That's something that I would never have done."

For Yaich, who has been sober for more than a year, addiction started at home. His parents had prescriptions sitting unused in the medicine cabinet. Yaich said he was 15 when he first tried them, crushing them up at night so his parents wouldn't hear the noise. The experiment became a habit. Then the supply started to dry up.

"One day I went to call my guy that was selling to me and he said he didn't have pills at that time, but he had something equally as good," said Yaich. "He said, 'You'll like it.'"

What the dealer had was heroin, and he was right. Yaich started by snorting it, then quickly moved on to shooting up. From one bag, he worked himself up to two, then five. At the height of his addiction, he said, he injected up to 25 bags a day.

Yaich's story is typical of those that Dr. Steven Matson hears from young people coming into his clinic at Nationwide Children's Hospital in Columbus. Matson, who helped Yaich recover, runs a program there that uses a fairly new medication called buprenorphine, a semi-synthetic opioid that when used correctly helps to curb cravings to assist in recovery.

When Matson started this work three years ago, the young people coming into his clinic were "fringe," he said. Now they are as often from upscale suburbs of Columbus as from poorer, more rural areas.

"Because of the availability of these drugs now, it is not an usual story that we hear, 'I went to a party, some friends there were doing heroin, so I shot up,'" he said. "It seems like madness that you would go to a party and never have used anything and then use heroin. But that's what's happening with some children."

Matson's program also helped Holly Yates recover. She's been sober since Thanksgiving Day 2010. For more than a year, she's held a job as a stylist at a local hair salon. She saved up to buy herself a silver Honda Accord. In the back seat are two car seats for her young nephews, who her older brothers now trust her to babysit.

But things can be lonely in Lancaster, where she says nearly everyone her age uses drugs, and many are hooked on heroin.

"It's just hard being young and staying clean," Yates said. "I mean this town, it's just, like, that's all that's here."

"I just want kids my age to know that you don't have to keep using," she added. "You can be clean, and you can have a better life."

What are Opiates?

Opiates belong to the large biosynthetic group of benzylisoquinoline alkaloids, and are so named because they are naturally-occurring alkaloids found in the opium poppy. The major psychoactive opiates are morphine, codeine, and thebaine. Papaverine, noscapine, and approximately 24 other alkaloids are also present in opium but have little to no effect on the human central nervous system, and as such are not considered to be opiates. Semi-synthetic opioids such as hydrocodone, hydromorphone, oxycodone, and oxymorphone, while derived from opiates, are not opiates themselves.

While the full synthesis of opiates from naphthoquinone (Gates synthesis) or from other simple organic starting materials is possible, they are tedious and uneconomical processes. Therefore, most of the opiate-type analgesics in use today are either directly extracted from *Papaver somniferum* or synthesized from the natural opiates, mainly from thebaine.

Terminology

The term *opiate* refers only to the alkaloids found naturally in opium, but is often incorrectly used to describe all drugs with opium- or morphine-like pharmacological action, which are more properly classified under the broader term *opioid*.

The alkaloids

Morphine

The most frequently-reported occurrences of opiate-induced pulmonary edema are among recreational heroin users. Although uncommon, reports of morphine-induced pulmonary edema are not unheard of. The primary difference is the more careful supervision of morphine administration compared to the lack of supervision and medical expertise among illicit heroin users. On the other hand, morphine may also be used in the treatment of pulmonary edema. Despite morphine's being the most medically-significant alkaloid, larger quantities of the milder codeine—most of it manufactured from morphine—are consumed medically, as codeine has a greater and more predictable oral bioavailability than morphine, making it easier to titrate one's dose.

As heroin is not pharmacologically active it must first be metabolized. The active metabolites of heroin are morphine, 6-monoacetylmorphine and 3-monoacetylmorphine.

Morphine (INN) (pron.: /ˈmɔrfiːn/; MS Contin, MSIR, Avinza, Kadian, Oramorph, Roxanol, Kapanol) is a potent opiate analgesic drug that is used to relieve severe pain. It was first isolated in 1804 by Friedrich Sertürner, first distributed by him in 1817, and first commercially sold by Merck in 1827, which at the time was a single small chemists' shop. It was more widely used after the invention of the hypodermic needle in 1857. It took its name from the Greek god of dreams Morpheus (Greek: Μορφεύς). Morphine is the most abundant alkaloid found in opium, the dried latex extracted by shallowly slicing the unripe seedpods of the *Papaver somniferum* poppy. Morphine was the first active principle purified from a plant source and is one of at least 50 alkaloids of several different types present in opium, poppy straw concentrate, and other poppy derivatives. Morphine is generally 8 to 14 percent of the dry weight of opium, although specially bred cultivars reach 26 percent or produce little morphine at all (under 1 percent, perhaps down to 0.04 percent). The latter varieties, including the 'Przemko' and 'Norman' cultivars of the opium poppy, are used to produce two other alkaloids, thebaine and oripavine, which are used in the manufacture of semi-synthetic and synthetic opioids like oxycodone and etorphine and some other types of drugs. *P. bracteatum* does not contain morphine or codeine, or other narcotic

phenanthrene-type, alkaloids. This species is rather a source of thebaine. Occurrence of morphine in other Papaverales and Papaveraceae, as well as in some species of hops and mulberry trees has not been confirmed. Morphine is produced most predominantly early in the life cycle of the plant. Past the optimum point for extraction, various processes in the plant produce codeine, thebaine, and in some cases negligible amounts of hydromorphone, dihydromorphine, dihydrocodeine, tetrahydro-thebaine, and hydrocodone (these compounds are rather synthesized from thebaine and oripavine). The human body produces endorphines, which are endogenous opioid peptides that function as neurotransmitters and have similar effects.

In clinical medicine, morphine is regarded as the gold standard, or benchmark, of opioid analgesics used to relieve severe or agonizing pain and suffering. Like other opioids, such as oxycodone, hydromorphone, and diacetylmorphine (heroin), morphine acts directly on the central nervous system (CNS) to relieve pain. Morphine has a high potential for addiction; tolerance and psychological dependence develop rapidly, although physiological dependence may take several months to develop.

Codeine

Codeine or **3-methylmorphine** (a natural isomer of methylated morphine, the other being the semi-synthetic 6-methylmorphine) is an opiate used for its analgesic, antitussive, antidiarrheal, antihypertensive, antianxiety, sedative and hypnotic properties, to suppress premature labor contractions, myocardial infarction, suppress coughing, as well as many other uses. Codeine is the second-most predominant alkaloid in opium, at up to three percent. Although codeine can be extracted from natural sources, a semi-synthetic process is the primary source of codeine for pharmaceutical use. It is considered the prototype of the weak to midrange opioids (tramadol, dextropropoxyphene, dihydrocodeine, hydrocodone, oxycodone).

Esters of Morphine

There are several semi-synthetic opioids derived from the opiate morphine. Heroin (diacetylmorphine) is a morphine prodrug, meaning that it is metabolized by the body into morphine after administration. One of the major metabolites of heroin, 6-monoacetylmorphine (6-MAM), is also a morphine prodrug. Nicomorphine (morphine dinicotinate), dipropanoylmorphine (morphine dipropionate), desomorphine (di-hydro-desoxy-morphine), methyldesorphine, acetylpropionylmorphine, dibenzoylmorphine, diacetyldihydromorphine, and several others are also derived from morphine.

Withdrawal effects

Opiate withdrawal syndrome effects are associated with the abrupt cessation or reduction of prolonged opiate usage.

In medical facilities such as hospitals and clinics, the threat of relapse is possible when Post-acute-withdrawal syndrome is under-emphasized to patients in transitional phases, especially with short-term buprenorphine, methadone or health facilities.

A Summary of Recent Findings Regarding Substance Abuse in Alaska

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December, 1999

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Overview

Since 1994 the State of Alaska, Division of Alcohol and Drug Abuse has been conducting and participating in a significant level of federal and state funded research, with resources provided by the Department of Health and Human Services, Center for Substance Abuse Treatment Agency as well as by the State.

The federally funded research efforts, or needs assessment, have been designed to determine the prevalence, severity and needs for treatment of Alaska's substance abuse problems. This research has been conducted by the Division of Alcoholism and Drug Abuse in close collaboration with the Division of Public Health, Section of Epidemiology. The needs assessment research has assessed the situation State-wide, as well as among demographic and geographic groupings within the State. We have also compared findings from this research with findings from similar research efforts conducted by or about other states. While our needs assessment efforts are still ongoing a key finding has been the limits imposed by many of our current data sources, and while the on-going research includes efforts to address these data source constraints it is important to note that the findings mentioned herein are preliminary in nature. However, our efforts so far have produced results that either (a) appear to be confirmed from several sources or (b) raise questions that point toward further investigation.

Additionally, this report summarizes state funded research conducted by the University of Alaska Anchorage, Institute for Circumpolar Health Studies, on the Alcohol Safety Action Program, as well as a chemical dependency treatment outcome study conducted by New Standards, Inc. on over 1600 Alaskan residential and outpatient clients. The intent of the Alcohol Safety Action Program study was to measure the effectiveness of the program in reducing the number of re-offenses of alcohol related offenders. The outcome study provides information about the State's residential and outpatient clients from their admission to a treatment program to one year following admission.

While we summarize our research efforts of the last 5 years in this publication, researchers and others interested in complete copies of these reports should contact the Division of Alcoholism and Drug Abuse at 1(800)478-2072 or the Division of Public Health's Section of Epidemiology (907)269-8000.

Needs Assessment Data Sources and Research Methods:

Needs assessment information has been compiled from two broad categories of data: interstate data sources that are available regarding all or many states, and intrastate data sources that have been collected solely for Alaska's analytic and program planning purposes. Both categories relied upon data sources presumed to have high face validity. As we have proceeded through our analyses, we have discovered some limits to these assumptions that are inherent to the data; these limits will be noted.

Interstate data sources to date have included:

(i) the National Drug and Alcohol Treatment Unit Survey (NDATUS) to determine persons in treatment;

(ii) the National Institute of Alcoholism and Alcohol Abuse (NIAAA) County Alcohol Problem Indicators to determine mortality, using data with specific mentions of alcohol as a cause of death;

(iii) the Center for Disease Control's Behavioral Risk Factor Survey (BRFSS) and

(iv) the FBI's Uniform Crime Reporting (UCR) Arrest Statistics for all drug abuse violations and for arrests for driving under the influence of alcohol.

Intrastate substance abuse and dependence research to date has included

(i) a statewide residential telephone survey of 8,167 households over an approximately four month span of time;

(ii) a voluntary survey and urinalysis of 658 arrestees from four booking sites in Anchorage, Fairbanks and Bethel, and

(iii) a review of existing state databases for treatment, mortality and arrest data from 1990-95 regarding alcohol and drug arrests, accident injury and mortality, and treatment.

(iv) A small area (borough level) estimates of substance abuse prevalence and dependence based on synthetic estimates from the household telephone survey data.

This research summary includes an Interstate Substance Abuse Indicator Chartbook that compares Alaska Statewide data with that of other states, and executive summaries from the four intrastate studies described above.

Please note that due to limits in data availability from the several states the interstate data is several years older than, and different from, much of the intra-state data. It also should be mentioned that our recent in-State studies have used nationally accepted operational definitions for substance dependence or abuse used by other states in similar research efforts. In our interview studies for example, an individual is defined as having a lifetime diagnosis of substance dependence or abuse who has both used and had a symptom as defined by DSM-III-R within the last eighteen months. These particular study respondents have also been considered persons who may have needed treatment within the last year.

Independent reviews of the various studies have found their methods and conclusions sufficient to support the major findings presented in the attached executive summaries. Highlights from the reports can be briefly describes as follows:

I. Prevalence Findings:

A. Alcohol:

"Need for substance abuse treatment" is defined as being in a state of substance abuse or dependence, and requiring help to stop or reduce substance use, to prevent relapse, or to recover from the effects of abuse. The operational definition of treatment need is a diagnosis of a substance use disorder, either abuse or dependence. According to these definitions, the survey found 12.6 % of residents in need of treatment for dependence upon or abuse of alcohol, with an

additional 1.2% also in need for treatment for drug abuse or dependence. In comparison, the survey finds 0.5% of adults are estimated to be in need for treatment of drug dependence or abuse only.

Data from all other studies support the finding that alcohol is Alaska's problem substance of choice. Interstate comparative data is consistent with these findings. The attached interstate indicator analysis finds that Alaska is among the states with the nation's most severe rates of alcohol problems; with problems of alcohol abuse and dependence and need for treatment far exceeds the problems of dependence, abuse and need for treatment associated with all other drugs. According to this data Alaska experiences the fifth most severe rate of alcohol problems in the nation, based on death, arrest and treatment data. Alaska holds the dubious distinction of being ranked first in deaths with an explicit mention of alcohol, and thirteenth for deaths due to alcoholic cirrhosis. Alaska ranked tenth nationally in DUI arrests, and thirteenth in motor vehicle fatalities with blood alcohol levels greater than .10%. The 1993 BRFSS Alaska survey data used for national comparisons among states found Alaska to rank first nationally in mothers of newborns who admitted to having 3-4 drinks per week; fourth in "binge drinking" (5 or more drinks at least once in the past month); and second in "chronic" drinking (60 or more drinks per month).

While it is to early to determine if there is a trend it is encouraging that more recent BRFSS survey data includes: an estimate that over the 1993-95 time period Alaska adults estimated to be at risk for chronic drinking declined from 5.3% to 2.9% (national median = 2.77%); the percent of Alaska adult males who reported having 60 or more drinks in the month prior to the survey declined from 8.6% to 4.6% over the 1993-95 time period and among adult Alaska females the reported decline was from 1.6% to 1.1%; the per cent of Alaska adults who reported they had been drinking and driving in the month prior to the survey declined over the 1993-95 time period from 2.5% to 1.3%

Our recent telephone survey has produced an estimate of 9.7% of all Alaska adults as having a lifetime alcohol dependency, with another 4.1% identified as alcohol abusers. The need for treatment appears greatest among adults from 25 to 44 years of age. Alcohol and dependency problems appear to be most severe in the BRFSS regions identified as Southeast and Bush Alaska. Alcohol dependency and abuse rates are found to be twice as high among men as among women, and lifetime dependency is estimated as approximately 50% higher among Alaska Natives and Native Americans than among whites.

The substance abuse indicator analysis of five available States data indicators show that while the problems remain extremely severe, overall the alcohol and drug abuse problem in Alaska showed some significant improvement by the mid-1990s compared to the early 1990s. Overall treatment admissions increased, at the same time that mortality rates and injury rates from accidents declined. While difficulties with the data are noted within the full reports, as well as in the attached review of the reports, nonetheless this can be regarded as an indicator of progress in providing treatment identified in the reports as clearly needed.

B. Controlled Drugs:

Alaska, according to interstate indicator data from 1991-93, is among the states with the lowest rates of controlled drug problems (ranked 40th according to the "Drug Problem Index" described in the included Interstate Substance Abuse Chartbook, among the 50 states). This finding is supported through the household telephone survey and the urinalysis results from our arrestee study. Dependence on controlled substances seems most problematic among the two youngest age groups of Alaska adults (18-24 and 25-44 years of age). Among controlled substances marijuana dependence is, by far, the controlled substance most subject to user dependence in Alaska according to the household telephone survey. Marijuana dependence appears to be most pronounced in the roadless areas of the State described as "the Bush" region – one of the four Alaska demographic subdivisions used for studies routinely conducted for the Center for Disease Control and other agencies by the Alaska Section of Epidemiology. (The other regions are described as "Urban", Gulf Coast" and Southeast". However, the substance abuse indicator study found arrest rates for controlled substances to be greatest in the Gulf Coast region. The survey found approximately 2.5% of Bush residents can be described as having a lifetime diagnosis of marijuana dependence or abuse, while Statewide the diagnosis is estimated to apply to 1.1% of the population. (It should be noted that the "lifetime" diagnosis includes anyone who both used a controlled substance and had a symptom as defined by DSM-IIIR diagnostic criteria within the last 18 months prior to the household telephone survey.)

The marijuana problem is most pronounced among the 18-24 year age group (4.2% estimated as dependent, and an additional 1.0% as abusers), and is three times as likely to be found among men (1.7%) than among women (0.5%). Race and ethnicity also appear to impact the diagnosis: Alaska Natives and Native Americans evidenced marijuana dependency (1.9%) at a rate nearly double that of whites (1.0%). These demographic results were generally supported through urinalysis findings of the arrestee study, and through the NDATUS Alaska marijuana treatment data (Alaska ranked 8th in per capita persons receiving marijuana treatment, with 1.3 times more persons being treated than arrested).

Cocaine was identified by the household survey as the second most serious controlled substance subject to abuse and dependence among adult Alaskans. However, the number of individuals so diagnosed is small, with 0.2% receiving a current dependency diagnosis, the largest proportion (0.3%) in the urban part of the State, and with men predominating in this diagnosis by four to one over women. However, in the arrestee study, 18.5% of those volunteering for the study were diagnosed as abusing or dependent upon cocaine, and women were more likely than men to be diagnosed with cocaine dependence or abuse. Among Alaska's arrestees, whites were diagnosed with cocaine dependency at a rate more than twice as great as found among Alaska Natives while the survey data indicated a prevalence among whites only about 50% greater than that found among Alaska Natives. The majority of those identified as dependent were found to be severely dependent.

A caution regarding drug-related disease findings should be noted: Homelessness and the levels of four contagious diseases- HIV-AIDS, TB, hepatitis and syphilis- are associated with drug use. Their levels frequently correlate well with the levels of drug dependency and abuse estimated from survey, treatment and arrest data. This is not the case in Alaska. No HIV-AIDS data is

available from Alaska, but Alaska's TB rates are very high, and hepatitis-B rates are higher than would be expected according to drug-related data. This may result from (a) the inherent constraints imposed by a household telephone survey that will not reach the homeless or those without telephones, or (b) non-drug factors associated with public health or geographic conditions that may account for the contagious disease variance.

The household survey found 0.1% of adult household residents Statewide evidenced a dependency on amphetamines, and 0.1% on hallucinogens, with dependence concentrated among the 18-24 year age group. Among this group 0.6% were diagnosed as dependent upon amphetamines, except for a lower rate in the Bush region, and 0.3% were diagnosed for hallucinogen dependence - except in the Gulf Coast region where the prevalence was indicated to be 0.9%). Although the percentage is small, Native Alaskans showed a prevalence of amphetamine dependency four times greater than among whites.

C. Need For Treatment

Findings from these studies as well as on-going studies are intended to be used for policy planning and program adjustment purposes. Among the key findings revealed through the survey regarding the need for treatment are that while need exceeded 14% among adults in all four BRFSS regions of the State, the estimated need for alcohol and drug treatment are greatest in the Bush and Southeast BRFSS regions. These regions are where in excess of 16% of the adult population is in need of treatment. Again, the greatest need for treatment among adults was found to be for alcohol dependency and abuse. Statewide 12.6% of adults are estimated to be in need of treatment for alcohol dependency or abuse, while only 0.5% are estimated to be in need of treatment for drug dependency; and an additional 1.2% in need of treatment for both alcohol and drug dependency. The need for drug or combined dependency treatment appears to be greatest in the Bush BRFSS regions, in which 1.1% of the adult population is estimated to need treatment for combined or drug dependency or abuse. A diagnosis of marijuana dependence contributed significantly to the formulation of this Bush regional estimate, as the estimated marijuana dependence/abuse rate of 1.3% was more than double that found in any other region of the State.

State funded research conducted by the Institute for Circumpolar Health Studies assisted the Division of Alcoholism and Drug Abuse in measuring the effectiveness of the ASAP program in reducing the number of re-offenses of alcohol/drug related offenders in several sites throughout the state - Juneau, Anchorage, Fairbanks & Mat-Su. A significant finding of the study was that 65-66 percent of the clients referred to the ASAP program on their first DWI did not re-offend during a subsequent 3 year period.

The chemical dependency treatment outcome study, or New Standards report, provides data on 1024 residential patients and 510 outpatients who consented to the follow-up study. The researchers were successful in contacting 42% of the eligible residential patients and 54% of the eligible outpatients one year after admission to treatment. The one-year outcome results provide a psychosocial and clinical profile of the residential and outpatient groups, as well as important job, medical, and legal cost-offsets impacted by treatment.

The attached executive summaries and reviews, along with the accompanying Interstate Substance Abuse Indicator Chartbook, provide a clear, detailed overview of the condition of

substance abuse and the needs for treatment within the State. The cooperation received in the data collection efforts from Alaska's public treatment programs, the Department of Public Safety, and the Department of Corrections were crucial to the accomplishment of these reports, and is greatly appreciated.

EXECUTIVE SUMMARY:

TECHNICAL REPORT

ALASKA ADULT HOUSEHOLD TELEPHONE SURVEY STATEWIDE and SUBSTATE PLANNING REGIONS

Submitted to:

Alaska Department of Health and Social Services

Division of Alcohol and Drug Abuse and to the Section of Epidemiology of the Division of Public Health

Submitted by:

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March 1998

EXECUTIVE SUMMARY

The resources that have been made available by the Center for Substance Abuse Treatment (CSAT) and the Alaska Department of Health and Social Services, Division of Alcoholism and Drug Abuse (ADA), for conducting the Alaska adult household survey have expanded needs assessment efforts in Alaska during the 1997-1998 time period. The Gallup Organization has been pleased to join ADA in collecting data for a statewide adult household survey, administered by telephone in the state of Alaska, as part of Alaska's family of studies to develop needs assessment capabilities in the area of substance abuse and need for treatment. Substate planning regions in Alaska are the Urban, Gulf Coast, Southeast, and Bush regions.

The purpose of the adult household telephone survey was: To provide information on substance dependence, abuse, prevalence and the extent of unmet need and demand for substance abuse treatment services for adults in Alaska at the state and substate planning region level.

Sample Methodology

For the purpose of sampling, the adult population was stratified into four regions. Sampling was accomplished independently within each region using the truncated Casady-Lepkowski method of telephone sampling. The goal of Gallup's sampling scheme was to estimate treatment needs for adult alcohol and other drug users aged 18 and older. Gallup also oversampled persons in the 18 to 44 age group by substate planning region since this is the age group with relatively higher rates of illicit drug use. Specific efforts were made to estimate treatment needs for alcohol and other drugs among injection drug users and women of childbearing age.

Maximization of Data Quality

Two critical aspects of maximizing data quality for this project were maintaining respondent confidentiality and maintaining quality control over interviewers' work. In order to ensure confidentiality: 1) all Gallup personnel who worked on this project signed a statement promising that they would maintain the confidentiality of all survey data; and 2) no personal identifying information was delivered to ADA with the final adult survey data set. To maintain quality control over interviewers' work, supervisors silently monitored the interviewers' work and checked interviewers' completed work for accuracy and completeness.

Characteristics of the Sample

Demographic data for persons who participated in the study provide the following information about the sample by county:

- 68.3% of the respondents were ages 18-44 with slightly more than half (55.9%) of the respondents found in the 25 to 44 years of age category.

- In all regions over 64% of the respondents were 18-44 years of age. This was due to the oversampling of persons of this age group.

- Females comprised 54.1% of the sample. For all regions, over half of the sample was female.

- More than seven in ten (72.7%) of the sample was white and 21.1% was Native American or Alaskan Native. "Other races" made up 6.2% of the sample.

- Most of the respondents had a high school education or greater (92%).

- 42.3% reported an income of less than $40,000.

SUBSTANTIVE ANALYSIS AND FINDINGS

Diagnosis Estimates for Dependence and Abuse

To determine whether a person should be diagnosed as dependent on or abusing a particular substance, the diagnosis criteria of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, 3rd revised edition (DSM-III-R), was used. To make a diagnosis, a respondent is asked a series of nine questions about his or her use of alcohol or a particular drug. A diagnosis of substance dependence requires meeting three of the nine DSM-III-R criteria and having some of the symptoms of disturbance that have persisted for at least one month, or have occurred repeatedly over time. The three criteria for dependence measure: 1) undesired excessive use, including resulting tolerance and withdrawal sickness; 2) problems in the critical realms of a person's life that are a result of excessive use; and 3) failed attempts to control substance use without help.

A diagnosis for substance abuse requires that two criteria are met: 1) continued use despite having recurrent social, occupational, psychological or physical problems exacerbated by it; and 2) recurrent use in situations where it is physically hazardous. Summary Tables 1a-3 present lifetime and current dependence and abuse estimates as well as estimates of lifetime treatment needs. All estimates are based on current (1997) estimates of census data. The weighting of the Alaska household survey data was done in early 1998, and the Claritas 1997 estimates were the most current estimates at the time.

Analysis of the Alaska adult household survey data produced the following lifetime diagnosis estimates for dependence and abuse.

- 9.7% (approximately 41,108) of adult Alaska residents were dependent on alcohol, and another 4.1% (approximately 17,294) were alcohol abusers.

- The proportion of alcohol dependence varied across all regions ranging from 8.5% to 11.9% for the Gulf Coast and Bush regions respectively.

- Alcohol abuse estimates ranged from 3.2% for the Bush region to 4.9% in the Southeast region.

- Diagnosis estimates of alcohol dependence and abuse were twice as high among men compared to women.

- Native Americans and Alaskan Natives had the highest lifetime estimates of alcohol dependence (14.9%) while the estimate for whites was 9.2%.

- The rate of marijuana dependence (1.1%) was about one-tenth of the estimated alcohol dependence (9.7%) Abuse of marijuana was low (0.4% at approximately 1,761 adults).

- Low rates of hallucinogen, cocaine, and amphetamine dependence (0.1%, 0.2%, and 0.1% respectively) were found in Alaska.

- No respondents were diagnosed as dependent on heroin or inhalants.

- Statewide abuse of hallucinogens was 0.1%, while no respondents were diagnosed as abusers of cocaine, heroin, inhalants, or amphetamines.

- Adults under 65 years of age were much more likely than those 65 or older to be dependent on or abusing drugs and alcohol.

Summary Table 1: Lifetime Estimates of Dependence and Abuse of Alcohol and Illicit Substances, Statewide and by Substate Planning Region

		Substate Planning Region			
	Alaska	***Urban***	***Gulf Coast***	***Southeast***	***Bush***
	N=423,997	N=277,071	N=50,796	N=52,538	N=43,592
Percentage diagnosed as	(n=8,167)	(n=2,543)	(n=1,587)	(n=2,017)	(n=2,020)
Dependent on:					
Alcohol	9.7	9.4	8.5	10.5	11.9
Marijuana	1.1	1.0	1.0	1.1	2.5
Hallucinogens	0.1	0.0	0.1	0.1	0.1
Cocaine	0.2	0.3	0.1	0.2	0.1
Heroin	0.0	0.0	0.0	0.0	0.0
Inhalants	0.0	0.0	0.0	0.0	0.0
Amphetamines	0.1	0.1	0.2	0.1	0.0
Abusing:					
Alcohol	4.1	4.1	3.9	4.9	3.2
Marijuana	0.4	0.4	0.5	0.4	0.2
Hallucinogens	0.1	0.1	0.0	0.0	0.0
Cocaine	0.0	0.0	0.0	0.0	0.0
Heroin	0.0	0.0	0.0	0.0	0.0
Inhalants	0.0	0.0	0.0	0.0	0.0
Amphetamines	0.0	0.0	0.0	0.0	0.0

Summary Table 2: Current Estimates of Dependence and Abuse of Alcohol and Illicit Substances, Statewide and by Substate Planning Region

		Substate Planning Region			
	Alaska	***Urban***	***Gulf Coast***	***Southeast***	***Bush***
Percentage diagnosed as	N=423,997 (n=8,167)	N=277,071 (n=2,543)	N=50,796 (n=1,587)	N=52,538 (n=2,017)	N=43,592 (n=2,020)
Dependent on:					
Alcohol	5.2	5.2	3.5	5.1	6.8
Marijuana	0.4	0.4	0.1	0.3	1.1
Hallucinogens	0.0	0.0	0.0	0.1	0.1
Cocaine	0.1	0.1	0.1	0.1	0.0
Heroin	0.0	0.0	0.0	0.0	0.0
Inhalants	0.0	0.0	0.1	0.0	0.0
Amphetamines	0.1	0.1	0.1	0.1	0.0
Abusing:					
Alcohol	2.1	1.9	1.8	3.5	2.0
Marijuana	0.1	0.1	0.1	0.2	0.1
Hallucinogens	0.0	0.0	0.0	0.0	0.0
Cocaine	0.0	0.0	0.0	0.0	0.0
Heroin	0.0	0.0	0.0	0.0	0.0
Inhalants	0.0	0.0	0.0	0.0	0.0
Amphetamines	0.0	0.0	0.0	0.0	0.0

Treatment Needs Based on Diagnoses

"Need for treatment" is defined as being in a state of substance abuse or dependence and requiring help to stop or cut down on substance use, to prevent relapse, or to recover from the effects of use. The operational definition of treatment need is a diagnosis of a substance use disorder, either abuse or dependence. Indeterminate diagnoses were not included in the definition of the need for treatment. Using the diagnoses for dependence and abuse of substances, the number of persons who need treatment for alcohol only, drugs only, and both alcohol and drugs were determined.

- 12.6% of adults (about 53,268 persons) in Alaska need treatment for alcohol only. Another 1.2% (approximately 5,134 persons) need treatment for both drugs and alcohol. 0.5% (approximately 2,270 persons) need treatment for drugs only.

- The proportion of persons who need alcohol treatment varies across the substate planning regions.

- The estimated need for alcohol treatment was found primarily in the 18-64 year old segment of the population (more than 10%). About half this rate, 5.1%, was reported by the 65 and older age group.

- A pronounced need for alcohol treatment only (48%) as well as both drug and alcohol treatment (14.5%) was found among injection drug users.

Summary Table 3: Lifetime Estimates of Need for Alcohol and Other Drug Treatment, Statewide and by Substate Planning Region

		Substate Planning Region			
Need for:	***Alaska*** N=423,997 (n=8,167)	***Urban*** N=277,071 (n=2,543)	***Gulf Coast*** N=50,796 (n=1,587)	***Southeast*** N=52,538 (n=2,017)	***Bush*** N=43,592 (n=2,020)
Alcohol Treatment Only	12.6	12.3	11.3	14.4	13.5
Drug Treatment Only	0.5	0.4	0.7	0.6	1.1
Both Alcohol and Drug Treatment	1.2	1.2	1.0	1.0	1.6

Unmet Demand for Self-Reported Treatment Needs

For policy planning purposes, the measurement of unmet demand is a key objective of needs assessment. "Unmet demand" is defined as the number of people who need and want treatment, but who have not received it because it was unavailable. Presumably, unmet demand is the prime reason for seeking additional funds, changing allocations of existing funds, and developing new programs that are appropriate for underserved populations. In the adult household survey, respondents were asked if they received treatment in the last year and, if so, what kind they obtained and if they had a desire for more treatment. For those who did not receive treatment in the past year, respondents were asked whether they needed treatment in the past year, whether they would have obtained treatment if it had been available, what type of treatment they would have wanted, and what obstacles, if any, prevented them from receiving treatment.

Among those who received treatment in the past 12 months and desired more treatment...(N=1,093)

The vast majority of Alaska adults who desired more treatment for their substance use problem were found to be aged 25 to 44 (79%). These persons were residents of all regions.

- 50.3% of the persons who desired more treatment for their substance use problem were women. Again, these persons were residents of all regions, with the largest proportions in the Urban and Southeast regions (55.4% and 54.7% respectively).
- Over two-thirds (72.8%) of the persons who desired more treatment were white.
- Among women of childbearing age, 50.3% desired additional treatment. These women were found in all regions except the Gulf Coast.
- Among injection drug users, 21% desired more treatment. These individuals were found in all regions, with the largest proportion (26.9%) in the Urban region.

Among those who desired treatment but did not obtain treatment in the past 12 months...(N=1,622)

- All adults (100%) who desired treatment but had not obtained treatment in the past 12 months were ages 18 to 64. More than three-quarters (79%) of the adults who desired treatment were ages 25 to 44.

- 59.6% of the adults who desired treatment but had not obtained treatment in the past 12 months, were men. This proportion of men was not uniform throughout the state. It ranged from 59.0% in the Urban region to 90.4% in the Bush region.

- More than two-thirds of adults who desired treatment but had not received treatment were white.

- Among those who did not receive treatment in the past 12 months, but desired treatment, the largest proportion were women of childbearing age (40.4%).

- Of the adults who desired treatment, 12.7% were injection drug users, and all of these drug users were in the Urban region.

Obstacles to Treatment

Among those who received treatment in the past 12 months and desired more treatment...(N=1,093)

Adults who received treatment in the past 12 months and who cited obstacles to receiving more treatment were found in all regions. The following obstacles were reported by 25% or more of these respondents on a statewide basis:

- Lack of insurance or other means to pay for treatment
- Specific treatment type was not available
- Program did not have the special services they needed.

Among those who desired treatment but did not receive treatment in the past 12 months...(N=1,622)

Adults who cited obstacles to obtaining treatment in the past 12 months were found in all regions. The following obstacles were reported by 25% or more of these respondents on a statewide basis:

- Lack of insurance or other means to pay for treatment
- Programs put them through too much red tape
- Long distance between them and the nearest treatment facilities
- Treatment facilities were full, and
- Could not get the type of treatment they wanted.

Conclusions

- 9.7% of adult Alaska residents were dependent on alcohol and another 4.1% were diagnosed as alcohol abusers. This translates into approximately 58,402 adult Alaska residents in need of treatment for alcohol.

- Looking at persons who are abusing or dependent on drugs only, 0.5% percent are in need of treatment. This translates into 2,270 persons needing treatment for drugs only.

- Among the defined age groups, the need for alcohol treatment is most pronounced in adults ages 25 - 44 (14.9%).

- 21% of the persons who had received treatment in the past 12 months and desired more treatment were injection drug users.

- The major obstacles to receiving treatment reported by persons who had received treatment in the past 12 months and desired more treatment were: lack of insurance or other means to pay, specific treatment type was not available, and the programs did not have the special services they needed.

- 40.4% of persons who desired treatment but had not received treatment in the past 12 months were women of childbearing age. Slightly more than one in eight (12.7%) were injection drug users.

- Obstacles to receiving treatment cited by those who desired it but had not received any treatment in the past 12 months included: lack of insurance or other means to pay, the programs put them through too much red tape, the nearest treatment facilities were too far away, the treatment programs were full, and respondents could not get the type of treatment they wanted.

- The data show that alcohol treatment needs varied across the four defined substate planning regions in Alaska.

EXECUTIVE SUMMARY:

TECHNICAL REPORT

SUBSTANCE ABUSE INDICATOR STUDY FOR TREATMENT RESOURCE ALLOCATION

Submitted to:

Alaska Department of Health and Social Services

Division of Alcohol and Drug Abuse and to the Section of Epidemiology of the Division of Public Health

Submitted by:

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December 1998

Executive Summary

The Alaska Substance Abuse Indicator Study (SAIS) was designed to allow the Alaska Division of Alcohol and Drug Abuse and Division of Public Health (ADA /DPH) to coordinate and compile related data within the state of Alaska on substance abuse; to develop substance abuse indicator models for application to allocate treatment service resources in the state of Alaska; and to understand the context of substance use in the state by looking at the trends of common indicators. In addition, the SAIS was also expected to improve communication linkages between ADA /DPH and those public and private agencies which monitor direct and indirect substance abuse indicators in order to further expand the utility of existing information.

Background

ADA /DPH currently takes into consideration the existing substance abuse indicator data at best marginally when determining substance abuse treatment resource allocation. ADA /DPH attempts to put core substance abuse services in each region. ADA /DPH requires needs assessment data to assess the proportion of the population in need of treatment which is able to receive treatment and the number of persons still in need of treatment in order to guide planning efforts. The division guides its treatment services resource allocation decisions on the basis of the population size, substance abuse prevalence and the need for core services in each region. ADA /DPH sought to address scientifically treatment planning needs, and received funding by the Center for Substance Abuse and Treatment (CSAT) to contract with The Gallup Organization (Gallup) to explore alternative approaches for resource allocation decisions.

The SAIS compared and contrasted three categories of treatment resource allocation models: 1) *population-based model*, 2) *indicator-based model*, and 3) *household survey-based model.*

The population-based model typically considers only the population size of the geographic unit in allocating resources. This approach may consider the variations in local cost index, but would hardly consider the data on local treatment service need.

The household and indicator-based models, in contrast to the population-based model, consider the local treatment need in allocating treatment resources. The household survey-based model considers the locally estimated need for treatment services. Treatment need, as measured in the latest Gallup adult household survey, is defined as those adults who were diagnosed as dependent on alcohol, drugs, or both drugs and alcohol, and those diagnosed as abusing one or more substances, as measured by the Diagnostic Statistical Manual (DSM-III-R) criteria. The main limitation in assessing treatment need with the household survey is that the data are expensive to collect and are not collected routinely by the state.

The indicator-based model offers a promising alternative approach, which is not only less costly but also promotes using the existing data from other state agencies. The indicator-based model The indicator-based model offers a promising alternative approach, which is not only less costly but also promotes using the existing data from other state agencies. uses the secondary data to determine the prevalence of substance abuse at the region level.

Method

The study was implemented from July 1996 to December 1998 in three phases: 1) data collection and coordination, 2) indicator selection and validation, and 3) modeling and resource allocation. Gallup, with assistance from ADA /DPH, collected substance abuse indicator data for the five year period of 1990 to 1994. The data were subjected to modeling efforts in a series of steps:

Step 1: Data on the substance abuse indicators were described as the *rates* (per 100,000 population) to allow for comparisons across the boroughs. The *rates* were calculated by using the region level data on each substance abuse indicator (such as number of arrests, mortality etc.) as the *numerator* and the six year (1990-95) average of Alaska Population or 1995 Alaska Population as the *denominator.*

Step 2: These rates were used to calculate the *severity indices* for each indicator and each region. Severity Indices were expressed on a scale of 0 to 100, where score of 100 fixes the top of the range of substance abuse problem. A region with the highest rate on a given indicator will have 100 as its severity index for that indicator. All other severity indices within a given region are expressed as a percentage of the largest problem.

Step 3: Severity indices were combined to develop a *composite severity index* (CSI) for each region. The CSIs score remains on a scale of 0 to 100 and is derived by taking an average of all severity indices for each region.

Step 4: The CSIs were multiplied with the adult region population to estimate the region's *problem size.* The problem size is an estimate of the substance abuse problem derived by multiplying the CSI with the region's five (1990-94) year population average.

Step 5: *Allocation factors*, in proportion to the region's problem size, were established to guide the treatment resource allocation decisions. The sum of the problem sizes of each region represents the total problem size for the state of Alaska and was used to establish the proportional resource allocation factor for each region in the state of Alaska.

Limits of the Data

The data on arrests and treatment cover the period 1990 to 1994, while the data on accident injuries accident fatalities, and mortality cover the period 1991-1995. In addition to different dates for the indicator data, two of the indicator data sets -- for accident injuries and accident fatalities -- do not include either the race or geographical variables.

The lack of a geographical variable is particularly important when considering the modeling to determine resource allocation. The purpose of resource allocation is to assess what proportion of resources are needed in each of the four regions in Alaska, and thus the lack of the geographical

variable for two of the indicators means that those indicators cannot be used to make those resource allocation estimates.

Trends in Rates of Treatment, Arrests, Mortality, Accident Injuries and Accident Fatalities

A comparison of the five indicators across the five years for which they are available shows that overall the alcohol and drug abuse problem in Alaska showed some significant improvement by the mid-1990s compared to the early 1990s. Overall treatment increased, at the same time that mortality rates and injury rates from accidents declined. There was little change in accident fatality rates, however, which were quite low. Arrests related to alcohol and drug abuse increased slightly across the state as a whole over the five-year period.

Alaska Treatment Resource Allocation Model

Of all the substance abuse indicator data elements included in the Alaska SAIS database, only two were chosen for modeling purposes because complete data grouped by region, race, gender were available. Others (accidents and injuries data) could not be included because of incomplete data sets. The two indicators chosen for modeling were the following:

- Total alcohol and drug related arrests
- Total drug and alcohol related mortality

Gallup's analysis showed that the indicator-based model emerges as a promising approach for allocating treatment resources among boroughs. Gallup developed two indicator-based models, a telephone survey model, and a population model for ADA /DPH to guide its treatment resource allocation decisions. ***Model One*** includes both the indicators but calculates the rates using the average of 1990-95 populations. ***Model Two*** considers both the indicators but calculates the rates based on the 1995 Alaska population. ***Model Three*** is based on the results of the telephone survey, while ***Model Four*** is based on the size of population. The treatment resource allocation factors, using these models, are shown in Table 1.

Table 1. Treatment Resource Allocation Factors Among the Various Models

	Urban Region	Gulf Coast Region	Southeast Region	Bush Region
Indicator Model #1	57.6%	13.8%	13.5%	15.1%
Indicator Model #2	58.0%	14.1%	13.4%	14.5%
Telephone Survey Model	63.7%	10.4%	13.9%	12.0%
Population Model	64.4%	11.6%	12.3%	11.7%

Recommendations

Gallup believes that the experience gained by ADA /DPH in designing and implementing the SAIS produced promising results. Gallup's recommendations focus on using the indicator-based model, updating the SAIS database, and meeting methodological challenges.

Using Indicator-Based Model

Gallup believes that ADA /DPH can achieve cost-effectiveness in resource allocation by guiding its decisions with the indicator-based model presented in this report. This approach not only takes into account the size of the population, but also the severity of the substance abuse problem in the region.

Updating the SAIS Database

Gallup encourages ADA /DPH to make arrangements to update the 1990 to 1994 SAIS database from cooperating agencies on an annual basis. In this way, any changes in the statistical relationships within and among social indicators can be determined. This would allow ADA /DPH to provide timely social indicator information to other public and private organizations with an interest in substance abuse prevention, treatment and related activities.

EXECUTIVE SUMMARY:

TECHNICAL REPORT

ALASKA SMALL AREA ESTIMATION STUDY

Submitted to:

Alaska Department of Health and Social Services

Division of Alcohol and Drug Abuse and to the Section of Epidemiology of the Division of Public Health

Submitted by:

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December 1998

EXECUTIVE SUMMARY

Introduction

The small area estimation study for the state of Alaska was undertaken as a follow-up task of the statewide Adult Household Survey conducted by the Gallup Organization in 1997-98. The main objective of the small area estimation study was to improve the overall precision of some of the key household study estimates at the 'small area' level. The resources provided by the Center for Substance Abuse Treatment (CSAT) and the Alaska Department of Health and Social Services, Division of Alcoholism and Drug Abuse (ADA) have expanded needs assessment efforts in Alaska during the 1997-1998 time period. The goal of the adult household survey was to provide information on substance dependence, abuse, prevalence and treatment needs for adults in the state of Alaska mainly at the state and the sub-state planning region level. For small areas, however, the traditional direct survey estimators based solely on the household study may have relatively large standard errors because of inadequate sample size at the 'small area' level. The objective of the small area estimation task, therefore, was to improve the precision of such small area estimates by taking advantage of relevant information at the small area level.

Methodology

In the state of Alaska, the boroughs within each sub-state planning region were chosen as 'small area' for the purpose of this small area estimation analysis. Estimates were computed to provide information on dependence, abuse, severity and treatment need for Alcohol, Marijuana and other drugs. Estimates for both lifetime and current diagnosis were derived. The analysis was carried out following the methodology proposed by Chattopadhyay et al. (1996). A detailed description of the estimation method is discussed in Section 2 of this report. Empirical Bayes estimates were computed at the small area (borough) level. In order to evaluate the appropriateness of the small area estimation methodology, Section 3 tables also include both the direct survey estimates (based on adult household survey data) and the small area estimates at the borough level. As expected, the small area estimates were, in general, found to be more precise than the direct survey estimates at the borough level.

Section 3 of this report presents the small area estimates for each borough. The estimates were computed for the following variables: (i) Diagnosis of alcohol dependence, abuse, and severity of alcohol dependence (ii) Diagnosis of marijuana dependence, abuse, and severity of marijuana dependence and (iii) Diagnosis of other drugs dependence, abuse, and severity of other drugs dependence. The 'other drugs' included the following five drugs: Hallucinogen, Cocaine, Heroin/Opiate, Amphetamine and Inhalants. Since very few respondents were diagnosed as dependent or abusers of these drugs particularly at the borough level, these drugs were put together in the 'other drugs' category. Respondents with diagnosis of dependence on any one of the five drugs, for example, were treated as diagnosed for dependence on 'other drugs.' For the severity variable, all respondents with diagnosis of severe dependence (on alcohol, marijuana or other drugs) were treated as being diagnosed for severity. The remaining (no severity, mild severity or moderate severity) were treated as being not diagnosed for severity. Besides the lifetime diagnosis variables mentioned above, small area estimates were also computed for

current diagnosis variables for alcohol, marijuana and other drugs. Using the diagnoses for dependence and abuse of substances, small area estimates of the percentage of adults who need treatment for alcohol only, drugs only, and both alcohol and drugs were also derived at the borough level. The definitions of diagnosis of dependence, abuse or severity according to the DSM-IIIR are available in the adult household study report.

The small area estimation analysis was based on the Alaska adult household survey data and current census data. For details of the methodology, definition of terms and data collection procedures used in the adult household study, please refer to the adult household survey report (1998) submitted by the Gallup Organization. The current estimates of the census data were obtained from the on-line database called CLARITAS if Ithaca, New York.

Major Findings

The small area estimation was carried out using the sample data of the Alaska Adult household Study. The sample size (# of completed interviews) at the borough level varied significantly. The maximum sample size was (1534) in Anchorage whereas the minimum size (49) was in Bristol Bay and Lake and Peninsula. Besides Anchorage, the boroughs with relatively higher sample size were Kenai Peninsula (1062), Juneau (855), Fairbanks Northstar (548), Bethel (483) and Ketchikan Gateway (412). Some other boroughs with relatively smaller sample size were Haines (67), Aleutians East (77) and Aleutians West (99). Use of small area estimation techniques become particularly important for the boroughs with smaller sample size.

As explained in this report, the boroughs were chosen as the 'small areas' for this analysis. It is found that the proposed small area estimates (the empirical bayes estimates) are more reliable (in terms of sampling error or precision) as compared to the direct survey estimators (based on the adult study) at the borough level. The empirical bayes estimates are, therefore, recommended at the borough level particularly for boroughs with smaller sample size.

The following findings are based on data presented in Table1 through Table 15 of Section 3 of this report.

Lifetime Diagnosis of Alcohol Dependence: The estimated percentage of adults with lifetime diagnosis of alcohol dependence varied across boroughs. Based on the empirical bayes estimates, the percentages ranged from 7.75 to 13.78. The top three boroughs were Yukon-Koyukuk (13.78), North Slope (13.78), Bethel (12.94). The bottom three boroughs were Kodiak Island (7.75), Kenai Peninsula (8.47), Matanuska-Susitna (8.96). The sampling error as measured by the square root of mean square error (mse) for the estimates were in the range of 0.75 to 2.76. The margin of error (precision) calculated as 1.96 times the square root of mse is always found to be less than 5 percent.

Lifetime Diagnosis of Alcohol Abuse: The estimated percentage of adults with lifetime diagnosis of alcohol abuse varied across boroughs. Based on the empirical bayes estimates, the percentages ranged from 2.33 to 6.67. The top three boroughs were Aleutians West (6.67), Prince of Wales (5.75)and Juneau (5.18). The bottom three boroughs were Bethel (2.33), Dillingham (2.83) and Wade Hampton (2.86). The sampling error as measured by the square root of mean square error (mse) for the estimates were in the range of 0.52 to 1.54. The maximum

margin of error (precision) calculated as 1.96 times the square root of mse is found to be only about 3 percent.

Lifetime Diagnosis of Marijuana Dependence: The estimated percentage of adults with lifetime diagnosis of marijuana dependence varied across boroughs. Based on the empirical bayes estimates, the percentages ranged from 0.59 to 2.88. The top three boroughs were North Slope (2.88), Wade Hampton (2.81) and Norhwest Arctic (2.70). The bottom three boroughs were Matanuska-Susitna (0.59), Sitka (0.85) and Haines (0.85). The sampling error as measured by the square root of mean square error (mse) for the estimates were in the range of 0.25 to 0.89. The maximum margin of error (precision) calculated as 1.96 times the square root of mse is only about 1.74 percent.

Lifetime Diagnosis of Marijuana Abuse: The estimated percentage of adults with lifetime diagnosis of marijuana abuse did not vary much across boroughs. Based on the empirical bayes estimates, the percentages ranged from 0.13 to 0.59. The top three boroughs were Kodiak Island (0.59), Valdez-Cordova (0.53) and Kenai Peninsula (0.51) where as the bottom three boroughs were Wade Hampton (0.13), Northwest Arctic (0.14) and Bethel (0.14). The sampling error as measured by the square root of mean square error (mse) for the estimates were in the range of 0.05 to 0.23. The maximum margin of error (precision) calculated as 1.96 times the square root of mse is less than .5 percent.

Lifetime Diagnosis of 'Other drugs' dependence and abuse: The estimated percentage of adults with lifetime diagnosis of dependence or abuse on 'other drugs' did not vary much across boroughs. There were very few cases reported in these categories and the maximum percentage estimate for dependence and abuse was only about 0.59 and 0.12 percent respectively. The margin of error (precision) calculated as 1.96 times the square root of mse was also very small (less than 0.5 percent).

Any Current Alcohol Diagnosis: The estimated percentage of adults with any current alcohol diagnosis varied across boroughs. Based on the empirical bayes estimates, the percentages ranged from 5.07 to 10.03. The top three boroughs were Prince of Wales (10.03), Lake and Peninsula (9.90) and Nome (9.54). The bottom three boroughs were Kenai Peninsula (5.07), Valdez-Cordova (5.23) and Kodiak Island (5.52). The sampling error as measured by the square root of mean square error (mse) for the estimates were in the range of 0.66 to 2.15. The maximum margin of error (precision) calculated as 1.96 times the square root of mse is always less than 5 percent.

Any Current Marijuana Diagnosis: The estimated percentage of adults with any current marijuana diagnosis did not vary significantly across boroughs. Based on the empirical bayes estimates, the percentages ranged from 0.24 to 1.40. The sampling error as measured by the square root of mean square error (mse) for the estimates were in the range of 0.10 to 0.47. The maximum margin of error (precision) calculated as 1.96 times the square root of mse is less than 1 percent.

Any Current Other Drug Diagnosis: The estimated percentage of adults with any current 'other Drugs' diagnosis did not vary significantly across boroughs. There were very few cases reported in this category and the percentages ranged from 0.05 to 0.37. The margin of error (precision)

calculated as 1.96 times the square root of mse was also very small (less than 0.5 percent).

Need for Alcohol Treatment only: The estimated percentage of adults needing alcohol treatment only varied across boroughs. Based on the empirical bayes estimates, the percentages ranged from 10.04 to 17.77. The top three boroughs were Prince of Wales (17.77), Aleutians West (16.95) and Ketchikan Gateway (15.59). The bottom three boroughs were Wade Hampton (10.04), Valdez-Cordova (10.95) and Kodiak Island (11.12). The sampling error as measured by the square root of mean square error (mse) for the estimates were in the range of 0.85 to 3.08. The margin of error (precision) calculated as 1.96 times the square root of mse is found to be about 6 percent.

Need for Drug Treatment only: The estimated percentage of adults needing drug treatment only did not vary significantly across boroughs. Based on the empirical bayes estimates, the percentages ranged from 0.34 to 1.30. The sampling error as measured by the square root of mean square error (mse) for the estimates were in the range of 0.10 to 0.56. The margin of error (precision) calculated as 1.96 times the square root of mse is found to be only about 1 percent.

Need for both Alcohol and Drug Treatment: The estimated percentage of adults needing both alcohol and drug treatment did not vary significantly across boroughs. Based on the empirical bayes estimates, the percentages ranged from 0.77 to 2.01. The sampling error as measured by the square root of mean square error (mse) for the estimates were in the range of 0.24 to 0.57. The margin of error (precision) calculated as 1.96 times the square root of mse is found to be only about 1 percent.

In summary, the number of adults diagnosed for dependence or abuse was significantly higher for alcohol as compared to other drugs. Among drugs excluding alcohol, marijuana had the maximum number of diagnosed cases. There were very few cases of diagnosis for other drugs consisting of Hallucinogen, Cocaine, Heroin/Opiate, Amphetamine and Inhalants. The pattern was similar for both lifetime and current diagnosis variables. The number of adults needing treatment was also much higher for alcohol as compared to other drugs.

EXECUTIVE SUMMARY:

TECHNICAL REPORT

ALASKA
SUBSTANCE ABUSE NEED for TREATMENT
Among ARRESTEES (SANTA)

Prepared by
Johnson, Bassin &Shaw

Submitted to:

Alaska Department of Health and Social Services

Division of Alcohol and Drug Abuse and to the Section of Epidemiology of the Division of Public Health

December 4, 1998

EXECUTIVE SUMMARY

The Federal Center for Substance Abuse Treatment (CSAT) provided several State agencies with funding to perform a family of studies to estimate statewide need for substance abuse and dependency treatment. One member of the family of studies is the Substance Abuse Need for Treatment among Arrestees (SANTA). As its name implies, SANTA is designed to provide preliminary estimates of treatment need among arrestees. Arrestees are targeted for special study because substance use and abuse are especially high in this population and because substance use is often associated with the commission of other crimes. The six objectives of the Alaska SANTA study were to: (1) profile arrestees who met DSM-III-R diagnostic criteria for substance abuse or dependence; (2) profile arrestees whose urinalyses were positive for at least 1 of 10 drugs tested; (3) compare results of self-report data and urinalyses; (4) describe the substance abuse treatment histories of arrestees who had positive urinalyses as well as treatment histories of arrestees with DSM-III-R substance abuse/dependence diagnoses; (5) identify factors associated with chemical detection and DSM-III-R diagnoses of substance abuse or dependence; and, (6) compare current SANTA results with previous Drug Use Forecasting (DUF) survey results.

The study participants were 658 adult arrestees from four jails at three sites: Anchorage, Fairbanks, and Yukon/Kuskokwim. Sites were selected for ethnic diversity, degree of urbanicity, high flow rates, and relatively high numbers of female arrestees. Participants were asked to complete a modified DUF interview, which measures DSM-III-R substance abuse and dependence diagnostic criteria, treatment history, and demographics. Participants also were asked to provide a urine sample, which provided chemical evidence of recent ingestion of 10 drugs. Eligibility requirements included arrest within the previous 48 hours, so that urinalysis results would indicate whether the arrestee was under the influence at the time of arrest.

Interviews were conducted by local college students with criminal justice or social science training or other relevant experience. Interviewers were trained by staff from the Center for Substance Abuse Research (CESAR). Urinalysis was conducted by Quest Diagnostics, Inc. Data were analyzed by JBS. More than half of study participants received a substance abuse or dependence diagnosis. Also, more than half tested positive for at least one drug. Alcohol was the substance most frequently associated with an abuse/dependence diagnosis. Cocaine was the illicit drug most frequently associated with a DSM-III-R substance abuse/dependence diagnosis, followed by marijuana. Marijuana was the illicit drug most frequently associated with a positive urine test, followed by cocaine. Males were more likely than females to be diagnosed with marijuana abuse/dependence or test positive for marijuana. Females were more likely than males to be diagnosed with cocaine abuse/dependence or test positive for cocaine. Arrestees who were older were more likely than those who were younger to receive an alcohol or cocaine abuse/dependence diagnosis. Older arrestees were also more likely than younger ones to have a urine test indicating cocaine use. Younger arrestees were more likely than older ones to test positive for marijuana or to be diagnosed as abusing or dependent on marijuana. Alcohol abuse and dependence were more prevalent among Alaskan Natives than other ethnic groups, while Alaskan Natives were less likely than other ethnic groups to be diagnosed with cocaine abuse/dependence.

For marijuana and cocaine there was a higher rate of positive urinalysis than DSM-III-R diagnosis. This indicates that some arrestees who use these drugs either do not currently meet the criteria for an abuse/dependence diagnosis, or that they are not honestly reporting their symptoms. For narcotics and amphetamines, more arrestees were diagnosed with abuse/ dependence than tested positive. Thus, many arrestees who are in need of substance use treatment for narcotics or amphetamine abuse/dependence either had not used their problem substance recently before arrest, or received a false negative urine test.

Urinalysis results and self-reports of last 3 days' use were often discrepant. With the exception of amphetamines, most arrestees who tested positive denied using the corresponding drug. In the case of amphetamines, the same proportion who tested positive reported using them within the last 3 days. Discrepant results may be due to resistance to giving socially undesirable responses, misunderstanding or procedural errors during the interview, or measurement error in the interview or urine tests.

Nearly three-fourths of those who tested positive for drug use had not received treatment within the past year. Over 60 percent of those with positive urinalyses who had not received treatment within the past year also did not perceive that they needed treatment for their substance use, indicating that this population is unlikely to seek or participate in treatment voluntarily. Just over 70 percent of arrestees with DSM-III-R substance abuse/dependence diagnoses did not report that they had received substance abuse treatment during the past year. Just under half of those with diagnoses who had not received treatment also did not perceive that they needed treatment. These findings suggest that efforts to treat this problem should include not only providing adequate treatment slots, but also outreach efforts to encourage participation.

Need for treatment may be predicted by ethnicity, sex, and type of crime committed. Logistic regression results indicate that white arrestees are more likely than others to test positive for drug use. A DSM-III-R diagnosis of illicit drug abuse/dependence was predicted by being white, female, or a felon. A DSM-III-R diagnosis of alcohol abuse/dependence was predicted by being non-white, over 25 years old, or a non-felon. DSM-III-R diagnoses of abuse or dependence on both alcohol and drugs were predicted by being white.

In general, Alaska SANTA study participants were less likely to test positive for drug use than 1996 DUF study participants. This was especially true for cocaine, opiates/narcotics and multiple drugs.

Current results are derived from a convenience sample, and therefore cannot be generalized to Alaska's population of adult arrestees. More precise estimates can be derived from further research on the number of arrestees in the State, and from estimates of need among a random, representative sample of arrestees.

The current preliminary finding that a total of 397 (60.3%) out of 658 arrestees meet criteria for a DSM-III-R diagnosis of substance abuse/dependence suggests that a large proportion, possibly the majority, of arrestees in Alaska may be in need of substance abuse treatment services.

Alaska's Treatment Needs Assessment: Critical Review of Conducted Studies and Preparation of Information for Systems Planning

Submitted to:
The Division of Alcoholism and Drug Abuse
State of Alaska, Department of Health and Social Services

By:
The North Charles Research and Planning Group of North Charles, Inc.

March 11, 1999

Introduction

This report provides a summary of the study conducted by the North Charles Research and Planning Group (NCRPG) that produced the appended critical reviews of treatment needs assessment studies conducted for the State of Alaska. The State invested its State Treatment Needs Assessment Project (STNAP) round one support in three studies: 1) a survey of substance abuse treatment needs in the general household population, 2) a survey of recent arrestees that featured a computer-assisted personal interview concerning treatment needs and collected urine specimens to confirm the self-reported use of illicit drugs, and 3) a substance abuse indicator study. The substance abuse indicator study also included the use of a new methodology for distributing survey information compiled for four large geo-political groups of Alaska communities to smaller areas within the major groups. The survey contractors submitted draft final reports for the household survey (The Gallup Organization, Inc.), the Substance Abuse and Need for Treatment among Arrestees (SANTA) study (JBS, Inc.) and a Substance Abuse Indicator Study for Treatment Resource Allocation (Gallup). The contractors also submitted the data sets resulting from completed interviews in the household and arrestee studies along with information describing the process of the studies. The data collected from reporting agencies that were used in the indicator study were provided to NCRPG.

Alaska contracted with NCRPG to help evaluate the work of the contractors and to insure that the studies' methodologies and data are in adequate condition for the comprehensive substantive analyses that NCRPG will perform in round two of Alaska's STNAP. It is very important that these checks be conducted soon after the data collection is completed. If there are problems in the data sets, fixing those problems may be possible if they are discovered immediately. The evaluation of the materials delivered by the contractors will help assure that the contractors were compliant with the conditions of their contracts with Alaska. NCRPG evaluated the quality of the data and the adequacy of the documentation of the data and data collection procedures.

In many other fields, it is commonplace to have an independent expert advise the project sponsor regarding the technical adequacy of the work being completed. NCRPG used its unique background and general technical expertise to evaluate the studies conducted under contract with Gallup and JBS. As the CSAT technical assistance contractor for five years, NCRPG designed the data collection studies conducted by Alaska's contractors. NCRPG also reviewed final reports from many states with similar studies conducted by Gallup and JBS as well as by other state contractors. Frequently, NCRPG advised states about the technical adequacy of the finished product.

Household Survey

NCRPG evaluated the household telephone survey by reviewing analyzing the survey database and the adequacy (e.g., completeness) of the draft final report and the data collection procedures and outcome. The evaluation is included as Appendix A to this final report. The evaluation focused on the major concerns of how the response rate was defined, the components of the response rate including process measures such as the success in converting respondents who initially refused to participate into completed interviews, the sampling design, and procedures for weighting the sample to the population of the state.

NCRPG's overall evaluation of the telephone survey was that the information base accurately describes the current need for substance abuse treatment among people living in Alaskan households. Some of the strengths of the household survey conducted for Alaska include a satisfactory response rate, the use of an effective procedure for allocating more interviews to geographic areas where problems with substances were more prevalent, and estimates of the level of need for treatment that were consistent with estimates from other sources including the NCRPG substance abuse problem index and current levels of met demand for treatment. The information produced by the survey should make an important contribution to further efforts by ADA to improve treatment services.

The review pointed out the need for further processing of the data set that would recode responses now designated as "additional responses" that should be included into existing response categories. A number of interviews identified by the interviewers as of poor quality or self-reported by the respondents to be less than truthful needed to be examined and the results of the survey adjusted for any impact these cases might have on the outcomes. The procedure for weighting survey results to represent the population of Alaska needed to be better defined in the report, but we concluded that the method used fewer than the necessary number of age groups to compute population weights. NCRPG's review yielded several suggestions for improving Gallup's report of survey outcomes including the need to present need estimates based on the actual survey sample as well as after the survey statistics were applied to the state population.

SANTA Study

The evaluation of the SANTA study included topics similar to those used for the evaluation of the household survey, e.g., the quality of the data, and topics that are unique to SANTA studies. The evaluation of the SANTA study is included as Appendix B of this report. Among the concerns unique to SANTA studies that were considered in NCRPG's evaluation was the contractor's success in obtaining biological specimens (urine) for testing, the length of time between arrest and acquisition of a urine sample, the completeness of the report of the SANTA study with respect to documenting differences among sites, across arrest types, by the day and time of the arrests, and the differences between respondents who provided specimens and those who did not.

NCRPG's review of the draft report and inspection of the collected information set indicated that the SANTA study was conducted using procedures that were consistent with the study protocol. The information base resulting from the study seemed to be devoid of major flaws. We did find errors in the data definitions that suggested the need for a careful review of the data dictionary. Despite a high rate of refusal to provide biological samples and a high rate of underreporting of drug use (e.g., 60% of the arrestees who denied using marijuana in the last three days tested positive for the drug and 47% of arrestees who denied using cocaine had traces in their urine) the findings from the SANTA study show rates of recent drug use that are much higher than rates observed in the general population. For example, 58% of the SANTA respondents who submitted a urine sample tested positive for at least one drug.

The practical uses of the SANTA data primarily involve the criminal justice system. Features of the SANTA study design and questionnaire limit the study's ability to add to Alaska's knowledge about the statewide prevalence of current need for treatment. However, the SANTA

study outcomes could be profitably used to alert constituencies of the need to develop policies and strategies that would incorporate substance abuse treatment into the criminal justice system at the point of arrest. Providing treatment instead of or as part of imprisonment has become a major national agenda. The economy of providing treatment rather than incarceration merits further efforts in this area. The SANTA data on treatment need outcomes can be used to demonstrate just how large that economy might be in Alaska

Substance Abuse Indicator Study

The substance abuse indicator study was subjected to a review that focused on the selection of variables used in the estimation model, the documentation of the data, the quality of the data in the database, and the contractor's methods for determining reliability and validity for the estimation model. The review of the substance abuse indicator study is included in this report as Appendix C.

Gallup produced a social indicator model that estimated need for combined alcohol and drug treatment in four geo-political areas of Alaska using alcohol- and drug-related arrests and alcohol- and drug-related deaths. NCRPG concluded that other indicators besides those two could have been used profitably in the study. Using just the four major regions as the unit of analysis instead of the smaller census boroughs reduced the usefulness of the needs estimates for planning. Similarly, Gallup used demographic variables aggregated to the regional level with the result that demographic characteristics have little variance across regions. NCRPG's review of the Gallup study was critical of the lack of separate models for alcohol and drug treatment needs. We also noted that Gallup performed no tests of the validity or reliability of the social indicator model. Our review strongly suggested Gallup should give more attention to its report presentation. The graphs were hard to read and the formatting of tables included a confusing use of line numbers. In many displays, numbers were expressed in tens rather than units, but not labeled as such; no reason was provided for using a non-standard metric. There were many syntactical errors and inconsistencies in the body of the report. The explications of such key points as variable selection procedures and the current allocation criteria should have been clearer than they were.

In addition to the social indicator analysis, Gallup included a smaller study that applied a statistical method for using survey information available from large areas to estimate values in communities whose populations were too small to provide enough observations for reliable information. The discussion of the small area estimation procedure at the contractors conference in January concluded that the procedure, when applied to the unique geography of Alaska and the structure of Alaskan communities, did not produce small area estimates that were consistent with other models and experiential evidence.

The State of Alaska recognized the need for an effective method of projecting treatment need information across both time and communities. The initial effort to produce a social indicator based model was informative, particularly in pointing out the information needs of an effective model and the level of commitment necessary to develop a social indicator system that can be applied year after year. The Alaska STNAP studies funded by CSAT include the development of a permanent Alaska-based social indicator system.

Interstate Analysis

In addition to reviewing the reports of studies conducted in round one of the STNAP program, Alaska asked NCRPG to compare the preliminary results of the studies with similar findings from other states. The household survey review (Appendix A) and the SANTA study review (Appendix B) both include comparisons between Alaska's results and those observed in other states. The comparison among states of surveys of the general household population does help to place Alaska's substance abuse treatment needs in a state-level framework. For example, we found that Alaska had higher substance use rates than Montana and North Dakota, even though the demographic characteristics of the three states are similar in many respects. Marijuana treatment need estimates for Alaska were slightly lower than the estimates for Montana but much higher than the estimates for North Dakota. Comparisons among SANTA surveys do not support meaningful comparisons because the SANTA studies lack comparable methodologies for sampling and data collection. We reported the results of the severity of substance use related problems among arrestees in a number of other states in our SANTA study review (Appendix B) with a caution against over-interpreting differences between Alaska and other states.

The State wanted to know how Alaska compares to other states with regard to deaths, arrests, diseases, and treatment services related to substance abuse. Most of the funds for treatment services in Alaska come from State, rather than federal, sources. By documenting that Alaska's problems are especially severe and that other states may be doing more to combat the problems, planners can advise the legislature that more resources are needed. Alaska felt that the state-level comparative analyses should be done as soon as possible to spark interest in Alaska's STNAP and to open discussions among decision makers about changes in the amount of resources available and how the resources should be allocated. NCRPG included an interstate analysis in this small contract. That analysis, "How Does Alaska Stack Up? An Interstate Substance Abuse Indicator Analysis" is provided as Appendix D of this report.{EDITOR"S NOTE: This document has been replaced by an updated "Interstate Substance Abuse Indicator Chartbook" provided herein}

Contractors Conference

The Division of Alcoholism and Drug Abuse (ADA) accelerated the project schedule in order to be able to take advantage of opportunities in January and February to present information on the progress of the STNAP studies and findings from those studies to other agencies and governing bodies. In November, ADA requested that preliminary reviews of all the round one studies would be presented at a conference with the contractors that would take place on January 7th and 8th in Anchorage. NCRPG agreed adjust its schedule to satisfy ADA 's request.

At the meeting in Anchorage, the contractors presented their preliminary final reports of the studies to representatives of ADA and the Epidemiology Group of the Department of Health and Social Services. The Gallup Organization was present at the meeting to discuss the household survey and the substance abuse indicator study. JBS staff participated by telephone. NCRPG's critical review of the preliminary final reports was represented by Dr. Richard LaBrie. The ensuing discussion provided clear direction to the contractors regarding how the reports needed to be revised to achieve an accurate and complete documentation of the study materials for transfer to ADA .

NCRPG also presented the results of their interstate analysis at this meeting. The demonstration of how Alaska compares to other states on important indicators of need for alcohol and drug treatment, how the contrasts among states can be clearly expressed using models that produce comprehensive indexes of both alcohol and drug treatment need, and how Alaska's treatment system is responding to the need for treatment were very well received. It was agreed at that meeting that NCRPG would make available the raw data used in the interstate analysis to assist ADA in its presentations of the STNAP program.

Summary of Tasks and Deliverables

NCRPG completed all of the tasks defined in the study protocol and submitted all the deliverables itemized in its agreement with ADA . NCRPG expended effort and resources in order to satisfy requests made by ADA . The major adjustments to ADA 's interests and needs were, 1) accelerating the reviews of preliminary reports of round one studies in order to present the reviews at the beginning of January, 2) traveling to Anchorage to attend the two-day contractors meeting, 3) expanding the comparisons of round one studies to results from other states to include a separate interstate model of alcohol and treatment need and met demand for services, and 4) providing the detailed state-level information used in the interstate model to ADA to assist in their presentations.

The following is a brief summary of the study activities organized as list of benchmark events.

Date	Benchmark Event
9/11/98	Contract between Alaska ADA and North Charles signed by both parties.
10/5/98	Conference on study tasks: NCRPG, Clay McDowall, and Loren Jones (by phone)
10/19/98	Monthly report sent to ADA .
11/2/98	Revised tasks, timeline, and deliverables defined.
11/3/98	Monthly report sent to ADA .
11/9/98	Study protocol sent to ADA .
11/10/98	January meeting date set and preliminary agenda defined.
12/1/98	Monthly report sent to ADA .
12/7/98	SANTA preliminary report received by NCRPG and ADA .
12/8/98	SANTA questionnaire and data dictionary received by NCRPG and ADA .
12/10/98	Substance abuse indicator study preliminary report received by NCRPG and ADA .
12/31/98	Final agenda for January meeting.
1/4/99	Draft review of household survey completed and sent to ADA .
1/5/99	Draft review of substance abuse indicator study completed and sent to ADA .

Date	Benchmark Event
1/6/99	Draft review of SANTA study completed. Report delivered at January 7th meeting.
1/7/99	First day of meeting in Anchorage. Reviews presented to contractors and discussed.
1/8/99	Second day of meeting in Anchorage. Interstate analysis presented and discussed. Monthly report presented. Planning for round two studies took place.
1/31/99	Monthly report accompanied transfer of interstate data to ADA .
2/26/99	Final reports on all reviewed studies and report of interstate analysis sent to ADA .
3/10/99	Final report sent to ADA .

EXECUTIVE SUMMARY:

ALASKA ALOCHOL SAFETY ACTION PROGRAM
ICHS Efficacy Study Report

Completed for:
The Division of Alcoholism and Drug Abuse
Department of Health and Social Services

Completed by:
Institute for Circumpolar Health Studies
University of Alaska Anchorage

July, 1999

Executive Summary

Alaska's Alcohol Safety Action Program (ASAP) is based on a national model that seeks to reduce the frequency of alcohol-related traffic accidents through early identification of problem-drinkers and the initiation of appropriate interventions to deter alcohol-related drinking behavior.

The Institute for Circumpolar Health Studies assisted the state of Alaska Division of Alcoholism and Drug Abuse to update data which measures the effectiveness of the ASAP program in reducing the number of re-offenses of alcohol-related offenders. It is important to note that 65 to 66 percent of the client population included in this study did not have a recorded re-offence of any kind within three years of the first DWI offense. This report, as directed by the Division of Alcoholism and Drug Abuse Services, is intended to gain further insight into the adjudication and treatment characteristics of the 34 to 35 percent of the cases that did re-offend.

This descriptive study intended to first collect and merge alcohol offender and treatment data from selected ASAP locations throughout Alaska in order to gain an understanding of the arrest, adjudication, intake, and treatment processes across the state. Second, the study evaluated ASAP client characteristics within populated and urban areas and compared the data to the earlier studies of Kelso (1980) and Araji (1994). Third, the study evaluated the data to determine differences across the selected ASAP sites. Fourth, the study assessed and identified significant determinants for becoming a re-offender. Fifth, the length of time for an ASAP client to re-offend and the variables associated with moderating that time was evaluated. Finally, recommendations were provided regarding intake data protocol enhancement, process improvement strategies, and identification of the *high-risk* problem drinker.

The recommendations include:

- *Evaluate and redesign (possibly simplify) intake processes and data collection protocols by specifying common practices and identifying required data fields.*
- Evaluate the issues and characteristics (e.g. socioeconomic, cultural, judicial, treatment environment, etc) that delineate the differences between the four ASAP sites, and modify intervention and treatment processes that are consistent with the community environments.
- Initiate process improvement activities to evaluate and redesign the ASAP client activities and functions that take place during the times from arrest to conviction and conviction to assignment. Include law enforcement, courts, ASAP, and treatment providers in the process improvement and redesign efforts.
- *Establish a* high-risk *ASAP client profile and redesign the identification, adjudication, intake, and treatment processes to target this population and then evaluate the efficacy of the modifications.*
- Develop and refine predicative models that can be used by ASAP staff in the field that will facilitate the identification of *high-risk* clients as early as possible in the arrest, conviction, assignment and treatment process.

EXECUTIVE SUMMARY:

CHEMICAL DEPENDENCY TREATMENT OUTCOME STUDY

(NEW STANDARDS REPORT)

Completed for:
The Division of Alcoholism and Drug Abuse
Department of Health and Social Services

Completed by:
New Standard, Inc.

December, 1998

Executive Summary

Results from a study of Alaska's chemical dependency treatment programs show that the state's efforts are succeeding on several fronts. Follow-up interviews with participants in both inpatient and outpatient treatment programs indicate that, after one year, arrests and hospitalization decreased, while participants' employment rates and work attendance increased.

The Alaska Division of Alcoholism and Drug Abuse commissioned the treatment outcome study to measure the effectiveness of publicly funded residential and outpatient treatment programs. Beginning in February 1994, the study surveyed 1024 residential/step-down patients and 510 outpatients who consented to assessments at admission, discharge, and six and 12 months after admission to treatment. The findings were collected by New Standards Inc., a Minnesota-based authority in studying treatment programs.

The study will provide information to help policymakers design the best treatment and after-care programs for Alaskans.

The outcome study found:

- Of Alaskan patients surveyed, 56 percent of those in outpatient programs abstained from alcohol for one year after treatment, compared to 42 percent of residential patients. Outpatients in the study received an average of 59 hours of care, while patients in residential programs received an average of 39 days of inpatient care.

- The study also found there is a strong association between abstinence rates and post-treatment levels of care and peer support groups like Alcoholics Anonymous. For 75 percent of residential patients, formal aftercare taken for a year resulted in a year of sobriety. Formal aftercare during the first six months appears to have the strongest impact on recovery among outpatients, with 71 to 77 percent reporting sobriety.

- Both residential and outpatient program participants reported substantial decreases in legal problems one year posttreatment. Criminal arrests, traffic arrests and motor vehicle accidents dropped. This yields overall societal benefits as a result of chemical dependency treatment by easing demands on already overburdened legal and insurance systems.

- Documented reductions in hospitalizations and emergency care and outpatient care for chemical dependency program patients support the notion that, following treatment there is a shifting away from costly hospital and emergency room "crisis" or urgent care, toward more timely and appropriate preventive or routine outpatient treatment.

- Employment rates changed dramatically from pretreatment through one year after treatment. Full-time employment increased from 30 percent before treatment to 45 percent at 12 months. Conversely, unemployment rates dropped from 45 percent to 24 percent.

- Both residential and outpatients reported significant reductions in tardiness and missing work. Outpatients in particular reported fewer problems with supervisors and fewer mistakes on the job.

- A significant number of patients surveyed reported sexual and physical abuse; 10 percent of the residential patients and 8 percent of the outpatients indicated incest by a male relative. Twenty-eight percent of the outpatients and 29 percent of the residential patients reported physical abuse prior to age 18.

Interstate Substance Abuse Indicator Chartbook

Statement PhRMA

In Opposition of Alaska House Bill 53
March 26, 2013

Position: PhRMA opposes HB 53, which would create an undue burden on Alaskans who need pain treatment and interferes with the relationship between the patient and the primary care provider.

The Pharmaceutical Research and Manufacturers of America (PhRMA) is a voluntary, nonprofit association that represents the country's leading pharmaceutical research and biotechnology companies, which are devoted to inventing medications that allow patients to live longer, healthier and more productive lives. PhRMA companies are leading the way in the search for new cures and treatments. Since 2000, PhRMA member companies have invested over $500 billion in the search for new treatments and cures, including an estimated $49.5 billion in 2011 alone.

PhRMA appreciates the opportunity to provide comments about Alaska House Bill 53. PhRMA shares the concerns about the growing non-medical use of prescription drugs. People who abuse prescription drugs get them from multiple sources. According to a 2011 Government Accountability Office (GAO) report,[1] controlled substances can be diverted in a variety of ways from illegal or improper prescribing, prescription forgery, pharmacy thefts, or "doctor shopping" and can occur through illegal sales of controlled substances through internet pharmacies or pain clinics.[2] PhRMA believes that all participants in the drug manufacturing and distribution system must participate in the efforts to reduce the abuse of prescription drugs, especially because the majority of the medicines dispensed in the classes of most commonly-abused drugs are generic medicines.[3] There is not a single, easy solution and it requires shared accountability and partnership among all stakeholders in order to develop strategies to reduce the prevalence of prescription drug abuse.

While the intent of the legislation is to reduce non-medical use of pain medicines, it will likely create unintended consequences for patients and healthcare providers in Alaska. Less than two years ago, Washington State passed similar legislation to House Bill 53 (WAC 246-918-800). According to anecdotal reports and media articles, patients in Washington are now having difficulty accessing pain treatment and some are forced to drive several hours in order to access it, if they are even able to receive it at all.

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[1] GAO, Prescription Drug Control: DEA Has Enhanced Efforts to Combat Diversion, but Could Better Assess and Report Program Results, No. GAO-11-744 (2011).

[2] "According to the DEA, from fiscal years 2006 through 2009, rogue Internet pharmacies were a major source of this problem." *Id.* at 2. *See also* Prescription Drug Diversion: Combating the Scourge, Hearing Before the Subcomm. on Commerce, Manufacturing and Trade of the H. Comm. on Energy and Commerce, 112th Cong. 2 (2012) (statement of Joseph T. Rannazzisi, Deputy Assistant Administrator, DEA).

[3] Within the categories of most abused medicines as identified by the National Institute on Drug Abuse, an estimated 91% of prescriptions at the retail level were for generic medicines with only 9% of the prescriptions at the retail level for brand name medicines in calendar year 2011, based on PhRMA analysis of retail claims data from IMS Vector One National Audit (VONA), February 27, 2012. VONA aggregates data received from more than half of all retail pharmacies nationwide, representing nearly half of all retail prescriptions dispensed, but does not include mail-order prescriptions or prescriptions dispensed by long-term care pharmacies.

HB 53 would add an unnecessary burden for the patient who would be required to seek out a pain care specialist, of which there are few in Alaska. According to the American Academy of Pain Management, there are only seventeen pain specialists in the state and most of them are concentrated in the Anchorage region. Given the rural nature of Alaska, it is not easy for patients to access primary care in some areas, let alone particular specialists. In addition, patients who are suffering from chronic pain or a condition that requires pain treatment must usually rely upon family members, caregivers or friends to coordinate their care, transport them and even pick up their medications. These loved ones often have to sacrifice vacation days or take off days from work, not to mention a loss in income, in order to help the patient. HB 53 only adds to the complexity for these patients, and their families, to access the treatments and care that they need in a timely manner.

By requiring a third person or "gatekeeper" to prescribe medications at a certain dose, this legislation creates a barrier between the patient and their provider. Healthcare prescribers such as nurse practitioners, physician assistants, and physicians may not have the specific education or training set out in the legislation, but they have many years of education, training and expertise that allow them to safely prescribe medications to their patients on a daily basis. Moreover, they are in the best position to be familiar with their patient and that patient's clinical situation, including the patient's history, medication regimen and whether they are likely to consistently take their medications as prescribed. Requiring a third person to provide a consultation before a patient can receive treatment that their healthcare provider feels is necessary further delays access to needed medications and could create more fragmented or uncoordinated care.

PhRMA supports effective treatment, which requires access to, as well as compliance with, the prescribed regimen. Maximizing the potential for medicines to improve health depends upon people seeking, receiving, and following through on recommended care. More specifically, realizing the full value of medicines depends on appropriate medication use: being prescribed the right medicine at a dose and regularity to achieve the desired clinical effects and taking the medicine as prescribed consistently for the time required.

PhRMA has taken many steps to reduce the abuse of prescription medicine and to develop treatments for those who become addicted to medicines or other substances.

Drug Development: One task that is uniquely a responsibility of the companies engaged in the research to develop new treatments is the development of treatments for addiction. A recent PhRMA report indicates that in 2012 there were 26 medicines in development to treat addiction. Of those, 7 are intended to treat opioid addiction, 7 to treat cocaine addition, 4 to treat alcohol abuse, and 2 are for general drug dependence.

In addition, PhRMA member companies are going above and beyond by investing in innovative technology and developing abuse deterrent formulations of both new and existing drugs, formulations that can greatly reduce the potential for abuse because of the technology. Six abuse deterrent formulations have been approved by the FDA and are on the market, while 15 are in development as of December of 2012. FDA has recently issued guidance for manufacturers interested in developing and conducting studies of abuse deterrent formulations of either existing or new medicines.

Prescription Drug Monitoring Programs: As part of the solution to combat prescription drug abuse and misuse, PhRMA supports the use of Prescription Drug Monitoring Programs (PDMPs) and encourages both program enhancements and continued evaluations of effectiveness. Important improvements in the PDMP process include interstate interoperability where states can share data with each other through "real time" access to the data for providers and pharmacists. Data that is two weeks or older is not as useful in detecting

doctor-shopping as data that is "real time."

Education Programs for Prescribers and the Public: PhRMA believes that it is important for prescribers to be aware of the risks of addiction to medicines and to alert patients about those risks. In addition, prescribers need to know how to assess whether a patient poses a risk for addiction, and how to work with such patients to limit that risk. HB 53 states that a consultation is needed for patients who require 120 milligrams or more of an opiate. However, a "one-size-fits-all" approach is not supported in scientific literature or medical experts. Patients have many different characteristics and there are other variables that may require different doses from other patients. Establishing an arbitrary threshold fails to address the real issue. Experts have developed treatment guidelines and patient agreements that are specifically designed to address the risk of addiction, but prescribers may not know about those options, or may not have the time within the insurers' payment structures to work closely with patients. Therefore, education about the possibility of addiction and how to work with patients to prevent addiction would be much more beneficial.

It is also important for patients, and their family members, to be aware of the risks posed by abuse of prescription drugs, including the risk of an overdose or of addiction. PhRMA has worked with several groups over the past few years to develop educational programs. Most recently, PhRMA helped sponsor and provide content for DRUGFREE.org Medicine Abuse Awareness Project, which helps educate parents, grandparents and caregivers about the dangers and consequences if medications are misused and abused, as well as specific tips as to how to raise this topic with your child. Research has shown that kids are 50 percent less likely to abuse medication if a parent has talked to them about the risks of this behavior. Some other industry-sponsored educational programs have focused on a specific age group, such as teens, college students, adults, and seniors. In Washington State, PhRMA worked with Washington Health Foundation to educate college students on college campuses throughout the state about prescription drug abuse. And most recently, PhRMA is part of the National Governors' Association (NGA) Prescription Drug Abuse Academy, a seven-state, one year pilot where states are working with the NGA to create a tailored action plan to support specific policies to reduce the prevalence of drug abuse.

PhRMA's overall message on prescription drug abuse includes the following:

- Take your medicine EXACTLY as prescribed by your healthcare provider
- Do not share your medications with anyone
- Store it appropriately
- Dispose of it properly through household trash unless otherwise indicated on the label

Treatment Programs: There are treatment programs for addiction, but they are expensive, often have long waiting lists, and are often not supported by insurers or state programs. PhRMA believes that it is important for states to look at the scope of treatment programs available and whether there are ways to improve access to treatments.

In summary, PhRMA does not believe that creating access barriers or unnecessary restrictions for patients who need pain treatment is the answer to reducing prescription drug abuse and instead, will likely create unintended consequences. Rather, efforts that focus on education of patients and healthcare providers to prevent this behavior would be more effective. **For all of these reasons, PhRMA opposes HB 53.**

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January 28, 2013

RE: HB 53, "An Act establishing a consultation requirement with respect to the prescription of opiates under certain circumstances."

TO: Health and Social Services Committee Members

1. As the Medical Director of Interior AIDS Association's Project Special Delivery, the methadone treatment program for opiate addiction in Fairbanks, I want to commend Representative Keller for sponsoring this bill. HB 53 is a step in the right direction in addressing the rising epidemic of prescription pain killer addiction that is gripping our state and the nation. While I see recent major, positive changes in the Interior with regards to the provision of chronic pain management, there remains outliers fueling the supply of prescription opiates in our area. These pain killers invariably end up on the street.

2. HB 53 will help ensure patient safety with regards to high dose opiate pain killer use (ie, OxyContin, hydrocodone/ Vicodin, Percocet, morphine, etc.) by requiring consultation with a specialist in pain management. These medications can be very dangerous and have many interactions with other medications, some deadly. (See the recent report on Toxicity and Hospitalization due to Opioid Pain Relievers - Alaska, 2001-2010)

3. However, I want to alert the Committee to two flaws in the bill as written:

   a. First, there is no exclusion in Section 1 (c) for opiate addiction treatment. There are two opiate addiction treatment clinics in Alaska - ours and Narcotic Drug Treatment Center in Anchorage. We use methadone, a synthetic opiate medication, for the treatment of opiate addiction. This is a long-standing, well-established, and standard treatment for opiate addiction. In this instance, methadone is not prescribed for pain. Consultation with a pain medicine specialist would not only be inappropriate, it would be a barrier to treatment. I do not imagine the intention of this bill was to limit the treatment of opiate addiction. Therefore, I recommend that HB 53 be amended in Section 1 (c) to include the following:

      "(8) the provision of medication-assisted treatment in a certified opiate addiction treatment program."

   b. Second, the 120 milligram requirement seems problematic as not all opioid pain killers are equivalent with regards to potency at that level. For instance, fentanyl, a synthetic opioid, is dosed in *micorgrams*. Fentanyl is extremely potent and certainly a drug of abuse. There would never be an instance where fentanyl prescription would ever come close to the 120 mg requirement, and therefore, it would essentially be excluded from the rule.

4. Unfortunately, I am unavailable to testify at the hearing on January 31st. Please contact me directly for any questions or concerns. My cell number is 907-322-6856, and my email is nfliss@mac.com. I would be very happy to talk with anyone about this bill and/or opiate addiction treatment.

Nicole J. Fliss, M.D.
Medical Director

Sec. 11.71.900. Definitions.

In this chapter, unless the context clearly requires otherwise,

(15) "opiate" means

(A) a substance having an addiction-forming or addiction-sustaining capability similar to morphine or being capable of conversion into a drug having addiction-forming or addiction-sustaining capability; and

(B) includes its racemic and levorotatory forms; but

(C) does not include the dextrorotatory isomer of 3-methoxy-n-methylmorphinan and its salts (dextromethorphan);

Results from the 2011 National Survey on Drug Use and Health: Summary of National Findings

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Behavioral Health Statistics and Quality

Nonmedical Use of Prescription Pain Relievers

NSDUH data indicated that nonmedical use of prescription drugs among youths aged 12 to 17 and young adults aged 18 to 25 in 2011 was the second most prevalent illicit drug use category, with marijuana being first. NSDUH data showed a decline in past month nonmedical prescription drug use among youths between 2002 (4.0 percent) and 2008 (2.9 percent), with no significant change between 2008 and 2011 (2.8 percent). Among young adults aged 18 to 25, past month prevalence of nonmedical prescription drug use was 5.0 percent in 2011. This prevalence in 2011 was lower than the rates in other years since 2003, which varied between 5.9 and 6.5 percent. The most prevalent category of misused prescription drugs is pain relievers. Nonmedical pain reliever use in the past month among youths declined from 3.2 percent in 2002 to 2.3 percent in 2011, while the rate among young adults was lower in 2011 (3.6 percent) than in 2010 (4.4 percent) as well as in years from 2002 to 2009 (between 4.1 and 5.0 percent).

NSDUH and MTF use different definitions and questioning strategies to track misuse of prescription drugs. For example, NSDUH defines misuse as use of prescription drugs that were not prescribed for the respondent or use of these drugs only for the experience or feeling they caused; MTF defines misuse as use not under a doctor's orders. MTF also does not estimate overall prescription drug misuse. However, MTF asks questions about "narcotics other than heroin," a category similar in coverage to the pain reliever category in NSDUH. These data are reported for 12th graders and for young adults. In addition, as is the case with NSDUH trends, methodological changes in MTF have sometimes resulted in discontinuities. For the data on use of narcotics other than heroin, there was a questionnaire change in the 2002 MTF that resulted in increased reporting of opiates, such that estimates prior to 2002 are not strictly comparable with estimates for 2002 and beyond.

Figure 8.5 shows NSDUH data for past year misuse of pain relievers from 2002 to 2011 for youths aged 12 to 17 and young adults aged 18 to 25 (comparable estimates for prior years are not available). MTF data for 12th graders and young adults (aged 19 to 24) are shown for past year misuse of narcotics other than heroin since 2002. Except for 12th graders in MTF, both surveys showed declines from 2006 to 2011 in the prevalence of past year misuse of pain relievers/narcotics other than heroin. Among youths (NSDUH only), the rate of past year use declined from 7.2 to 5.9 percent. Among young adults, NSDUH showed a decline from 12.5 to 9.8 percent, while MTF showed a decline from 9.9 to 7.7 percent (**Table 8.5**). MTF estimates for 12th graders were similar between 2006 and 2011 (9.0 and 8.7 percent). However, the pattern of

estimates for 12th graders in MTF between 2006 and 2011 was in the same direction as those for youths in NSDUH and young adults in both surveys.

Figure 8.5 is titled "Past Year Nonmedical Pain Reliever Use among Youths and Young Adults in NSDUH and MTF: 2002 through 2011." It is a line graph, where the survey years for 2002 through 2011 are shown on the horizontal axis and the percentage using pain relievers nonmedically in the past year is shown on the vertical axis. There is a note under the figure that says, "MTF = Monitoring the Future; NSDUH = National Survey on Drug Use and Health." Another note says, "Data for MTF are for 'narcotics other than heroin.'" For each data source, there is a line representing the percentage using pain relievers nonmedically during the past year for the years shown. Tests of statistical significance at the .05 level were performed between 2011 and each of the previous years listed; significant results are indicated where appropriate.

According to NSDUH data for youths aged 12 to 17, the percentage reporting past year nonmedical pain reliever use was 7.6 percent in 2002, 7.7 percent in 2003, 7.4 percent in 2004, 6.9 percent in 2005, 7.2 percent in 2006, 6.7 percent in 2007, 6.5 percent in 2008, 6.6 percent in 2009, 6.3 percent in 2010, and 5.9 percent in 2011. The differences between the 2011 estimate and the 2002 through 2007 and the 2009 estimates were statistically significant.

According to NSDUH data for young adults aged 18 to 25, the percentage of young adults reporting past year nonmedical pain reliever use was 11.4 percent in 2002, 12.0 percent in 2003, 11.9 percent in 2004, 12.4 percent in 2005, 12.5 percent in 2006, 12.2 percent in 2007, 12.0 percent in both 2008 and 2009, 11.1 percent in 2010, and 9.8 percent in 2011. The differences between the 2011 estimate and the 2002 through 2010 estimates were statistically significant.

According to MTF data for 12th graders, the percentage reporting past year nonmedical pain reliever use was 9.4 percent in 2002, 9.3 percent in 2003, 9.5 percent in 2004, 9.0 percent in both 2005 and 2006, 9.2 percent in 2007, 9.1 percent in 2008, 9.2 percent in 2009, and 8.7 percent in both 2010 and 2011.

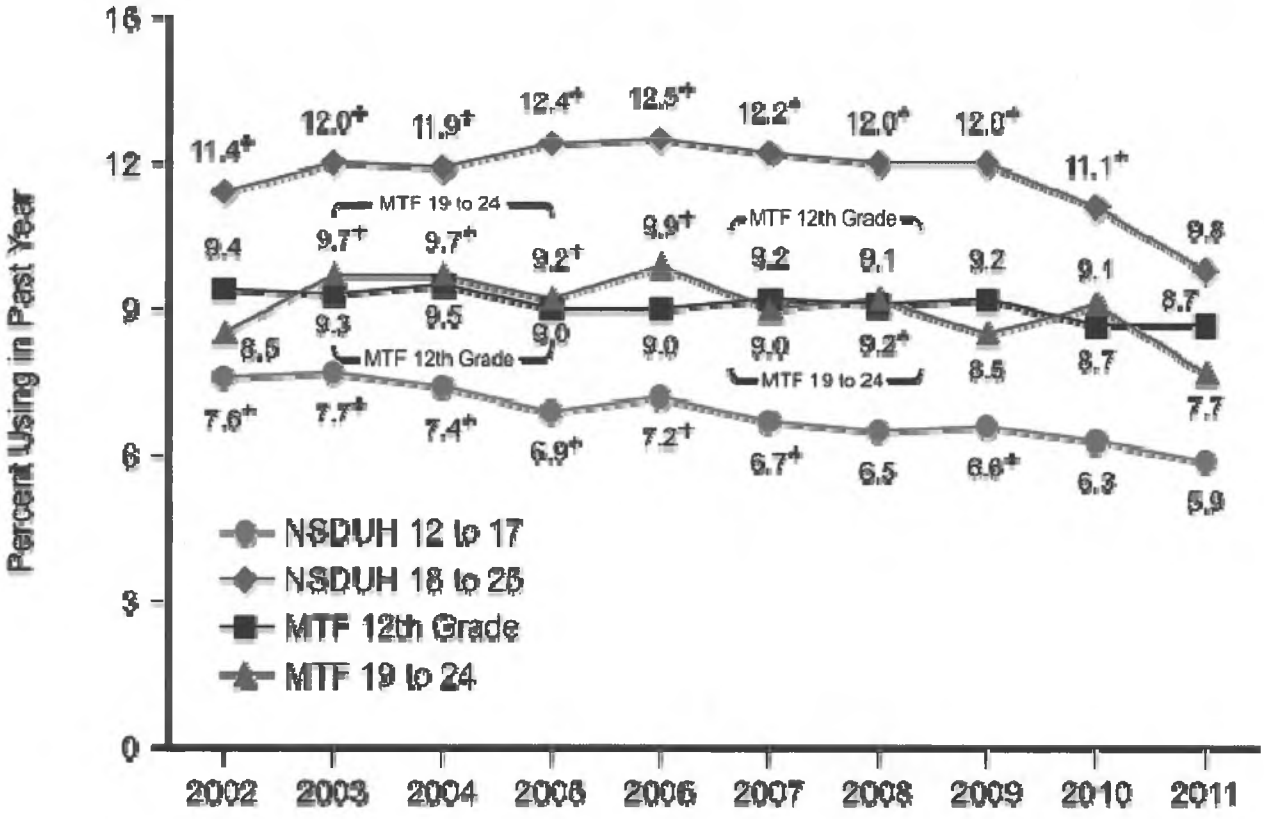
According to MTF data for young adults aged 19 to 24, the percentage reporting past year nonmedical pain reliever use was 8.5 percent in 2002, 9.7 percent in both 2003 and 2004, 9.2 percent in 2005, 9.9 percent in 2006, 9.0 percent in 2007, 9.2 percent in 2008, 8.5 percent in 2009, 9.1 percent in 2010, and 7.7 percent in 2011. The differences between the 2011 estimate and the 2003 through 2006 and the 2008 estimates were statistically significant.

Although the focus of attention is primarily on drug use among young people, NSDUH data demonstrate that the majority (57 percent) of past year nonmedical pain reliever users were aged 26 or older in 2011. Among this age group, the percentage that had used pain relievers nonmedically in the past 12 months rose from 3.1 percent in 2002 to 3.6 percent in 2006 and 2007, then declined to 3.2 percent in 2011.

These data generally indicate a decline in nonmedical pain reliever use from 2002 to 2011. However, other trends indicate a growing problem. According to NSDUH, initiation rates for nonmedical pain reliever use, although declining, were second to initiation rates for marijuana in 2010 and 2011 and were similar to or greater than marijuana initiation rates in 2002 to 2009.

There have been 1.9 million or more new nonmedical pain reliever users each year since 2002. The sustained numbers of new and continuing users have contributed to increases in indicators of problems associated with use, especially among adults. The number of persons with nonmedical pain reliever dependence increased from 936,000 in 2002 to 1.4 million in 2011. An estimated 56.1 percent of these pain reliever-dependent persons in 2011 were aged 26 or older, but about one third (472,000) were aged 18 to 25. The number of persons receiving specialty substance abuse treatment within the past year for misuse of pain relievers increased during this period, from 199,000 to 438,000. In 2011, 63.7 percent of those receiving specialty substance abuse treatment for pain relievers were aged 26 or older, and 29.6 percent were aged 18 to 25. TEDS and DAWN data confirm these trends. Special analyses of TEDS admissions data indicate that admissions to publicly funded substance abuse treatment programs for a nonheroin opiate problem increased from 91,000 in 2002 to 259,000 in 2010; in 2010, 69 percent of such admissions were aged 25 or older, and 28 percent were aged 18 to 24. According to DAWN data, the number of emergency department visits involving nonmedical use of narcotic pain relievers increased from 145,000 in 2004 to 360,000 in 2010 (Center for Behavioral Health Statistics and Quality, 2012).

Figure 8.5 Past Year Nonmedical Pain Reliever Use among Youths and Young Adults in NSDUH and MTF: 2002-2011



MTF = Monitoring the Future; NSDUH = National Survey on Drug Use and Health.
Note: Data for MTF are for "narcotics other than heroin."
+ Difference between this estimate and the 2011 estimate is statistically significant at the .05 level.