STATE OF MAINE
128th LEGISLATURE
FIRST REGULAR SESSION

Task Force to Address the Opioid Crisis in the State
Interim Report
April 2017

Revised May 15, 2017

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Sen. Scott W. Cyrway
Sen. James F. Dill
Sen. Geoffrey M. Gratwick
Rep. Joyce "Jay" McCreight, Chair
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Introduction

The Task Force to Address the Opioid Crisis in the State was created by the 1st Regular Session of the 128th Maine State Legislature by Joint Order, SP 210 (See Appendix 1). As a general mission, the Opioid Task Force (OTF) was required 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 OTF was further tasked with the following specific responsibilities:

- Review the 2016 report and recommendations of the Maine Opiate Collaborative;
- 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.

Following the spirit of the Joint Order, as a part of its initial review phase, the OTF has also initiated a detailed review of current opioid-related legislation currently before the First Regular Session of the 128th Legislature. This review effort was manifested in an extensive spreadsheet compiling 56 separate bills as of April 17, 2017 and is available for viewing at the OTF website: http://www.maine.gov/legis/opla/OpioidTaskForce.htm.

The members of the OTF 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. The OTF is also required to to submit a final report with any recommendations and suggested legislation to the Legislature by December 6, 2017. The OTF is currently composed of the following appointed members:

- Senator Andre E. Cushing III, Chair;
- Senator Scott C. Cyrway;
- Senator Geoffrey M. Gratwick;
- Senator James A. Dill;
- Representative Joyce "Jay" McCreight, Chair;
- Representative Anne "Pinny" Beebe-Center;
- Representative Harold "Trey" L. Stewart III;
- Representative Karen R. Vachon;
- 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;
- Robert Fowler, LCSW, CCS, Executive Director, Milestone Foundation;
- Dr. Trip 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;
- Janet T. Mills, Attorney General, State of Maine; and
- Hon. William R. Stokes, Justice, Maine Superior Court.

To accomplish the short term goal of submitting the required initial report by April 30, 2017, the OTF met on April 7, 2017 and April 21, 2017.

OTF Approach

Given the relative time limitations of producing an initial report in a month's time, the OTF used the two meetings in April 2017 to:

- Conduct a broad overview of the major topics pertaining to the opioid crisis in Maine;
- Ascertain the results and recommendations of recent studies; and
- Review and compile current legislative proposals before the First Regular Session of the 128th Maine State Legislature.

The overall purpose of the OTF's first two meetings was to obtain a broad overview of the current dimensions and factors of the opioid epidemic in Maine. The OTF intends to use the information gathered in these first two meetings as a basis for beginning to discern the gaps in the current efforts to stem the opioid crisis, which programming efforts are proving to be most promising and what statutory recommendations can be made to help complete a focused effort to stem the use of opioids in Maine. In considering the mandate contained in the OTF's authorizing legislation, the OTF has used these first meetings as an opportunity to become informed about the various aspects of the opioid crisis and intends to avoid replicating the several existing current reports which have produced a plethora of useful recommendations. The OTF further intends to hone in on the most essential existing recommendations, determine which of these have already been achieved, which ones need further emphasis and what recommendations should be included in the OTF final report, which will be submitted in early December of 2017.

Basic Statistics on the Opioid Crisis in Maine

The OTF was established to deal with the burgeoning opioid crisis in the State of Maine. Due to the rapidly increasing dimensions of this crisis, the most recently available data do not yet fully reflect the current horrific dimensions of how this epidemic is affecting Maine. While Maine is not alone among the states in attempting to deal with what is effectively a nationwide crisis, several of the most recent basic statistics are extremely sobering.

- 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 a 38% increase from 2015 or an increase of 104 deaths;
    - Of the 376 overdose deaths, 330 (88%) were accidental overdoses, 38 (10%) were suicides and 8 (2%) were of an undetermined nature;
    - 79% of drug 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 and this cause of overdose deaths has increased by 71% since 2015;
    - Deaths attributable to pharmaceutical opioids have remained relatively stable at 33% of the total; and
    - The average age of drug deaths in Maine for 2016 was 41 and males outnumber females by 2 to 1.

- According to another report commissioned by DHHS in 2015 titled "SEOW Special Report: Heroin, Opioids, and Other Drugs in Maine":
    - 8% of 18 to 25 year olds in Maine are perceived as needing, but not receiving treatment (2012-13);

- In 2014, about 1 in 4 (24%) primary treatment admissions were related to heroin; up from 7% in 2010; and
- Almost 6 out of 10 admissions for substance abuse treatment also had a previously diagnosed mental health disorder; this rate has steadily increased since 2010.

OTF Meetings

As mentioned earlier, the OTF used its first two meeting in April 2017 to create a systematic and structured overview of the current status of the opioid epidemic in Maine and what efforts currently exist, or are underway, to deal with this crisis. In addition, the OTF has obtained a great deal of information about promising opioid-related programs that have been implemented by other states. The following sections briefly describe the discussions, presentations and materials that were covered in each meeting. It is important to acknowledge that the flow of information to the OTF is continuous and immense; thus, the following descriptions do not itemize every report, article and other inputs that were provided to the OTF during these two meetings. All of the documents cited in this report are posted on the OTF website or can be obtained directly by contacting OTF staff. http://www.maine.gov/legis/opla/OpioidTaskForce.htm

April 7, 2017 OTF Meeting

The first meeting of the OTF on April 7th included the following presentations and materials:

1. OTF member Dr. Trip Gardner made a brief presentation regarding the brain chemistry of opioid addiction;
2. The largest segment of the April 7th meeting was devoted to several presentations from members of the Maine Opiate Collaborative (MOC). The MOC was formed in response to the heroin/opiate epidemic in late 2015 through the efforts of:

    a. Thomas E. Delahanty II, US Attorney, District of Maine;
    b. Janet T. Mills, Attorney General, State of Maine; and
    c. John E. Morris, Commissioner, Maine Department of Public Safety.

    The MOC was composed of three separate task forces:

    a. Prevention/ Harm Reduction;
    b. Treatment; and
    c. Law Enforcement.

    In conducting its work, the MOC held more than 20 public forums that were held across the state and were attended by more than 1200 Maine citizens. As a result of these heavily attended public forums and extended meetings, the MOC generated a large number of recommendations which were detailed in a report that was issued in May of 2016. The MOC presentations during the April 7th meeting corresponded to the three task forces used by the MOC to categorize its work:

    a. Law Enforcement Task Force – This presentation was made by the Co-Chairs Sheriff Joel Merry (Sagadahoc County) and Portland Chief of Police Michael Sauschuk. Briefly summarized, the recommendations from this task force included:

        i. Destigmatize substance use disorders within the law enforcement community;
        ii. Identify and prosecute major drug traffickers;
        iii. Establish pre-charge diversion programs in every public health district;
        iv. Expand the use of Problem Solving Courts (aka “Drug Courts”);
        v. Provide treatment for county jail inmates with substance abuse disorders;
        vi. Provide case management services for inmates transitioning from jails.

In his comments, Chief Sauschuk offered his personal opinion that the number one priority was the expansion of Medicaid; he further explained that once an inmate is detoxed there often is no treatment available for uninsured individuals and many released county jail inmates with Opioid Use Disorder do not have any insurance coverage.

b. Treatment Task Force – The Treatment Task Force presentation was made by Eric Haram, LADC. The recommendations from this task force included the following:

   i. Expand access and availability of the Addiction Recovery Center model (ARC);
   ii. Expand access to evidence-based programs that integrate Medication Assisted Treatment (MAT) with counseling and provide a wraparound support from the community which reduce recidivism rates;
   iii. Begin to break down the barriers to the expansion of high quality MAT services in primary care practices throughout the state of Maine; and
   iv. Reduce harm to the general populace by creating standards for chronic, non-cancer pain.

c. Prevention and Harm Reduction Task Force – The presentation for this task force was made was made by Co-Chair Scott Gagnon, MPP, PS-C, Substance Abuse Prevention Manager for Healthy Androscoggin. The many recommendations from this task force included the following:

   i. Decrease risk factors for substance abuse among youth;
   ii. Reduce the instances of over-prescribing of pharmaceutical opioids;
   iii. Decrease the number of drug-affected babies born in Maine;
   iv. Increase the availability of naloxone for opioid users; and
   v. Reduce barriers to treatment.

In addition, the MOC Task force recommendations were supplemented by spreadsheets compiled by OTF staff which comprehensively listed the various recommendations and their corresponding strategies. A copy of the complete MOC report can be viewed at the following link: http://www.maine.gov/legis/opla/OpioidTaskForce.htm.

3. The remainder of the available meeting time was devoted to a short presentation of the following spreadsheets compiled by OTF Staff:

- Proposed Opioid Legislation in Maine – ongoing – This spreadsheet lists (to date) the differing opioid-related legislation proposed during the First Regular Session of the 128th Legislature. The spreadsheet includes the following information:

  - LD number;
  - Bill title;
  - Sponsor;
  - Committee of reference;
  - Date of public hearing;
  - Date of work session;
  - Committee report;
  - Amendments;
  - Summary; and
  - Fiscal note.

  The intent of this spreadsheet is to provide OTF members with a comprehensive listing of all opioid-related legislation, which can be evaluated at the conclusion of the First Regular

Session to ascertain what actually has become law and to then determine which of the MOC recommendations may have been addressed.

- Other State and National Opioid Programs, Laws and Resources – This spreadsheet offers a partial list and certain details of existing state and national programs and laws that have been implemented in response to the opioid epidemic. The spreadsheet also lists centralized resources that are available for further inquiry. The purpose of this spreadsheet is to begin to address the directive of the OTF's authorizing legislation to review successful initiatives undertaken by other states.

In addition to the materials and presentations listed for the April 7th meeting, the OTF was provided access through e-mails and web postings to the following documents:

- "State Solutions to the Opioid Epidemic" – 3/21/17 webinar presented by the Council on State Governments;
- Presentations on Opioid Addiction and Treatment by MaineHealth to the Health and Human Services Committee, 4/11/17 – these presentations, supplemented by written documents, included:
  - Medical Basis of Addiction – presented by Jonathan C. Fellers, MD, Maine Medical Center, MaineHealth;
  - The Hub and Spoke Model Works – presented by Jonathan C. Fellers, MD, Maine Medical Center, MaineHealth;
  - Methadone – presented by Vijay Amarendran, MD, MS, Acadia Hospital; and
  - Outpatient Treatment of Individuals with Opioid Use Disorder – presented by Kristen Silva, MD, Maine Health; and
- "No opioids, please: A growing movement lets patients refuse prescriptions" – an AP article which appeared in the 3/19/17 edition of State News.

April 21, 2017 OTF Meeting

1. The second meeting of the OTF occurred on April 21, 2017 and featured the following presentations arranged by OTF member Bob Fowler:

   a. Detoxification Services – presented by Dr. Mary Dowd, Medical Director of the Milestone Foundation. In her presentation, Dr. Dowd discussed detoxification as but the first step towards opioid treatment and further mentioned that the likelihood of relapse with just detox is up to 95%. Dr. Dowd's presentation included comments on:
      i. Population served at Milestone – people from all over Maine; half of the admissions are for alcoholics and the other half is for opioid addicts. The detox facility includes 16 beds with a staff of 2 nurses and one CNA;
      ii. Other medical problems – many patients have serious medical problems including Hepatitis C, blood clots, heart valve infections and PTSD;
      iii. Why do they come? – reasons include inability to quit on their own, self-hatred, behavior which leads to family destruction, desire to regain custody of children and a desire to have a normal life again;
      iv. What is opioid withdrawal like? – symptoms like cramps, nausea, sweats and chills, increased heart rate, and significant anxiety start within 1 to 2 days after last opioid use, worsen over 2 to 3 days and then diminish over the next 3 to 5 days; and

v. How to treat withdrawal? – either for symptoms (generally less effective) or with opioid replacement, usually with suboxone (more effective).

Dr. Dowd supplemented her presentation with the distribution of a handout entitled, "Maintenance Medication for Opiate Addiction: The Foundation of Recovery" (NIH Public Access, Gavin Bart, MD, July 2012).

b. Opioid Health Homes – presented by OTF member Malory Shaughnessy, Executive Director of the Alliance for Addiction and Mental Health Services. Ms. Shaughnessy focused her presentation around a description of a newly implemented DHHS program known as Opioid Health Homes (OHH). Her discussion of OHHs included the following information:

i. OHHs are designed to provide coordinated care to patients with multiple chronic health conditions, including mental health and substance abuse disorders;
ii. OHHs feature a team based approach which includes the individual and family members;
iii. OHHs are located in primary care or behavioral health provider's offices and are not located in residential settings;
iv. OHHs must offer six core services:

1. Comprehensive care management;
2. Care coordination;
3. Health promotion;
4. Comprehensive transitional care/follow-up;
5. Individual and family support; and
6. Referral to community and social support services.

v. Eligibility for OHHs requires that the individual must be diagnosed with either:

1. One chronic condition with being at risk for a second; or
2. Two chronic conditions; or
3. A serious mental illness; and

vi. Those states that have implemented Medicaid health homes receive a 90/10 federal match for the first eight fiscal quarters of the OHH existence.

In additional remarks, Ms. Shaughnessy also commented on several aspects of OHH rulemaking and implementation in Maine:

a. It appears that DHHS rules may not provide for allowing a relapsed individual to retain services from an OHH;
b. The number of uninsured individuals receiving treatment at an OHH may be capped at only 170 statewide;
c. There may be some redundancy in the licensed professionals that are required to be in the OHH Clinical Team;
d. The costs of Intensive Outpatient Treatment (IOP) that are frequently used in Maine may not be covered for OHH reimbursement; and

e. The rule requires that OHHs be licensed as substance abuse treatment facilities. This precludes primary care offices from qualifying as an OHH.

Ms. Shaughnessy also provided OTF members with copies of a recent Bangor Daily News editorial (4/10/17) titled, "Maine's 'Opioid Health Homes' Are So Intricate There Will Probably Be Only a Few".

c. Residential Treatment Services – The next presentation was made by Ms. Sara Bachelder, LADC, CCS, Clinical Team Leader of Milestone's Extended Care Program. In her presentation, Ms. Bachelder made the following comments:

i. Residential treatment for individuals with opioid use disorder tend to vary in length and correspond to treatment needs determined on a Continuum of Care developed by the American Society of Addiction Medicine, ASAM (see copy: http://www.maine.gov/legis/opla/asamcontinuumcare.pdf)
ii. The residential treatment services provided by Milestones are long term and serve mostly men who are eligible for MaineCare; over 50% of the individuals applying for treatment at Milestones are uninsured and are not eligible for treatment, an estimated 35 to 40% of residential applicants are homeless; 3 beds at Milestones are grant funded for uninsured; wait lists for these beds are up to a year;
iii. Applicants come to Milestones upon release from correctional centers, detoxification programs and from the community;
iv. Lengths of stay vary according to the individual's treatment needs as determined by the ASAM Continuum of Care model; the more intensive treatment needs fall on the residential treatment scale provided by the ASAM Continuum of Care model;
v. Milestones and other treatment facilitates use level of care assessment based on the ASAM model which helps to determine the level of substance abuse, the current living environment, overall medical condition, mental health and the family situation;
vi. Individuals needing residential services tend to have significant needs in many of the areas addressed the level of care assessment; the needs of these individuals cannot typically be met by out-patient treatment services;
vii. Residential treatment is important for several reasons. Many studies have shown that the longer a person is in treatment the higher their probability of success; stays of 90 days or more have a much lower probability of relapse, help individuals to become productive members of society and be then be able to return to employment and become insured- therefore saving money for residential programs, insurers and individuals; and
viii. Many individuals in long term care started using substances very early in life such as the age of 12 or 13 and therefore do not have important social and problem solving skills, are not able to cope with stress and are impaired in many ways that interfere with their overall coping skills. Extended residential treatment provides an opportunity to acquire some of these desperately needed skills.

d. Intensive Outpatient (IOP) and Outpatient Treatment – This presentation was made via speaker phone by Peter McCorison, Behavioral Health Services Director, Aroostook Mental Health Center. In his presentation, Mr. McCorison made the following points:

i. Intensive Outpatient Services (IOP) is a level of treatment within a continuum outlined by the American Society of Addiction Medicine;

ii. IOPs consist of a group process that meets three times a week for a minimum of three hours per meeting;
iii. IOPs represent a multi-disciplinary approach that includes an assessment of the client's overall physical and emotional health and determines the appropriate level of treatment and provides each client with an appropriate and much needed level of structure and support; and
iv. IOPs can include "partial hospitalization" as part of the continuum of care; partial hospitalization provides a higher level of support and structure and requires attendance at more group meetings per week.

2. For the next part of the April 21st meeting, the OTF had a presentation on Drug Courts by Anne Jordan, Esq., Manager of Criminal Process and Specialty Dockets, State of Maine Judicial Branch. During her presentation, Ms. Jordan offered the following information:

i. There are currently six Adult Drug Treatment Courts (ADTC) in Maine located in York, Cumberland, Androscoggin, Washington, Penobscot and Hancock counties;
ii. Each ADTC has a maximum caseload of 30 individuals;
iii. Maine's ADTCs differ from other states in that high-risk individuals are required to enter a guilty plea to whatever criminal charge has been made against the individual; in return, successful completion of the ADTC program will result in a significantly less severe sentence;
iv. Admission to the ADTC program is dependent upon an evaluation conducted by Maine Pretrial Services to determine whether the individual meets the following eligibility criteria:

1. Referral to the program by an attorney, probation officer or community member;
2. Defendant application and interview;
3. Independent verification of information gathered in interview;
4. Substance abuse, mental health and trauma screening;
5. Review of demographic information;
6. Defendant screening;
7. Document review of defendant's court paperwork;
8. Records request and review for substance abuse, mental health services and treatment;
9. Coordination with defense counsel, prosecutor and probation officer (if on probation);
10. Creation, review and execution of informed releases of information; and
11. Report to the ADTC team.

v. Participants are required to meet at least every other week with the presiding judicial officer and to maintain regular contact with the case manager, and, if applicable, the probation officer. Failure to meet any of these requirements can result in termination from the program and/or the imposition of new court sanctions;
vi. In 2016, the ADTCs had a total participation of 247 participants; of that total, 52 persons graduated from the program, 62 were terminated for noncompliance;

vii. The ADTC process represents significant savings to the state's criminal justice system; for every $1 spent of ADTC treatment, $1.87 in savings is realized. The average savings per ADTC participant is estimated to be $12,218;

viii. Participation in the ADTC process has resulted in significantly lower rates of recidivism for successful participants; a recent study showed a recidivism rate of 16% for ADTC graduates as opposed to a rate of up to 49% for participants who were terminated from the program;

ix. The ADTCs were first created by Maine law in 2000; and

x. Funding for the ADTC has two sources: judge, clerk and marshal time are funded by the Judicial Branch; all other treatment and case management costs are borne by the Office of Substance Abuse and Mental Health Services within DHHS.

3. The final part of the April 21st meeting was devoted to determining the content of this report and the direction of future OTF meetings.

   In addition to the previously cited documents provided during the course of the April 21st meeting, the following documents were distributed to OTF members either by e-mail or postings to the OTF website at http://www.maine.gov/legis/opla/OpioidTaskForce.htm:

   - 2016 Annual report on Maine's Adult Drug Treatment Courts – State of Maine Judicial Branch;
   - Proposed Opioid Legislation in Maine – ongoing – this previously cited spreadsheet lists (to date) the differing opioid-related legislation proposed during the First Regular Session of the 128th Legislature. As of 4/17/17, this staff-generated spreadsheet compiled vital information on a total of 56 opioid-related pieces of proposed legislation;
   - Recovery–Oriented Systems of Care (ROSC) Resource Guide; September 2010 – Substance Abuse and Mental Health Services Administration;
   - Continuum of Care – American Society of Addiction Medicine;
   - DHHS Substance Abuse Expenditures from FY 12 to FY 16 – spreadsheet provided by the Office of Substance Abuse and Mental Health Services, DHHS; and
   - State Opioid – Related Programs – Revised – this staff-generated spreadsheet compiles basic information on program descriptions within DHHS, Department of Public Safety and the Judicial Branch.

Conclusions and Topics of Further Inquiry

Upon consideration of what to include in this Interim Report, the OTF concluded that, given the early stage of the task force's existence, it would premature for the OTF to make any formal recommendations or draw substantive conclusions about what can be done to stem the opioid crisis in Maine. Instead, the OTF decided to use this Interim Report as a means of providing a "snapshot" of the current status of the in-state efforts to quell the opioid epidemic and to report on the contents of the two OTF meetings that have been held to-date. The OTF is also using this report as an opportunity to identify specific topics for further inquiry. In no particular order, these topics include the following:

- What is the current estimate on the number of individuals with Opioid Use Disorder in Maine?
- What is the current estimate of how many individuals are in opioid-related treatment programs in Maine?
- What is the current estimate of how many individuals are undergoing treatment for Opioid Use Disorder through primary care practitioners?
- How many individuals with Opioid Use Disorder in Maine are currently uninsured?
- How many individuals with Opioid Use Disorder in Maine are currently homeless?
- How many opioid treatment "beds" currently exist in Maine? How many of these slots accept uninsured patients? What is the range of cost for these treatment beds? What is the breakdown of currently available treatment beds in terms of long term vs. short term?
- How many re-entry programs currently exist in Maine and is there a need for more?
- With regards to MaineCare, under current law (or regulation), what is the process for a former county jail inmate to be reinstated and how long does this usually take?
- What is the relationship between bail conditions and the likelihood of former county jail inmates to be returned to jail as a result of a substance abuse related violation of law?
- How many individuals are currently receiving prescriptions containing each of the following medications: Buprenorphine, Naltrexone and Methadone?
- How many individuals are currently receiving prescriptions containing each of the following medications: Buprenorphine, Naltrexone and Methadone per year over the last three years?
- How much is the total spending in Maine for opioid-related programming?
- What is the potential for more detox/residential treatment beds in Maine?
- What are the particulars of current Department of Health and Human Services (DHHS) rulemaking for Opioid Health Homes? To what extent do the dictates of 42 Code of Federal Regulations (CFR) impede or conflict with the current effort to implement OHHs in Maine?
- What are some of the success stories of other countries in addressing the opioid epidemic?
- What can be done to break the endless cycle that often occurs within the Judicial Branch when an individual is frequently detained on a pre-trial basis for a long period of time, ordered to discontinue the use of illicit drugs (which is the very issue which led to the legal charges), sometimes sentenced to county jail with inadequate treatment resources, eventually released from county jail and required to participate in treatment programs which have a long waiting list, and frequently lapsing back to opioid use which often then leads to repeated violations and the cycle repeats itself.
- In terms of available treatment beds: How many long and short term beds exist in Maine for for the purpose of treating other than Opioid Use Disorder? How many treatment beds are available for specialty populations such as women and adolescents? Where are the treatment beds located throughout the state?
- With regards to treatment options like Intensive Outpatient, how many programs exist and where are they located? Do these programs also serve specialty populations such as women and adolescents? Do these programs have wait lists and if so, which programs and how long are the wait lists?

- What is the range of rates charged for Opioid Use Disorder treatment options and when were these rates last changed?
- How many individuals with Opioid Use Disorder are currently being incarcerated for low level drug crimes who could be better served by treatment?

Appendix 1

Authorizing Legislation for the Task Force to Address the Opioid Crisis in the State

SP 210, First Regular Session of the 128th Maine State Legislature

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 2

Common Descriptions of Terms Used in Discussing Opioid Use Disorder

Description of Difference Between Opiates and Opioids

Source: http://detoxanswers.com/questions/420/opiate-vs-opioid-what-is-the-difference-between-opiate-and-opioid

"An opiate is a substance derived from the poppy plant (which contains opium). Opiates are sometimes called "natural" since the active ingredient molecules are made by nature, not manufactured by chemical synthesis. Common opiates include morphine and codeine, both made directly from poppy plants.

An opioid is a substance (molecule) that is synthetic or partly synthetic, meaning the active ingredients (molecules) are manufactured via chemical synthesis. Opioids may act just like opiates in the human body, because of the similar molecules.

opiate - narcotic analgesic derived from a opium poppy (natural)

opioid - narcotic analgesic that is at least part synthetic, not found in nature

The terms are often used interchangeably. On the street, "heroin" may mean synthetic, natural, or semi-synthetic compounds. Manufactured opioids like Oxycontin are sometimes called "synthetic heroin", also adding to the confusion. Genuine "heroin" as originally formulated is technically considered an opioid, since it is chemically manufactured, although molecules from the opium plant are used in the process. Some of heroin's active ingredient molecules are not found in nature.

Currently many references are using opioid to refer to all opium-like substances (including opiates and opioids), and limiting the use of "opiates" to only natural opium poppy derived drugs like morphine."

Common Description of Carfentanil / Remifentanil

Source: https://www.randoxtoxicology.com/products/elisa/carfentanil-remifentanil/

Carfentanil or carfentanyl (also known as 4-carbomethoxyfentanyl) is an analog of the synthetic opioid analgesic fentanyl. It is 10,000 times more potent than morphine, making it among the most potent commercially used opioids. Carfentanil was first synthesized in 1974 by a team of chemists at Janssen Pharmaceutica.

Side effects of carfentanil are similar to those of fentanyl, which include itching, nausea and respiratory depression, which can be life-threatening. Fentanyl analogs have killed hundreds of people throughout Europe and the former Soviet republics since the most recent resurgence in use began in Estonia in the early 2000s, and novel derivatives continue to appear.

Carfentanil is classified as Schedule II under the Controlled Substances Act in the United States. In 2016, carfentanil was identified as an additive in heroin sold in Ohio, leading to a spike in the number of overdose cases.

Descriptions of Medications Used to Treat Opioid Use Disorder

Source: http://drugabuse.com/library/medication-assisted-treatment/#types-of-medications-used-in-mat

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.