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**Task Force to Address the Opioid Crisis in the State
Final Report
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Staff:

**Anna Broome, Legislative Analyst
Erin Lundberg, Legislative Analyst
Office of Policy & Legal Analysis
13 State House Station
Room 215 Cross Office Building
Augusta, ME 04333-0013
(207) 287-1670
www.maine.gov/legis/opla**

Members:

**Sen. Andre E. Cushing III, Chair
Rep. Joyce "Jay" McCreight, Chair
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Sen. James F. Dill
Sen. Geoffrey M. Gratwick
Rep. Anne "Pinny" Beebe-Center
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Robert Fowler
Vernon Gardner
Katie Fullam Harris
Ross Hicks
Hon. Janet T. Mills
Malory Shaughnessy
Gordon H. Smith
Hon. William R. Stokes
Jeffrey Trafton
Christopher Pezzullo**

Table of Contents

EXECUTIVE SUMMARY	i
I. BACKGROUND	1
II. SUMMARY OF MEETINGS.....	6
III. RECOMMENDATIONS	10
A. Prevention and Harm Reduction	10
i. Parenting programs for families of drug-affected babies	10
ii. Long-acting reversible contraceptives	11
iii. Youth prevention programs	12
iv. Stigma-reducing language	13
v. Preventing diversion of prescription drugs	14
vi. Syringe exchange programs.....	15
B. Treatment	15
i. Hub and spoke and opioid health home treatment models	16
ii. Access to treatment.....	18
iii. Confidentiality provisions under federal law	18
iv. Housing and recovery residences	19
v. Access to information regarding treatment services	21
vi. Peer recovery centers and recovery coaching.....	22
C. Law Enforcement	22
i. Pre-diversion programs.....	23
ii. Specialty courts.....	24
iii. Treatment programs in jails and prisons.....	25
iv. Forfeiture funds.....	27

Appendices

- A. Authorizing legislation, Joint Order S.P. 210
- B. Membership list, Task Force to Address the Opioid Crisis in the State
- C. Department of Health and Human Services narrative on its efforts to address the opioid crisis
- D. Department of Health and Human Services presentation on opioid health homes
- E. Department of Health and Human Services September 27, 2017 answers to task force's questions
- F. Preliminary analysis of opioid treatment claims from the Maine Health Data Organization
- G. Prescription Monitoring Program data on total prescriptions, patients and unique prescribers of buprenorphine products
- H. Letter to the Department of Health and Human Services regarding the Snuggle ME curriculum and the Maine Enhanced Parenting Project
- I. Letters to medical provider organizations regarding long-action reversible contraceptives
- J. Resolve, Requiring the Department of Education to Establish a Work Group Regarding Drug Prevention Programs
- K. An Act To Implement the Recommendations of the Task Force to Address the Opioid Crisis Regarding Respectful Language
- L. Letter to the Drug Enforcement Administration requesting information on the National Prescription Drug Take-Back Day in Maine
- M. Letter to the Maine Board of Pharmacy about the disposal of excess medications
- N. MaineHealth's hub and spoke treatment model
- O. Letter to the Department of Health and Human Services regarding hub and spoke and opioid health home treatment models
- P. Letter to the Department of Health and Human Services regarding uninsured slots in opioid health homes and other treatment services
- Q. Letter to the Legislative Council in support of introducing legislation in the Second Regular Session
- R. Letters to congressional delegation and federal agencies regarding federal confidentiality laws.
- S. Letter to Maine State Housing Authority regarding a work group to develop a certification process for recovery housing
- T. Letter to the Department of Health and Human Services regarding the development of a database containing treatment services
- U. Letter to the 2-1-1 program requesting a report on areas of improvement to services regarding substance use disorders
- V. Substance abuse treatment programs in the state prison system
- W. An Act to Establish the State Coordinating Council on Corrections Practices Relating to Substance Use Treatment Programs
- X. Letter to the Joint Standing Committee on Appropriations and Financial Affairs expressing support for Sections 1 and 4 of LD 1429, An Act Regarding the Epidemic of Opiate Abuse
- Y. Descriptions of medications used to treat opioid use disorder

EXECUTIVE SUMMARY

In 2016, there were a total of 376 drug-induced deaths in Maine, which is more than one death a day. Because of the urgency of the opioid crisis, the Task Force to Address the Opioid Crisis in the State was created by the First Regular Session of the 128th Maine State Legislature by Joint Order, S.P. 210. The Opioid Task Force (the “task force”) was established to “examine the current laws in the State addressing opiate abuse and heroin use, including, but not limited to, existing laws focused on law enforcement, prevention, treatment and recovery.” The task force was further tasked with the following specific responsibilities:

- Review the 2016 report and recommendations of the Maine Opiate Collaborative (MOC);
- Review initiatives undertaken by other states, with particular attention to proposals regarding opioid treatment, enforcement and prevention; and
- Develop recommendations to address Maine’s opioid crisis.

The members of the task force were appointed by late March of 2017 and were required by the Joint Order to submit an initial report to the Legislature by April 30, 2017, which was submitted in April and revised in May 2017. The task force was also required to submit a final report with any recommendations and suggested legislation to the Legislature by December 6, 2017. The task force met ten times and finalized its recommendations at the November 28 meeting. As part of its deliberations, the task force divided into small groups to consider prevention/harm reduction, treatment/recovery and law enforcement.

The task force recognized that the final recommendations to address the opioid crisis needed to take an integrated and comprehensive approach. The recommendations are broken into three categories to reflect the work of the small groups and the approach of the MOC. However, in developing the recommendations, the task force did not lose sight of how the categories are interrelated.

The task force presents the following unanimous recommendations. The Executive Branch participated in the task force by providing information and collaborating with members but did not take any positions on particular recommendations or legislation.

Prevention and Harm Reduction Recommendations

The task force considers prevention and harm reduction a critical piece of addressing the opioid crisis. It is more efficient to prevent problems before they begin. Harm reduction minimizes the negative impact of the problem.

1. Request by letter that Maine Department of Health and Human Services report to the Joint Standing Committee on Health and Human Services by March 1, 2018 on the dissemination to providers of the updated Snuggle ME curriculum and other evidence-based programs and recommend expansion of Positive Parenting Program to parents and families who would benefit. (Appendix H.)

2. Request by letter that medical provider organizations communicate the importance of counseling patients on the importance of and availability of long-acting reversible contraception, including coverage under MaineCare. (Appendix I.)
3. The Joint Standing Committee on Education and Cultural Affairs consider introducing legislation directing the Department of Education to establish a work group to evaluate existing drug prevention programs targeting school-age children and how to incorporate those programs into educational curriculum. The work group should include the Maine Education Association, Maine School Management Association, Maine Principals Association, Maine Interscholastic Athletic Administrators Association and representatives of law enforcement and organizations that promote and facilitate programs relating to public health, drug prevention and the welfare of children. (Appendix J.)
4. The Joint Standing Committee on Health and Human Services consider introducing legislation directing the Office of the Revisor of Statutes to update the statutes to reflect current terminology relating to substance use disorders. (Appendix K.)
5. Promote programs that take back prescription drugs but do not create a consumer-borne cost for that program. Request by letter that Maine Drug Enforcement Administration report to the Joint Standing Committee on Criminal Justice and Public Safety by March 1, 2018 about the successes of the drug take-back programs; publicity of the collection days; the use of alternative drug disposal options, such as Deterra; and expanded placement of take-back units in appropriate law enforcement or other secure facilities. (Appendix L.) Request by letter to the Maine Board of Pharmacy that it require pharmacies to place a notice in an obvious place informing patients about disposing of excess medication. (Appendix M.)

Treatment and Recovery Recommendations

The task force spent a considerable amount of time considering treatment options because more than one person a day dies from an opioid overdose. Treatment is therefore critical to addressing the immediate needs of the crisis.

6. Request by letter to the Department of Health and Human Services to examine how the opioid health home model under the current Centers for Medicare and Medicaid Services waiver could integrate evidence-based treatments, such as the hub and spoke model in LD 1430, an Act To Develop a Statewide Resource and Referral Center and Develop Hub-and-spoke Models To Improve Access, Treatment and Recovery for Those with Substance Use Disorder, which was carried over to any Special or Regular Session of the 128th Legislature. Fund a continuum of evidence-based services of differing intensities that meet the treatment needs of individuals depending upon stage of recovery, including integrated medication-assisted treatment across the state and integrated community-based relationships. (Appendix O.)

7. Request by letter to the Department of Health and Human Services that it immediately increase access to treatment across the state for patients, including those who lack insurance or the means to pay, by increasing grant funds available to evidence-based programs that provide treatment to patients at varying levels of acuity. Request that the Department of Health and Human Services consider allowing minimum security offenders in custody or people in community release programs to access treatment slots for the uninsured. (Appendix P.)
8. Increase access to treatment across the state by increasing access to health insurance coverage. Write a letter to the Legislative Council to support the introduction of LR 2755, An Act Regarding Health Care Ombudsman Services, in the Second Regular Session. LR 2755 would assist people with accessing health insurance. (Appendix Q. The appeal to the Legislative Council was successful and the bill was approved for introduction.)
9. Request by letter to the congressional delegation, U.S. DHHS, SAMHSA and CMS that the federal government amend 42 CFR Part 2 and the related federal statute to allow for greater information sharing between providers regarding medication-assisted treatment and treatment of substance use disorders. (Appendix R.)
10. Support the development of recovery housing that meets the standards of the Maine Association of Recovery Residences to serve people in recovery, including those who are engaged in integrated medication-assisted treatment. Request by letter that Maine State Housing Authority convene a work group to develop a certification process for recovery housing and investigate available funding resources and development opportunities and to report quarterly to the Joint Standing Committees on Labor, Commerce, Research and Economic Development and Health and Human Services for one year, beginning March 1, 2018. The work group should include Maine's Department of Health and Human Services, Finance Authority of Maine, Maine Real Estate and Development Association, the Maine Association of Recovery Residences and representatives of treatment providers, housing services, affordable housing developers, the recovery community and persons experiencing homelessness. (Appendix S.)
11. Write a letter to the Legislative Council to support the introduction of two bill requests in the Second Regular Session dealing with recovery housing that are on appeal: LR 2744, An Act to Save Lives and Create the Homeless Opioid User Service Engagement Pilot Project and LR 2521, An Act to Ensure Quality of and Increase Access to Recovery Residences. (Appendix Q. The appeal to the Legislative Council for LR 2744 was successful and the bill was approved for introduction. The appeal for LR 2521 was tabled.)
12. Request by letter to Maine Department of Health and Human Services that the department evaluate the options for developing a database of available treatment services, including what information the database would contain; whether it could include real-time data and the usefulness of that data; how to accurately identify provider capacity and waitlists; how much it could cost; and how it could be implemented and

funded. The department shall report back to the Joint Standing Committee on Health and Human Services by March 1, 2018. (Appendix T.)

13. Request by letter to the 2-1-1 program of United Way of Mid-Maine that it report by March 1, 2018 to the Joint Standing Committee on Health and Human Services regarding ongoing improvements to the 2-1-1 service in relation to substance use disorders, including the accuracy and ease of accessibility of the website and database; staff training; outreach to providers who are not licensed by the State; and plans for increasing public awareness of 2-1-1 services, including alternative platforms to access information. (Appendix U.)

Law Enforcement Recommendations

The intersection between the criminal justice system and mental illness, substance use disorders or co-occurring disorders is well known. These recommendations address several aspects of the criminal justice system.

14. Develop and fund pre-charge diversion programs at the municipal, county and state levels. The programs should be developed in consultation with prosecutors, law enforcement and other stakeholders. The programs should minimize a person's contact with the criminal justice system by connecting them with treatment and recovery services, including case management, at the appropriate level based on an assessment process. Because implementing this recommendation requires the cooperation of the criminal justice and treatment communities, the Joint Standing Committees on Health and Human Services, Criminal Justice and Public Safety and Judiciary should collaborate to develop the programs.
15. The Joint Standing Committee on Judiciary consider introducing legislation that develops additional drug courts or increases access to existing drug courts across the state and provides the necessary funding.
16. The Joint Standing Committee on Criminal Justice and Public Safety consider introducing legislation that develops and funds assessments and services in jails upon intake for mental health and substance use disorders, including integrated medication-assisted treatment.
17. The Joint Standing Committee on Criminal Justice and Public Safety consider introducing legislation that develops and funds assessment and services for people in jails and prisons for mental health and substance use disorders, including integrated medication-assisted treatment and access to hub and spoke services in the community, for people serving their sentences.
18. The Joint Standing Committee on Criminal Justice and Public Safety consider introducing legislation that develops and funds programs that prepare inmates for their release into the community, including connections with integrated medication-assisted treatment and access to hub and spoke services in the community. These programs

should include family members or other supportive people in the inmate's life so they can be natural supports during reintegration.

19. The Joint Standing Committee on Criminal Justice and Public Safety consider introducing legislation that enacts an advisory board to advise the Department of Corrections and county or regional jails on the treatment programs and rehabilitation needs of the facility populations. The advisory board will evaluate on an ongoing basis existing services and evidence-based practices for managing the needs of offenders and pretrial defendants and recommend the implementation of appropriate programs. (Appendix W.)
20. Write a letter to the Joint Standing Committee on Appropriations and Financial Affairs expressing support for Sections 1 and 4 of LD 1429, An Act Regarding the Epidemic of Opiate Abuse, which has been carried over on the appropriations table. (Appendix X.)

I. BACKGROUND

The Opioid Crisis in Maine

The Opioid Task Force was established to deal with the burgeoning opioid crisis in the State of Maine. The membership of the task force reflects a broad diversity of experience with the opioid crisis, including legislators, providers of treatment services and recovery services, law enforcement and persons with recovery experience. The opioid crisis affects people from all walks of life, including every socioeconomic class, profession, gender, age group and ethnicity. The victims of the crisis reflect a broad cross-section of society. Because of that, the effects of the opioid crisis are far-reaching and have ripple effects on families, employers, the criminal justice system, child welfare, medical costs and a myriad of other facets of life.

There are a number of causes of the opioid crisis that have been explored, including over-prescribing of opioids, traumatic events, social isolation and Adverse Childhood Experiences (ACEs). Over-prescribing practices have been curtailed and this is described below. The task force believes that ACEs, in particular, are of tremendous significance in the growth and depth of the opioid crisis. Investing in the safety and wellbeing of children to reduce the number of adverse experiences would be an effective long-term prevention strategy. However, there is no single solution to the ACEs problem. Addressing this issue is complex and would have required the task force to exceed the scope of its expertise. Consequently, the task force focused on recommendations that could be accomplished in the short term.

The statistics about the extent of the crisis in Maine are alarming. According to data contained in a report commissioned by the Maine Attorney General titled, "Expanded Maine Drug Death Report for 2016:"

- In 2016, there were a total of 376 drug-induced deaths in Maine; this number represents an increase of 104 deaths, which is a 38% increase from 2015;
- Of the 376 overdose deaths, 330 (88%) were accidental overdoses, 38 (10%) were suicides and 8 (2%) were of an undetermined nature;
- 79% of overdose deaths in 2016 were caused by two or more drugs;
- 84% of the overdose deaths were caused by at least one opioid, including pharmaceutical and illicit opioid drugs;
- 63% of the overdose deaths were attributable to either fentanyl and/or heroin/morphine;
- 16% of the overdose deaths were attributable to cocaine, an increase by 71% since 2015;
- Deaths attributable to pharmaceutical opioids have remained relatively stable at 33% of the total; and
- The average age of overdose deaths in Maine for 2016 was 41. Males outnumber females by 2 to 1.

Between January and June of 2017, the Attorney General reported that there were 185 deaths attributable to drug overdose. Of those drug overdose deaths, 61% were caused by fentanyl and 30% were caused by pharmaceutical opioids. In a little over one-third of opioid deaths, the

victims were treated with naloxone. In 2016, 25% of persons who died from an overdose received were treated with naloxone.¹

The State Epidemiological Outcomes Workgroups Report, Substance Abuse Trends in Maine, State Epidemiological Profile 2017, identified basic statistics for treatment for people with substance use disorders:

- In 2013-14, young adults aged 18 to 25 years were the most likely age group to need but not receive treatment for drugs or alcohol. About one in eight 18 to 25 year olds in Maine needed but did not receive treatment for alcohol use and nearly one in ten needed but did not receive treatment for illicit drug use;
- In 2016, a little more than one in three substance use treatment admissions listed alcohol as the primary reason for treatment, following by heroin/morphine and other opiates/synthetics. 58% of the primary admissions were related to opioids. Primary admission rates related to heroin/morphine have steadily increased since 2012 and have surpassed synthetic opiates as the second most common substance; and
- Of the admissions that listed a secondary substance, nearly one in three was related to marijuana and one in four was related to synthetic opiates. Rates related to synthetic opiates have steadily decreased while rates involving heroin/morphine have progressively increased.

Creation of the Opioid Task Force

Because of the urgency of the opioid crisis, the Task Force to Address the Opioid Crisis in the State was created by the First Regular Session of the 128th Maine Legislature by Joint Order, S.P. 210 (Appendix A). The Opioid Task Force (the “task force”) was established to “examine the current laws in the State addressing opiate abuse and heroin use, including but not limited to existing laws focused on law enforcement, prevention, treatment and recovery.” The task force was further tasked with the following specific responsibilities:

- Review the 2016 report and recommendations of the Maine Opiate Collaborative (MOC);
- Review initiatives undertaken by other states, with particular attention to proposals regarding opioid treatment, enforcement and prevention; and
- Develop recommendations to address Maine’s opioid crisis.

The members of the task force (Appendix B) were appointed by late March 2017² and were required by the Joint Order to submit an initial report to the Legislature by April 30, 2017, which was submitted in April and revised in May 2017. The task force was also required to submit a final report with any recommendations and suggested legislation to the Legislature by December 6, 2017. The task force finalized its recommendations at the November 28 meeting.

¹ See <http://www.maine.gov/ag/news/article.shtml?id=765461>

² Dr. Christopher Pezzullo, Chief Health Officer with the Department of Health and Human Services (DHHS), joined the task force beginning with the September 12, 2017 meeting. The Executive Branch participated in the task force by providing information and collaborating with members but does not take any positions on particular recommendations or legislation.

Opioid Task Force approach and process

The task force met ten times between April and November 2017. The purpose of the task force's first two meetings was to obtain a broad overview of the scale and factors of the opioid epidemic in Maine. The task force intended to use the information gathered in these first two meetings as a basis for beginning to learn about the various aspects of the opioid crisis and receive an overview of the current status of the opioid epidemic in Maine by:

- Discerning the gaps in the current efforts to stem the opioid crisis;
- Identifying which programming efforts currently exist, including those in other states;
- Identifying which programs are proving to be effective; and
- Determining recommendations for laws and initiatives necessary to stem the opioid crisis in Maine.

The task force took the approach that addiction/substance use disorder is a chronic disease similar to diabetes, high blood pressure or asthma. At the first meeting, task force member Dr. Vernon Gardner provided a briefing on the brain chemistry of opioid addiction. He stated that, "[a]ddiction is a primary disease of brain circuits that affects emotions, memory, motivation and reward leading to biological, psychological, social and spiritual symptoms." Addiction is influenced by both biological genetic factors that affect a person's vulnerability to addiction and environmental factors, such as adverse childhood experiences (ACEs). Dr. Gardner also stated that marginalization and criminalization are not effective in reducing addiction. In separate materials distributed to the task force from a presentation to the Joint Standing Committee on Health and Human Services, Dr. Jonathan Fellers explained that addiction alters the brain so that the individual's ability to exert self-control is seriously impaired. Individuals with substance use disorders may relapse several times before recovery. Because of the medical basis of substance use disorders, research has demonstrated that integrated medication-assisted treatment (IMAT), which combines medication with behavioral supports, is the best practice.³

The task force's recommendations build on the process and progress of the MOC. The MOC was a coalition formed after a summit held by Governor LePage in August 2015 to address the opioid epidemic in the State. It was led by Thomas Delahanty, U.S. Attorney; Janet Mills, Attorney General; and Commissioner John Morris of the Department of Public Safety. The collaborative was organized into three groups focusing on (1) law enforcement, (2) prevention and harm reduction and (3) treatment. The MOC began its work in October 2015 and held multiple meetings and more than 20 public forums around the state. It issued its final report on May 6, 2016, which is available here: <https://www1.maine.gov/ag/docs/20160513084630118.pdf>.

The task force recognized that the final recommendations to address the opioid crisis needed to take an integrated and comprehensive approach. Many of the areas implicated in addressing the opioid crisis – the criminal justice system, availability of treatment services and public education, for example – are interrelated and interdependent and require a coordinated system. However, in order for the task force to be able to evaluate and develop recommendations in a manageable way and honor the work of the MOC, it decided to divide into three small groups –

³ When this reports identifies data provided by DHHS that references medication-assisted treatment (MAT), it is not an indication that the actual services being provided do not include behavioral supports.

prevention/harm reduction, treatment/recovery and law enforcement. The task force did not lose sight of how the small groups are interrelated. The small groups frequently identified in its meetings how many recommendations could fall into multiple small groups and were conscious of not creating “silos.”

The small groups began their discussions by reviewing the final recommendations of the MOC. The small groups reviewed which of those recommendations had already been accomplished and with regard to which legislative action is no longer necessary. The small groups also evaluated each of the MOC recommendations for ease and impact. Carol Kelly of Pivot Point, Inc., as a consultant for the Maine Medical Association, led the small groups through the matrix she developed to assess recommendations based on how easy they would be to implement and how great an impact they would have. The small groups used this exercise as a starting point to begin discussing recommendations in more detail and to determine where there was consensus among the members. The small groups also identified additional ideas for recommendations. The small groups met over the course of two meetings and reported back their recommendations to the full task force.

The task force reconvened as a whole group to receive the report backs from the small groups and continue their evaluation and discussion of which recommendations to put forward as a group. The task force used informal voting methods to identify the recommendations with the most support from the members.

During this time, the task force also received detailed information from the Department of Health and Human Services (“DHHS” or “the department”) through task force member Dr. Christopher Pezzullo. The task force engaged in a constructive dialogue with Dr. Pezzullo on understanding the efforts of the department to address the opioid crisis, understanding the data presented and any limitations of that data, feedback on accessing department programs and identifying areas where there could be collaboration. The task force also received a few additional presentations on background information as they decided on their final recommendations.

In order for the task force to make recommendations for the future, it identified existing legislation that addressed some of the recommendations of the MOC and gathered information about current activities of the Executive Branch relating to substance use disorders.⁴

In State Fiscal Year (SFY) 2017, the Office of MaineCare Services within DHHS spent over \$20 million for medication-assisted treatment (MAT) and the Office of Substance Abuse and Mental Health Services (SAMHS) spent \$880,000. In SFY 18, SAMHS has a \$5.5 million MAT budget, including \$2 million for opioid health homes (OHHs). OHHs are based on an integrated care delivery model, including substance use disorders counseling, care coordination, MAT, peer support and recovery coaching and medical consultation. OHHs were based on the behavioral health home (BHH) model, which also integrated physical and behavioral health services. Both BHHs and OHHs are reimbursed with a bundled rate rather than fee-for-service. In the spring of 2017, the Legislature authorized funding in a supplemental budget for the creation of OHHs to provide services to MaineCare members and the uninsured. The first OHH provider was approved by the end of April. As of September 2017, five OHHs had been approved with eight

⁴ Please see Appendix C for the narrative provided by DHHS outlining its efforts to address the opioid crisis.

distinct sites and 15 applications in process. The first OHH to begin serving MaineCare members is in Calais and was anticipated to begin offering services in October 2017. Other approved providers include two methadone clinics and one Federally Qualified Health Center. (See Appendix D for DHHS's presentation on OHHs received by the task force.)

In an effort to understand the number of individuals currently receiving MAT, the task force requested information from the department and from the Maine Health Data Organization (MHDO). Because there is no single source for data, the task force received a variety of data in an attempt to try to answer the question of the number of individuals in treatment:

- The department stated that as of September 18, 2017 there were 3,872 individuals in methadone treatment, 5,172 participants in buprenorphine (suboxone) treatment and 46 individuals in naltrexone treatment. This data represents a moment in time. (See Appendix E.)
- The MHDO provided a preliminary analysis of pharmacy and medical claims paid by commercial insurance in 2016. Different insurance companies use different medical codes to describe similar procedures and pharmaceuticals, making an exact count of individuals, prescriptions and costs very difficult. MHDO identified 2,412 pharmacy claims for buprenorphine/naloxone and 1,718 pharmacy claims for suboxone in 2016. MHDO stated that 739 members were covered for naltrexone and 525 for methadone. For medical claims, 65 members received inpatient detoxification and four received outpatient detoxification. 410 received outpatient substance use disorders treatment and 313 were covered for methadone treatment. (See Appendix F).
- Buprenorphine prescribing is entered into the Prescription Monitoring Program (PMP), which gives an indication of the actual number of prescribers, total patients and total prescriptions. In 2016, 892 prescribers treated 15,294 patients and prescribed 190,576 prescriptions. Between January 1, 2017 and September 30, 2017, 1,091 prescribers treated 15,064 patients and prescribed 178,765 buprenorphine prescriptions. (See Appendix G.) More physicians are qualified to prescribe buprenorphine through a Drug Enforcement Administration (DEA) waiver than actually prescribe. Knowing the number of physicians along with the number of patients the physician could manage does not give an accurate indication of the number of slots available for buprenorphine treatment for individuals with substance use disorders.

The task force also attempted to quantify the treatment capacity in the state, including the numbers of licensed residential treatment beds, intensive outpatient slots, detoxification beds and the length of waitlists. As will be discussed in the recommendations later, some members of the task force believe that the ability to quantify treatment capacity will help people access treatment services.

In addition to the actions of the Executive Branch, the Legislature has also taken a number of steps to address the opioid crisis. A number of task force members reiterated the importance of laws limiting the prescribing of opioid prescriptions. Public Law 2015, chapter 488, Public Law 2017, chapter 213 and Resolve 2017, chapter 16 enacted a new statutory and regulatory framework for opioid prescribing. The new laws limit opioid prescriptions to seven days for

acute pain and 30 days for chronic pain, as well as limiting new prescriptions to no more than 100 morphine milligram equivalents, with exceptions for surgery, cancer treatment and after care, palliative care and direct administration by health professionals in emergency rooms and nursing facilities. The laws also mandate the use of the PMP by prescribers and pharmacists in most prescribing circumstances. The limits imposed by the laws are intended to limit the supply of opioids available for diversion as well as recognize current treatment best practices for acute and chronic pain (including the CDC guidelines published in early 2016⁵).

Task force members recognize the importance of alternative treatments such as physical therapy, acupuncture, meditation and neurofeedback to address chronic pain. The Legislature has also taken steps to expand availability of alternative treatments. Public Law 2017, chapter 185 establishes a cost-neutral pilot project within the MaineCare program to treat substance use disorders with acupuncture. In addition, the Joint Standing Committee on Insurance and Financial Services carried over LD 453, Resolve, Regarding Insurance Coverage for Alternative Therapies for Addiction and Recovery. LD 453 requires the Superintendent of Insurance to convene interested parties to evaluate commercial insurance coverage for substance use disorders treatment and recovery alternatives.

The Legislature increased the availability of naloxone. Public Law 2015, chapter 508 directed the Maine Board of Pharmacy to establish procedures and standards for authorizing pharmacists to dispense naloxone by prescription drug order or standing order pursuant to a collaborative practice agreement. The law was amended in Public Law 2017, chapter 249 to require rulemaking to allow pharmacists to dispense naloxone over-the-counter to individuals at risk of an overdose or to friends or family members of an individual at risk of an overdose (this section of law sunsets on July 1, 2019). At the time of writing this report, the rules were in process and not yet adopted. Similarly, Public Law 2015, chapter 351 allowed community-based drug overdose prevention programs to obtain naloxone through standing orders and administer it to individuals who appear to be experiencing an opioid-related drug overdose. DHHS is currently in the process of adopting rules to implement this legislation. Task force members reiterated at several meetings the importance of these pharmacy and community organization rules. In addition, Public Law 2017, chapter 220 allowed state, county and regional corrections officers to administer naloxone. Jails were previously unable to have naloxone available if an individual who had recently been arrested and entered the jail experienced an overdose.

In line with MOC recommendations, the Legislature enacted Public Law 2017, chapter 265 to allow for credits from coursework in addiction counseling at an accredited college or university to count towards clinical practice hours requirements for licensure as a drug and alcohol counselor. The law also requires MaineCare to reimburse a licensed clinical professional counselor at the same rate as a licensed clinical social worker. It reduces the requirements for continuing professional education and increases the number of distance learning hours that qualify as a continuing education activity. MOC recommendations were aimed at increasing the supply of treatment providers for substance use disorders.

⁵ See <https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm> for CDC guidelines.

II. SUMMARY OF MEETINGS

The task force held ten meetings on the following dates in 2017: April 7, April 21, June 9, July 12, August 16, September 12, September 27, October 31, November 13 and November 28. The task force will be holding one additional meeting on December 12, 2017, to strategize the presentation of its report to the Second Regular Session of the 128th Legislature, but will not be making any substantive changes to its recommendations.

The meetings of the task force are briefly summarized here.⁶ Any documents distributed to the task force at the meetings are posted on the task force website:

<http://www.maine.gov/legis/opla/OpioidTaskForce.htm>.

1. **April 7, 2017:** The task force received the following presentations:
 - a. Task force member Dr. Vernon Gardner made a brief presentation regarding the brain chemistry of opioid addiction.
 - b. Members of the MOC presented its recommendations. Co-Chairs Sheriff Joel Merry (Sagadahoc County) and Portland Chief of Police Michael Sauschuk presented the recommendations from the prevention/harm reduction task group. Eric Haram, LADC presented the recommendations of the treatment task force. Co-Chair Scott Gagnon, MPP, PS-C, Substance Abuse Prevention Manager for Healthy Androscoggin presented the recommendations from the law enforcement task force.
 - c. Spreadsheets compiled by contract staff containing pending opioid-related legislation in Maine and a partial list of other state's programs and national programs in response to the opioid crisis.
2. **April 21, 2017:** The task force received the following presentations:
 - a. Dr. Mary Dowd, Medical Director of the Milestone Foundation, presented on detoxification services.
 - b. Task force member Malory Shaughnessy, Executive Director of the Alliance for Addiction and Mental Health Services, presented on OHHs.
 - c. Sara Bachelder, LADC, CCS, Clinical Team Leader of Milestone's Extended Care Program, presented on residential treatment services.
 - d. Peter McCorison, Behavioral Health Services Director, Aroostook Mental Health Center, presented on intensive outpatient and outpatient treatment.
 - e. Anne Jordan, Esq., Manager of Criminal Process and Specialty Dockets, State of Maine Judicial Branch, presented on drug courts in Maine.

⁶ For more detailed descriptions of the task force's April meetings, please refer to the task force's Interim Report.

3. June 9, 2017: The task force received the following presentations:

- a. Tom Kivler, LCPC, CCS, Director of Behavioral Health, Addiction Resource Center (ARC), Mid Coast Hospital, presented on ARC's program.
- b. Robbie Moulton, Scarborough Chief of Police, presented on Operation HOPE.
- c. Scott Gagnon, MPP, PS-C, Sally Mannient and Liz Blackwell-Moore, Drug Free Communities, presented on Drug Free Communities' program model.

For the next meeting, members of the task force were directed to identify the top three barriers to addressing the opioid crisis.

4. July 12, 2017: The task force received the following presentations:

- a. Senator Eric Brakey and Representative Patricia Hymanson, Chairs of the Health and Human Services Committee, presented on opioid-related legislation proposed in the First Regular Session of the 128th Legislature.
- b. Representative Charlotte Warren, Chair of the Criminal Justice and Public Safety Committee, presented on opioid-related legislation proposed in the First Regular Session of the 128th Legislature. Senator Kimberly Rosen, Chair of the Criminal Justice and Public Safety Committee, was invited but was unable to attend.
- c. Task force members Justice William Stokes and Representative Pinny Beebe-Center presented a flow chart depicting the effect of substance abuse violations on the judicial process.

Task force Co-Chair Representative Joyce "Jay" McCreight led the task force in a compilation of and discussion of the barriers identified by task force members. The task force decided to break into small groups on prevention/harm reduction, treatment/recovery and law enforcement for the next meeting. Before the next meeting the task force members were directed to evaluate the recommendations of the MOC for relative ease and impact.

5. August 16, 2017: The prevention/harm reduction small group met first for two hours, followed by the treatment/recovery and law enforcement small groups. Each small group received a brief presentation from Carol Kelly on understanding the matrix she created with the results of the members' evaluation of the recommendations of the MOC for ease and impact. Each small group then moved into their discussions of the MOC recommendations, including additional brainstorming of recommendations and discussions of barriers affecting the recommendations. The prevention/harm reduction small group tasked its members with finding out more information on certain topics before the next meeting. The treatment/recovery small group heard from Pat Kimball, former director of Wellspring, on issues she experienced when working with persons affected by substance use disorders; and from Mary Beth Hasset, acupuncturist, on alternative pain treatments.

- 6. September 12, 2017:** The prevention/harm reduction small group met first for two hours, followed by the treatment/recovery and law enforcement small groups. During this meeting, the small groups evaluated both MOC recommendations and brainstormed additional ideas. Task force staff presented each small group with a list of carry over bills. Before reporting back small group recommendations to the entire task force, the members were directed to rank all of the potential recommendations discussed by the small groups in order to see which ones had the most support among the members.
- 7. September 27, 2017:** The task force received the following presentations:

 - a. Kelley Bowden, Maine Medical Center, presented on the Snuggle ME program.
 - b. Jan Bindas-Tenney and Bill Burns from Preble Street presented on the Homeless Opioid Users Service Engagement (HOUSE) Pilot Project.
 - c. Nathan Cermelj from Liberty Bay Recovery Center presented about its residential program.
 - d. Task force member Dr. Christopher Pezzullo, State Health Officer at DHHS, presented on OHHs and other questions the task force submitted to the department. The task force requested additional follow up information for the next meeting.
- 8. October 31, 2017:** Dr. Pezzullo provided responses to the task force's follow up questions. The small groups reported on their process and recommendations to the entire task force. Before the next meeting, the members of the task force were directed to identify their priorities among the recommendations supported by the small groups.
- 9. November 13, 2017:** Task force staff compiled the priorities received from members and presented it to the task force. The task force reviewed the aggregated priorities and started developing recommendations. Before the next meeting, the members of the task force were directed to draft narratives in support of any ideas that the task force had not addressed in its discussions.
- 10. November 28, 2017:** Task force staff drafted the task force's recommendations based on the discussions from the last meeting. The task force reviewed the narratives presented by members of the task force and further explored and refined those recommendations in this final meeting.

III. RECOMMENDATIONS

Prevention and Harm Reduction

The task force considers prevention and harm reduction critical to addressing the opioid crisis. It is more efficient to prevent problems before they begin. If a problem has developed, harm reduction minimizes the negative impact. The task force focused on the following topics.

Parenting programs for families of drug-affected babies

Maine law requires a health care provider involved in the delivery or care of an infant born affected, or suspected to be affected, by prenatal exposure to illegal or legal drugs and an infant who has fetal alcohol spectrum disorder to notify DHHS (22 MRSA § 4011-B). In 2016, there were 1,024 reports regarding infants exposed to substances, constituting 8.1% of all live births in Maine. This is a similar percentage to 2015, but is a 10% increase over 2013.⁷ If an infant is identified as a drug-affected baby, additional medical care and programs to support a mother and family, including parenting programs, should be provided.

A number of programs to support mothers, families and babies are available around the state. The task force does not want to recommend one particular program but wants providers to be aware of programs and how to access them. The Snuggle ME curriculum is considered to be a particularly effective program and Kelley Bowden of the Maine Medical Center and Dr. Pezzullo presented on the curriculum to the task force on September 27. The program screens pregnant women for substance use disorders and provides treatment for women and infants. The program was developed in partnership with DHHS. It was introduced in 2013 with copies of the curriculum delivered to Maine hospitals with obstetric departments. The guidelines were also posted to the Internet. The Maine Medical Center worked with Maine Quality Counts on a webinar to encourage providers to use the program. The second edition of Snuggle ME will be released soon. In response to a question about barriers to the program's use, Ms. Bowden mentioned that time was often a constraint for providers and that some providers already felt that they knew what they were doing.

Other programs exist around the state to support mothers and drug-affected babies. The Children and Recovering Mothers (CHARM) Collaborative is a group of providers in the Waldo County area who meet monthly to coordinate care for these families. Providers include medical health providers and behavioral health providers who provide both mental health and medication-assisted treatment for substance use disorders. In the Bangor area, the Collaborative Home Alternative Medication Program (CHAMP) Clinic is an outpatient weaning clinic for babies born substance exposed or with Neonatal Abstinence Syndrome who need medical treatment.

DHHS launched a pilot program in August 2016 called the Maine Enhanced Parent Project (MEPP). The program pairs intensive outpatient treatment with the Positive Parenting Program (Triple P). The Triple P is an evidence-based program of intensive parent education intervention

⁷ Substance Abuse Trends in Maine; State Epidemiological Profile 2017. Produced for the Maine Department of Health and Human Services Statewide Epidemiology Outcomes Workgroup.

for families experiencing moderate to severe behavioral or emotional difficulties. At the time of launching the pilot, the department planned to serve 250 Maine parents annually at six sites across the state (Scarborough, Kennebunk, Bangor, Ellsworth, Houlton and Machias). In March 2016, the Edmund N. Ervin Pediatric Center (EEPC) was awarded \$15,000 by DHHS to support its Triple P Pilot project. This public/private partnership included matching funds from MaineGeneral and EEPC philanthropic activities (Cakes for a Cause) and was used to train providers in the techniques of Triple P. Internal review board approval was sought and obtained and outcomes of the project are being measured by Hornby-Zelleher on 25 families. The project will be completed by the end of December 2017. In December 2016, the EEPC developed a proposal to join the MEPP and was officially accepted into the program in the spring of 2017. Staff were hired in July 2017 and contracts were developed with Crisis in Counseling and Community Health and Counseling Services expanding the program to cover Oxford, Franklin, Androscoggin, Kennebec, Somerset, Waldo, Knox, Lincoln and Sagadahoc counties. This program began seeing individual clients in October 2017 and started group sessions in November 2017. Twenty-two clients are in the program thus far. Funding exists for another two years, until January 2020.⁸ The task force would like the department to consider expanding the program.

Recommendation: Request by letter that the Maine Department of Health and Human Services report to the Joint Standing Committee on Health and Human Services by March 1, 2018 on the dissemination to providers of the updated Snuggle ME curriculum and other evidence-based programs and recommend expansion of Positive Parenting Program to parents and families who would benefit. (Appendix H.)

Long-acting reversible contraceptives

An overarching goal for the task force is to reduce the number of drug-affected babies by preventing pregnancies for women at risk as well as helping pregnant women with substance use disorders become and remain healthy during pregnancy. One family planning strategy for women with substance disorders who wish to avoid an unplanned pregnancy is the use of a long-acting reversible contraceptive (LARC). LARCs provide effective contraception for an extended period with less vigilance by the individual. Examples include hormonal and nonhormonal intrauterine devices and subdermal implants.

During the legislative interim, DHHS amended the MaineCare Benefits Manual, Chapter 45 (hospital services), to include reimbursement to providers for inserting a LARC during a postpartum inpatient hospital stay, in addition to the existing payments to hospitals for procedures relating to the birth (Diagnosis-Related Group payment). Women covered by MaineCare who are in a hospital giving birth could be offered reproductive counseling while still in the hospital and contraceptive options could include LARCs. The task force applauds this change in MaineCare reimbursement and recommends that professional medical associations, such as the Maine Medical Association, the Maine Osteopathic Association and Maine Nurse Practitioners Association, conduct outreach to members to ensure awareness.

⁸ The current status of the MEPP and Triple P programs was provided by task force member Dr. Steven Diaz.

Recommendation: Request by letter that medical provider organizations communicate the importance of counseling patients on the importance of and availability of long-acting reversible contraception, including coverage under MaineCare. (Appendix I.)

Youth prevention programs

The task force believes that youth prevention is an important key to combatting the opioid epidemic. In the past, prevention programs operated partly through Healthy Maine Partnerships. Currently, the University of New England (UNE) is the substance use prevention services vendor with a \$2.3 million contract from the Maine Center for Disease Control within DHHS to provide statewide substance use prevention services to Maine youth and young adults. The focus of substance use prevention efforts is to reduce heroin use, alcohol use and binge drinking, marijuana use and prescription drug misuse. UNE subcontracts with 19 local community agencies that work with the District Coordinating Councils for Public Health.

Different options for recommendations for prevention programs were considered. One option was a pilot project in a specific area of the state that could generate findings to be applied to the rest of the state. During the First Regular Session of the 128th Legislature, LD 144, An Act To Create a Pilot Project To Reduce Substance Use Disorders among Youth in Piscataquis County To Be Used as a Model for All Maine Communities, was sponsored by Representative Higgins on behalf of the Maine Medical Association and was considered as a recommendation. The bill was a concept draft aimed at developing a comprehensive prevention program in Piscataquis County. The Joint Standing Committee of Health and Human Services had voted 11 “ought not to pass” to 2 “ought to pass as amended.” The minority report of the bill proposed to establish the pilot project and this proposal was seriously considered as a possible recommendation of the task force.

The task force determined that the prevention recommendations should focus on children. There is evidence that youth prevention programs prior to high school are effective. Task force members had differing perspectives about the optimal age for programs and program content. At the November 28 meeting, members discussed the success of the Icelandic Model of Adolescent Substance Use Prevention and task force member Malory Shaughnessy provided a peer reviewed study. In the 1990s, Icelandic teenagers had high rates of substance use. The Icelandic model’s interventions, showed significant drops over a 20-year period between 1997 and 2007, in the rates of adolescents reporting being drunk during the last 30 days, smoking one or more cigarettes per day or having tried hashish once. In addition, the study reported substantial increases in the proportion of adolescents spending time with their parents and their parents knowing with whom their adolescents were spending time.⁹ The model focuses on reducing known risk factors for substance use while strengthening a broad range of parental, school and community protective factors.

Task force members determined that the Maine Department of Education is in the best position to identify the prevention programs that currently exist, programs that are most effective and evidence-based and the best way to incorporate programs into the school curricula. The task

⁹ Inga Dóra Sigfúsdóttir et al, “Substance use prevention for adolescents: the Icelandic Model.” *Health Promotion International* 24(1), 2008.

force recommends that the Joint Standing Committee on Education and Cultural Affairs consider the proposed legislation relating to this recommendation. The task force also believed it would be useful for the Department of Education to examine other programs, including the Icelandic Model, to see if there might be lessons that could be applied in Maine schools.

Recommendation: The Joint Standing Committee on Education and Cultural Affairs consider introducing legislation directing the Department of Education to establish a work group to evaluate existing drug prevention programs targeting school-age children and how to incorporate those programs into educational curriculum. The work group should include the Maine Education Association, Maine School Management Association, Maine Principals Association, Maine Interscholastic Athletic Administrators Association and representatives of law enforcement and organizations that promote and facilitate programs relating to public health, drug prevention and the welfare of children. (Appendix J.)

Stigma-reducing language

Terminology, such as “substance abuse,” “addict,” and “drug addicted baby,” used in the discussions of substance use disorders can suggest moral failing, that substance use disorder is a choice, or that a person lacks willpower or character. The task force discussed the importance of placing the person first rather than the disorder first and using language that does not include judgment. It is more accurate and less stigmatizing to use terminology such as “substance use disorder,” “person with a substance use disorder,” “person in recovery,” “drug-affected baby,” and so on. Medical organizations such as the American Medical Association, American Society of Addiction Medicine and others have recommended the use of clinical, non-stigmatizing language for substance use issues.¹⁰ The task force is aware that care must be taken to ensure the continuation or compliance with federal programs that may use outdated language.

Person-first language is also increasingly being adopted for other medical conditions or disabilities. In 2012, the Maine Legislature enacted Public Law 2011, chapter 542, An Act To Implement the Recommendations of the Department of Health and Human Services and the Maine Disabilities Council Regarding Respectful Language, which stressed the importance of treating individuals with intellectual disabilities with respect and dignity and replaced the language of “mental retardation” and “the mentally retarded” with “intellectual disability” and “persons with intellectual disabilities.” Task force members agreed that a similar legislative change regarding substance use disorders would be beneficial.

Recommendation: The Joint Standing Committee on Health and Human Services consider introducing legislation directing the Office of the Revisor of Statutes to update the statutes to reflect current terminology relating to substance use disorders. (Appendix K.)

¹⁰ See Memorandum to Heads of Executive Departments and Agencies, January 9, 2017, from Director Michael P. Botticelli, Executive Office of the President, Office of National Drug Control Policy on “Changing Federal Terminology Regarding Substance Use and Substance Use Disorders” at: <https://www.whitehouse.gov/sites/whitehouse.gov/files/images/Memo%20-%20Changing%20Federal%20Terminology%20Regrading%20Substance%20Use%20and%20Substance%20Use%20Disorders.pdf>.

Preventing diversion of prescription drugs

The prevention/harm reduction small group considered the suggestion of the MOC to increase safe storage and disposal of prescription drugs and public education and believed that it is critical to being able to prevent prescription medications from being used by someone who has not been prescribed the medication. Increasing safe storage and disposal has consistently been suggested as a strategy for reducing the supply of prescription opioids available for diversion.

Currently, the Maine Drug Enforcement Agency (MDEA) holds prescription drug take-back days twice a year. The MDEA bears all of the costs of publicizing collection events with posters and press releases, providing collection boxes and bags and transporting the medications to an incinerator located in Massachusetts. MDEA coordinates the event with all of the sheriff's offices and police departments across Maine. Sheriff's offices and police departments provide collection points, which are monitored by an off-duty officer. The sheriff's offices and police departments then transport collection boxes to a regional collection point where the MDEA has large trucks waiting to transport them to the incinerator. The only cost incurred by the sheriff's offices or police departments is the cost of paying the off-duty officer to staff the collection point. Many sheriff's offices and police departments maintain drug collection boxes in their stations throughout the year so that the public does not have to keep unneeded prescription drugs in their homes and medicine cabinets while waiting for a spring or fall collection event. The sheriff's offices and police departments store those drugs in their evidence lockers and turn them in on the federal collection dates in the spring and fall. The collection boxes cost approximately \$1,000 each to buy. Collecting and storing the drugs are done by existing sworn staff, at no additional cost.¹¹ Drug take-back programs are an example of a strategy that straddles the silos of prevention, harm reduction and law enforcement.

Drug take-back programs in pharmacies are an example of a product stewardship program and are another option to have the public return unneeded prescription drugs. Under this model, pharmacies would maintain secure collection receptacles, provide mailer envelopes, or hold collection events where customers could return prescription drugs. More information is needed about how to craft a system like this in Maine and how it would be financed.

The Attorney General informed the task force about Deterra, which is a product that deactivates certain pharmaceuticals by using a chemical process. This might be a method to explore more for use in disposing of prescription drugs with area agencies on aging, law enforcement collection sites and pharmacy collection sites.

The task force agrees that prescription drug take-back programs that do not create any consumer-borne costs for those programs should be promoted.

Recommendation: Promote programs that take back prescription drugs but do not create a consumer-borne cost for that program. Request by letter that Maine Drug Enforcement Administration report to the Joint Standing Committee on Criminal Justice and Public

¹¹ Most of the text of the section on the DEA program was provided by task force member Sheriff Jeffrey Trafton.

Safety by March 1, 2018 about the successes of the drug take-back programs; publicity of the collection days; the use of alternative drug disposal options, such as Deterra; and expanded placement of take-back units in appropriate law enforcement or other secure facilities. (Appendix L.) Request by letter to the Maine Board of Pharmacy that it require pharmacies to place a notice in an obvious place informing patients about disposing of excess medication. (Appendix M.)

Syringe exchange programs

The task force considered syringe or hypodermic apparatus exchange programs as a harm reduction strategy; although, the task force did not make a recommendation about these programs.

Maine has six syringe exchange programs in Bangor, Ellsworth, Machias, Portland, Augusta and Lewiston, which currently serve about 2,700 people per year. Syringe exchange programs allow clients to bring their used needles and obtain clean supplies in exchange. Maine's syringe exchange programs have consistently collected more syringes than they have dispensed. Staff at those programs develop relationships with clients over time and connect them with resources when they are ready for help with their substance use. In addition to making treatment referrals for persons with substance use disorders, syringe exchange programs help prevent the spread of hepatitis C and HIV infections by providing clients clean syringes.

The most common way hepatitis C is transmitted is through intravenous drug use. The U.S. Centers for Disease Control has reported that one-third of injection drug users are infected with hepatitis C. A single treatment for hepatitis C can cost up to \$90,000 and Maine has spent between \$18 million and \$24 million per year on treatment since 2015.¹² HIV is also transmitted through intravenous drug use and for every \$1 invested in a syringe program, \$7 is saved in HIV treatment.

The Maine Legislature recently considered two bills relating to syringe exchange programs. Part of LD 1326 (128th Legis. 2017), An Act to Reduce Morbidity and Mortality Related to Opioid Misuse, included an appropriation of \$75,000 to DHHS for syringe exchange programs for each year of the biennium. The committee amendment to the bill removed the funding for the syringe exchange program. LD 1552 (127th Legis. 2015), An Act to Reduce Morbidity and Mortality Related to Injected Drugs, proposed to appropriate \$75,000 for existing and new syringe exchange programs as part of a bill related to change the methodology for distributing funds for syringe exchange programs and directing DHHS to amend the rules regarding distributing funds, certification renewal and complaint investigations. A Senate Amendment removed the appropriations section. Public Law 2015, chapter 507 was enacted without funding for syringe exchange programs.

¹² Some of the information about syringe exchange programs and the statistics about Hepatitis C are from the series on hepatitis C by MainePublic, available at <http://mainepublic.org/term/hepatitis-c#stream/0>.

Treatment and Recovery

The task force spent a considerable amount of time considering treatment options. Because more than one person a day dies from an opioid overdose, providing treatment is critical to addressing the immediate needs of the crisis.

Hub and spoke and opioid health home treatment models

During the First Regular Session of the 128th Legislature, Representative Vachon sponsored LD 1430, An Act To Develop a Statewide Resource and Referral Center and Develop Hub-and-spoke Models To Improve Access, Treatment and Recovery for Those with Substance Use Disorder. The bill was carried over into the Second Regular Session. The bill was based on the Vermont hub and spoke model for substance use disorders treatment. Hub and spoke has also been more generally applied in healthcare, not just to substance use disorders treatment. In general, the model means having multiple practicing sites with the hub as the anchor site for the specialty and the spokes connecting secondary sites serving the specialty.

In Vermont, the hub and spoke model consists of two access points for medication-assisted treatment. The hubs are regional specialty substance use disorders treatment centers that provide intensive treatments to patients. Spokes are more general medical settings, including primary care practices that provide enhanced staffing to treat substance use disorders and receive consultation support from the hubs. In Vermont, the hubs initiate treatment, provide care through the period of initial stabilization, coordinate referrals to ongoing care and provide consultation and support to ongoing care. Medication-assisted treatment is provided in hubs. Spokes are the ongoing care system, including health and addiction professionals who monitor adherence to treatment, coordinate access to recovery supports and community services and provide counseling, care coordination and case management. The state funds some additional staffing for the spokes.¹³ The task force received a peer reviewed article and presentation that indicated that the hub and spoke model has been associated with substantial increases in Vermont's substance use disorders treatment capacity, with Vermont now having the highest capacity for treatment of substance use disorders in the U.S., including a 64% increase in physicians waived to prescribe buprenorphine and a 50% increase in patients served per waived physician.¹⁴

MaineHealth's Hub and Spoke Treatment Model is outlined in Appendix N. The Maine model is based on similar principles as the Vermont model but is adjusted for the Maine healthcare environment. Individuals with the greatest acute need receive services in the hubs, including inpatient care and intensive outpatient services, until they are stabilized and can be transferred to spokes, usually primary care practices for MAT, behavioral health supports and other medical services. Included in the model is support from the hubs to the spokes, including training. It is

¹³ "Vermont. Case Study: Medication Assisted Treatment Program for Opioid Addiction." Accessed: <http://www.astho.org/Health-Systems-Transformation/Medicaid-and-Public-Health-Partnerships/Case-Studies/Vermont-MAT-Program-for-Opioid-Addiction/>.

¹⁴ John R. Brooklyn and Stacey C. Sigmon. 2017. "Vermont Hub-and-Spoke Model of Care for Opioid Use Disorder: Development, Implementation, and Impact," *Journal of Addiction Medicine* 11(4) 286-292.

the combination of medical and behavioral treatments that constitutes the evidence-based treatment of IMAT. The task force differentiated the long-term needs of establishing the hub and spoke model and the short-term need to increase immediate access to treatment. LD 605, An Act To Support Evidence-based Treatment for Opioid Use Disorder, was carried over to any special or regular session of the 128th Legislature. LD 605 proposes to provide increased funding for the uninsured to receive IMAT services.

The task force had considerable discussion about the intersection between the hub and spoke model and the department's OHHs initiative. In the spring of 2017, the Legislature authorized funding in a supplemental budget for the creation of OHHs to provide services to MaineCare members and the uninsured. The department applied for and received a waiver from the Centers for Medicare and Medicaid Services. OHHs are based on an integrated care delivery model, including substance use disorders counseling, care coordination, MAT, peer support and recovery coaching and medical consultation. OHHs are based on the behavioral health home model, which also integrated physical and behavioral health services. Both BHHs and OHHs are reimbursed with a bundled rate rather than fee-for-service. Some task force members raised issues of access to uninsured slots and Dr. Pezzullo commented that members should let the department know if individuals needing treatment services are unable to gain access. Additionally, some task force members identified the following concerns about OHHs: the staffing required in OHHs; the bundled payments do not support treatment of patients in more acute phases of need; potential future effectiveness of OHHs across the continuum of need; and lack of current evidence that this program will meet the state's needs.

The task force determined that the department should be involved in considering how the hub and spoke model operated by MaineHealth could be extended in LD 1430, especially given the waiver already received by the department for OHHs. The department has focused on providing services in the OHHs for the uninsured through grant funds. The task force identified a significant need for IMAT services for individuals involved in the criminal justice system. DHHS will be asked to consider providing treatment to the uninsured in pre-diversion programs, minimum security offenders in jails and prisons, jail inmates on community and work release programs and state inmates in supervised community confinement or community transition programs (work release).

Recommendation: Request by letter to the Department of Health and Human Services to examine how the opioid health home model under the current Centers for Medicare and Medicaid Services waiver could integrate evidence-based treatments, such as the hub and spoke model in LD 1430, an Act To Develop a Statewide Resource and Referral Center and Develop Hub-and-spoke Models To Improve Access, Treatment and Recovery for Those with Substance Use Disorder, which was carried over to any Special or Regular Session of the 128th Legislature. Fund a continuum of evidence-based services of differing intensities that meet the treatment needs of individuals depending upon stage of recovery, including integrated medication-assisted treatment across the state and integrated community-based relationships. (Appendix O.)

Recommendation: Request by letter to the Department of Health and Human Services that it immediately increase access to treatment across the state for patients, including those

who lack insurance or the means to pay, by increasing grant funds available to evidence-based programs that provide treatment to patients at varying levels of acuity. Request that the Department of Health and Human Services consider allowing minimum security offenders in custody or people in community release programs to access treatment slots for the uninsured. (Appendix P.)

Access to treatment

Increasing access to treatment for substance use disorders includes both increasing the available slots for the uninsured as well as increasing access to health insurance coverage. Under both Maine law and the federal Affordable Health Care Act (ACA), insurers are required to have parity of coverage for both physical and mental health issues. Providers of treatment services on the task force express concern for treatment access for those without insurance rather than concerns about individuals with insurance being denied coverage for substance use disorders treatment. Additionally, because of the complexity and lack of awareness about this particular provision of the ACA, people in recovery who have been able to enter or reenter the workforce are missing out on accessing health care through their employers outside of the annual enrollment period. Employment and returning to employment is an important part of long-term recovery. The task force supported the introduction of LR 2755, An Act Regarding Health Care Ombudsman Services, sponsored by task force member Representative Karen Vachon. LR 2755 would create an ombudsman to help individuals complete an application with healthcare.gov in order to qualify for premium tax credits and special enrollment and to obtain private health insurance outside of the regular enrollment period. The appeal to the Legislative Council for LR 2755 was successful and the bill was approved for introduction on November 30, 2017.

Recommendation: Increase access to treatment across the state by increasing access to health insurance coverage. Write a letter to the Legislative Council to support the introduction of LR 2755, An Act Regarding Health Care Ombudsman Services, in the Second Regular Session. LR 2755 would assist people with accessing health insurance. (Appendix Q. The appeal to the Legislative Council was successful and the bill was approved for introduction.)

Confidentiality provisions under 42 U.S.C. § 290dd-2 and 42 C.F.R. Part 2

Federal law sets forth confidentiality requirements for records of patients with substance use disorders, including requirements for patient consent at 42 U.S.C. § 290dd-2. The Confidentiality of Substance Use Disorder Patient Records Rule, 42 C.F.R. Part 2, adopted pursuant to 42 U.S.C. § 290dd-2, imposes restrictions upon the disclosure and use of records of patients with substance use disorders maintained by individuals, entities, medical facilities and medical personnel that provide substance use disorders diagnosis, treatment, or referral for treatment (42 C.F.R. §§ 2.11 & 2.12(b)). Maine law on the confidentiality of health care records incorporates the federal law statute and regulations. 22 M.R.S. § 1711-C(11). The confidentiality requirements on programs that provide substance use disorders treatment are

more restrictive than the Health Insurance Portability and Accountability Act (HIPAA) in three important ways, which creates significant challenges for addressing the opioid crisis.¹⁵

First, the definition of patient under the federal regulations is expanded to include any individual who has applied for *or* has been given a diagnosis or treatment of a substance use disorder (42 C.F.R. § 2.11). Organizations that receive federal alcohol and drug treatment funds are restricted from even acknowledging that a person might have requested (not even received) services from the program, unless a specific release is obtained from the client.

Second, these programs are required to obtain written patient authorization in advance of each and every disclosure to other healthcare professionals, including information about treatment, payment, or operations (42 C.F.R. § 2.31). The confidentiality requirements limit the coordination of care between organizations treating the patient and results in a fragmented system along the continuum of care. Primary care providers who are responsible for the “whole person” do not have ready access to important information about some patients’ health care conditions and needs, adding to the stigma of substance use disorders by treating substance use disorders differently from every other medical condition (even though stigma was the purpose of the rule in the first place). The confidentiality requirement also means that substance use information must be protected and shared differently and requires cumbersome and expensive workarounds in electronic health records systems that are neither patient nor provider friendly. This contributes to higher healthcare costs for patients with behavioral health needs.

Finally, these programs are required to maintain a list of all disclosures made (42 C.F.R. § 2.13(d)), requiring programs to establish a tracking and reporting system and further adding to the cost of the programs.

In support of providing comprehensive treatment to a person receiving treatment for substance use disorders along the entire continuum of care, the task force recommends the federal government amend the confidentiality statute and regulations.

Recommendation: Request by letter to the congressional delegation, U.S. DHHS, SAMHSA and CMS that the federal government amend 42 CFR Part 2 and the related federal statute to allow for greater information sharing between providers regarding medication-assisted treatment and treatment of substance use disorders. (Appendix R.)

Housing and recovery residences

Lack of safe housing is a barrier to a person’s treatment and recovery from substance use disorders. When a person lacks safe housing, he or she is more likely not to engage in treatment or to relapse. A “recovery residence” is a type of safe housing in which people in treatment live together to support each other’s recovery, but it is not a treatment center or facility. “Recovery residence” is the less-stigmatizing term than “sober housing,” because it is focused on a person’s recovery generally rather than identifying recovery only by an abstinence-based model. Currently, there is no state certification process for recovery housing, resulting in an inconsistency in quality among residences. The Maine Association of Recovery Residences has

¹⁵ Task force members Katie Fullam Harris and Robert Fowler contributed substantially to this section.

developed voluntary criteria for identifying recovery housing that would allow residents to engage in medication-assisted treatment. The task force supports increasing access to housing and recovery residences. This is consistent with recommendations from the President's Commission on Combating Drug Addiction and the Opioid Crisis.¹⁶

Discussions around housing occurred at numerous meetings of the task force. In planning for treating an individual with substance use disorders comprehensively such as in the hub and spoke model, housing is a critical "spoke" that supports a person with other facets of life, including maintaining employment. At the July 12 meeting, each member of the task force identified three barriers to implementing strategies to address the opioid crisis and lack of safe housing was a recurring theme. During the task force's small group meetings, both the prevention/harm reduction and treatment/recovery groups identified safe housing as a key component to recovery.

There are different approaches to housing models. For example, the Housing First model is an approach that seeks to quickly find homes for persons experiencing homelessness and then connect them with case management and other support services to address substance use, mental health, or other conditions. It recognizes that homelessness and substance use disorders are often correlated. Another approach was presented by Preble Street at the September 27 meeting. This pilot project, the Homeless Opioid Users Service Engagement (HOUSE), is the subject of LR 2744, An Act to Save Lives and Create the Homeless Opioid User Service Engagement Pilot Project (sponsored by Representative Gattine). If enacted and funded, the project would target 50 people from community hospitals, the criminal justice system and the streets and connect them with low-barrier medication-assisted treatment, a variety of stable housing options to suit the person's needs and wrap-around services, including case management and peer recovery supports. LR 2744 did not receive initial approval by the Legislative Council for introduction to the Second Regular Session of the 128th Legislature but the task force supported the sponsor's appeal. The appeal to the Legislative Council for LR 2744 was successful and the bill was approved for introduction on November 30, 2017. Similarly, the task force supported LR 2521, An Act to Ensure Quality of and Increase Access to Recovery Residences (sponsored by Senator Bellows). The Legislative Council tabled the appeal for LR 2521 on November 30, 2017.

Recommendation: Support the development of recovery housing that meets the standards of the Maine Association of Recovery Residences to serve people in recovery, including those who are engaged in integrated medication-assisted treatment. Request by letter that Maine State Housing Authority convene a work group to develop a certification process for recovery housing and investigate available funding resources and development opportunities and to report quarterly to the Joint Standing Committees on Labor, Commerce, Research and Economic Development and Health and Human Services for one year, beginning March 1, 2018. The work group should include Maine's Department of Health and Human Services, Finance Authority of Maine, Maine Real Estate and Development Association, the Maine Association of Recovery Residences and representatives of treatment providers, housing services, affordable housing developers, the recovery community and persons experiencing homelessness. (Appendix S.)

¹⁶ See Recommendation 51 of The President's Commission on Combating Drug Addiction and the Opioid Crisis, available here: https://www.whitehouse.gov/sites/whitehouse.gov/files/images/Final_Report_Draft_11-1-2017.pdf.

Recommendation: Write a letter to the Legislative Council to support the introduction of two bill requests in the Second Regular Session dealing with recovery housing that are on appeal: LR 2744, An Act to Save Lives and Create the Homeless Opioid User Service Engagement Pilot Project and LR 2521, An Act to Ensure Quality of and Increase Access to Recovery Residences. (Appendix Q. The appeal to the Legislative Council for LR 2744 was successful and the bill was approved for introduction. The appeal for LR 2521 was tabled.)

Access to information regarding treatment services

The task force frequently discussed the lack of accessibility or availability of information about treatment services. The task force identified that people do not know where to go to receive information on services and that information on services available is often inaccurate. Members of the law enforcement small group commented that law enforcement, District Attorneys and judges often do not know who to call to refer people to treatment services. In the prevention/harm reduction small group, the members discussed the value of having greater access to real-time information about available resources, including a treatment locator map by county, the availability of IMAT services (included primary care providers who prescribe suboxone), wait list information and provider capacity data. Task force discussions centered around developing a central database with this information and associated challenges.

The task force also heard that 2-1-1, a DHHS program that is operated through a contract with United Way and Opportunity Alliance, also has incomplete information and would benefit from access to the central database suggested above. 2-1-1 is a free, confidential resource to connect people to information to resources around the state, including health and human services, energy assistance, disaster information and volunteer opportunities. 2-1-1 launched a separate Opiate Helpline in April 2016 which received 541 calls between April 1, 2016 and November 1, 2017. The Opiate Helpline provides immediate warm referrals to services for women who are pregnant. The task force heard from members that the database used by 2-1-1 has incomplete information about providers and lacks information about treatment services in some areas of the state. In addition, many people in Maine do not know about the services offered by 2-1-1.

Recommendation: Request by letter to Maine Department of Health and Human Services that the department evaluate the options for developing a database of available treatment services, including what information the database would contain; whether it could include real-time data and the usefulness of that data; how to accurately identify provider capacity and waitlists; how much it could cost; and how it could be implemented and funded. The department shall report back to the Joint Standing Committee on Health and Human Services by March 1, 2018. (Appendix T.)

Recommendation: Request by letter to the 2-1-1 program of United Way of Mid-Maine that it report by March 1, 2018 to the Joint Standing Committee on Health and Human Services regarding ongoing improvements to the 2-1-1 service in relation to substance use disorders, including the accuracy and ease of accessibility of the website and database; staff training; outreach to providers who are not licensed by the State; and plans for increasing

public awareness of 2-1-1 services, including alternative platforms to access information. (Appendix U.)

Peer recovery centers and recovery coaching

Outside of the medical model of recovery, peer recovery centers and recovery coaching are an important part of the social support services that assist individuals in recovery. Recovery coaches are another resource for people in recovery. Recovery coaches offer support and help obtain community-based services. Recovery coaches provide hope and can be a positive role model. They work with individuals in recovery to develop individual recovery plans and with friends or family members who have been affected by another person's substance use disorder. They are not therapists, counselors, clinicians, clergy, or 12-step sponsors, although training in recovery coaching is required.

Peer support programs are based on persons in recovery using their experiences to assist others in their recovery journeys. Peer centers operate in the mental health arena in addition to the substance use disorders setting. In Maine, the Portland Recovery Community Center and the Bangor Area Recovery Network offer services to people in recovery from substance use disorders, connect them with a wider community of people living in recovery, promote social activities and connect them with multiple services in the community.

In the Second Regular Session of the 127th Legislature, two bills were enacted that included the development of new peer support recovery centers recognizing the importance and value of these centers. The two laws resulted in two request for proposal (RFP) processes (both RFPs are currently in process and are not yet completed). The two peer support recovery centers authorized in Public Law 2015, chapter 378, Part D were specified in the law to be in "underserved areas of the state." The peer support recovery centers in Public Law 2015, chapter 481, Part F, specified that two of the three centers authorized in the law must be in "currently underserved areas that are outside of Maine's largest cities." However, the definition applied in both RFPs defined "underserved" as at least 30 miles from Augusta, Bangor, Lewiston, Portland and Waterville. Underserved is equated with rural even though the law only specified that two centers must be outside of Maine's largest cities. The statute, in contrast, defined "underserved" as any area with a documented need for recovery services that did not have those resources.

Members of the task force expressed concern over the underserved definition in the RFPs because organizations in urban areas were unable to apply for either RFP even though there is a significant need for peer recovery services in both urban and rural areas. The concern over the requirements for individuals providing peer support services in the centers to be Certified Intentional Peer Support Specialists – a model developed for mental health peer services rather than substance use disorders peer services. During task force meetings, Dr. Pezzullo recognized the issues presented, but was unable to talk specifically about RFPs that are currently active and in process. He assured the task force that the department clearly heard the concerns from the task force.

Law Enforcement

The intersection between the criminal justice system and mental illness, substance use disorders or co-occurring disorders is well known. SAMSHA estimates that 53% of people in state prisons and 68% in jails have substance use disorders compared to approximately 8.5% of the general public aged 18 or older.¹⁷ In 2016, new male admissions into the Maine prison system for sentences for drug crimes accounted for 31% of the year's total admissions (a 37% increase over the year before). For female admissions, sentences for drug crimes accounted for 41% of the 2016 admissions, an 18% increase over the year before. In addition, 67% of the male prisoners and 89% of female prisoners admitted into Maine Department of Corrections facilities were assessed as needing outpatient or residential substance use disorders treatment. (See Appendix V.)

Pre-diversion programs

The task force discussed the lack of services to divert individuals before being charged with a crime. However, task force member Sheriff Jeffrey Trafton reminded the task force that law enforcement officers' interactions with individuals with substance use disorders are frequently community activities unrelated to criminal activity. Maine lacks pre-trial diversion programs available to municipal police departments, county sheriff offices and the state police.

In early 2017, a pre-diversion pilot program was launched in Bangor funded by a planning grant from the Open Society Foundation received by the Health Equity Alliance. The Law Enforcement Assisted Diversion (LEAD) program is pre-charge diversion program that connects people with treatment and recovery services. It was originally launched in Seattle in October 2011. The Bangor program is based on the LEAD program. LEAD is a coalition of law enforcement agencies, public officials and community groups. The program diverts low level drug and prostitution offenders into treatment and support services, including immediate referral to a case manager, rather than processing those individuals through the criminal justice system. An evaluation of the program, conducted by University of Washington researchers, concluded that there were positive effects on criminal recidivism over six-month and longer time frames as well as improved housing outcomes.¹⁸

A different type of program operated by the Scarborough Police Department, modeled on the Gloucester, Massachusetts program and replicated by some other Maine police departments, is Operation HOPE. Operation Hope is a program that connects persons with substance use disorders who have detoxed with an inpatient treatment facility. Task force members are concerned about the level of need considerably outstripping resources for these programs, as well

¹⁷ "Guidelines for Successful Transition of People with Mental or Substance Use Disorders from Jail and Prison: Implementation Guide" (2017), Substance Abuse and Mental Health Services Administration. Available at: <https://store.samhsa.gov/shin/content/SMA16-4998/SMA16-4998.pdf>.

¹⁸ Susan E. Collins et al, "Seattle's Law Enforcement Assisted Diversion (LEAD): Program effects on recidivism outcomes" *Evaluation and Program Planning* 64 (2017) 49-56; Seema L. Clifasefi et al, "Seattle's Law Enforcement Assisted Diversion (LEAD) Program: Within-Subjects Changes on Housing, Employment, and Income/Benefit Outcomes and Associations with Recidivism" *Crime & Delinquency* 63 (2017) 429-445.

as the lack of in-state programs, resulting in some individuals going out of state to inpatient treatment programs.

Recommendation: Develop and fund pre-charge diversion programs at the municipal, county and state levels. The programs should be developed in consultation with prosecutors, law enforcement and other stakeholders. The programs should minimize a person’s contact with the criminal justice system by connecting them with treatment and recovery services, including case management, at the appropriate level based on an assessment process. Because implementing this recommendation requires the cooperation of the criminal justice and treatment communities, the Joint Standing Committees on Health and Human Services, Criminal Justice and Public Safety and Judiciary should collaborate to develop the program.

Specialty courts

The task force received a presentation in April on Drug Courts from Anne Jordan, Esq., Manager of Criminal Process and Specialty Dockets, State of Maine Judicial Branch.¹⁹ Following an initial pilot project in Cumberland County, known as Project Exodus, Drug Courts were first recognized in legislation in Maine in 2000. The Maine Judicial Branch currently operates six adult drug treatment courts in Alfred, Portland, Auburn, Bangor, Ellsworth and Machias/Calais; a co-occurring disorders and veterans court in Augusta; and three family recovery courts in Bangor, Auburn and Augusta. In 2016, six adult drug treatment courts served 204 individuals, the co-occurring disorders and veterans court had 43 participants and the family recovery courts served 73 parents. Fifty-two individuals successfully graduated from the adult drug treatment court/ co-occurring disorders and veterans court in 2016 while 62 were terminated for non-compliance.

Court personnel costs for all courts are covered by the State General Fund while funding for counseling, treatment and case management services are primarily from DHHS through federal SAMHSA grants. Additional funding for treatment of veterans is provided by the U.S. Veterans Administration. The General Fund is used to provide additional resources for participants in the family recovery courts. In 2017, the Coordinator of the Specialty Dockets was able to secure outside funding to provide intensive training for the adult drug treatment court teams in March and October, 2017 and specialized training for the co-occurring disorders and veterans court team scheduled for August 2018. The Maine Bureau of Highway Safety has provided federal highway safety grant funds to send the adult drug treatment court judges to specialized training for judges regarding individuals driving under the influence of drugs in November 2017.

Each participant is screened before admission and is required to adhere to a rigorous program of substance use disorders counseling, mental health and trauma treatment, random drug screening, work or educational requirements and to pay all fines, restitution, child support and taxes. Each participant is required to maintain sobriety and abide by all court-ordered conditions of participation. Failure to meet any of these requirements can result in termination from the program and/or the imposition of new court sanctions.

¹⁹ Most of the text of this section was provided by Anne Jordan, Esq. and Justice William Stokes.

The most recent evaluation of the adult drug treatment courts and the co-occurring disorders and veterans court concluded that the recidivism rate (defined as a criminal conviction within 18 months post-admission) for graduates was 16% compared to 49% for those who were admitted but later expelled. Individuals with similar criminal histories but on probation had recidivism rates between 39.6% and 47.1%.

During the presentation, Anne Jordan stated that the adult drug treatment court process represents a significant savings to the state's criminal justice system. For every \$1 spent of adult drug treatment court treatment, \$1.87 in savings is realized. The average savings per participant in adult drug treatment court is estimated to be \$12,218. In addition, the family recovery courts can point to 66 drug-free babies born to participants. Estimated average costs for drug-affected babies in Maine is \$32,016 per newborn compared to a national average of \$4,000 per child for drug-free newborns, meaning that the deliveries of these 66 babies saved more than \$1.8 million in medical costs.

The task force supports the use of drug courts and other specialty courts and co-occurring courts such as Veterans' Court. LD 111, An Act To Establish an Additional Veterans Treatment Court, was carried over by the Appropriations and Financial Affairs Committee, on the Appropriations Table.

Recommendation: The Joint Standing Committee on Judiciary consider introducing legislation that develops additional drug courts or increases access to existing drug courts across the state and provides the necessary funding.

Treatment programs in jails and prisons

Task force members identified a lack of treatment for mental health issues and substance use disorders in the state's county jails and prison facilities. There is a need for assessments and services for those in jails awaiting trial as well as those who have been sentenced up to one year. Services for inmates and their families upon release into the community are insufficient. Individuals released into the community with untreated substance use disorders are at particular risk of unintentional overdose in the days and weeks after release.²⁰

There are no IMAT services in the jail system except for a Vivitrol trial pilot recently launched in the Penobscot County Jail. There are therapeutic community programs such as Alcoholics Anonymous. Kennebec County also has a program with a case manager (sheriff deputy) component that follows individuals after release. Concerns about diversion of suboxone is a significant issue in the jails at the same time as a significant proportion of the population have mental health and substance use disorders needs that go unaddressed.

Residential and outpatient treatment programs for substance use disorders are available in the Department of Corrections (DOC) facilities. As of July 2012, DOC contracted with Correct Care Solutions to provide medical and behavioral health services to adult and juvenile populations. In July 2015, CCS began providing substance use disorders treatments in adult facilities paid for by both DOC and DHHS funding. Day One provides substance use disorders treatment at Mountain

²⁰ SAMHSA (2017). See footnote 17.

View Correctional Facility paid for by DHHS funding. The residential treatment program graduated 54 prisoners but the need is great and at the end of 2016, 150 male prisoners were on the DOC waitlist for residential substance use disorders treatment. In 2016, 518 male prisoners and 181 prisoners completed outpatient substance use disorders treatment while incarcerated. At the end of 2016, 540 male prisoners and 55 female prisoners remained on the waitlist for outpatient treatment. (See Appendix X.)

Criminal justice institutions around the country are beginning to develop treatment programs for substance use disorders. For example, the Barnstable County Sheriff's Office launched a Vivitrol program in April 2012 to sentenced inmates as part of a comprehensive pre-release program. The program includes both the monthly Vivitrol medication and behavioral health services. Two hundred and one inmates were served in Barnstable County in the first three years of the program. Approximately 40-45% of these inmates remained in treatment or completed treatment and remained sober (higher than success rates without treatment) and 82% of those in the program have not been incarcerated. Since April 2012, the program was extended to selected pre-trial inmates through the Barnstable County Drug Court and the Barnstable County Sheriff's Office has assisted other counties in Massachusetts with offering Vivitrol programs.²¹

Task force members support IMAT programs being offered in correctional institutions as well as connecting minimum security inmates in jails and prisons to hub and spoke treatment programs outside of the institutions. Minimum security jail inmates on work release programs, prison inmates in supervised community confinement and community transition programs could be connected to treatment programs.

Task force members commented that, over time, knowledge and philosophies around appropriate treatment and programming for inmates change. A permanent advisory commission to correctional facility administrators would allow institutions to keep up with the evolution of knowledge and needs.

Recommendation: The Joint Standing Committee on Criminal Justice and Public Safety consider introducing legislation that develops and funds assessments and services in jails upon intake for mental health and substance use disorders, including integrated medication-assisted treatment.

Recommendation: The Joint Standing Committee on Criminal Justice and Public Safety consider introducing legislation that develops and funds assessment and services for people in jails and prisons for mental health and substance use disorders, including integrated medication-assisted treatment and access to hub and spoke services in the community, for people serving their sentences.

Recommendation: The Joint Standing Committee on Criminal Justice and Public Safety consider introducing legislation that develops and funds programs that prepare inmates for their release into the community, including connections with integrated medication-assisted treatment and access to hub and spoke services in the community. These programs should

²¹ Barnstable County Sheriff's Office, <http://www.bsheriff.net/vivitrol.html>.

include family members or other supportive people in the inmate's life so they can be natural supports during reintegration.

Recommendation: The Joint Standing Committee on Criminal Justice and Public Safety consider introducing legislation that enacts an advisory board to advise the Department of Corrections and county or regional jails on the treatment programs and rehabilitation needs of the facility populations. The advisory board will evaluate on an ongoing basis existing services and evidence-based practices for managing the needs of offenders and pretrial defendants and recommend the implementation of appropriate programs. (Appendix W.)

Forfeiture funds and availability of data

Task force members recognize the serious need to fund programs for individuals involved in the criminal justice system because of their substance use disorders, including pre-diversion programs, Drug Courts, treatment programs, and post-release into the community. The task force supports sections 1 and 4 of LD 1429, An Act Regarding the Epidemic of Opiate Abuse, a bill submitted by the Attorney General, which has been carried over to any Special or Regular Session of the 128th Legislature. The bill includes a section that would allow flexibility in distributing funds received from civil forfeitures. The agency that made a substantial contribution to the investigation or prosecution of a criminal case could request that the funds be redirected to a law enforcement agency that provides case management and other social services to persons with substance use disorders.

Separately, section 4 of the bill would allow certain aggregate data to be reported from the prescription monitoring program that would allow policy makers to see trends in prescribing rates and compare those rates to other data regarding the opioid epidemic, including the location of overdose deaths. This information would help determine where additional resources may need to be directed.

Recommendation: Write a letter to the Joint Standing Committee on Appropriations and Financial Affairs expressing support for Sections 1 and 4 of LD 1429, An Act Regarding the Epidemic of Opiate Abuse, which has been carried over on the appropriations table. (Appendix X.)

APPENDIX A

Authorizing legislation, Joint Order S.P. 210

PLEASE NOTE: Legislative Information **cannot** perform research, provide legal advice, or interpret Maine law. For legal assistance, please contact a qualified attorney.

Joint Order, Establishing the Task Force To Address the Opioid Crisis in the State

ORDERED, the House concurring, that, notwithstanding Joint Rule 353, the Task Force To Address the Opioid Crisis in the State, referred to in this order as "the task force," is established as follows.

1. Appointment; composition. The task force consists of members appointed as follows:

A. Four members of the Senate, appointed by the President of the Senate, including 2 members of the party holding the largest and 2 members of the party holding the 2nd-largest number of seats in the Senate;

B. Four members of the House of Representatives, appointed by the Speaker of the House, including 2 members of the party holding the largest and 2 members of the party holding the 2nd-largest number of seats in the House of Representatives;

C. One member who is an administrator at a hospital in the State, appointed by the President of the Senate;

D. One member representing the interests of law enforcement, appointed by the President of the Senate;

E. One member representing the interests of providers of services at opioid treatment facilities, appointed by the President of the Senate;

F. One member representing a statewide association of physicians in the State, appointed by the President of the Senate;

G. One member who is recovering from opioid addiction, appointed by the Speaker of the House;

H. One member representing the interests of providers of substance abuse and recovery services, appointed by the Speaker of the House;

I. One member who is a physician specializing in addiction treatment, appointed by the Speaker of the House; and

J. One member who is a behavioral health specialist, appointed by the Speaker of the House.

The President of the Senate and the Speaker of the House shall invite to participate as members of the task force the Governor, or the Governor's designee; the Attorney General, or the Attorney General's designee; and a representative of the judicial branch.

2. Chairs. The first-named Senator is the Senate chair of the task force and the first-named member of the House of Representatives is the House chair of the task force.

3. Appointments; convening. All appointments must be made no later than 30 days following passage of this order. The appointing authorities shall notify the Executive Director of the Legislative Council once all appointments have been made. When the appointment of all members has been

completed, the chairs of the task force shall call and convene the first meeting of the task force. If 30 days or more after the passage of this order a majority of but not all appointments have been made, the chairs may request authority and the Legislative Council may grant authority for the task force to meet and conduct its business.

4. Duties. The task force shall examine the current laws in the State addressing opiate abuse and heroin use, including but not limited to existing laws focused on law enforcement, prevention, treatment and recovery. As part of its study, the task force shall review the report and recommendations of the Maine Opiate Collaborative issued on May 6, 2016 as well as initiatives that have been successfully undertaken by other states, including but not limited to proposals for increased law enforcement personnel or funding; substance abuse prevention, treatment and peer recovery services; and substance abuse prevention and education in schools and communities, and shall develop recommendations to address the opioid crisis in the State.

5. Compensation. The legislative members of the task force are entitled to receive the legislative per diem, as defined in the Maine Revised Statutes, Title 3, section 2, and reimbursement for travel and other necessary expenses related to their attendance at authorized meetings of the task force. Public members not otherwise compensated by their employers or other entities that they represent are entitled to receive reimbursement of necessary expenses and, upon a demonstration of financial hardship, a per diem equal to the legislative per diem for their attendance at authorized meetings of the task force.

6. Quorum. A quorum is a majority of the members of the task force, including those members invited to participate who have accepted the invitation to participate.

7. Staffing. The Legislative Council shall contract for necessary staff support for the task force during the legislative session and may contract for such staff support for a longer period to the extent needed and if sufficient funding is available. At the request of the task force, the Legislative Council may provide drafting assistance to the task force during the legislative session and other staffing support to the task force when the Legislature is not in session.

8. Reports. No later than April 30, 2017, the task force shall submit an initial report that includes its findings and recommendations, including suggested legislation, for introduction to the First Regular Session of the 128th Legislature. No later than December 6, 2017, the task force shall submit a final report that includes its findings and recommendations, including suggested legislation, for introduction to the Second Regular Session of the 128th Legislature.

APPENDIX B

Membership list, Task Force to Address the Opioid Crisis in the State

**Task Force to Address the Opioid Crisis in the State
Membership List
December 2017**

Appointments by the President

Sen. Andre E. Cushing III - Chair	Senate Member
Sen. Scott W. Cyrway	Senate Member
Sen. Geoffrey M. Gratwick	Senate Member
Sen. James F. Dill	Senate Member
Dr. Steven Diaz	Chief Medical Officer, MaineGeneral Health
Katie Fullam Harris	Senior Vice President, Government Relations and Accountable Care, MaineHealth
Gordon H. Smith	Executive Vice President, Maine Medical Association
Jeffrey Trafton	Sheriff, Waldo County

Appointments by the Speaker

Rep. Joyce “Jay” McCreight - Chair	House member
Rep. Karen Vachon	House member
Rep. Anne “Pinny” Beebe-Center	House member
Rep. Harold “Trey” L. Stewart III	House member
Robert Fowler, LCSW, CCS	Executive Director, Milestone Foundation
Dr. Vernon Gardner	Chief Psychiatric Officer, Medical Director of Homeless Health Services, Penobscot Community Health Care
Ross Hicks	Harm Reduction Coordinator, Health Equity Alliance
Malory Shaughnessy, MPPM	Executive Director, Alliance for Addiction and Mental Health Services, Maine Behavioral Health Foundation

Invited Participants

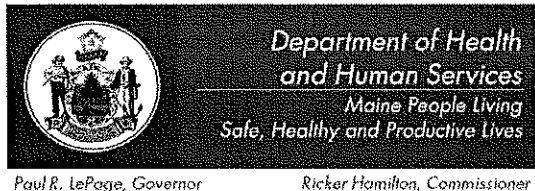
Hon. Janet T. Mills	Attorney General, State of Maine
Hon. William R. Stokes	Justice, Maine Superior Court
Dr. Christopher Pezzullo	Chief Health Officer, Maine Department of Health and Human Services

Staff:

Anna Broome, Legislative Analyst
Erin Lundberg, Legislative Analyst
Office of Policy and Legal Analysis

APPENDIX C

Department of Health and Human Services narrative on its efforts to address the opioid crisis



Department of Health and Human Services
Commissioner's Office
221 State Street
11 State House Station
Augusta, Maine 04333-0011
Tel.: (207) 287-3707; Fax (207) 287-3005
TTY Users: Dial 711 (Maine Relay)

November 29, 2017

MEMORANDUM

TO: Senator Andre E. Cushing, III, Chair
Representative Joyce McCreight, Chair
and Members of the Opioid Task Force

FROM: The Department of Health and Human Services (DHHS)

SUBJECT: **DHHS Narrative of Efforts to Address the State's Opioid Health Crisis**

Affecting every state in the nation and now officially designated as a national public health crisis, states are being hit with the devastating impacts of opioid addiction. Today, nearly half of all U.S. overdose deaths involve a prescription opioid, with an estimated 91 Americans dying every day from an opioid overdose. Last year in Maine, 376 people were reported to have died from drug overdoses, a vast majority at the hands of opioids. The reach of this disorder affects the lives of nearly every individual in Maine, and it is imperative that the administration, the legislature, and the many statewide stakeholders take unified action to stop this crisis from escalating further. Protecting the lives of Mainers by tackling this opioid crisis head on is a top priority for this Department. To ensure our efforts are effective, we have implemented a multimodal approach, founded on evidence-based programs and initiatives aimed at supporting the treatment and prevention of an opioid use disorder.

To combat the statewide opioid crisis at the root, DHHS has taken action in prioritizing effective methods for the prevention and diversion of prescription drugs. In July of 2016, DHHS successfully implemented the Chapter 488 Prescription Monitoring Law, which tightened the limitations surrounding opioid prescriptions. The law restricts daily opioid prescription dosages, outside of designated exemptions, to 100 morphine milligram equivalents (MME), limits the opioid prescription duration to 7 days for acute pain and 30 days for chronic pain, and requires prescribers review patients' prescription history in the Prescription Monitoring Program prior to prescribing opioids. In an effort to effectively cover all areas of possible exploitation and diversion, the law includes veterinarians in the definition of prescribers and requires mandatory electronic prescribing of opioids as of July 1, 2017. Prescribers must also complete an additional 3 hours of education requirements through participation in opioid addiction training, which aids our prevention efforts by ensuring providers are informed and equipped to offer the most effective services. Since the law's installment, the Department has seen a 10 percent reduction in Maine opioid prescriptions over the course of one year, translating to roughly 10 million fewer doses of opioids in Maine communities.

Additionally, we have dedicated \$4.8 million toward the new Opioid Health Home (OHH) initiative. The OHH program is a unique and innovative approach using evidence-based treatment in providing an all-inclusive, team-based model of care for patients undergoing opioid addiction treatment. Closely aligned with the Department's Behavioral Health Home model, the primary care "health homes" are composed of a comprehensive group of providers supporting individuals with whole-person care, which integrates physical, social, and emotional wellbeing in addressing addiction. Services include substance abuse counseling, care coordination, Medication-Assisted Treatment peer support, and medical consultation, all of which are offered in a bundled rate with no fee-for-service.

In an effort to decrease the number of Maine babies born substance-exposed, we have developed the screening tool SnuggleME for providers to reference when caring for pregnant women or women of child-bearing age.

SnuggleME couples substance use education with traditional prenatal care by presenting care providers with specific checklists and guidelines to follow when screening expectant mothers to reduce prenatal exposure and enhance pregnancy outcomes. DHHS has also introduced new reporting requirements for providers aiding in the treatment of opioid addicted pregnant women, as well as new procedures integrating prenatal care and substance abuse treatment to help pregnant women with substance use disorder achieve both long term recovery and a successful and healthy child birth.

DHHS has worked hard to reduce barriers to treatment access through significant increases in state resources directed toward substance use disorder treatment services for both Medicaid and the uninsured. Funding has increased by 43 percent from \$57 million to \$82 million. In response to the statewide opioid crisis, the Department has positioned the funding of its programs and services to be person-centric, prioritizing direct funding at the individual level to ensure accountability for measurable treatment outcomes.

The Department has introduced changes to rules regarding methadone treatment administration in accordance with an evidence-based model to ensure patients are receiving the most effective treatment. These rule changes require that within 60 days of beginning treatment, providers submit a formal plan of care to DHHS. This plan establishes specific goals and a treatment baseline for each patient receiving methadone treatment. After 24 months of methadone treatment, providers must then submit a prior authorization form documenting the patient's response to the treatment. Additionally, the new rules also require counseling be provided for each member.

To address the impact substance use disorder has on families, the Department has focused efforts toward programs for at-risk families in order to reduce substance abuse and improve competence in Maine parents. Moving towards achieving these goals, DHHS is providing substance abuse treatment and parenting education through the Matrix Model Intensive Outpatient Program and the Positive Parenting Program (Triple-P), respectively. These programs work to:

- Improve parental competence in managing common child behavior challenges and developmental issues;

- Decrease use of punitive methods to manage children's behavior;
- Decrease parental stress and increase parental confidence; and
- Reduce parental substance abuse during treatment.

Finally, DHHS has also been working in collaboration with the Penobscot County Jail and Penobscot Community Health Care to initiate a Vivitrol Pilot Project. Having launched this past spring, the program administers monthly Vivitrol injections to incarcerated women who have volunteered to participate. The injections start two months prior to their release date and the program offers services for continued counseling and housing assistance following discharge. Vivitrol is the brand name of Naltrexone and differs from other opioid use disorder treatments in a few ways. Vivitrol works as an opiate antagonist, blocking the brain's opioid receptors. Unlike Suboxone and Methadone, Vivitrol cannot be used to get high. It also only requires a monthly shot. Other treatment medications typically require a daily dose.

DHHS has been working tirelessly to develop comprehensive and effective strategies in addressing the statewide opioid crisis. The Department has prioritized the critical areas of prevention and harm reduction, treatment, and law enforcement at the forefront of the epidemic's impact on Maine citizens. Our recent efforts have tightened prescription regulations, established provider guidelines for methadone treatment and pregnancy screening, implemented new and innovative treatment programs, and have significantly increased state resources toward treatment services. There is still work to be done, but if we continue with this comprehensive and unified approach our efforts will help save the lives of hundreds of Mainers.

APPENDIX D

Department of Health and Human Services presentation on opioid health homes

MaineCare Services

Opioid Health Homes



Department of Health
and Human Services

*Maine People Living
Safe, Healthy and Productive Lives*

Paul R. LePage, Governor Ricker Hamilton, Acting Commissioner

Opioid Health Home (OHH) Background

Timeline

Spring 2017: Funding authorized

In spring 2017, the Maine Legislature passed legislation to allow for the implementation of the OHH program.

April 2017: Emergency rule adopted

Recognizing the urgency of this issue, the OHH rule was adopted via emergency rulemaking in April 2017, and the Department of Health and Human Services began accepting applications from potential OHH providers. The first OHH provider was approved by the end of April.

May 2017: Public hearing held

In May, the Department held the public hearing for the permanent rulemaking, and based on public comments, made significant changes to the program design prior to the rule's final adoption in July.

July 2017: Final rule adopted

Opioid Health Home (OHH) Overview

What it is

The OHH model is an innovative and evidence-based program that provides treatment for MaineCare members and the uninsured who are struggling with opioid dependency. It is a team-based model of care that focuses on treating the whole person through:

- Substance abuse counseling
- Care coordination
- Medication-assisted Treatment (MAT)
- Peer support
- Medical consultation

Opioid Health Homes are comprised of a comprehensive group of providers that furnish services based on an integrated care delivery model that is focused on whole-person treatment. Through this model, individuals are provided with care that is focused on their physical, social, and emotional wellbeing, instead of just their addiction.

Opioid Health Home (OHH) Overview

Program Design

The OHH program is designed with flexibility and accessibility in mind for the providers and members. The OHH model is closely aligned with the Department's Behavioral Health Home (BHH) model and shares similarities in the team design and core standards.

Also like the BHH model, the payment rate is bundled; there is no fee-for-service. There are two payment and program-design options for providers to choose from in order to ensure maximum flexibility, allowing members to access medication in the office or at local pharmacy.

Providers have access to their members' utilization data, which makes care coordination more possible and effective.

With a rolling application process, providers may apply to become an OHH at any point in time.

Opioid Health Home (OHH) Overview

Option A

- Dispensing Medication: \$1,000/PMPM
- One (1) Section 93.05-7 office visit with the MAT prescriber and member each month; AND
- The OHH must provide adequate counseling to address opioid substance use disorder. Section 93.05-8 counseling must be provided to each member at a minimum of one (1) counseling session per month; AND
- Delivery of at least one additional covered service described in Sections 93.05-1 through 93.05-6, to an enrolled member within the reporting month, pursuant to the member's Plan of Care/ITP.
- Provision of a maximum of a thirty (30) day supply of medication (Section 93.05-9); AND

Option B

- Prescribing Medication: \$496/PMPM
- One (1) Section 93.05-7 office visit with the MAT prescriber and member each month; AND
- The OHH must provide adequate counseling to address opioid substance use disorder. Section 93.05-8 counseling must be provided to each member at a minimum of one (1) counseling session per month; AND
- Delivery of at least one additional covered service described in Sections 93.05-1 through 93.05-6, to an enrolled member within the reporting month, pursuant to the member's Plan of Care/ITP.

Opioid Health Home (OHH) Overview

Program Design

Opioid Health Home Team
Clinical Team Lead
Opioid Dependency Counselor
Nurse Care Manager
MAT Prescriber
Peer Recovery Coach

Opioid Health Home Core Standards
Demonstrated Leadership
Team-Based Approach to Care
Population Risk Stratification and Management
Enhanced Access
Practice Integrated Care Management
Behavioral-Physical Health Integration
Inclusion of Members and Families
Connection to Community Resources and Social Support Services
Commitment to Reducing Waste, Unnecessary Healthcare Spending, and Improving Cost-Effective Use of Healthcare Services
Integration of Health Information Technology

Opioid Health Home (OHH) Overview

Eligibility & Accessibility

Any entity that meets the eligibility requirements and core standards is allowed to become an OHH. Providers can be, but are not limited to, mental health and substance abuse agencies, including methadone clinics, FQHCs, or practices that are part of a larger health system. To ensure maximum accessibility for members, care can be provided anywhere, and can be customized to work in almost any setting. Arrangements can look like:

- A primary care office working with a local behavioral health agency
- An FQCH providing all services under one roof
- A methadone clinic
- A behavioral health agency partnering with local MAT provider to provide services in-house
- Mobile services

Opioid Health Home (OHH) Overview

Eligibility & Accessibility

Opioid Health Home services are available for MaineCare members and the uninsured, with identical eligibility criteria, core standards, and enrollment process.

OHHs serving the uninsured population must have access to HealthInfoNet to access claims data. OHHs serving MaineCare members can access the Department's VMS portal for claims data.

Like MaineCare members, uninsured individuals who receive OHH services must have a connection with a primary care provider, which they would receive through free care rather than MaineCare coverage.

Opioid Health Home (OHH) Overview

Current Status

At this time, there are four approved OHH providers, with seven distinct sites. There are an additional 16 applications in the approval process.

Providers vary from Federally Qualified Health Centers (FQHCs) to methadone clinics and other substance abuse providers, to behavioral health providers.

The Department anticipates receiving applications from a number of primary care providers who intend to provide OHH as an integrated service, or partner with a substance abuse provider.

The first OHH to begin serving MaineCare members is located in Calais and will begin offering services in October.

APPENDIX E

Department of Health and Human Services September 27, 2017 answers to task force's questions



Paul R. LePage, Governor Ricker Hamilton, Acting Commissioner

Department of Health and Human Services
Commissioner's Office
221 State Street
11 State House Station
Augusta, Maine 04333-0011
Tel.: (207) 287-3707; Fax: (207) 287-3005
TTY Users: Dial 711 (Maine Relay)

September 27, 2017

MEMORANDUM

TO: Senator Andre E. Cushing III, Senate Chair
Representative Joyce "Jay" McCreight, House Chair
Members, Task Force to Address the Opioid Crisis in the State

FROM: Ricker Hamilton, Acting Commissioner

SUBJECT: Answers from DHHS to the Opioid Task Force

1. *What is the current estimate of how many individuals are in opioid use disorder treatment programs in Maine? Please include a breakdown of those in methadone treatment, Suboxone, naltrexone, residential treatment beds, intensive outpatient programs, detox beds, and other types of treatment programs. (We understand that there are more Suboxone prescribers licensed to prescribe than actual prescribers; we are interested in the number actually receiving Suboxone prescriptions and services.)*

Department's Response:

In SFY 18, SAMHS has \$5.5 million available for MAT funding.

Number of licensed residential treatment beds: 174
Number of licensed intensive outpatient beds: 2,844
Number of licensed detox beds: 46

As reported on 9/18/2017, the following numbers represent active participants in treatment in Maine.

Methadone treatment: 3,872
Buprenorphine: 5,172
Naltrexone: 46

2. *Please include any information available regarding payment source – MaineCare, insurance, uninsured.*

Department's Response:

Last Fiscal Year MaineCare spent over \$20 million for opiate MAT funding and SAMHS spent \$880,000 for MAT funding. This fiscal year, SAMHS has a \$5.5 million MAT budget, including \$2 million for Opioid Health Homes.

3. *What is the range of cost for residential treatment beds and detox beds?*
4. *Please provide any information available regarding the differing length of stay for residential beds. Are there long term and short term beds?*

Department's Response to questions 3 and 4:

Range of Costs Residential and Detox per OMS

Residential Type 1	219.78	Per day
Residential Type 2	117.17	Per day
Non-Hospital Based Detoxification	212.96	Per day
Adolescent Residential Rehabilitation	183.77	Per day
Halfway House Services	103.89	Per day
Extended Care Services	114.96	Per day
Personal Care (Shelter Services)	55.69	Per day
FMI on Services: See www.maine.gov/sos/cec/rules/10/ch101.htm		
Section 97		

Residential Type I – MaineCare limits residential rehabilitation type 1 to thirty (30) days for any single admission, with a limit of two (2) admissions and thirty (30) covered days on an annual basis per member. These limits allow some clinical flexibility should additional treatment be required or should a member drop out very early in treatment and are admitted at a later date.

Residential Rehabilitation Type II will provide a structured therapeutic environment for members who are on a waiting list for treatment, or who have either completed detoxification treatment, or are otherwise not in need of detoxification services. The primary objectives of Residential Rehabilitation Type II are; to stabilize the substance abuser in order to provide continuity of treatment, to enable the member to develop an appropriate supportive environment, to remain substance free and to develop linkages with community services. The term of residency shall not exceed forty-five (45) days.

Non-Hospital Based Detox – MaineCare limits non hospital based detoxification services to seven (7) days for each admission episode, with no limit on the number of admissions or covered days on an annual basis. The facility may provide detoxification services for a longer period if medical necessity is substantiated and ordered by the medical director, and documented in the member's clinical file by the facility's designated medical staff.

Adolescent residential rehabilitation PNMIs provide the opportunity for recovery through modalities, which emphasize personal growth through family and group support and interaction. The PNMI's qualified staff shall teach attitudes, skills, and habits, conducive to facilitating the member's transition back to the family and community. Adolescent residential rehabilitation PNMI's are designed to last at least three (3) months and are limited to twelve (12) months per single admission.

Halfway House – MaineCare limits halfway house services to a single admission of one hundred eighty (180) covered days on an annual basis per member. Any stay in excess of one hundred eighty (180) days requires documented need in the member's service plan.

Extended Care – MaineCare limits extended care services to a single admission of two hundred seventy (270) covered days on an annual basis per member. Any stay in excess of two hundred seventy (270) days requires documented need in the member's treatment plan.

Personal Care Services – PNMI's approved and funded by Adult Mental Health Services in licensed facilities must also provide necessary personal care services for the promotion of ongoing treatment and recovery. MaineCare does not cover personal care services provided by a family member.

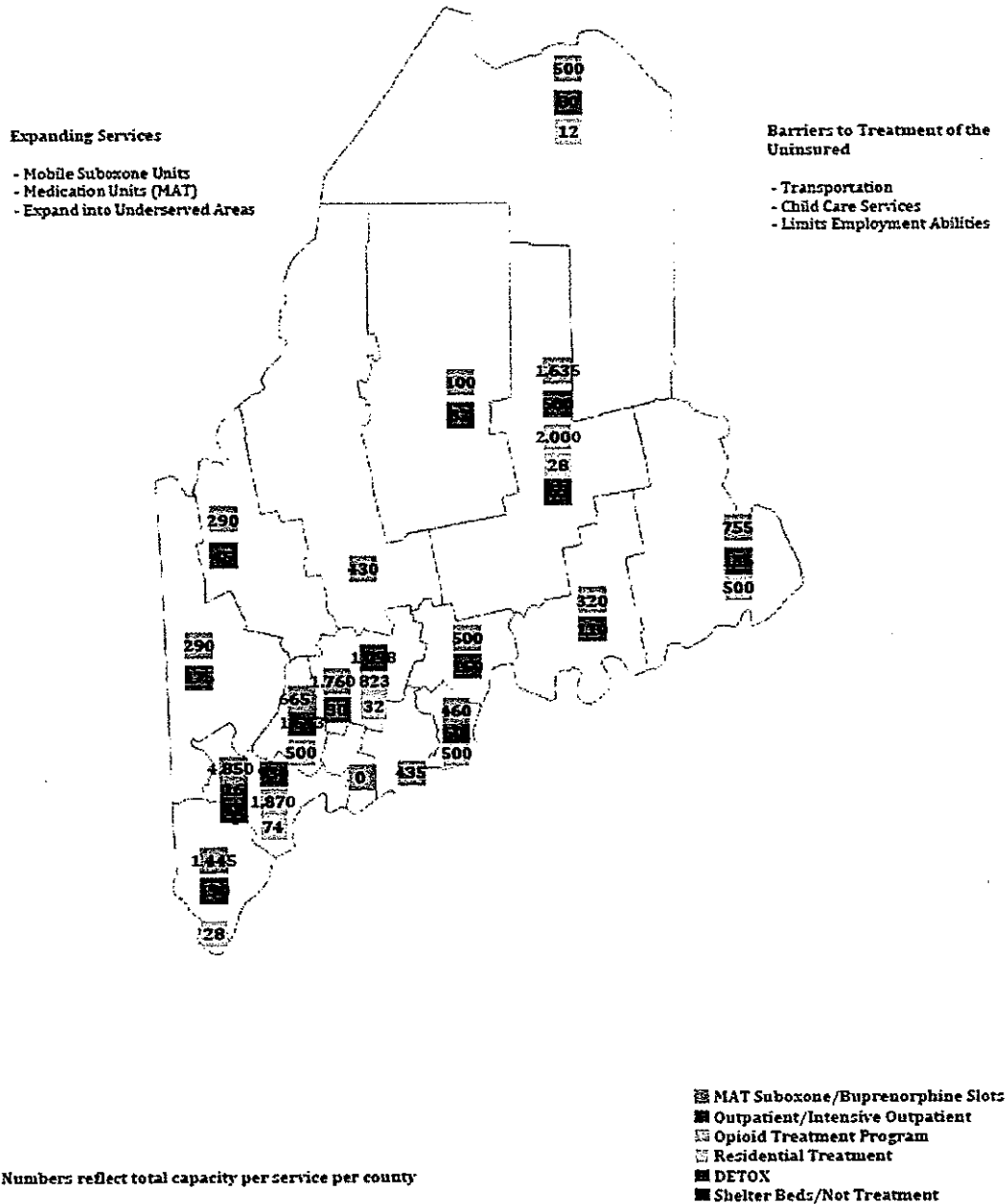
5. *Please provide any information available regarding specialty populations for residential beds, such as pregnant women, women, adolescents, others?*

Department's Response:

All residential treatment programs must prioritize clients as described above. We provide funds to Crossroads (15 bed) and Wellspring (10 bed) for pregnant and parenting woman and to Day One (27 beds) for adolescents.

6. Please provide a geographical breakdown of residential beds, intensive outpatient programs, methadone treatment, suboxone, detox etc beds. The HHS committee received a chart during work sessions on opioid use disorder bills with a breakdown by county – could this be updated and broken down further within counties?

Substance Abuse Services Capacity per County (Updated May 2017)



7. *Please provide information on the Opioid Health Home initiative. How many OHHs have been approved to provide services to those with substance use disorder? How many individuals are receiving services through OHH? How many do you expect to be served? How many are being served under MaineCare? How many slots are available for the uninsured? Please provide a breakdown of how the \$3.5m funding in the supplemental budget is being spent?*

Department's Response:

OHH presentation

8. *Please outline how the grants from the federal government through 21st Century CURES Act (\$2m) and Comprehensive Addiction and Recovery Act of 2016 are being spent.*

Department's Response:

- In July 2016, President Obama signed into law bipartisan Comprehensive Addiction and Recovery Act (CARA). This legislation sought to advance evidence-based treatment and prevention measures intended to reduce the rate of OPR and heroin misuse and addiction. In December 2016, Congress enacted the 21st Century Cures Act (Cures Act), a sweeping bill that included, among other things, reforms to the FDA approval process and funding for cancer, Alzheimer's disease, and biomedical research. In particular, the Cures Act also included several provisions intended to treat and prevent mental health problems and to reduce the impact of SUD and opioid use disorders (OUD).
- (5) Organizations will be providing MAT services utilizing the State Targeted Response allocation of \$1,614,457.00.
- The remaining amount of this federal grant includes 15% allocated to Maine CDC and 5% for administration.

9. *Please provide an update on the RFP for mental health peer centers. Also please provide information on the current efforts of the department to provide recovery coaching services.*

Department's Response:

- (11) Contracts have been awarded for mental health peer recovery centers. These are slated to begin 10/1/17.
- There are two additional RFPs in process right now: Substance Abuse Peer Support Recovery Center, and Substance Abuse Peer Support Recovery Centers: Education, Prevention and Coordination Services for which proposals have been received and are currently being evaluated. Both RFPs contain components of activities associated with recovery coaching services.
- Peer Recovery Coaching has been built into Medicaid rule through Opioid Health Homes.

10. *Please provide information on the Snuggle ME contract. How much funding is allocated for the program? How many are served?*

Department's response: Snuggle ME is not a program, per se. Snuggle ME is a toolkit, or set of guidelines, developed by the Department along with input from community stakeholders for healthcare providers that work with pregnant women. It discusses universal screening for substance use disorders, as well as information regarding treatment for women with substance use disorders and their infants.

These guidelines are being updated currently, but the original version can be found at:
<http://www.maine.gov/dhhs/mecdc/documents/SnuggleME-Project.pdf>.

11. Is generic Suboxone covered by MaineCare?

Department's Response: Yes.

APPENDIX F

Preliminary analysis of opioid treatment claims from the Maine Health Data Organization

Opioid Treatment- Preliminary Analysis

Pharmacy Claims -See the Methodology Tab for the details included in the Rx information below

Drug	Member Count	Claim Count	Total Cost	Cost per Member
Buprenorphine/Naloxone	2,412	29,716	\$1,120,733.76	\$464.65
Suboxone	1,718	21,270	\$880,863.28	\$512.73
Natroxone	739	2,637	\$93,827.73	\$126.97
Methadone	525	4,936	\$49,243.13	\$93.80

Notes: 2016 MHDO Commercial Pharmacy Claims. Total members with Pharmacy Claims: 475,331.

Medical Claims -See the Methodology Tab for the details included in the inpatient and outpatient information below

Service	Member Count	Claim Count	Total Cost	Cost per Member
Inpatient (Detox)	65	204	\$643,418.01	\$9,898.74
Outpatient	410	15,540	\$1,708,796.97	\$4,167.80
Detox (OP)	4	6	\$9,584.52	\$2,396.13
Methadone Treatment	313	14,874	\$789,844.85	\$2,523.47

Notes: 2016 MHDO Commercial Medical Claims. Total members with Medical claims: 457,143.

Produced 10/30/17

V. 1.0

Maine Health Data Organization

Methodology

For all of the analyses, 2016 commercial LOB was coded using the following codes:

Insurance Product Type Codes (Commercial)

12 Preferred Provider Organization (PPO)

13 Point of Service (POS)

14 EPO Plan

15 Indemnity Insurance

HM Health Maintenance Organization

Pharmacy Claims Analysis

For the buprenorphine analysis, all the codes from the "Buprenorphine" tab were included (list provided to MHDO).

For the suboxone analysis, all the codes that included "Suboxone" in the ProdName column from the "Buprenorphine" tab were included (list provided to MHDO).

For the naltrexone analysis, all the codes from the "Naltrexone" tab were included (list provided to MHDO).

For the methadone analysis, we used the CDC Morphine Milligram Equivalent - found in the CDC compilation of benzodiazepines, muscle relaxants, stir

Medical Claims Analysis

For the inpatient analysis, the following codes were used:

Revenue Codes - Matches what is in the IP_Detox tab (list provided to MHDO)

0116 DETOX/PVT

0126 DETOX/SEMI-PVT

0136 DETOX/3&4BED

0140 ROOM-BOARD/DLX

0146 DETOX/DLXPVT

0156 DETOX/WARD

CPT/HCPCS

HZZZZZZ Detoxification Services for Substance Abuse Treatment (Non-OR)

Detox Subcategory

HZZZZZZ

0116 DETOX/PVT

0126 DETOX/SEMI-PVT

0136 DETOX/3&4BED

0146 DETOX/DLXPVT

0156 DETOX/WARD

We included the following codes in the inpatient analysis overall and under the detox category

- H0008 Alcohol and/or drug services; sub-acute detoxification (hospital inpatient)
- H0009 Alcohol and/or drug services; acute detoxification (hospital inpatient)
- H0010 Alcohol and/or drug services; sub-acute detoxification (residential addiction program inpatient)
- H0011 Alcohol and/or drug services; acute detoxification (residential addiction program inpatient)

ICD-10 CM Codes (Rows 2-75 from the HCUP document)

For the **outpatient analysis**, the following codes were used:

CPT/HCPCS

- H0012 Alcohol and/or drug services; sub-acute detoxification (residential addiction program outpatient)
- H0013 Alcohol and/or drug services; acute detoxification (residential addiction program outpatient)
- H0014 Alcohol and/or drug services; ambulatory detoxification; Report this code for detoxification services for alcohol and drugs in which a provider
- H0015 Alcohol and/or drug services; intensive outpatient (treatment program that operates at least 3 hours/day and at least 3 days/week and is ba
- H0020 Alcohol and/or drug services; methadone administration and/or service (provision of the drug by a licensed program) (This includes the acqu
- J1230 Injection, methadone HCl, up to 10 mg
- S0109 Methadone, oral, 5 mg
- H0007 Alcohol and/or drug services; crisis intervention (outpatient)
- H0016 Alcohol and/or drug services; medical/somatic (medical intervention in ambulatory setting)
- S9475 Ambulatory setting substance abuse treatment or detoxification services, per diem

Detox subcategory for Outpatient including the following codes.

- H0012 Alcohol and/or drug services; sub-acute detoxification (residential addiction program outpatient)
- H0013 Alcohol and/or drug services; acute detoxification (residential addiction program outpatient)
- H0014 Alcohol and/or drug services; ambulatory detoxification; Report this code for detoxification services for alcohol and drugs in which a provider

Methadone subcategory

- H0020
- J1230

S0109

ICD-10 CM Codes . Rows 2-75 from the HCUP document)

Final Note: The information in this analysis is a representative sample of what is in the commercial claims data based on the methodology described above. Due to a federal rule that restricts the submission of substance abuse disorder data to States. There may be claims data for the treatment of substance abuse disorders that has not been submitted to the MHDO. Although we think the methodology used to create this report is comprehensive there may be codes that are used to classify a treatment program that have not been included in this analysis.

l to MHDO).

mutants, zolpidem, and opioid analgesics with oral morphine milligram equivalent conversion factors, 2017 version.

r in an outpatient setting monitors mild to moderate symptoms associated with withdrawal from alcohol or drugs. Should there be a detox subca
sed on an individualized treatment plan), including assessment, counseling; crisis intervention, and activity therapies or education
isition and cost of the Methadone and administration)

r in an outpatient setting monitors mild to moderate symptoms associated with withdrawal from alcohol or drugs.

APPENDIX G

Prescription Monitoring Program data on total prescriptions, patients and unique prescribers of buprenorphine products

Total Prescriptions, Patients and Unique Prescribers= Buprenorphine products for MAT				
	2016		*2017	
	Prescriptions	Patients	Prescriptions	Patients
Androscoggin	20,854	1,426	17,795	1,359
Aroostook	7,760	720	7,301	645
Cumberland	32,742	3,293	28,537	3,040
Franklin	3,013	226	2,863	265
Hancock	7,647	623	8,144	594
Kennebec	22,407	1,541	19,223	1,637
Knox	14,722	893	15,716	831
Lincoln	7,513	552	6,994	543
Oxford	8,675	680	8,723	756
Penobscot	19,417	1,655	18,840	1,552
Piscataquis	1,891	135	1,699	139
Sagadahoc	3,864	316	3,381	308
Somerset	8,017	654	8,758	708
Waldo	6,086	469	6,871	479
Washington	6,774	552	6,815	585
York	19,194	1,559	17,105	1,623
Total Prescribers	892		1,091	
Total Patients	15,294		15,064	
Total Prescriptions	190,576		178,765	
<i>*2017 data are preliminary and only include dispensations that occurred from 1/1/2017 through 9/30/2017</i>				
<i>**County is based on patient residence</i>				

Source: PMP

APPENDIX H

Letter to the Department of Health and Human Services regarding the Snuggle ME curriculum and the Maine Enhanced Parenting Project

Sen. Andre E. Cushing III, Chair
Sen. Scott W. Cyrway
Sen. Geoffrey M. Gratwick
Sen. James F. Dill
Steven Diaz
Katie Fullam Harris
Gordon H. Smith
Jeffrey Trafton
Robert Fowler
Vernon Gardner



Rep. Joyce "Jay" McCreight, Chair
Rep. Karen Vachon
Rep. Anne Beebe-Center
Rep. Harold "Trey" L. Stewart III
Ross Hicks
Malory Shaughnessy
Hon. Janet T. Mills
Hon. William R. Stokes
Christopher Pezzullo

Staff:
Anna Broome
Erin Lundberg

STATE OF MAINE
ONE HUNDRED AND TWENTY-EIGHTH LEGISLATURE

TASK FORCE TO ADDRESS THE OPIOID CRISIS IN THE STATE

December 12, 2017

Ricker Hamilton, Commissioner
Department of Health and Human Services
11 State House Station,
Augusta, Maine 04333-0011

Re: Snuggle ME curriculum and Maine Enhanced Parenting Project

Dear Commissioner Hamilton,

We are writing on behalf of the Task Force to Address the Opioid Crisis in the State of Maine, which consists of legislators and community experts in the fields of prevention, treatment and law enforcement, and was created by the First Regular Session of the 128th Legislature by Joint Order, S.P. 210.

The Task Force applauds the work of DHHS and other stakeholders in updating the curriculum for the Snuggle ME program and we are hearing that the new version will be disseminated to providers soon. As you know, Snuggle ME is a particularly effective screening program that also provides treatment for women with substance use disorders and teaches skills to parents of drug-affected babies. Our hope is that the Snuggle ME curriculum and other similar programs are promoted as widely as possible to all providers who come into contact with these populations.

The Task Force supports the expansion of the Maine Enhanced Parenting Project (MEPP) to all families who could benefit from it. The MEPP is an evidence-based program combining intensive outpatient treatment with the Positive Parenting Program (Triple P). The Triple P is an evidence-based program of intensive parent education intervention for families experiencing moderate to severe behavioral or emotional difficulties.

The Task Force asks that the Department report the results its work and recommendations regarding Snuggle ME and other similar programs and expansion of the MEPP by March 1, 2018 to the Joint Standing Committee on Health and Human Services.

December 12, 2017

Page 2

Thank you for working on these important programs and we look forward to learning more.

Sincerely,

Sen. Andre E. Cushing III
Senate Chair

Rep. Joyce "Jay" McCreight
House Chair

cc: Members, Task Force to Address the Opioid Crisis in the State
Members, Joint Standing Committee on Health and Human Services

APPENDIX I

Letters to medical provider organizations regarding long-action reversible contraceptives

Sen. Andre E. Cushing III, Chair
Sen. Scott W. Cyrway
Sen. Geoffrey M. Gratwick
Sen. James F. Dill
Steven Diaz
Katie Fullam Harris
Gordon H. Smith
Jeffrey Trafton
Robert Fowler
Vernon Gardner



Rep. Joyce "Jay" McCreight, Chair
Rep. Karen Vachon
Rep. Anne Beebe-Center
Rep. Harold "Trey" L. Stewart III
Ross Hicks
Malory Shaughnessy
Hon. Janet T. Mills
Hon. William R. Stokes
Christopher Pezzullo

Staff:
Anna Broome
Erin Lundberg

STATE OF MAINE
ONE HUNDRED AND TWENTY-EIGHTH LEGISLATURE

TASK FORCE TO ADDRESS THE OPIOID CRISIS IN THE STATE

December 12, 2017

Dr. Charles F. Pattavina, President
Maine Medical Association
P.O. Box 190
Manchester, ME 04351

Dear Dr. Pattavina,

We are writing on behalf of the Task Force to Address the Opioid Crisis in the State of Maine, which consists of legislators and community experts in the fields of prevention, treatment and law enforcement, and was created by the First Regular Session of the 128th Legislature by Joint Order, S.P. 210.

An overarching goal for the task force is to reduce the number of drug-affected babies. This includes preventing unplanned pregnancies for women at risk. One birth control strategy for women with substance use disorders who wish to avoid an unplanned pregnancy is the use of a long-acting reversible contraceptive (LARC) since they require less vigilance on the part of the individual.

The Department of Health and Human Services recently amended the MaineCare Benefits Manual, Chapter 45 (hospital services) to include reimbursement to providers for inserting a LARC during a postpartum inpatient hospital stay, in addition to the existing payments to hospitals for procedures relating to the birth. Women covered by MaineCare who are in hospitals giving birth could be offered reproductive counseling while still in the hospital and those options would include LARCs. We request that the Maine Medical Association conducts outreach to its members through continuing medical education, rounds, newsletters, etc. to ensure that they are aware of this benefit and offer it to women when it is appropriate. We thank you for your attention to this important matter.

Sincerely,

Sen. Andre E. Cushing III
Senate Chair

Rep. Joyce "Jay" McCreight
House Chair

cc: Members, Task Force to Address the Opioid Crisis in the State

Sen. Andre E. Cushing III, Chair
Sen. Scott W. Cyrway
Sen. Geoffrey M. Gratwick
Sen. James F. Dill
Steven Diaz
Katie Fullam Harris
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Rep. Joyce "Jay" McCreight, Chair
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Staff:
Anna Broome
Erin Lundberg

STATE OF MAINE
ONE HUNDRED AND TWENTY-EIGHTH LEGISLATURE

TASK FORCE TO ADDRESS THE OPIOID CRISIS IN THE STATE

December 12, 2017

Dr. Merideth C. Norris, President
Maine Osteopathic Association
128 State Street, Suite 102
Augusta, ME 04330

Dear Dr. Norris,

We are writing on behalf of the Task Force to Address the Opioid Crisis in the State of Maine, which consists of legislators and community experts in the fields of prevention, treatment and law enforcement, and was created by the First Regular Session of the 128th Legislature by Joint Order, S.P. 210.

An overarching goal for the task force is to reduce the number of drug-affected babies. This includes preventing unplanned pregnancies for women at risk. One birth control strategy for women with substance use disorders who wish to avoid an unplanned pregnancy is the use of a long-acting reversible contraceptive (LARC) since they require less vigilance on the part of the individual.

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Sincerely,

Sen. Andre E. Cushing III
Senate Chair

Rep. Joyce "Jay" McCreight
House Chair

cc: Members, Task Force to Address the Opioid Crisis in the State

Sen. Andre E. Cushing III, Chair
Sen. Scott W. Cyrway
Sen. Geoffrey M. Gratwick
Sen. James F. Dill
Steven Diaz
Katie Fullam Harris
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Rep. Joyce "Jay" McCreight, Chair
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Christopher Pezzullo

Staff:
Anna Broome
Erin Lundberg

STATE OF MAINE
ONE HUNDRED AND TWENTY-EIGHTH LEGISLATURE

TASK FORCE TO ADDRESS THE OPIOID CRISIS IN THE STATE

December 12, 2017

Pam Cahill, Executive Director
Maine Nurse Practitioners Association
1 Columbia Street
Augusta, ME 04330

Dear Ms. Cahill,

We are writing on behalf of the Task Force to Address the Opioid Crisis in the State of Maine, which consists of legislators and community experts in the fields of prevention, treatment and law enforcement, and was created by the First Regular Session of the 128th Legislature by Joint Order, S.P. 210.

An overarching goal for the task force is to reduce the number of drug-affected babies. This includes preventing unplanned pregnancies for women at risk. One birth control strategy for women with substance use disorders who wish to avoid an unplanned pregnancy is the use of a long-acting reversible contraceptive (LARC) since they require less vigilance on the part of the individual.

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Sincerely,

Sen. Andre E. Cushing III
Senate Chair

Rep. Joyce "Jay" McCreight
House Chair

cc: Members, Task Force to Address the Opioid Crisis in the State

APPENDIX J

**Resolve, Requiring the Maine Department of Education to Establish a Work Group
Regarding Drug Prevention Programs**

**Resolve, Requiring the Department of Education to Establish a Work Group
Regarding Drug Prevention Programs**

Sec. 1. Department of Education to establish work group regarding drug prevention programs. Resolved: That the Department of Education shall form a work group to evaluate existing drug prevention programs targeting school-age children, investigate programs that have proven effective in other areas of the U.S. or in other countries, identify funding resources, and determine how prevention programs are best incorporated into educational curriculum.

Sec. 2. Membership. Resolved: That the work group established in section 1 must include representatives from the educational organizations including the Maine Education Association, Maine School Management Association, Maine Principals Association and Maine Interscholastic Athletic Administrators Association, representatives of law enforcement and representatives of organizations that promote and facilitate programs focusing on public health, drug prevention, and the welfare of children.

Sec. 3. Report. Resolved: That no later than January 1, 2019, the Department of Education shall report its findings including any recommended legislation to the joint standing committee having jurisdiction over educational matters. The joint standing committee may report out legislation based upon the report to the First Regular Session of the 129th Legislature.

SUMMARY

This resolve is a recommendation of the Task Force to Address the Opioid Crisis in the State. It requires the Department of Education to establish a work group to evaluate existing drug prevention programs targeting school-age children, investigate programs that have proven effective outside of the State, identify funding resources, and determine how prevention programs should be incorporated into the educational curriculum. The work group must include representatives of educational, law enforcement and public health organizations. The report is due no later than January 1, 2019 to the joint standing committee having jurisdiction over educational matters.

APPENDIX K

**An Act To Implement the Recommendations of the Task Force to Address the
Opioid Crisis Regarding Respectful Language**

An Act To Implement the Recommendations of the Task Force to Address the Opioid Crisis Regarding Respectful Language

Emergency preamble. Whereas, Acts of the Legislature do not become effective until 90 days after adjournment unless enacted as emergencies; and

Whereas, treating a person with substance use disorder with respect, including in the language that is used in referring to the person, to the system of delivering services and to the services, offices and personnel of the Department of Health and Human Services is important to the dignity of the person and to reducing stigma associated with having a disease and should be accomplished at the earliest possible time; and

Whereas, in the judgment of the Legislature, these facts create an emergency within the meaning of the Constitution of Maine and require the following legislation as immediately necessary for the preservation of the public peace, health and safety; now therefore,

Sec. 1. Revisor of Statutes to prepare legislation. Resolved: That the Revisor of Statutes shall prepare legislation that amends all references to “substance abuse” in the Maine Revised Statutes to read “substance use disorder” no later than January 6, 2019. The legislation shall be referred to the Joint Standing Committee having jurisdiction over health and human services matters to be considered during the First Regular Session of the 129th Legislature; and be it further

Sec. 2. Rename the Office of Substance Abuse and Mental Health Services. Resolved: Notwithstanding any other provision of law, the Department of Health and Human Services shall rename the Office of Substance Abuse and Mental Health Services using respectful language; and be it further

Sec. 3. Department of Health and Human Services rules, forms, policies and publications. Resolved: When adopting or amending its rules and developing, publishing and issuing forms, policies and publications, the Department of Health and Human Services shall replace references to “substance abuse” with references to “substance use disorder” and shall ensure that language referring to persons with substance use disorders is consistent with respectful language recommended in the final report of the Task Force to Address the Opiate Crisis; and be it further

Sec. 4. Intent; effect. Resolved: This resolve is not intended to and does not change the eligibility requirements for services or benefits or result in an expansion of services or benefits provided by the Department of Health and Human Services or impact eligibility or requirements for federal programs and grants.

Sec. Emergency Clause. In view of the emergency cited in the preamble, this resolve takes effect when approved.

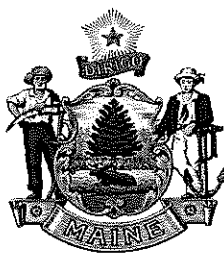
SUMMARY

This resolve is a recommendation of the Task Force to Address the Opiate Crisis. It requires the Revisor of Statutes to prepare legislation for the joint standing committee of the Legislature having jurisdiction over health and human services matters to consider in the First Regular Session of the 129th Legislature that amends the references to “substance abuse” to be replaced with “substance use disorder”. The changes in language are intended to be respectful and minimize stigma for individuals who suffer with this disorder. There is no intention to impact the state’s ability to participate in federal policies, programs or grants.

APPENDIX L

**Letter to the Drug Enforcement Administration requesting information on the National
Prescription Drug Take-Back Day in Maine**

Sen. Andre E. Cushing III, Chair
Sen. Scott W. Cyrway
Sen. Geoffrey M. Gratwick
Sen. James F. Dill
Steven Diaz
Katie Fullam Harris
Gordon H. Smith
Jeffrey Trafton
Robert Fowler
Vernon Gardner



Rep. Joyce "Jay" McCreight, Chair
Rep. Karen Vachon
Rep. Anne Beebe-Center
Rep. Harold "Trey" L. Stewart III
Ross Hicks
Malory Shaughnessy
Hon. Janet T. Mills
Hon. William R. Stokes
Christopher Pezzullo

Staff:
Anna Broome
Erin Lundberg

STATE OF MAINE
ONE HUNDRED AND TWENTY-EIGHTH LEGISLATURE

TASK FORCE TO ADDRESS THE OPIOID CRISIS IN THE STATE

December 12, 2017

Michael W. Wardrop, Resident Agent in Charge
U.S. Drug Enforcement Administration
Portland ME Resident Office
1355 Congress St., Suite D
Portland, ME 04102

Re: Drug Take-Back Programs

Dear Agent Wardrop,

We are writing on behalf of the Task Force to Address the Opioid Crisis in the State of Maine, which consists of legislators and community experts in the fields of prevention, treatment and law enforcement, and was created by the First Regular Session of the 128th Legislature by Joint Order, S.P. 210. We have heard from Sheriff Trafton from Waldo County, a member of the Task Force, about the important work the Drug Enforcement Agency is doing with its biannual National Prescription Drug Take-Back Day.

We are respectfully requesting that your agency provide information to the Joint Standing Committee on Criminal Justice and Public Safety by March 1, 2018, about the successes of National Prescription Drug Take-Back Day in Maine, including the amount of prescription drugs collected; how the program is publicized; and whether your agency has investigated the use of alternative drug disposal options, such as Deterra, as well as any other efforts of your agency to reduce the availability of prescription drugs. We hope that you will encourage your law enforcement and other partners to place additional take-back units in appropriate secure facilities. Thank you for your all of your efforts to help reduce the availability of excess prescription drugs.

Sincerely,

Sen. Andre E. Cushing III
Senate Chair

Rep. Joyce "Jay" McCreight
House Chair

cc: Members, Task Force to Address the Opioid Crisis in the State
Members, Joint Standing Committee on Criminal Justice and Public Safety

APPENDIX M

Letter to the Maine Board of Pharmacy about the disposal of excess medications

Sen. Andre E. Cushing III, Chair
Sen. Scott W. Cyrway
Sen. Geoffrey M. Gratwick
Sen. James F. Dill
Steven Diaz
Katie Fullam Harris
Gordon H. Smith
Jeffrey Trafton
Robert Fowler
Vernon Gardner



Rep. Joyce "Jay" McCreight, Chair
Rep. Karen Vachon
Rep. Anne Beebe-Center
Rep. Harold "Trey" L. Stewart III
Ross Hicks
Malory Shaughnessy
Hon. Janet T. Mills
Hon. William R. Stokes
Christopher Pezzullo

Staff:
Anna Broome
Erin Lundberg

STATE OF MAINE
ONE HUNDRED AND TWENTY-EIGHTH LEGISLATURE

TASK FORCE TO ADDRESS THE OPIOID CRISIS IN THE STATE

December 12, 2017

Geraldine L. Betts, Administrator
Board of Pharmacy
35 State House Station
Augusta, ME 04333-0035

Re: Drug Take-Back Programs

Dear Administrator Betts,

We are writing on behalf of the Task Force to Address the Opioid Crisis in the State of Maine, which consists of legislators and community experts in the fields of prevention, treatment and law enforcement, and was created by the First Regular Session of the 128th Legislature by Joint Order, S.P. 210.

In our work on the task force, we have heard about the importance of programs such as the National Prescription Take-Back Day, to reducing availability of excess medications. We are asking for your help to educate the public about how to dispose of excess medication safely by requiring pharmacies to place a notice in an obvious place informing patients about local disposal options. We believe that this would be one way to increase outreach to the public in order to curb the availability of excess prescription drugs.

Thank you for your consideration of our request.

Sincerely,

Sen. Andre E. Cushing III
Senate Chair

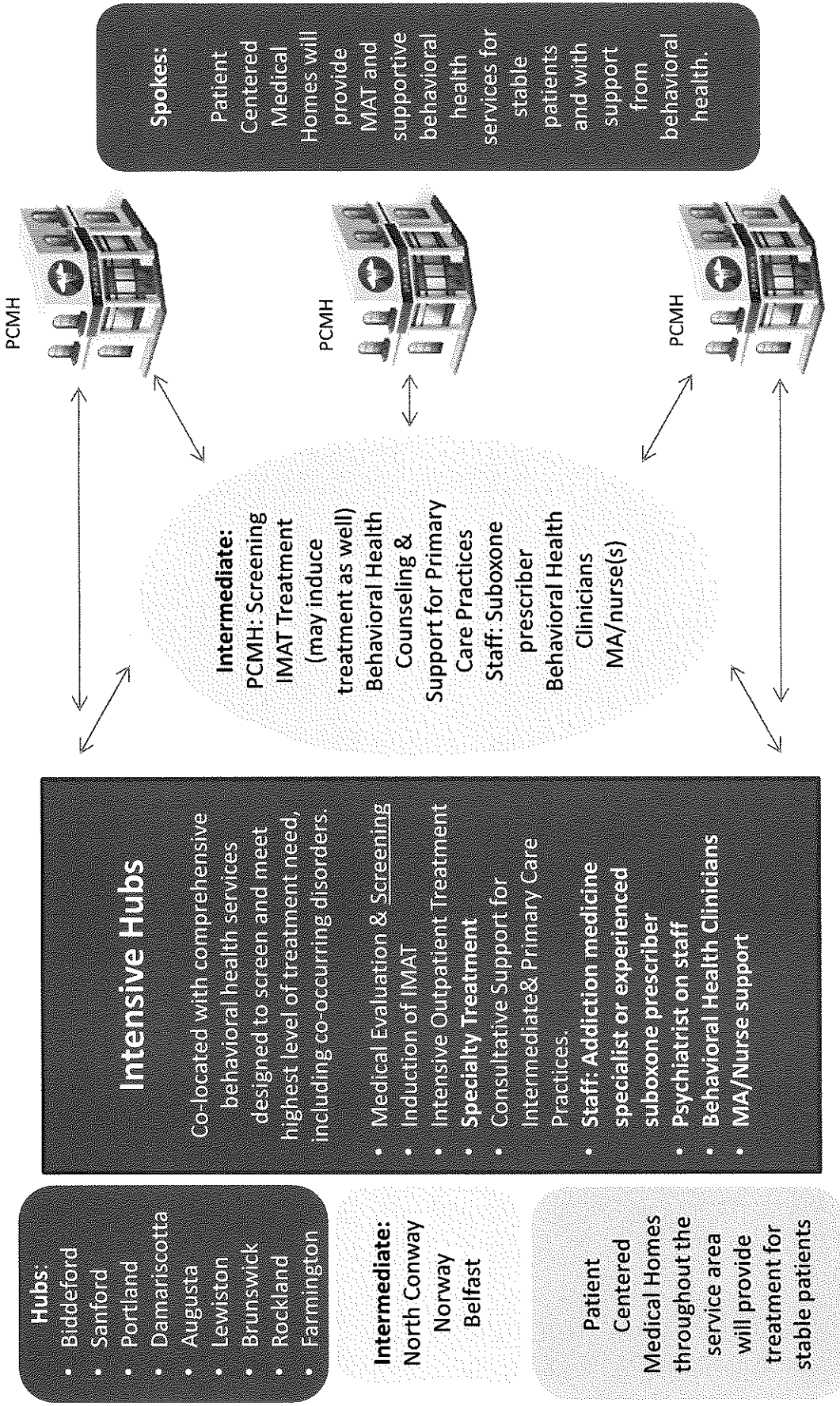
Rep. Joyce "Jay" McCreight
House Chair

cc: Anne Head, Commissioner, Department of Professional and Financial Regulation
Members, Task Force to Address the Opioid Crisis in the State

APPENDIX N

MaineHealth's hub and spoke treatment model

MaineHealth's Hub and Spoke Treatment Model



APPENDIX O

**Letter to the Department of Health and Human Services regarding hub and spoke
and opioid health home treatment models**

Sen. Andre E. Cushing III, Chair
Sen. Scott W. Cyrway
Sen. Geoffrey M. Gratwick
Sen. James F. Dill
Steven Diaz
Katie Fullam Harris
Gordon H. Smith
Jeffrey Trafton
Robert Fowler
Vernon Gardner



Rep. Joyce "Jay" McCreight, Chair
Rep. Karen Vachon
Rep. Anne Beebe-Center
Rep. Harold "Trey" L. Stewart III
Ross Hicks
Malory Shaughnessy
Hon. Janet T. Mills
Hon. William R. Stokes
Christopher Pezzullo

Staff:
Anna Broome
Erin Lundberg

STATE OF MAINE
ONE HUNDRED AND TWENTY-EIGHTH LEGISLATURE

TASK FORCE TO ADDRESS THE OPIOID CRISIS IN THE STATE

December 12, 2017

Ricker Hamilton, Commissioner
Department of Health and Human Services
11 State House Station,
Augusta, Maine 04333-0011

Re: Hub and spoke and opioid health home treatment models

Dear Commissioner Hamilton,

We are writing on behalf of the Task Force to Address the Opioid Crisis in the State of Maine, which consists of legislators and community experts in the fields of prevention, treatment and law enforcement, and was created by the First Regular Session of the 128th Legislature by Joint Order, S.P. 210.

We are requesting that the Department of Health and Human Services consider how the hub and spoke model operated by MaineHealth and outlined in LD 1430, An Act To Develop a Statewide Resource and Referral Center and Develop Hub-and-spoke Models To Improve Access, Treatment and Recovery for Those with Substance Use Disorder, and other evidence-based treatments might build on the opioid health home model under the current CMS waiver. We are interested in funding integrated medication assisted treatment across the state, creating integrated community-based relationships, and providing services of differing intensities depending on the stage of recovery and needs of the individual.

The Task Force asks that the Department report the results its work and recommendations by March 1, 2018 to the Joint Standing Committee on Health and Human Services. Thank you in advance for considering these recommendations and we look forward to seeing the results of your hard work.

Sincerely,

Sen. Andre E. Cushing III
Senate Chair

Rep. Joyce "Jay" McCreight
House Chair

cc: Members, Task Force to Address the Opioid Crisis in the State
Members, Joint Standing Committee on Health and Human Services

APPENDIX P

**Letter to the Department of Health and Human Services regarding uninsured slots
in opioid health homes and other treatment services**

Sen. Andre E. Cushing III, Chair
Sen. Scott W. Cyrway
Sen. Geoffrey M. Gratwick
Sen. James F. Dill
Steven Diaz
Katie Fullam Harris
Gordon H. Smith
Jeffrey Trafton
Robert Fowler
Vernon Gardner



Rep. Joyce "Jay" McCreight, Chair
Rep. Karen Vachon
Rep. Anne Beebe-Center
Rep. Harold "Trey" L. Stewart III
Ross Hicks
Malory Shaughnessy
Hon. Janet T. Mills
Hon. William R. Stokes
Christopher Pezzullo

Staff:
Anna Broome
Erin Lundberg

STATE OF MAINE
ONE HUNDRED AND TWENTY-EIGHTH LEGISLATURE

TASK FORCE TO ADDRESS THE OPIOID CRISIS IN THE STATE

December 12, 2017

Ricker Hamilton, Commissioner
Department of Health and Human Services
11 State House Station,
Augusta, Maine 04333-0011

Re: Uninsured slots in opioid health homes and other treatment services

Dear Commissioner Hamilton,

We are writing on behalf of the Task Force to Address the Opioid Crisis in the State of Maine, which consists of legislators and community experts in the fields of prevention, treatment and law enforcement, and was created by the First Regular Session of the 128th Legislature by Joint Order, S.P. 210.

We are requesting that the Department of Health and Human Services immediately increase access to treatment across the state for patients, including those who lack insurance or the means to pay, by increasing grant funds available to evidence-based programs that provide treatment to patients at varying levels of acuity. The task force is grateful to Dr. Pezzullo for his suggestion to call the department when uninsured individuals are unable to gain access to OHHs because slots are available. However, need for treatment is critical and we should maximize the number of slots available.

We also request that the department examine the possibility of allowing access to treatment services to minimum-security offenders in custody or in community release programs or otherwise come into contact with law enforcement. There is a significant need for medication-assisted treatment services for individuals involved in the criminal justice system. In addition, individuals moving into the community from the criminal justice system are particularly vulnerable to accidental overdose. Connecting those individuals to services could save their lives, help them reintegrate into the community and prevent recidivism. We applaud the efforts of the department to fund slots for the uninsured. Could the Department consider extending some of those uninsured slots to this population?

December 12, 2017

Page 2

The task force asks that the department report the results its work and recommendations by March 1, 2018 to the Joint Standing Committee on Health and Human Services. Thank you in advance for considering these recommendations and we look forward to seeing the results of your hard work.

Sincerely,

Sen. Andre E. Cushing III
Senate Chair

Rep. Joyce "Jay" McCreight
House Chair

cc: Members, Task Force to Address the Opioid Crisis in the State
Members, Joint Standing Committee on Health and Human Services

APPENDIX Q

**Letter to the Legislative Council in support of introducing legislation in the Second
Regular Session**

Sen. Andre E. Cushing III, Chair
Sen. Scott W. Cyrway
Sen. Geoffrey M. Gratwick
Sen. James F. Dill
Steven Diaz
Katie Fullam Harris
Gordon H. Smith
Jeffrey Trafton
Robert Fowler
Vernon Gardner



Rep. Joyce "Jay" McCreight, Chair
Rep. Karen Vachon
Rep. Anne Beebe-Center
Rep. Harold "Trey" L. Stewart III
Ross Hicks
Malory Shaughnessy
Hon. Janet T. Mills
Hon. William R. Stokes
Christopher Pezzullo

Staff:
Anna Broome
Erin Lundberg

STATE OF MAINE
ONE HUNDRED AND TWENTY-EIGHTH LEGISLATURE

TASK FORCE TO ADDRESS THE OPIOID CRISIS IN THE STATE

November 28, 2017

Hon. Sara Gideon, Chair
Hon. Michael D. Thibodeau, Vice-Chair
Legislative Council
Maine State Legislature
115 State House Station
Augusta, ME 04333-0115

Dear Speaker Gideon and President Thibodeau,

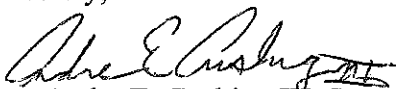
We are writing on behalf of the Task Force to Address the Opioid Crisis in the State. The Task Force is comprised of legislators and community experts in the fields of prevention, treatment and law enforcement, and was created by the 1st Regular Session of the 128th Legislature by Joint Order, S.P. 210. On appeal before the Legislative Council are bill requests on issues of importance to the Task Force.

During our work this year, the Task Force consistently heard that the lack of safe housing is a barrier to a person's treatment and recovery from substance use disorder. As part of our recommendations to the Legislature, we will be supporting the availability of stable housing for persons in recovery. Two bills supporting recovery residences are currently before Legislative Council: (1) LR 2521, *An Act to Ensure Quality of and Increase Access to Recovery Residences* (sponsored by Senator Bellows); and (2) LR 2744, *An Act to Save Lives and Create the Homeless Opioid User Service Engagement Pilot Project* (sponsored by Representative Gattine).

Additionally, the Task Force heard that access to treatment is critical to recovery and that more people can access treatment when they have health insurance. LR 2755, *An Act Regarding Health Care Ombudsman Services* (sponsored by Representative Vachon), currently before Legislative Council, would create an ombudsman to help people complete an application with healthcare.gov to help them qualify for premium tax credits and special enrollment and to obtain private health insurance outside of the regular enrollment period.

We are in support of the introduction of LR 2521, LR 2744, and LR 2755 addressing recovery housing and access to health insurance in the Second Regular Session. Thank you for your consideration.

Sincerely,


Sen. Andre E. Cushing III, Senate Chair
cc: Members, Task Force to Address the Opioid Crisis in the State


Rep. Joyce "Jay" McCreight, House Chair

APPENDIX R

**Letters to congressional delegation and federal agencies regarding federal
confidentiality laws**

Sen. Andre E. Cushing III, Chair
Sen. Scott W. Cyrway
Sen. Geoffrey M. Gratwick
Sen. James F. Dill
Steven Diaz
Katie Fullam Harris
Gordon H. Smith
Jeffrey Trafton
Robert Fowler
Vernon Gardner



Rep. Joyce "Jay" McCreight, Chair
Rep. Karen Vachon
Rep. Anne Beebe-Center
Rep. Harold "Trey" L. Stewart III
Ross Hicks
Malory Shaughnessy
Hon. Janet T. Mills
Hon. William R. Stokes
Christopher Pezzullo

Staff:
Anna Broome
Erin Lundberg

STATE OF MAINE
ONE HUNDRED AND TWENTY-EIGHTH LEGISLATURE

TASK FORCE TO ADDRESS THE OPIOID CRISIS IN THE STATE

December 12, 2017

The Honorable Angus King
United States Senate
133 Hart Building
Washington, DC 20510

The Honorable Susan Collins
United States Senate
413 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Chellie Pingree
United States House of Representatives
2162 Rayburn House Office Building
Washington, DC 20515

The Honorable Bruce Poliquin
United States House of Representatives
1208 Longworth House Office Building
Washington, DC 20515

Re: Confidentiality provisions related to persons with substance use disorders

Dear Senators King and Collins and Representatives Poliquin and Pingree,

We are writing on behalf of the Task Force to Address the Opioid Crisis in the State of Maine, which consists of legislators and community experts in the fields of prevention, treatment and law enforcement, and was created by the First Regular Session of the 128th Legislature by Joint Order, S.P. 210. As part of our Final Report of recommendations, enclosed, we are writing to you regarding the confidentiality restrictions for treatment providers of substance use disorders in the hopes that you will work to amend the statute and regulations to allow for greater information sharing across the continuum of care.

Federal law sets forth confidentiality requirements for records of patients with substance use disorders. 42 U.S.C. § 290dd-2; 42 C.F.R. Part 2. These confidentiality requirements for programs that provide treatment for substance use disorders are more restrictive than the Health Insurance Portability and Accountability Act (HIPAA). This creates significant challenges for addressing the opioid crisis.

The confidentiality requirements limit the coordination of care between organizations treating the patient and results in a fragmented system along the continuum of care. Primary care providers who are responsible for the "whole person" do not have ready access to important information about some patients' health care conditions and needs, which adds to the stigma of substance use disorders by treating them differently from every other medical condition. The confidentiality requirement also means that records for persons with substance use disorders

must be protected differently and shared differently, which requires cumbersome and expensive workarounds in Electronic Health Records systems and contributes to higher healthcare costs for patients with behavioral health needs.

We would be happy to answer any questions you may have about our request. Thank you for your attention to this important issue.

Sincerely,

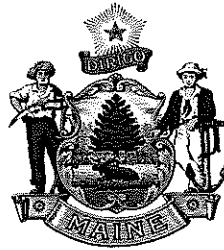
Sen. Andre E. Cushing III
Senate Chair

Rep. Joyce "Jay" McCreight
House Chair

Enclosures: Final Report of the Task Force to Address the Opioid Crisis in the State
Letter dated December 12, 2017 to U.S. DHHS, SAMHSA, and CMS

cc: Members, Task Force to Address the Opioid Crisis in the State

Sen. Andre E. Cushing III, Chair
Sen. Scott W. Cyrway
Sen. Geoffrey M. Gratwick
Sen. James F. Dill
Steven Diaz
Katie Fullam Harris
Gordon H. Smith
Jeffrey Trafton
Robert Fowler
Vernon Gardner



Rep. Joyce "Jay" McCreight, Chair
Rep. Karen Vachon
Rep. Anne Beebe-Center
Rep. Harold "Trey" L. Stewart III
Ross Hicks
Malory Shaughnessy
Hon. Janet T. Mills
Hon. William R. Stokes
Christopher Pezzullo

Staff:
Anna Broome
Erin Lundberg

STATE OF MAINE
ONE HUNDRED AND TWENTY-EIGHTH LEGISLATURE

TASK FORCE TO ADDRESS THE OPIOID CRISIS IN THE STATE

December 12, 2017

Eric D. Hargan, Acting Secretary
U.S. Dept. of Health and Human Services
200 Independence Avenue S.W.
Washington, D.C., 20201

Elinore F. McCance-Katz, Assistant Secretary
for Mental Health and Substance Use
Substance Abuse and Mental Health Services
Administration
5600 Fishers Lane
Rockville, MD 20857

The Honorable Seema Verma, Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human
Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

Re: 42 C.F.R. Part 2

Dear Secretaries Hargan and McCance-Katz and Administrator Verma,

We are writing on behalf of the Task Force to Address the Opioid Crisis in the State of Maine, which consists of legislators and community experts in the fields of prevention, treatment and law enforcement, and was created by the First Regular Session of the 128th Legislature by Joint Order, S.P. 210. As part of our Final Report of recommendations, enclosed, we are writing to you regarding the confidentiality restrictions for treatment providers of substance use disorders in the hopes that you will work to amend the statute and regulations to allow for greater information sharing across the continuum of care.

Federal law sets forth confidentiality requirements for records of patients with substance use disorders. 42 U.S.C. § 290dd-2; 42 C.F.R. Part 2. These confidentiality requirements for programs that provide treatment for substance use disorders are more restrictive than the Health Insurance Portability and Accountability Act (HIPAA). This creates significant challenges for addressing the opioid crisis.

First, the definition of patient under the federal regulations is expanded to include any individual who has applied for *or* has been given a diagnosis or treatment of a substance use disorder. 42 C.F.R. §§ 2.11. Organizations that receive federal alcohol and drug treatment funds are restricted from even acknowledging that a person might have requested (not even received) services from the program, unless a specific release is obtained from the client. Second, these programs are required to obtain written patient authorization in advance of each and every disclosure to other healthcare professionals, including information about treatment, payment, or operations. 42 C.F.R. § 2.31. The confidentiality requirements limit the coordination of care between organizations treating the patient and results in a fragmented system along the continuum of care. Primary care providers who are responsible for the “whole person” do not have ready access to important information about some patients’ health care conditions and needs, which adds to the stigma of substance use disorders by treating them differently from every other medical condition. The confidentiality requirement also means that records for persons with substance use disorders must be protected differently and shared differently, which requires cumbersome and expensive workarounds in Electronic Health Records systems and contributes to higher healthcare costs for patients with behavioral health needs. Finally, these programs are required to maintain a list of all disclosures made, 42 C.F.R. § 2.13(d), requiring programs to establish a tracking and reporting system and adding to the cost of the programs.

We would be happy to answer any questions you may have about our request. Thank you for your attention to this important issue.

Sincerely,

Sen. Andre E. Cushing III
Senate Chair

Rep. Joyce “Jay” McCreight
House Chair

Enclosure: Final Report of the Task Force to Address the Opioid Crisis in the State

cc: Members, Task Force to Address the Opioid Crisis in the State

APPENDIX S

Letter to Maine State Housing Authority regarding a work group to develop a certification process for recovery housing

Sen. Andre E. Cushing III, Chair
Sen. Scott W. Cyrway
Sen. Geoffrey M. Gratwick
Sen. James F. Dill
Steven Diaz
Katie Fullam Harris
Gordon H. Smith
Jeffrey Trafton
Robert Fowler
Vernon Gardner



Rep. Joyce "Jay" McCreight, Chair
Rep. Karen Vachon
Rep. Anne Beebe-Center
Rep. Harold "Trey" L. Stewart III
Ross Hicks
Malory Shaughnessy
Hon. Janet T. Mills
Hon. William R. Stokes
Christopher Pezzullo

Staff:
Anna Broome
Erin Lundberg

STATE OF MAINE
ONE HUNDRED AND TWENTY-EIGHTH LEGISLATURE

TASK FORCE TO ADDRESS THE OPIOID CRISIS IN THE STATE

December 12, 2017

John Gallagher, Director
Maine State Housing Authority
353 Water Street
Augusta, ME 04330

Re: Work group on recovery residences

Dear Mr. Gallagher,

We are writing on behalf of the Task Force to Address the Opioid Crisis in the State of Maine, which consists of legislators and community experts in the fields of prevention, treatment and law enforcement, and was created by the First Regular Session of the 128th Legislature by Joint Order, S.P. 210. We are writing to you in support of the development of recovery housing in Maine and are asking for your help.

We are requesting that your agency convene a work group to develop a certification process for recovery housing that is consistent with the standards of the Maine Association of Recovery Residences to serve people in recovery, including those who are engaged in integrated medication-assisted treatment. We are also requesting that this work group investigate and make recommendations regarding available funding resources and development opportunities. The work group should include Maine's Department of Health and Human Services, Finance Authority of Maine, Maine Real Estate and Development Association, Maine Association of Recovery Residences and representatives of treatment providers, housing services, affordable housing developers, the recovery community, and persons experiencing homelessness.

The task force asks that the work group report the result its work and recommendations beginning March 1, 2018, and then quarterly for one year, to the Joint Standing Committees on Labor, Commerce, Research, and Economic Development and Health and Human Services. Thank you in advance for your efforts in organizing this work group and we look forward to seeing the results of your hard work.

Sincerely,

Sen. Andre E. Cushing III
Senate Chair

Rep. Joyce "Jay" McCreight
House Chair

cc: Members, Task Force to Address the Opioid Crisis in the State
Members, Joint Standing Committee on Labor, Commerce, Research, and Economic
Development
Members, Joint Standing Committee on Health and Human Services
Ricker Hamilton, Commissioner, Maine Department of Health and Human Services
William Norbert, Governmental Affairs & Communications Manager, Finance Authority
of Maine
Paul E. Peck, President, Maine Real Estate and Development Association
Sarah Coupe, President, Maine Association of Recovery Residences

APPENDIX T

**Letter to Department of Health and Human Services regarding the development of
a database containing treatment services**

Sen. Andre E. Cushing III, Chair
Sen. Scott W. Cyrway
Sen. Geoffrey M. Gratwick
Sen. James F. Dill
Steven Diaz
Katie Fullam Harris
Gordon H. Smith
Jeffrey Trafton
Robert Fowler
Vernon Gardner



Rep. Joyce "Jay" McCreight, Chair
Rep. Karen Vachon
Rep. Anne Beebe-Center
Rep. Harold "Trey" L. Stewart III
Ross Hicks
Malory Shaughnessy
Hon. Janet T. Mills
Hon. William R. Stokes
Christopher Pezzullo

Staff:
Anna Broome
Erin Lundberg

STATE OF MAINE
ONE HUNDRED AND TWENTY-EIGHTH LEGISLATURE

TASK FORCE TO ADDRESS THE OPIOID CRISIS IN THE STATE

December 12, 2017

Ricker Hamilton, Commissioner
Department of Health and Human Services
11 State House Station,
Augusta, Maine 04333-0011

Re: Centralized database of treatment resources

Dear Commissioner Hamilton,

We are writing on behalf of the Task Force to Address the Opioid Crisis in the State of Maine, which consists of legislators and community experts in the fields of prevention, treatment and law enforcement, and was created by the First Regular Session of the 128th Legislature by Joint Order, S.P. 210.

The task force identified that often people do not know where to go to receive information on services and that information that is available on services available is often inaccurate. This creates a barrier for people with substance use disorders to access treatment. We are requesting that the Department of Health and Human Services evaluate the options for developing a database of available treatment services, including what information the database would contain; whether it could include real-time data and the usefulness of that data; how to accurately identify provider capacity and waitlists; how much it would cost; and how it could be implemented and funded, including whether legislation would be required to implement the database.

The task force asks that the department report the results its work and recommendations by March 1, 2018 to the Joint Standing Committee on Health and Human Services. Thank you in advance for considering these recommendations and we look forward to seeing the results of your hard work.

Sincerely,

Sen. Andre E. Cushing III
Senate Chair

Rep. Joyce "Jay" McCreight
House Chair

cc: Members, Task Force to Address the Opioid Crisis in the State
Members, Joint Standing Committee on Health and Human Services

APPENDIX U

**Letter to the 2-1-1 program requesting a report on areas of improvement to services
regarding substance use disorders**

Sen. Andre E. Cushing III, Chair
Sen. Scott W. Cyrway
Sen. Geoffrey M. Gratwick
Sen. James F. Dill
Steven Diaz
Katie Fullam Harris
Gordon H. Smith
Jeffrey Trafton
Robert Fowler
Vernon Gardner



Rep. Joyce "Jay" McCreight, Chair
Rep. Karen Vachon
Rep. Anne Beebe-Center
Rep. Harold "Trey" L. Stewart III
Ross Hicks
Malory Shaughnessy
Hon. Janet T. Mills
Hon. William R. Stokes
Christopher Pezzullo

Staff:
Anna Broome
Erin Lundberg

STATE OF MAINE
ONE HUNDRED AND TWENTY-EIGHTH LEGISLATURE

TASK FORCE TO ADDRESS THE OPIOID CRISIS IN THE STATE

December 12, 2017

Nikki Busmanis
2-1-1 Maine Program Manager
United Way of Mid-Maine
105 Kennedy Memorial Drive
Waterville, ME 04901

Re: Improvements to 2-1-1

Dear Ms. Busmanis,

We are writing on behalf of the Task Force to Address the Opioid Crisis in the State of Maine, which consists of legislators and community experts in the fields of prevention, treatment and law enforcement, and was created by the First Regular Session of the 128th Legislature by Joint Order, S.P. 210. Thank you for presenting to our task force on November 28, 2017 about your program's ongoing efforts to improve the 2-1-1 service.

We are requesting that your program continue to identify areas for improvement and implement those changes to the 2-1-1 service in relation to substance use disorder, including the accuracy and ease of accessibility of the website and database; staff training; outreach to providers who are not licensed by the State; and plans for public awareness of 2-1-1 services, including alternative platforms to access information.

The task force asks that you report the results your work by March 1, 2018 to the Joint Standing Committee on Health and Human Services. Thank you in advance for your efforts to work toward improving access to information about treatment resources for substance use disorders and we look forward to seeing the results of your hard work.

Sincerely,

Sen. Andre E. Cushing III
Senate Chair

Rep. Joyce "Jay" McCreight
House Chair

cc: Members, Task Force to Address the Opioid Crisis in the State
Members, Joint Standing Committee on Health and Human Services

APPENDIX V

Substance abuse treatment programs in the state prison system

Substance Abuse Treatment Programs in the State Prison System

Associate Commissioner Ryan Thornell, Ph.D.

Revised 2.2.2017

The Maine Department of Corrections (DOC) offers substance abuse treatment programs at all of its secure adult facilities, including the Maine State Prison (MSP), Maine Correctional Center (MCC), Mountain View Correctional Facility (MVCF), and Women's Center (WC). Additionally, programs are offered at the Bolduc Correctional Facility (BCF) and Women's Reentry Center (WRC). The Department partners with Correct Care Solutions (CCS) and Day One to provide these services.

- As of July 2012, MDOC entered into a contract with Correct Care Solutions to provide both medical and behavioral health services to the adult and juvenile populations. In July 2015, Correct Care Solutions began providing substance abuse treatment services across the Department's adult facilities. The substance abuse treatment services provided by Correct Care Solutions are paid for by the DOC (general funds), with support from the DHHS SAMHS Office (general funds).
- Also in July 2015, the juvenile facility at Mountain View was repurposed into a secure adult correctional facility focused on providing treatment programs to male prisoners. Day One, the previous provider of juvenile substance abuse treatment services at this location, was retained and began offering the substance abuse treatment services at the Mountain View Correctional Facility, including the Substance Abuse Unit. The services provided by Day One are paid for by the DHHS SAMHS Office.

Substance Abuse Treatment Need

- In 2016, the number of new male admissions into the DOC on new sentences for drug crimes accounted for 31% of the year's total admissions (201 new drug admissions). This number of new admissions is an increase of 37% from the year 2015 (147 new admissions), and an increase of 53% from the year 2014 (131 new admissions).
- In 2016, the number of new female admissions into the DOC on sentences for drug crimes accounted for 41% of the year's total admissions (39 new drug admissions). This number of new admissions is an increase of 18% from the year 2015 (33 new admissions), and an increase of 56% from the year 2014 (25 new admissions).
- Upon admission into the DOC, male and female offenders are screened, and if necessary, further assessed to identify their level of substance abuse treatment need. In 2016, 1,188 offenders were screened and/or assessed.
- In 2016, the male prisoners admitted into the Department's institutions were assessed as having the following substance abuse treatment need:
 - 48% were assessed as needing outpatient substance abuse treatment;
 - 19% were assessed as needing residential substance abuse treatment;
 - 33% were assessed as not needing substance abuse treatment;
- In 2016, the female prisoners admitted into the Department's institutions were assessed as having the following substance abuse treatment need:
 - 88% were assessed as needing outpatient substance abuse treatment;
 - 1% were assessed as needing residential substance abuse treatment;
 - 11% were assessed as not needing substance abuse treatment;
- The Department has two residential substance abuse treatment programs for male prisoners, the Correctional Recovery Center at MCC and the Substance Abuse Unit at MVCF.
- The remaining treatment programs offered across the facilities are outpatient substance abuse programs.

Provided to HHS committee (LD605, 12th)

Residential Substance Abuse programs

- The Correctional Recovery Center (MCC) is a 12 month residential substance abuse treatment program, provided by Correct Care Solutions, that has the goal of reducing prisoner's dependency on drugs and alcohol. The Correctional Recovery Center utilizes a therapeutic community structure, which emphasizes routine, structure, and peer-accountability. Upon completion of the program, prisoners either transfer to a minimum security facility or are released to the community. Across the last 18 months, this program has graduated 55 prisoners.
- The Substance Abuse Unit (MVCF) opened in July 2015 and is a 12 month residential substance abuse treatment program, provided by Day One, focused on reducing prisoner's dependency on drugs and alcohol. This unit utilizes a modified-therapeutic community structure, which emphasizes routine, structure, and peer-accountability. Upon completion of the program, prisoners either transfer to a minimum security facility or are released to the community. Since it opened, this program has graduated 54 prisoners.
- At the end of 2016, approximately 150 male prisoners remained on the Department's "waitlist" for residential substance abuse treatment.

Outpatient Substance Abuse programs

- The Department offers evidence-based outpatient substance abuse programming at all of its adult facilities (excluding Downeast Correctional Facility). These programs are delivered by Correct Care Solutions.
- The primary outpatient substance abuse program utilized is *Cognitive Behavioral Interventions for Substance Abuse*, a curriculum developed by the University of Cincinnati Corrections Institute. This program is approximately six (6) months in duration.
- The Department offers other outpatient substance abuse programs to both male and female prisoners. *Seeking Safety* is an outpatient program that addresses both trauma and substance abuse, and may be offered to male and female prisoners. At the female facilities, *Co-Dependent No More* is also offered.
- At the minimum security facilities (excluding Downeast Correctional Facility), *Living in Balance* is also offered to address substance abuse treatment needs in a more flexible manner. This open-enrollment curriculum is focused on substance abuse recovery and is able to be individualized based upon the prisoner's substance abuse treatment needs, allowing for the flexibility needed at a minimum security facility. The program has up-to 47 different program lessons to be included in the program delivery.
- In 2016, 518 male prisoners and 181 female prisoners successfully completed outpatient substance abuse treatment while incarcerated.
- At the end of 2016, 540 male prisoners remained on the Department's "waitlist" for outpatient substance abuse treatment.
- At the end of 2016, 55 female prisoners remained on the Department's "waitlist" for outpatient substance abuse treatment.

APPENDIX W

**An Act to Establish the State Coordinating Council on Corrections Practices Relating to
Substance Use Treatment Programs**

An Act to Establish the State Coordinating Council on Corrections Practices
Relating to Substance Use Treatment Programs

Sec. 1. 5 MRSA § 12004-I, sub-§ 4-D is enacted to read:

<u>Corrections</u>	<u>State Coordinating Council on Corrections Practices Relating to Substance Use Treatment Programs</u>	<u>Expenses Only</u>	<u>34-A MRSA § 1209- C</u>
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Sec. 2. 34-A MRSA § 1209-C is enacted to read:

§ 1209-C. State Coordinating Council on Corrections Practices Relating to Substance Use Treatment Programs

1. Definitions. As used in this section, unless the context otherwise indicates, the following terms have the following meanings.

A. "Person with a substance use disorder" has the same meaning as the terms "alcoholic," "drug abuser," "drug addict," and "drug-dependent person" in Title 5 section 20003.

B. "Treatment" has the same meaning as the term "treatment" in Title 5 section 20003.

C. "Treatment program" has the same meaning as the term "treatment program" in Title 5 section 20003.

2. Council established. The State Coordinating Council on Corrections Practices Relating to Substance Use Treatment Programs, established in Title 5, section 12004-I, subsection 4-D and referred to in this section as "the council," is created for the purpose of conducting continuous study and coordination of corrections practices related to persons with substance use disorder in jails and correctional facilities. The council shall promote and implement the most effective evidence-based modalities in order to support the treatment and recovery of persons with substance use disorder.

2. Membership. The council is composed of the following members:

A. The commissioner or the commissioner's designee and 2 state corrections officials designated by the commissioner, one of whom is from Adult Community Corrections;

B. The Commissioner of Public Safety or the commissioner's designee;

C. A representative of a statewide association of county commissioners nominated by the

association and appointed by the Governor;

D. A representative of a statewide association of county sheriffs nominated by the association and appointed by the Governor;

E. A representative of a statewide association of county jails nominated by the association and appointed by the Governor;

F. A representative of a statewide association of prosecutors nominated by the association and appointed by the Governor;

G. A representative of a statewide association of criminal defense attorneys nominated by the association and appointed by the Governor;

H. A representative of a statewide municipal association nominated by the association and appointed by the Governor;

I. The Commissioner of the Department of Health and Human Services or the commissioner's designee;

J. A representative from a community-based organization with experience working with persons in recovery and persons transitioning out of the criminal justice system;

K. A representative from a provider organization that treats persons with substance use disorder using evidence-based practices, such as integrated Medication Assisted Treatment.

The Governor also shall ask the Chief Justice of the Supreme Judicial Court to serve as or to name a designee to serve as a member of the council and to appoint one trial judge or another designee to serve as a member of the council.

3. Chair; terms; vacancies. The Governor shall appoint a member to serve as chair. Members of the council serve for terms of 2 years and may be reappointed. If a member cannot serve for any reason, the vacancy for the member's unexpired term must be filled by the appointing authority.

4. Meetings. The council shall meet at least 4 times a year and keep minutes and records of the meetings.

5. Duties. The council shall coordinate criminal justice information and collaborate with persons who work in the criminal justice and treatment fields. Specifically, the council shall:

A. Advise the Department of Corrections and county or regional jails on the treatment programs and rehabilitation needs that would best serve the needs of offenders and pretrial defendants;

B. Evaluate on an ongoing basis existing treatment programs and rehabilitation services

available to offenders and pretrial defendants;

C. Develop recommended evidence-based correctional practices and services for managing the treatment and rehabilitation needs of offenders and pretrial defendants;

D. Promote, support, and implement the use of the recommended evidence-based correctional practices and services for managing the treatment and rehabilitation needs of offenders and pretrial defendants;

E. Provide information and assistance to county and state corrections officials regarding current evidence-based correctional practices and services for managing the treatment and rehabilitation needs of offenders and pretrial defendants and provide a forum for sharing information on evidence-based practices and services that are used throughout the State; and

F. Review laws and policies and monitor proposed legislation and policies that affect the state and county criminal justice and correctional systems relating to substance use treatment and make recommendations to the legislative, executive and judicial branches regarding these proposals.

6. Report. At the beginning of the first regular session of each Legislature and no later than January 15th, the council shall submit a report to the joint standing committee of the Legislature having jurisdiction over criminal justice and public safety matters and to the Governor. The report must include recommendations and any necessary implementing legislation with respect to matters related to the council's duties and accomplishments, including recommendations on state compliance.

7. Departmental duties and powers. The duties and powers of the department with regard to this section are as follows.

A. The department shall serve as the fiscal agent of the council.

B. The department may accept funds from the Federal Government, from any political subdivision of the State or from any individual, foundation or corporation and may expend those funds for purposes consistent with this section.

C. The department shall provide technical assistance to counties and criminal justice planning committees, as established in Title 30-A, section 1671, to aid them in the planning and development of community corrections.

8. Funds not to lapse. Funds appropriated to carry out the purposes of this section do not lapse but must be carried forward from year to year.

9. Reimbursement of expenses. The members of the council must be compensated according to the provisions of Title 5, chapter 379.

SUMMARY

This bill establishes the State Coordinating Council on Corrections Practices Relating to Substance Use Treatment Programs. The council is to study, evaluate, and promote evidence-based treatment programs to support the recovery of persons with substance use disorder. It identifies the membership of the council, the number of meetings, the duties, and the reporting requirements of the council.

APPENDIX X

**Letter to the Joint Standing Committee on Appropriations and Financial Affairs
expressing support for Sections 1 and 4 of LD 1429, An Act Regarding the Epidemic
of Opiate Abuse**

Sen. Andre E. Cushing III, Chair
Sen. Scott W. Cyrway
Sen. Geoffrey M. Gratwick
Sen. James F. Dill
Steven Diaz
Katie Fullam Harris
Gordon H. Smith
Jeffrey Trafton
Robert Fowler
Vernon Gardner



Rep. Joyce "Jay" McCreight, Chair
Rep. Karen Vachon
Rep. Anne Beebe-Center
Rep. Harold "Trey" L. Stewart III
Ross Hicks
Malory Shaughnessy
Hon. Janet T. Mills
Hon. William R. Stokes
Christopher Pezzullo

Staff:
Anna Broome
Erin Lundberg

STATE OF MAINE
ONE HUNDRED AND TWENTY-EIGHTH LEGISLATURE

TASK FORCE TO ADDRESS THE OPIOID CRISIS IN THE STATE

TO: James M. Hamper, Senate Chair
Drew Gattine, House Chair
Joint Standing Committee on Appropriations and Financial Affairs

FROM: Andre E. Cushing III, Senate Chair
Joyce "Jay" McCreight, House Chair
Task Force to Address the Opioid Crisis in the State of Maine

DATE: December 12, 2017

RE: LD 1429, An Act Regarding the Epidemic of Opiate Abuse

We are writing on behalf of the Task Force to Address the Opioid Crisis in the State of Maine, which consists of legislators and community experts in the fields of prevention, treatment and law enforcement, and was created by the First Regular Session of the 128th Legislature by Joint Order, S.P. 210. We are in support of Sections 1 and 4 of LD 1429, An Act Regarding the Epidemic of Opiate Abuse, which has been carried over on the appropriations table. The Task Force takes no position on Sections 2 and 3.

Section 1 would allow flexibility in distributing funds received from civil forfeitures. The agency that made a substantial contribution to the investigation or prosecution of a criminal case could request that the funds be redirected to a law enforcement agency in Maine that provides case management and other social services to persons with substance use disorders. The ability to direct funds to support the treatment needs of persons with substance use disorders would be a critical component of addressing the opioid crisis in the State.

Section 4 would allow certain aggregate data to be reported from the prescription monitoring program that would allow policy makers to see trends in prescribing rates and compare those rates to other data regarding the opioid epidemic, including the location of overdose deaths. This information would help determine where additional resources may need to be directed.

Thank you for your consideration of our recommendations.

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Date: (Filing No. H-)

CRIMINAL JUSTICE AND PUBLIC SAFETY

Reproduced and distributed under the direction of the Clerk of the House.

**STATE OF MAINE
HOUSE OF REPRESENTATIVES
128TH LEGISLATURE
FIRST REGULAR SESSION**

COMMITTEE AMENDMENT “ ” to H.P. 983, L.D. 1429, Bill, “An Act Regarding the Epidemic of Opiate Abuse”

Amend the bill by inserting after section 1 the following:

Sec. 1. 17-A MRSA §1105-A, sub-§1, ¶¶K and L, as enacted by PL 2003, c. 476, §2, are amended to read:

K. Death of another person is in fact caused by the use of that scheduled drug one or more scheduled drugs, the scheduled drug trafficked by the defendant is a contributing factor to the death of the other person and the drug is a schedule W drug. A violation of this paragraph is a Class A crime; or

L. Serious bodily injury of another person is in fact caused by the use of that scheduled drug one or more scheduled drugs, the scheduled drug trafficked by the defendant is a contributing factor to the serious bodily injury of the other person and the drug is a schedule W drug. A violation of this paragraph is a Class B crime.'

Amend the bill by adding after section 4 the following:

Sec. 5. Appropriations and allocations. The following appropriations and allocations are made.

INDIGENT LEGAL SERVICES, MAINE COMMISSION ON

Maine Commission on Indigent Legal Services Z112

Initiative: Provides funds for an anticipated increase in indigent legal services costs resulting from additional prosecutions involving death or serious bodily injury to a person.

GENERAL FUND	2017-18	2018-19
All Other	\$8,250	\$11,000
	_____	_____

COMMITTEE AMENDMENT

1 GENERAL FUND TOTAL \$8,250 \$11,000
2
3 Amend the bill by relettering or renumbering any nonconsecutive Part letter or
4 section number to read consecutively.

5 **SUMMARY**

6 This amendment adds to the bill new variants of aggravated trafficking of scheduled
7 drugs that includes trafficking in scheduled drugs when the trafficked scheduled drug was
8 a contributing factor in the death of another person, a Class A crime, or serious bodily
9 injury of another person, a Class B crime.

10 The amendment also adds an appropriations and allocations section.

11 **FISCAL NOTE REQUIRED**

12 (See attached)



128th MAINE LEGISLATURE

LD 1429

LR 666(02)

An Act Regarding the Epidemic of Opiate Abuse

Fiscal Note for Bill as Amended by Committee Amendment " "

Committee: Criminal Justice and Public Safety

Fiscal Note Required: Yes

Fiscal Note

Potential current biennium revenue decrease - General Fund

Potential current biennium revenue increase - Municipal and County Law Enforcement

	FY 2017-18	FY 2018-19	Projections FY 2019-20	Projections FY 2020-21
Net Cost (Savings)				
General Fund	\$8,250	\$11,000	\$11,000	\$11,000
Appropriations/Allocations				
General Fund	\$8,250	\$11,000	\$11,000	\$11,000

Correctional and Judicial Impact Statements

Establishes new Class A and Class B crimes, increases correctional and judicial costs.

The collection of additional fines may also increase General Fund revenue by minor amounts.

Fiscal Detail and Notes

The bill includes General Fund appropriations of \$8,250 in fiscal year 2017-18 and \$11,000 in fiscal year 2018-19 for the Maine Commission on Indigent Legal Services to support the anticipated increase in costs resulting from additional prosecutions involving death or serious bodily injury to a person.

Under current statute, the court determines the disposition of forfeited property and may order it deposited to the General Fund or that it go to a municipality, county, or state agency that has made a substantial contribution to the investigation or prosecution of a related criminal case. This bill keeps that language and adds to the court's options by also allowing disposition of forfeited property to, upon request of the investigating agency or prosecuting agency, a law enforcement agency in this State that provides case management and other social services to persons with substance use disorders. In any future case where the court will opt to use the new provision to redirect forfeited property from the General Fund to a local law enforcement agency, revenue will be increased to the receiving agency and reduced to the General Fund. No estimate of the amounts redirected can be made at this time.

Any additional costs to the Department of Health and Human Services from the provisions of this bill are expected to be minor and can be absorbed within existing budgeted resources.



128th MAINE LEGISLATURE

FIRST REGULAR SESSION-2017

Legislative Document

No. 1429

H.P. 983

House of Representatives, April 13, 2017

An Act Regarding the Epidemic of Opiate Abuse

Submitted by the Department of the Attorney General pursuant to Joint Rule 204.
Reference to the Committee on Health and Human Services suggested and ordered printed.

A handwritten signature in cursive script that reads "R B. Hunt".

ROBERT B. HUNT
Clerk

Presented by Representative GROHMAN of Biddeford.
Cosponsored by Senator DION of Cumberland and
Senators: CYRWAY of Kennebec, DESCHAMBAULT of York.

1 **Be it enacted by the People of the State of Maine as follows:**

2 **Sec. 1. 15 MRSA §5826, sub-§6**, as amended by PL 1999, c. 408, §3, is further
3 amended to read:

4 **6. Final order of disposition of property; public education campaign.** Following
5 the entry of a verdict of forfeiture of property pursuant to this section or the entry of a
6 guilty plea in open court on the record and following the court's disposition of all
7 petitions for hearing timely filed by 3rd parties, the State has clear title to property that is
8 the subject of the indictment, information or complaint. The final order must provide for
9 the deposit of the property or the proceeds from the disposition of the property, less the
10 reasonable expenses of the forfeiture proceedings, seizure, storage, maintenance of
11 custody, advertising and notice, in the General Fund, except that, to the extent that the
12 court finds it reasonable, the court may order forfeiture of as much of the property as is
13 appropriate, less the reasonable expenses of the forfeiture proceedings, seizure, storage,
14 maintenance of custody, advertising and notice, to a municipality, county or state agency
15 that has made a substantial contribution to the investigation or prosecution of a related
16 criminal case or, upon request of the investigating agency or the prosecuting agency, to a
17 law enforcement agency in this State that provides case management and other social
18 services to persons with substance use disorders.

19 **Sec. 2. 17-A MRSA §1105-B, sub-§1, ¶D**, as enacted by PL 2003, c. 476, §5, is
20 amended to read:

21 D. Death or serious bodily injury of another person is in fact caused by the use of
22 that counterfeit drug one or more drugs and the drug furnished by the defendant is a
23 contributing factor to the death or serious bodily injury of the other person.

24 **Sec. 3. 17-A MRSA §1105-C, sub-§1, ¶K**, as enacted by PL 2003, c. 476, §7, is
25 amended to read:

26 K. Death of another person is in fact caused by the use of that scheduled drug one
27 or more drugs and the drug is a schedule W drug furnished by the defendant is a
28 contributing factor to the death of the other person. A violation of this paragraph is a
29 Class B crime. It is an affirmative defense to prosecution under this paragraph that
30 the drug furnished was lawfully possessed by the defendant prior to furnishing and
31 that the death was not a reasonably foreseeable consequence of the use of that
32 scheduled drug. In determining whether the death was reasonably foreseeable, the
33 jury shall consider:

- 34 (1) The factual circumstances surrounding the furnishing of the drug;
- 35 (2) The total quantity of the drug furnished;
- 36 (3) The dosage of the units furnished;
- 37 (4) The nature of the drug;
- 38 (5) The overdose risk presented by use of the drug; and
- 39 (6) Any safety warnings provided to the defendant at the time of dispensing the
40 drug; or

1 **Sec. 4. 22 MRSA §7250, sub-§7** is enacted to read:

2 **7. Report regarding program.** The department shall provide to the joint standing
3 committee of the Legislature having jurisdiction over health and human services matters
4 on or before January 15th of each year, and at such other times as the committee requests,
5 data pertaining to the aggregate number of prescriptions of each drug required to be
6 included in the program, the number of prescribers participating in the program
7 categorized by specialty, any historical trends or patterns in prescribing practices within
8 the State, any progress in the implementation of information sharing agreements
9 authorized by subsection 4-A and any other information pertaining to the work of the
10 program as requested by the committee that is reasonably available to the department, as
11 long as all information reasonably likely to reveal the patient or the prescriber or other
12 person who is the subject of the information has been removed.

13 **SUMMARY**

14 This bill addresses the opiate crisis in Maine by:

15 1. Allowing funds from property forfeited pursuant to a criminal forfeiture action to
16 be assigned by the court, upon the request of the investigating or prosecuting agency, to a
17 law enforcement agency in this State that provides case management and other social
18 services to persons with substance use disorders;

19 2. Clarifying that the Class B crimes of aggravated furnishing of scheduled drugs and
20 aggravated trafficking or furnishing of counterfeit drugs are for the death of another
21 person, whose death was caused by drugs furnished by the defendant; and

22 3. Requiring the Department of Health and Human Services to provide an annual
23 report to the joint standing committee of the Legislature having jurisdiction over health
24 and human services matters regarding the Controlled Substances Prescription Monitoring
25 Program, including the number of prescribers participating and trends in prescription
26 practices.

APPENDIX Y

Descriptions of medications used to treat opioid use disorder

Buprenorphine

Buprenorphine [aka Suboxone] , which is a partial opioid agonist, is used to treat someone who is addicted to an opioid – whether the substance being abused is heroin or a prescription painkiller, such as OxyContin or Vicodin. Of the few medications used for opioid dependence, buprenorphine is the first that can be prescribed for and obtained directly from the doctor’s office. To date, other drugs used to treat opioid dependency – such as methadone – can only be administered in clinics.

This increased access for buprenorphine reflects a change in the level of urgency that the opioid epidemic presents to the medical community – one that demands broadened patient access to opioid dependency medication and other forms of treatment.

Buprenorphine isn’t prescribed in isolation; it’s one component of a comprehensive recovery program designed to address the patient’s individual needs.

Buprenorphine alone has potential for abuse and prescription diversion due to its opioid effects. However, formulations that contain a combination of buprenorphine and naloxone decrease the potential for abuse because naloxone otherwise blocks a robust opioid effect and, further, will initiate withdrawal symptoms if attempts are made to misuse it via injection.

When used properly, these buprenorphine-containing medications can both alleviate unpleasant opioid withdrawal and decrease associated cravings.

These medications are also difficult to overdose on, due to the ceiling effect that buprenorphine has (and to the opioid antagonism of naloxone, in the combination formulations). Once you reach a certain dose, the effects plateau and don’t increase with higher doses.

Probuphine

In May 2016, the FDA approved , the first buprenorphine implant designed to treat opioid dependence. Like methadone and naltrexone, Probuphine is designed to help individuals recover from an opioid addiction by alleviating cravings and withdrawal symptoms without creating a euphoric high. By stabilizing the patient and reducing the sometimes overwhelming cravings associated with opioid addiction, the individual is better able to engage in treatment and therapy.

The Probuphine implant is made of four rods that are inserted into the upper arm. The rods administer a continuous dose of buprenorphine into the bloodstream for a treatment period of 6 months—making it a convenient alternative to the other forms of buprenorphine (daily pills and dissolvable films). The drug is prescribed to patients who are currently stable on low-to-moderate doses of buprenorphine. Probuphine is not recommended beyond two 6-month treatment periods (which would necessitate sequential rod insertion into each arm).

This medication presents advantages over other maintenance medications like methadone. Specifically:

Probuphine does not require daily administration, as it releases a low dose of the drug on a continuous basis.

Probuphine cannot be abused if the implant stays in place.

NOTE: If the implant does get expelled or removed, there is potential for either accidental exposure or intentional misuse.

Methadone

Methadone is a full opioid agonist, which means that it produces similar effects to other opioids. However, because it is longer-acting than drugs like heroin, the effects are milder and shouldn't significantly impact the individual's ability to function.

Methadone is used to alleviate withdrawal symptoms and drug cravings in those addicted to heroin or painkillers. In fact, one dose can prevent cravings and withdrawal for up to a day and a half, according to the Center for Substance Abuse Treatment (CSAT). In order to prevent abuse, methadone is administered in a clinic on a set schedule.

Despite its relatively mild effects (no extreme highs associated with it), those taking methadone would likely still experience unpleasant withdrawal symptoms if methadone therapy were to suddenly stop, so it's important to talk to your doctor if you want to go off methadone.

Naloxone

Naloxone is an opioid antagonist, which means that it blocks the activity of opioids at the receptor sites – potentially reversing or preventing life-threatening overdoses. A naloxone injection may be administered in a medical emergency to those who are experiencing an opioid overdose. As a potentially life-saving intervention, both opioid users and family members should understand how naloxone works and how to use it in the event of an overdose.

Naloxone can come in automatic injection devices, which are sometimes handed out as a harm reduction measure in communities hit hard by heroin abuse. Automatic naloxone injection devices have voice control and walk the injector through administration in a step-by-step manner. If you're using opioids and have been given a naloxone injection device, keep it on you at all times in the event of an emergency.

It's essential to know the warning signs of an opioid overdose so that you can recognize an emergency situation and administer naloxone, if accessible. The following are signs of an opioid overdose:

Tiny, constricted pupils.

Shallow breathing.

Severe drowsiness.

Loss of consciousness.

Unresponsiveness.

Naltrexone

Naltrexone, which can come in an injectable or pill form, is used to treat patients who suffer from an addiction to alcohol or opioids. The injectable version is called Vivitrol. It may be administered intramuscularly, and therefore only requires monthly dosing. Oral dosing occurs once a day. Unlike buprenorphine and methadone, naltrexone lacks potential for diversion and abuse.

Naltrexone works by blocking the opioid receptors. What this means is that if you take the drug and then take alcohol or opioids, you won't experience the usual euphoria or "high" associated with those substances. It may also decrease the general urge to use opioids or alcohol.

It's important to note that naltrexone decreases your tolerance to opioids, so relapse can potentially be dangerous if you return to taking the amount you once did. Overdose and fatal respiratory depression may result.

Conversely, there aren't any risks associated with drinking while taking the appropriate amount of naltrexone. When taken in excess, it can lead to severe liver damage, which is why patients should follow their doctor's instructions carefully. Within prescribed parameters, there aren't any specific contraindications to using naltrexone concurrently with alcohol. Despite any overt effects to serve as a deterrent to drinking however, it will still aid in decreasing drinking behaviors due to the lack of euphoria experienced. While naltrexone blocks the individual from experiencing fully the rewarding effects of alcohol, it does not decrease the other intoxicating effects, such as impaired judgment and coordination.