ASSEMBLY STANDING COMMITTEE
COMMITTEE OF THE WHOLE
THE CITY AND BOROUGH OF JUNEAU, ALASKA

February 26, 2018, 7:00 PM.
Municipal Building - Assembly Chambers

Assembly Work Session - No Public Comment - Meeting will start at 7 pm or immediately follow the Special Assembly Meeting, which starts at 5:30 p.m.

I. ROLL CALL

II. APPROVAL OF AGENDA

III. APPROVAL OF MINUTES

A. **February 5, 2018 Committee of the Whole Meeting**
B. **February 13, 2018 Committee of the Whole Minutes**

IV. AGENDA TOPICS

A. **National Council on Alcoholism and Drug Dependence (NCADD) Opioid Grant**

B. **Centennial Hall Governance**

C. **Public Safety Task Force Recommendations**

V. ADJOURNMENT

ADA accommodations available upon request: Please contact the Clerk's office 72 hours prior to any meeting so arrangements can be made to have a sign language interpreter present or an audiotape containing the Assembly's agenda made available. The Clerk's office telephone number is 586-5278, TDD 586-5351, e-mail: city.clerk@juneau.org

ASSEMBLY STANDING COMMITTEE
COMMITTEE OF THE WHOLE
THE CITY AND BOROUGH OF JUNEAU, ALASKA

February 5, 2018, 5:00 PM.
Municipal Building - Assembly Chambers

Assembly Work Session - No Public Testimony

I. ROLL CALL

Deputy Mayor Jerry Nankervis called the meeting to order at 5:00 p.m. in the Assembly Chambers.

Assemblymembers Present: Mary Becker, Rob Edwardson, Maria Gladziszewski, Norton Gregory, Loren Jones, Jesse Kiehl, Ken Koelsch, Jerry Nankervis, and Beth Weldon.

Assemblymembers Absent: None.

Staff present: Rorie Watt, City Manager; Amy Mead, Municipal Attorney, Beth McEwen, Deputy Clerk; Bob Bartholomew, Finance Director.

II. APPROVAL OF AGENDA

Hearing no objection, the agenda was approved as presented.

III. APPROVAL OF MINUTES

A. January 29, 2018 Committee of the Whole Meeting

Hearing no objection, the minutes of the January 29, 2018 Committee of the Whole meeting were approved with minor corrections.

IV. AGENDA TOPICS

A. Proposed Purchase of AVISTA / AEL&P by Hydro One

Mr. Watt noted the significant amount of public comments submitted to the Assembly on this topic and there are approximately 100 comments on the RCA website. There are many documents before the Assembly. On January 22, Mr. Watt gave the Assembly a preliminary approach. It is most constructive to define policy goals to achieve first and then work on the method to achieve the goals. If he was directed to "intervene" by the Assembly, he needed to know what the specific interests are and what the best way is to get there. He drew attention to the document from Renewable Juneau, which summarizes the main policy goals people are advocating for and it gives the Assembly a road map for discussion. He recommended the Assembly work through that process, to work on which policy goals to adopt and the process afterwards. The biggest issue is "what happens with Snettisham."

Mayor Koelsch asked for goals from the Assembly. He listed five of his own:

1. The Snettisham assets remain with the State of Alaska or local CBJ ownership.
2. The 55 specific master list of commitments regarding regulatory rate, governance, business operation, local presence, community involvement commitments are to be included in the transfer agreement as applicable and practicable (to the extent possible).
3. AEL&P will publish information on the process by which other energy developers become able to use AEL&P's transmission distribution and the affect that has on current and future rate payers.
4. AEL&P's advance utility planning be presented to the Juneau public every two years.
5. RCA's public hearing and deliberation in reference to the acquisition of Avista / AEL&P by

Hydro One should be held in Juneau.

Mr. Kiehl said several members of the public have asked to discuss the issue of land.

Mr. Jones said Avista / AEL&P and CBJ are part of a unitization agreement. The Assembly approved the only name changes when AVISTA bought AEL&P. The unitization agreement covers all of the land, and whether it is part of this negotiation or others, the new owners should be willing to sit down at the table with CBJ and relook at the unitization agreement. This may be a way to get to Mr. Kiehl's issue.

Mr. Watt said there are lands that a sister company that AEL&P owns that are successor properties from the AJ Mine. In the early to mid-70's the city obtained properties from the former owner of the AJ Mine as did the power company. The parties unitized the properties that were thought to have mineral value, and this is a subset of the land AJT has, including the old fuel dock across from Foodland. When the two parties acquired the lands from AJ Industries, CBJ selected the Gold Creek Watershed and the historical ore body for AJ Mine, Perseverance Mine. AEL&P selected more land over in Douglas that was traditionally the Treadwell ore body. Each owns mineral rights to the ore bodies. If you wanted to develop the AJT properties, you would have to cross AEL&P properties to access the CBJ lands. He spoke about how the royalties were to work.

Mr. Nankervis suggested a sixth goal could be "Ask about the possibility of re-examining the unitization agreement with Hydro One."

Mr. Jones discussed intervention into the rate setting process and having rates as a policy issue and some understanding of rates currently and historically. He suggested discussion about notice before rates go to the RCA and providing information about rates.

Mr. Edwardson asked under what conditions would the CBJ be within its rights to intervene.

Ms. Mead said intervention is the process to use if there is an argument to the RCA that an entity believe that it is or should be a party to transfer process. The timeline for protest has come and gone. The RCA would review factors to be considered: whether there is a way under the statute to be made part of the proceeding (she did not believe that was true in this case), the nature and extent of any property, financial, or other interest that CBJ holds that is not being attended to by another party in the transfer process, the effect on that interest that might be affected by the order authorizing or approving the transfer from Avista to Hydro One (you need to show how the transfer of the property is going to effect CBJ's property interests), the availability of any other means to get at the same issue, the extent to which a party's interest will be represented by other parties, the extent that the CBJ's participation will create a good record and will not unreasonably delay the process. The RCA would need to find CBJ met some of the factors.

Mr. Nankervis asked if intervention could address a public hearing in Juneau. Ms. Mead said the RCA has broad discretion to impose any conditions it finds warranted or necessary as part of the transfer process. CBJ could request a public hearing from the RCA at any time, that is not an intervention issue.

Ms. Becker said there has been a lot of talk about how AELP customers pay more than what Hydro One charges and asked about profits. Is there any way that CBJ can require some kind of bonding to protect the assets of AELP, Snettisham, the lines in case of another emergency such as the avalanche. Ms. Mead said the process before RCA right now is a request by Hydro One to take a controlling interest of Avista. It is a transfer of the already existing certificate. It is not a rate setting process, it doesn't address rates. The only issue RCA looks at is whether Hydro One is willing and able and has the necessary means to operate the certificate. If there are things that might occur with the transfer, for example, Hydro One becomes the owner of some asset currently held by Avista / AEL&P, and you think the transfer might have a negative impact on CBJ for some reason, that is what is brought up in intervention. Mr. Watt referred the members to the packet and the statement "AELP will not seek to recover in rates any premium associated with the acquisition of

Avista stock, or transaction costs, associated with the proposed transaction."

Ms. Becker said a seventh goal could be to include discussion of repair bonding.

Mr. Edwardson said he was sufficiently convinced that the public of Juneau wants us to intervene and we are just struggling how to do this.

Ms. Gladziszewski said these goals are not the same as intervention or the legal possibility for intervention. These are legitimate goals. Is intervention a way to address these goals, and do we have legal standing to intervene. Joint property may be a way to get into the intervention door. How much would intervention cost?

Ms. Mead said based on the analysis from a private attorney, it is estimated that 30-50 hours are needed to do the initial assessment and 55 hours and two days in Anchorage to draft the petition and the hearing itself. The cost for the attorney is approximately $300 - 350 for the senior level and $250 for associates, so $30 - 50,000 to intervene, plus.

Mr. Watt suggested there is an escalating level of involvement, beginning with calling them up and telling them what we want, making comments to the RCA about the things we want, and at the other end of the spectrum, intervention.

Mr. Nankervis said the list of goals was to 7, including bonding for repair. Would any of those items qualify for intervention. Ms. Mead said it depended. The goals could be fit into a petition, whether the RCA found that the standards for intervention are met is not known. There is a timing issue by the RCA that requires a formal notice within a timeline to intervene, that is the second order that has not been issued by the RCA at this point. The regulation on intervention also lays out a regulatory timeline of 30 days from the hearing. The hearing is set for May 20, so 30 days prior to that is the deadline for intervention.

MOTION, by Gregory, to file to become an intervenor and that CBJ allocate $75,000 from the general fund or any other fund that the staff deem appropriate to fund this intervention and that we seek legal expertise that we need to file for intervention and asked for unanimous consent.

Ms.Weldon was interested in giving direction to the City Manager to enter into negotiations with AEL&P to negotiate the goals, to seek resolution prior to any intervention.

Mr. Watt said that there is time to negotiate while the appropriation ordinance went through its public process and the two parallel tracks can take place.

Ms. Mead explained the difference between submitting public comment from CBJ to RCA and intervention, which makes the CBJ a party to the suit, in which CBJ would state that there is something that will be harmed or lost through this regulatory process, and no other party is protecting CBJ's interest and if CBJ can't participate, there is a legal effect or right that the RCA may not be looking out for. CBJ would be party to cost allocation in intervention. Ms. Mead said at the end of a case, costs can be allocated to the prevailing party from the other parties.

Hearing no objection, the motion carried by unanimous consent.

Mr. Watt suggested introduction of the appropriating ordinance at the regular meeting on February 12, and public hearing and Assembly action at a special Assembly meeting on February 26 immediately preceding the Committee of the Whole meeting.

MOTION by Weldon, that the Assembly give direction to the City Manager to enter into negotiations with AEL&P to negotiate the goals discussed at this meeting and to request the City Manager provide an update as of the Special Assembly meeting on February 26, 2018. Hearing no objection, it was so ordered.

Mr. Kiehl said the CBJ should negotiate for open access, non-discriminatory tariffs. That is not something currently in the Alaska rules and he would like to make open access a condition of the license. The Assembly further discussed the matter.

Mr. Watt said he will get what he can in the negotiations and the discussion will inform the range of options to report on at the meeting on 2/26.

Mr. Nankervis thanked the public for their input.

V. ADJOURNMENT

There being no further business to come before the committee, the meeting adjourned at 6:35 p.m.

Submitted by Laurie Sica, Municipal Clerk

ASSEMBLY STANDING COMMITTEE
COMMITTEE OF THE WHOLE
THE CITY AND BOROUGH OF JUNEAU, ALASKA

February 13, 2018, 6:30 PM.
Assembly Chambers - Municipal Building

Assembly Work Session - No Public Testimony

I. ROLL CALL

Deputy Mayor Jerry Nankervis called the meeting to order at 6:30 p.m. in the Assembly Chambers.

Assemblymembers Present: Mary Becker, Rob Edwardson, Maria Gladziszewski, Norton Gregory, Loren Jones, Jesse Kiehl, Ken Koelsch, Jerry Nankervis, and Beth Weldon.

Assemblymembers Absent: None.

Planning Commission Members Present: Andrew Campbell, Nathaniel Dye, Carl Greene, Ben Haight, Dan Hickok, Mike Levine, Paul Voelkers.

Planning Commission Members Absent: Percy Frisby, Dan Miller.

Staff present: Rorie Watt, City Manager; Amy Mead, Municipal Attorney, Mila Cosgrove, Deputy City Manager; Laurie Sica, Municipal Clerk; Robert Palmer, Assistant Attorney; Beth McKibben, Planning Manager; Laura Boyce, Senior Planner; Jill McLean, Senior Planner; Tim Felstad, Planner, Allison Eddins, Planner; Nate Watts, Code Compliance Officer.

II. APPROVAL OF AGENDA

Hearing no objection, the agenda was approved as presented.

III. APPROVAL OF MINUTES

A. January 31, 2018 Committee of the Whole Meeting

Hearing no objection, the minutes of the January 31, 2018 COW meeting were approved with minor corrections.

IV. AGENDA TOPICS

A. Assembly and Planning Commission - Joint Discussion

Chair Nankervis welcomed the Planning Commission members and introductions were made around the table.

Ben Haight, Chair of the Planning Commission, acknowledged and listed each Planning Commissioner's office and / or service as a participant or liaison to a variety of other boards, commissions, or subcommittees to the Planning Commission, acknowledging the time they give to the community.

Mr. Haight wanted to reviewed the Planning Commission's accomplishments, projects they are currently working on and projects they are looking forward to. In 2017, the Planning Commission:

- Reviewed 21 Conditional Use Permits - 8 of which were for marijuana operations
- Recommended 3 rezones for approval (Honsinger, Catholic Diocese block, Front Street, Douglas)
- Denied 2 rezones (Duran's Mendenhall Loop D-5 to D-10, Schmidt's Auke Bay D-10 to LC)

- Reviewed Pederson Hill Subdivision twice
- Approve 1 Variance (Tyler Rental)
- Denied 2 Variances (Cinderella House)
- Recommended approval of 11 CBJ project and 1 State project (Egan)
- Approved 1 Alternative Development Overlay District permit
- Recommended Code Amendments to Assembly for:
    - Parking Waivers
    - Wireless Communication Plan
    - Alternative Development Overlay District
    - Eagles
    - Panhandle Subdivisions
    - Essential Public Facilities
    - Recommended Lemon Creek Plan for approval
- Reviewed 1 Flood Zone Exception (Statter)
- Reviewed 1 Wireless Communication Towner (Lemon Creek)
- Met as Title 49 Committee 12 times to consider code changes
- Met 4 times as PC COW to work on projects

Mr. Haight said code amendments in progress include the following topics:

- Street Reconstruction Waiver
- Variances
- Auke Bay zoning/incentives
- Streamside Buffers
- Nonconformities
- Accessory Apartments
- Tine Homes
- Waste Management
- Downtown residential zoning
- Canopies
- Urban Agriculture
- City State Project Review
- Process for Amending the Comprehensive Plan
- Privately Maintained Access in a Right of Way within the Urban Service Area

Mr. Haight said future planning efforts will include:

- Downtown Plan
- Comprehensive Plan
- Wetlands Management Plan update
- Historic Preservation Plan

Mr. Levine said the Planning Commission also revised the Rules of Procedure to better address submission of public comment and to provide time limits for public testimony.

Mr. Nankervis asked if this was a normal workload. Mr. Voelker said it has been a little slower in the permitting but they are staying busy with code amendments and planning. Ms. McKibben said that there have been several changes to the code to allow approval by department staff through a building permit, such as accessory apartments, childcare homes, and the major subdivision is 13 lots or more now instead of 4, so fewer permit applications are being reviewed by the Planning Commission. Some reduction in applications can be attributed to the economy.

Topics of discussion between the Assembly and the Planning Commission at this meeting included a discussion of variances, the need for a street grid system in Auke Bay, viewplanes and tree planting, non-conforming uses, the sunset date on the overlay districts, urban agriculture and farm animals and FEMA mapping.

There was discussion about the processing of City/State Project reviews, and concern about providing comment at a timely point in the design process, rather than once the plans are complete.

The Assembly and Planning Commission members discussed the Comprehensive Plan, and whether a "review" or an "update" was needed, the process to do the work, and the staffing required to do the work, in light of the full workload of the Planning Commission.

Mr. Nankervis suggested that the City Manager, the planning staff and the Planning Commission discuss and return a proposal to the Assembly regarding whether a "review" or an "update" is needed (an update being a more thorough re-write of the plan), and what the process might be, whether it is done "in-house" or contracted out, and a timeline.

Mr. Haight referenced the downtown plan memo from Ms. McKibben, and encouraged the Assembly to read and offer comments. This review includes the historic and culture preservation plan. In addition, the PC will be reviewing mining code updates, streamside buffers, code changes on tiny homes, and the overlay district sunset dates. They will address the code for canopies, rights of way in urban service area and signs, which are all topics on the back burner.

Mr. Nankervis said the other goals that came out of the retreat were to increase affordable workforce housing through identifying and implementing strategies from the Housing Action Plan, area plans - Downtown, then Douglas, finish development of Pederson Hill and begin the disposal process, in addition to the comprehensive plan. All were important to the Assembly.

Mr. Nankervis, on behalf of the Assembly, thanked the Planning Commissioner for their diligent work.

V. ADJOURNMENT

There being no further business to come before the committee, the meeting was adjourned at 7:58 p.m.

Submitted by Laurie Sica, Municipal Clerk

CBJ and Opioid Misuse

An Examination of Efforts and Opportunities to Collaborate

The Problem

Alaska Partnerships For Success (PFS)

- Strategic Prevention Framework
- Prevention-oriented
- Age group focus: 12-25 years old
- Five step framework
- Two guiding principles

PFS Juneau Strategies

- Rx disposal bag and information kits
- Prescriber Pledge
- Enhance and promote MAT access
- Media campaign x2
- Institutional adherence to CDC prescribing guidelines
- Online resource

Juneau Opioid Work Group

- Meet 1x/month, at Juneau Public Health Center
- Coalition established to share and collaborate on community efforts
- Participants include JPD, State, CCTHITA, local services
- Strategy development for community response

Alaska PFS Partnerships for Success

Relevance to Juneau

- Death
- Higher incidence of disease, worsened health outcomes
- Burden on public services
- Sustained Rx levels
- Multi-generational issues (NAS, ACEs, etc.)

Alaska PFS
Partnerships for Success

Requests

- CBJ liaison to Juneau Opioid Work Group
- Public, visible CBJ engagement with coalition efforts, prevention efforts

Alaska Opioid Policy Task Force
FINAL RECOMMENDATIONS

2017

Alaska Opioid Policy Task Force Members

- Jay Butler, MD, Chief Medical Officer, Alaska Department of Health and Social Services
- Gunnar Ebbesson, LPC, Chairman, Advisory Board on Alcoholism and Drug Abuse
- Jeff Jessee, CEO, Alaska Mental Health Trust Authority
- Byron Maczynski, Bethel City Council
- Shane Coleman, MD, Southcentral Foundation
- Captain Michael Duxbury, Alaska State Troopers
- Randall Burns, State Opioid Treatment Authority, Alaska Division of Behavioral Health
- Christina Love, Person in Recovery
- Nick Kraska, Person in Recovery
- Kerby Kraus, Person in Recovery
- Tina Woods, PhD, Alaska Native Tribal Health Consortium
- Perry Ahsogeak, Fairbanks Native Association
- Erich Scheunemann, Assistant Chief, Emergency Medical Services, Municipality of Anchorage
- Robert Henderson, JD, Chairman of Controlled Substances Advisory Committee/Andrew Peterson, JD, Assistant Attorney General
- Mark Simon, MD, Fairbanks Memorial Hospital
- Erin Narus, PharmD, State Medicaid Pharmacist, Alaska Department of Health and Social Services
- Elizabeth Ripley, Executive Director, Mat-Su Health Foundation
- Anna Nelson, Executive Director, Interior AIDS Association
- Kim Zello, family member
- Raegan Eidsness-Haugse, family member
- Representative Paul Seaton, *ex officio,* Alaska House of Representatives
- Senator Cathy Giessel, *ex officio,* Alaska State Senate
- Sarah Health, *ex officio,* Governor's Office

Staff: Kate Burkhart, Executive Director, Advisory Board on Alcoholism and Drug Abuse
Katie Baldwin-Johnson, Program Officer, Alaska Mental Health Trust Authority
Ray Michaelson, Program Officer, Mat-Su Health Foundation

Introduction

The Alaska Opioid Policy Task Force,* after substantial expert and public input, endorses a public health approach to the prevention and reduction of opioid use, misuse, and abuse in our state. The task force believes that implementing comprehensive prevention strategies will mitigate the harm that heroin and opioids are causing Alaskans and their families and communities.

The National Survey on Drug Use and Health reports that, in 2015, 18.9 million people aged 12 or older (7.1%) misused prescription psychotherapeutic drugs in the past year. This number included 12.5 million people who misused pain relievers in the past year (4.7%). Of people who used heroin in the past year, 72.1% also misused pain relievers. Of people who used alcohol in the past year, 5.9% also misused pain relievers. About 1% percent of people aged 12 or older (2.7 million) had a prescription drug use disorder in the past year; 2 million of those people had a pain reliever misuse disorder. Among people who misused pain relievers in the past year, the most common source of the pain reliever was a friend or relative (53.7%). About 33% misused a prescription from one doctor. Only about 5% reported buying the last pain reliever they misused from a drug dealer or stranger. (*Prescription Drug Use and Misuse in the United States: Results from the 2015 National Survey on Drug Use and Health*, SAMHSA NSDUH Data Review, September 2016.)

The Alaska Epidemiology Section reported in 2015 that the rate of heroin poisoning resulting in hospital admissions doubled between 2008 and 2012 and "during 2008–2013, the number of heroin-associated deaths more than tripled in Alaska, and in 2012, the rate of heroin-associated deaths in Alaska was 42% higher than that for the U.S. overall (2.7 per 100,000 vs. 1.9 per 100,000, respectively)." Admissions to publicly funded substance use disorder treatment for heroin dependence increased 58% between 2009 and 2013. The majority of those individuals seeking treatment were age 21-29. (*Health Impacts of Heroin Use in Alaska,* State of Alaska Epidemiology Bulletin, July 14, 2015)

Primary prevention policies supporting "upstream" efforts to improve the overall health and wellness of individuals across the lifespan can help reduce the risk of opioid use, misuse, and abuse at the population level. Programs that support healthy childhood development, prevent adverse childhood experiences, and promote whole-person health can strengthen protective factors against opioid (and other substance) abuse.

Opioid use disorders, like other substance use disorders, are a disease that responds to treatment. Access to appropriate levels of treatment when a person seeks help, as close to home as possible, is critical to helping Alaskans move from opioid dependence to recovery. Understanding that not every person who needs treatment will seek it out, the task force sees value in harm reduction policies that protect public health and safety and increase individuals' treatment readiness.

Supporting Alaskans in recovery from opioid use disorders reduces the risk of relapse. Ensuring that individuals in recovery have immediate access to services to prevent relapse, or to reduce the harm

* The task force is comprised of twenty volunteer members representing diverse stakeholder groups from across the state. The task force met eleven times to hear presentations from experts in a variety of fields, and to hear public comment. The task force met twice to draft and finalize recommendations. The meeting schedule, presentations, and minutes are available at http://dhss.alaska.gov/AKOpioidTaskForce/Pages/Meetings.aspx.

of relapse, is critical. Likewise, recidivism is reduced when individuals are supported to transition successfully from incarceration to the community.

Only by working together can Alaskans turn the tide on the opioid crisis. The task force appreciates the significant contributions of federal and state agencies, the legislature, community organizations, and individuals that have helped to:

- Increase public awareness and understanding;
- Reduce the stigma associated with opioid dependence and overdose;
- Encourage individuals and families to seek treatment and support;
- Comfort those who have lost someone to an opioid overdose;
- Increase access to naloxone;
- Increase access to opioid use disorder treatment, including withdrawal management and medication assisted treatment; and
- Reinforce that recovery is possible.

Recommendations

These recommendations are derived from information provided to task force members by Alaskan and national experts, public comment at task force meetings and other forums around the state, input from local community heroin/opioid coalitions, research and evidence. They are organized according to a public health framework promoted by the Association of State and Territorial Health Officials.

Environmental Controls and Social Determinants of Health

Reducing and Controlling Access to Opioids

1. Communities statewide provide timely and convenient access to medication take-back and disposal programs.[1]
    - Take-back programs provide a safe, convenient, and responsible means of disposing of prescription drugs, while also educating the general public about the potential for abuse of medications.
    - Reduced access to prescription opioids and other medications will contribute to the outcomes:
        - Reduced number of hospital admissions for prescription overdose;
        - Reduced number of deaths by prescription overdose.

2. Local, state, tribal, and federal authorities work together to increase security measures to prevent importation of opioids (and other drugs) on bush airlines, small planes, ferries, boats, etc.[2]
    - Heroin, prescription opioids, and other drugs make their way to rural Alaska *via* transport that is not subject to the same level of federal security/ inspection as that of major commercial airlines.
    - The Alaska State Troopers (AST) Statewide Drug Enforcement Unit includes 6 investigative teams. The AST and local law enforcement agencies partner with federal authorities, including the U.S. Coast Guard, to prevent drug trafficking. State

and federal constitutional protections limit the ability of law enforcement to seize and/or search baggage or cargo while in transit.
- Increased security measures by commercial carriers at ports, ferry terminals, and rural airports would complement law enforcement efforts to prevent drug trafficking in rural Alaska.
- Increased security measures will contribute to the outcomes:
    - Reduced quantity of heroin, opioids, and other illicit drugs in rural communities;
    - Reduced number of hospital admissions for overdose;
    - Reduced number of deaths by overdose.

3. a. The State of Alaska engages in continuous optimization of the Prescription Drug Monitoring Program to improve ease of use and incentivize participation by prescribers.
b. All prescribers utilize the Prescription Drug Monitoring Program to the fullest extent possible as provided in SB 74.
c. The Department of Health and Social Services analyzes data from the Prescription Drug Monitoring Program, as allowed by SB 74, "for the purpose of identifying and monitoring public health issues in the state."[3]
    - Prescription Drug Monitoring Programs (PDMP) are tools for health care providers, used to make prescribing decisions based on patient's histories. They are useful when consulted by health care providers as they make prescribing decisions, pharmacists as they fill prescriptions, and when actively managed by public health officials to monitor and respond to population level trends.
    - Full utilization of the PDMP by health care providers and the State Alaska will contribute to the outcomes:
        - Increased consistency in opioid prescribing practices;
        - Increased utilization of evidence-based non-opioid pain management for acute conditions;
        - Reduced number of hospital admissions for prescription overdose;
        - Reduced number of deaths by prescription overdose.

4. Public and private health plans reimburse alternatives to narcotic pain management.[4]
    - Non-pharmacologic therapies and non-opioid medications are effective options for managing pain in many cases. If patients and prescribers have access to non-narcotic pain management options through their health plans, opioid pain medications will be reserved for treating chronic and the most acute pain.
    - Reimbursement of alternatives to narcotic pain management will contribute to the outcomes:
        - Increased consistency in opioid prescribing practices;
        - Increased utilization of evidence-based non-opioid pain management for acute conditions;
        - Reduced number of hospital admissions for prescription overdose;
        - Reduced number of deaths by prescription overdose.

5. A regulatory body is granted statutory authority to add substances of abuse to the state controlled substances schedule by regulation, including emergency regulation, to allow the State of Alaska to react quickly to public health dangers posed by synthetic and other emerging opioids and substances of abuse.[5] More nimble regulation of opioid substances of

abuse will help law enforcement, public health, and health care organizations prevent trafficking in and misuse/abuse of these substances, and will contribute to the outcome:

- Reduced number of deaths by overdose.

Reducing Risk of Opioid Misuse, Abuse, and Dependence

1. State and local authorities implement evidence and research based policies promoting healthy childhood development.
    - Research shows that strengthening the bond between parents and children, especially soon after birth, reduces the risk of child neglect and improves lifetime health outcomes. Effective programs include (but are not limited to) promoting and supporting breastfeeding and providing new parents with education and in-home parenting supports.[6]
    - Early and Periodic Screening, Diagnostic, and Treatment (EBSDT) services are available to Medicaid-eligible children age 0-21 and can help identify and intervene early to treat delays and disabilities. EPSDT services are not well utilized, especially after early childhood.
    - Healthy childhood development enhances protective factors and reduces risk factors, contributing to the outcomes:
        - Reduced incidence of child neglect and maltreatment (short-term);
        - Reduced incidence of under-age use of alcohol and/or other drugs (long-term);
        - Reduced incidence of adult heroin, opioid, and other drug misuse, abuse, and dependence (long-term).

2. State and local authorities implement evidence and research based policies preventing and mitigating the impacts of adverse childhood experiences.[7]
    - Alaskans report high rates of adverse childhood experiences, particularly parental incarceration and household substance abuse. Nearly 30% of Alaskan adults surveyed in the Behavioral Risk Factor Surveillance System report substance abuse in their household growing up, and 11.3% report having a parent or household member incarcerated during their childhood. Adverse childhood experiences like these can increase an individual's risk of developing mental health and/or substance use disorders, arthritis, and other chronic health problems.
    - Preventing and addressing the trauma of adverse childhood experiences will contribute to the outcomes:
        - Reduced incidence of child neglect and maltreatment (short-term);
        - Reduced incidence of under-age use of alcohol and/or other drugs (long-term);
        - Reduced incidence of adult heroin, opioid, and other drug misuse, abuse, and dependence (long-term).

3. Local, state, tribal, and federal authorities work together to maintain and expand comprehensive school-based prevention programs.
    - Evidence-based comprehensive prevention programs can help reduce youth risk behaviors, including prescription drug abuse.[8] These programs contribute to the outcomes:
        - Reduced incidence of under-age use of alcohol and/or other drugs (long-term);

- Reduced incidence of adult heroin, opioid, and other drug misuse, abuse, and dependence (long-term).

4. Health care professionals have access to information and tools to provide patient education on nutrition, as well as referrals to nurse-family partnerships and nutrition support programs such as WIC, SNAP, and local food pantries.
    - Improved nutrition is a cost-effective way to help Alaskans safeguard their bodies and minds against stress and may reduce the types of physical injuries that can lead Alaskans, especially young athletes, to their first opioid prescription. Research also indicates that proper levels of nutrients such as Omega-3 fatty acids and vitamin D can reduce anxiety, depression, and other mental stresses that can compound existing behavioral health concerns. The northern latitude and transition away from traditional foods increases Alaskans' risk of a nutritional deficiency in vitamin D.[9]
    - Increased patient education and resources related to healthy nutrition can contribute to the outcomes:
        - Reduced rates of vitamin D deficiency and rickets;
        - Reduced number of opioid prescriptions to youth and young adults for sports related injuries;
        - Reduced number of opioid prescriptions to older Alaskans for hip fractures and other bone and joint issues;
        - Reduced rate of depression, anxiety, and other mental health disorders.

Chronic Disease Screening, Treatment, and Management

Screening and Referral

1. a. Public and private health plans promote and reimburse Screening, Brief Intervention, and Referral to Treatment (SBIRT) in all health care settings.[10]
   b. Public and private health plans promote SBIRT and peer-supported referral to substance use disorder treatment after emergency admissions for opioid overdose.
    - SBIRT is an evidence-based model of care that identifies patients at risk of or experiencing substance misuse or abuse, provides brief behavioral interventions, and can connect patients to more intensive substance use disorder treatment. It has been effectively implemented by some Alaska health care providers and Public Health Nursing, but is not available in all health care settings or in all communities.
    - SBIRT is reimbursed by Medicaid. Reimbursement of the model by private health plans will further incentivize health care providers to implement SBIRT.
    - After emergency treatment for an overdose, the patient may experience a desire for treatment. Taking advantage of that period of treatment readiness, and facilitating referral to treatment with peer support services, can increase the likelihood the patient will enter treatment. Reimbursement of the services will incentivize implementation.
    - Implementing SBIRT and peer-supported referrals can contribute to the outcomes:
        - Increased utilization of outpatient substance use disorder treatment;
        - Reduced number of hospital admissions for overdose;
        - Reduced number of deaths by overdose.

2. Public and private health plans reimburse clinical assessment of risk of abuse and overdose whenever opioids prescribed.[11]
    - Assessment of risk of misuse, abuse, and dependence is included in the prescribing guidelines adopted by Alaska's licensing boards, as well as the Centers for Disease Prevention and Control Guidelines. Reimbursement of assessment will incentivize health providers to provide the service and will contribute to the outcomes:
        - Reduced number of hospital admissions for prescription overdose;
        - Reduced number of deaths by prescription overdose.

3. a. The Department of Public Safety implements Mental Health First Aid and Crisis Intervention Team in the Alaska State Trooper Academy curriculum, so that troopers as well as local law enforcement and village public safety officers have access to research-based education and tools. [12]
   b. State and local authorities support effective implementation of public safety assisted addiction and recovery models (also known as the Gloucester Model of responding to individuals experiencing substance use disorders).[13]
    - Law enforcement officers trained to identify when someone is experiencing a substance abuse or mental health related crisis will be better able to connect that person to appropriate community treatment resources in lieu of arrest and incarceration.
    - Implementing training and equipping public safety officers and responders to facilitate a referral to substance use disorder treatment will contribute to the outcomes:
        - Reduced arrests, incarcerations of individuals experiencing behavioral health crises;
        - Increased referrals of individuals to behavioral health treatment by law enforcement agencies.

4. a. The State and its partners ensure that Aging and Disability Resource Centers, care coordination providers, Alaska 211, or other referral resources can provide up-to-date information about local behavioral health treatment services to health care providers.[14]
   b. Pain management specialists have information/tools, and are reimbursed, for screening patients for depression and other mental health disorders that may be contributing to or exacerbating conditions causing pain, and providing "warm hand-off" referrals of patients to appropriate mental health treatment.[15]
    - Health care providers will be more likely to screen for and identify substance use and mental health disorders if they have concrete services to which to refer patients in need of treatment. This will contribute to the outcomes:
        - Increased utilization of outpatient substance use disorder treatment;
        - Reduced number of hospital admissions for overdose;
        - Reduced number of deaths by overdose.

Treatment

1. The State of Alaska adopts a "chronic disease management" framework for substance use disorder treatment policies and system reform.[16]
    - Expressly adopting a chronic disease framework will contribute to the outcomes:
        - Decreased stigma associated with opioid dependence;

- Decreased stigma associated with providing treatment for opioid dependence;
- Increased utilization of outpatient substance use disorder treatment;
- Reduced number of hospital admissions for overdose;
- Reduced number of deaths by overdose.

2. Alaskan medical professional organizations develop and/or deliver education to train and support health care providers in implementing the state prescribing guidelines.
    - The task force appreciates the thoughtful consideration that the Alaska State Medical and Dental Boards, Board of Pharmacy, Board of Nursing, Board of Optometry, and Division of Professional Licensing gave to the issue of establishing prescribing guidelines for Alaska-licensed practitioners. The task force appreciates that, after a thorough public process, these boards have agreed to incorporate the Interagency Guideline on Prescribing Opioids for Pain Developed by the Washington State Agency Medical Directors' Group and stakeholders in 2015 – with the important amendment of a **morphine equivalent dose limit of 90 mg/day**. Washington's comprehensive guidelines (with the amended morphine equivalent dose of 90mg/day) will address many concerns related to prescribing practices.
    - Training and support will be needed for health care providers to effectively implement those guidelines, which will contribute to the outcomes:
        - Reduced number of hospital admissions for prescription overdose;
        - Reduced number of deaths by prescription overdose.

3. a. Encourage all state licensed, registered, and certified health care professionals to have completed addiction medicine continuing education hours prior to each license renewal.
   b. State and health care organizations partner to provide free or low-cost access to approved addiction medicine continuing education.
    - Many changes to prescribing practices; patient screening, assessment, and referral; and provision of substance use disorder treatment in integrated settings are contemplated by national and state prescribing guidelines as well as these recommendations. In order to meet these expectations, health care professionals will need to understand the science of addiction.
    - Encouraging addiction medicine continuing education will contribute to the outcomes:
        - Decreased stigma associated with opioid dependence;
        - Decreased stigma associated with providing treatment for opioid dependence;
        - Increased utilization of outpatient substance use disorder treatment;
        - Reduced number of hospital admissions for overdose;
        - Reduced number of deaths by overdose.

4. The State of Alaska coordinates a comprehensive withdrawal management system (detoxification) in a variety of health care settings, specifically including rural and correctional health care settings.
    - Managing withdrawal symptoms is critical to treating individuals experiencing opioid use disorders. Lack of effective withdrawal management services is a huge barrier to treatment readiness and can pose a grave health risk, given the severity of the symptoms of withdrawal.

- Access to facility-based withdrawal management is severely limited, leaving emergency departments to deal with emergency withdrawal cases in which the person's life is at risk.
- Ensuring a comprehensive withdrawal management system statewide, so that any Alaskan seeking to (or due to circumstances must) withdraw from opioids and enter treatment has timely access will contribute to the outcomes:
    - Increased utilization of outpatient substance use disorder treatment;
    - Reduced number of hospital admissions for overdose;
    - Reduced number of deaths by overdose.

5. a. Public and private health plans reimburse the cost of medications used for medication assisted treatment (MAT), as well as the administration of the medication. [17]
   b. Public and private health plans minimize barriers to access MAT.
   c. Public and private health plans reimburse, and educate providers about reimbursement options for, urine drug testing as part of MAT.
   d. Require substance use disorder treatment providers and programs licensed/certified by the State of Alaska to ensure that patients receive psychosocial treatment along with MAT, if clinically indicated. [18]
    - Lack of or disparate reimbursement for all the costs of MAT (medications, administration, labs, professional services) discourages health care providers from offering the service.
    - While prior authorization requirements can create barriers to treatment by discouraging health care providers from participating in the service, they can also help ensure the quality of MAT services provided to high-risk populations.
    - Access to MAT will contribute to the outcomes:
        - Increased utilization of outpatient substance use disorder treatment;
        - Reduced number of hospital admissions for overdose;
        - Reduced number of deaths by overdose.

6. The Advisory Board on Alcoholism and Drug Abuse and partners convene a working group to review and provide revisions to the statutes for commitment of individuals incapacitated by drug and alcohol intoxication to treatment, with the goal of increasing utilization and access for appropriate patients.
    - Family members, providers, and law enforcement officers all report difficulty in accessing treatment services for individuals incapacitated by their opioid and other drug use disorders, due in part to the legal framework for involuntary commitments to treatment.
    - Review and revision of Title 47 commitment statutes will contribute to the outcomes:
        - Increased utilization of intensive treatment for individuals acutely disabled by chronic substance use disorders;
        - Reduced arrests, incarcerations of individuals experiencing behavioral health crises.

7. State and federal authorities work together to remove barriers to offering clinically appropriate methods of managing withdrawal symptoms, specifically the regulation of which medications can be used (i.e. Tramadol).
    - Federal decisions regarding the scheduling of medications, particularly Tramadol, as a controlled substance significantly reduced the ability of Alaskan withdrawal management providers to provide clinically appropriate services.
    - Removing barriers to offering clinically appropriate methods of managing withdrawal symptoms will contribute to the outcomes:
        - Increased utilization of withdrawal management services;
        - Reduced number of hospital admissions for overdose;
        - Reduced number of deaths by overdose.

8. Public and private health plans provide parity for inpatient and residential substance use disorder treatment.
    - Despite federal parity requirements, many insurers do not cover inpatient and residential substance use disorder treatment the way that hospitalization for other chronic diseases is covered.[19]
    - Federal law prevents large (more than 16 beds) facility-based substance use disorder treatment programs. This makes it difficult for health care organizations to offer/sustain long-term inpatient or residential treatment without state funding.[20]
    - Reimbursement of inpatient and residential substance use disorder treatment will contribute to the outcomes:
        - Increased number of inpatient/residential treatment beds;
        - Increased utilization of inpatient/residential treatment services;
        - Reduced arrests, incarcerations of individuals experiencing substance use disorders;
        - Reduced number of hospital admissions for overdose;
        - Reduced number of deaths by overdose.

9. State and federal authorities work together to expand access to drug courts and therapeutic justice alternatives.
    - Drug courts and therapeutic justice programs reduce recidivism by connecting criminal defendants to appropriate substance use disorder treatment, as well as social supports, in a structured environment of accountability.[21]
    - Increased access to drug courts will contribute to the outcomes:
        - Increased utilization of substance use disorder treatment by justice-involved individuals;
        - Reduced recidivism for drug-related offenses (and related crimes).

Harm Reduction

Overdose Prevention

1. Public and private health plans establish or maintain systems to identify and intervene with high-risk prescriptions (frequent refills, large dosages, etc.).[22]
    - Insurers can implement systems to complement PDMPs, providing tools for health care providers and pharmacists to identify when patients are at risk due to high-dosage or high-volume opioid prescriptions. This will contribute to the outcomes:

- Increased monitoring of prescription histories by public and private health plans;
- Reduced number of hospital admissions for prescription overdose;
- Reduced number of deaths by prescription overdose.

2. a. Public health plans shall reimburse cost-effective naloxone preparations.
   b. Prescriptions and training for naloxone accompany all prescriptions exceeding 90mg/day morphine equivalent dose.
   - Access to affordable naloxone is an essential strategy to reducing opioid overdose deaths. Ensuring that patients with high dosage opioid prescriptions have naloxone available will contribute to the outcomes:
     - Increased access to naloxone through prescription/pharmacy;
     - Reduced number of hospital admissions for prescription overdose;
     - Reduced number of deaths by prescription overdose.

3. a. Local, state, tribal, and federal authorities work together to ensure consistent, affordable access to naloxone and education on its use in the community for family/caregivers of individuals addicted to opioids.
   b. All first responders (EMTs, firefighters, police, etc.) are trained and equipped with naloxone.
   c. Education on administration of naloxone is included in basic CPR and First Aid Training curricula.
   - Access to naloxone immediately upon overdose is an essential strategy to reducing opioid overdose deaths and will contribute to the outcomes:
     - Reduced number of hospital admissions for prescription overdose;
     - Reduced number of deaths by prescription overdose.

Syringe Exchange

1. a. State, tribal, and local authorities work together to reimburse syringe exchange programs that provide disease prevention supplies and exchange, screening/testing for sexually transmitted infections (STI) where appropriate, referral to local resources for treatment, and arrange for safe disposal of used syringes and needles.
   b. State, tribal, and local authorities work together to Incentivize expansion of syringe/needle disposal services.
   - Syringe exchange programs are an effective public health intervention to reduce infections, overdoses, and the transmission of STIs.[23]
   - Lack of local, affordable syringe/needle disposal services creates a barrier to implementing syringe exchange programs.
   - Expanding access to syringe exchange programs will contribute to the outcomes:
     - Increased utilization of syringe exchange services statewide.
     - Increased availability of licensed syringe/needle disposal services.
     - Reduced reports of needle/syringe litter found in the community.
     - Reduced rates of Hepatitis C in communities with syringe exchange programs.
     - Reduced rates of HIV, other STIs in communities with syringe exchange programs.
     - Increased utilization of substance use disorder treatment by syringe exchange participants.

Recovery

1. Public and private health plans reimburse – and support providers to offer – peer support services.[24]
    - According to the Substance Abuse and Mental Health Services Administration, "peer support facilitates recovery and reduces health care costs. Peers also provide assistance that promotes a sense of belonging within the community. The ability to contribute to and enjoy one's community is key to recovery and well-being. Another critical component that peers provide is the development of self-efficacy through role modeling and assisting peers with ongoing recovery through mastery of experiences and finding meaning, purpose, and social connections in their lives."
    - Peer support is an integral part of effective substance use disorder treatment, and contributes to the outcomes:
        - Increased access to peer support services in hospital emergency departments;
        - Increased access to peer support services in community behavioral health centers;
        - Increased access to peer support services in private substance use disorder treatment practices;
        - Reduced number of deaths by overdose.

2. a. Local, state, tribal, and federal authorities work together to incentivize, educate, and support "second chance" employers (employers willing to hire people in recovery from opioid and other substance use disorders).
   b. Local, state, tribal, and federal authorities expand services for individuals in recovery who are re-entering the community from incarceration and residential substance use disorder treatment, to include supportive and transitional housing services.
    - Employers willing to hire people in recovery from opioid and other substance use disorders need tools and resources to effectively support these employees in their work performance and recovery.
    - Individuals re-entering the community, whether from corrections or residential treatment, need support to connect to employment, housing, health care, and healthy social networks.
    - Supportive effective re-entry to the community contributes to the outcomes:
        - Increased rates of employment among Alaskans in substance use disorder treatment or who have completed substance use disorder treatment;
        - Increased rates of housing among Alaskans in substance use disorder treatment or who have completed substance use disorder treatment;
        - Reduced recidivism for opioid, other drug related offenses.

3. a. Support expansion of existing recovery networks to include people in recovery from opioid addiction, including those receiving MAT.
   b. The Department of Corrections increases access to 12-step, other group recovery models in its institutions.
    - Access to recovery supports, such as 12-step programs and culturally-relevant support groups, are essential to preventing relapse. People receiving MAT may not be able to access or comfortable going to traditional 12-step programs.
    - Expanding access to recovery networks will contribute to the outcomes:

- Increased rates of substance use disorder treatment participation;
- Increased length of time of recovery between relapse episodes;
- Reduced number of repeat hospital admissions for overdose.

Collaboration

1. The Department of Health and Social Services and its partners identify and work together to address barriers to integration and coordination of care between prescribers and behavioral health treatment providers.
    - Coordinated and integrated behavioral and primary health care results in improved health outcomes, especially for individuals with chronic and co-morbid conditions and for those who overuse emergency and acute care services. Comprehensive information about integration of care is available from the SAMHA-HRSA Center for Integrated Health Solutions.
    - Expanding access to integrated and coordinated care can contribute to the outcomes:
        - Increased access to substance use disorder treatment;
        - Increased number of primary care practices providing substance use disorder screening, referral, and/or treatment;
        - Increased number of MAT providers.

2. a. Local, state, tribal, and federal authorities strengthen partnerships with public safety in community prevention efforts (prevention coalitions, school-based programs, etc.).
   b. State and tribal authorities partner with community coalitions in evidence-based substance abuse prevention education and awareness efforts.
    - Population health is improved through effective prevention strategies implemented with local support and planning. Increased prevention efforts will contribute to the outcomes:
        - Increased rates of youth not misusing prescription medications;
        - Increased rates of youth not using heroin;
        - Increased rates of youth not using alcohol, marijuana, and other drugs;
        - Reduced number of hospital admissions for overdose;
        - Reduced number of deaths by overdose.

3. State and tribal authorities work together to mitigate the collateral consequences of incarceration for drug-related offences, to increase the likelihood that persons re-entering the community are successful.
    - Effective re-integration into the community will reduce the likelihood that individuals will resume opioid use and associated criminal activities, thereby preventing relapse and recidivism.[25]
    - Supporting successful re-entry to the community will contribute to the outcomes:
        - Increased rates of employment among Alaskans re-entering the community after a period of incarceration for drug-related offenses.
        - Increased rates of housing among Alaskans re-entering the community after a period of incarceration for drug-related offenses.
        - Increased rates of health care insurance among Alaskans re-entering the community after a period of incarceration for drug-related offenses.
        - Reduced recidivism for drug-related offenses.

Conclusion

The recommendations described herein are meant to provide a guide to policymakers, offering a consistent and comprehensive public health framework for addressing Alaska's opioid crisis at all levels. The task force recognizes that the "devil is in the details" when it comes to implementation of these recommendations. Task force members are available to contribute their expertise to support organizational, local, and statewide efforts to implement these recommendations.

We would like to thank the dozens of presenters and members of the public who attended meetings and contributed to task force discussions, as well as every Alaskan who shared their experience and input to tailor these recommendations to the needs of our state and our unique communities.

Endnotes

[1] Congress passed the Secure and Responsible Drug Disposal Act in 2010, amending the Controlled Substances Act to give the U.S. Drug Enforcement Agency (DEA) to regulate safe and effective disposal by public and private entities. Pursuant to this law, the DEA issued regulations in 2014 that expanded the types of entities that can collect and dispose of medications.
"Proper Medication Disposal" is one of four strategies adopted by the Office of National Drug Control Policy in its 2011 strategic plan, Epidemic: Responding to America's Prescription Drug Abuse Crisis. This strategy – reducing access to unwanted and expired medication -- is based on the data that shows that the majority of individuals misusing prescription medications, and specifically pain relievers, get those medications from friends and/or family.
The DEA reported that, between September 2010 and September 2015, National Prescription Drug Take Back Initiative events collected 5,525,021 pounds of drugs nationwide. (DEA Press Release, October 1, 2015.) The DEA reported that the April 30, 2016 Drug Take-Back Day event collected 893,498 pounds of medications at 5,400 collection states nationwide; Alaska's 15 sites collected 4,162 pounds of medications. (DEA Press Release, May 6, 2016.)

[2] The Alaska State Troopers (AST) report that prescription medications are most often "obtained through illicit means, either by theft, prescription fraud, or overseas mail order." AST also reports that "there has been an increase in the availability of heroin throughout the state and it is no longer isolated to the urban areas." Heroin traffickers use "internal body secretion" and "mules" from outside of Alaska to avoid detection. (*2015 Annual Drug Report*, Alaska State Troopers.) Alcohol bootlegging practices have long included use of local air carriers, private aircraft, boat, and snow machine, providing routes for traffickers of heroin and controlled substances. Given the mechanisms of trafficking, and the limitations on when and how law enforcement officers can search or seize baggage/cargo, increasing the role of commercial carriers in screening of the property they transport will reduce the flow of controlled substance into rural communities.

[3] Prescription Drug Monitoring Programs (PDMP) are one of four strategies adopted by the Office of National Drug Control Policy in its 2011 strategic plan, Epidemic: Responding to America's Prescription Drug Abuse Crisis. PDMPs support the identification of and intervention with prescribers who deviate from accepted standards of practice or exhibit prescribing practices not characteristic of their specialty. (*Using PDMP Data to Guide Interventions with Possible At-Risk Prescribers*, PDMP Center of Excellence at Brandeis, October 2014.) Research of states with PDMPs showed that "the presence of a PDMP reduces per capita supply of prescription pain relievers and stimulants," which "reduces the probability of abuse." (*An Evaluation of Prescription Drug Monitoring Programs,* Simeone R, Holland L., funded by the U.S. Department of Justice, Office of Justice Programs, September 1, 2006.)

[4] "Pain is one of the oldest challenges for medicine. Despite advances in evidence and understanding of its pathophysiology, chronic pain continues to burden patients in a medical system that is not designed to care for them effectively. Opioids have been used in the treatment of pain for centuries, despite limited evidence and knowledge about their long-term benefits, but there is a growing body of clear evidence regarding their risks." *Chronic Pain Management and Opioid Misuse: A Public Health Concern*, American Academy of Family Physicians
When considering treatment options for pain, physicians and patients look to the options that are most effective **and** most affordable. Health plans often limit pain management/ treatment to pharmacological options. However, the CDC cites research that "several nonpharmacologic and

nonopioid pharmacologic treatments have been shown to be effective in managing chronic pain in studies ranging in duration from 2 weeks to 6 months." CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016
The National Pain Strategy Final Report, issued by the Interagency Pain Research Coordinating Committee of the National Institutes of Health in 2016, includes strategies for multidisciplinary and "multimodal pain treatment" that includes medical, surgical, psychological, behavioral, and rehabilitative services.

[5] The US DEA reports that proliferation of synthetic (also known as designer) drugs has grown significantly since 2008. These substances are made without regulation, often outside the United States. The effects of synthetic drugs vary, depending on the chemicals used, and can be life-threatening. Deaths due to misuse of synthetic opioids, "likely driven primarily by illicitly manufactured fentanyl," increased 72.2% between 2014 and 2015. *Increases in Drug and Opioid-Involved Overdose Deaths — United States, 2010–2015*, Centers for Disease Control and Prevention (December 30, 2016).
The State of Alaska Epidemiology Bulletin, *Overview of Recent Synthetic Opioid Overdose Deaths* (November 7, 2016) provides information about the rise of overdoses related to synthetic opioids since 2014.
Controlling access to synthetic drugs is difficult, as statutes must be specific in order to be enforceable. However, the need for specificity results in legislative processes which are not always able to respond immediately to emerging public health risks. Creating a nimble regulatory process that provides authority to a state agency to administratively schedule synthetic drugs for a limited amount of time until lawmakers can decide whether to permanently control access to the substances (similar to the emergency scheduling authority provided under the Controlled Substances Act, 21 USC 811(h)) will help prevent harm caused by synthetic opioids/drugs.

[6] An overview of the biology of kinship and its relationship to health outcomes is available from Dr. Mark Erickson, MD: *Preventing Opioid Dependency Across Generations (September 16, 2016).*

[7] "A scientific consensus is emerging that the origins of adult disease are often found among developmental and biological disruptions occurring in the early years of life. . . there can be a lag of many years, even decades, before adverse experiences are expressed in the form of disease." Shonkoff, J. et al. (2009) JAMA 301:2252-2259.

[8] The National Institute on Drug Abuse has compiled "Lessons from Prevention Research" in the form of 12 principles derived from extensive research on the origins of drug use/abuse and effective prevention programs. NIDA's research program focuses on risks for drug abuse and other risky behaviors that can occur during a child's development, from pregnancy through young adulthood. Federally-funded research shows that early intervention can prevent many adolescent risk behaviors. The National Registry of Evidence-based Programs and Practices provides a catalog of behavioral health prevention (and other) programs that have been found, after third party evaluation, to be effective means of achieving various prevention outcomes.

[9] There is a large body of research related to nutrition and Vitamin D and how they affect a person's physical and behavioral health. The Harvard School of Public Health provides an overview of some research related to Vitamin D, including research on Vitamin D's impact on the incidence of bone fracture (an injury that can lead to pain that is then treated with opioids). See also

"Recommendations Abstracted from the American Geriatrics Society Consensus Statement on Vitamin D for Prevention of Falls and Their Consequences," *American Geriatrics Society Workgroup on Vitamin D supplementation for Older Adults* (December 18, 2013).

[10] Screening, Brief Intervention, and Referral to Treatment (SBIRT) has been endorsed by the Substance Abuse and Mental Health Services Administration and Veterans Administration as an effective evidence-based practice. While primarily focused on alcohol abuse, SBIRT has shown to be an effective tool for helping patients identify and address problem drug use. A comprehensive SBIRT approach was found to be effective in reducing risky drug use, including cocaine and heroin use (*SBIRT for Illicit Drug and Alcohol Use at Multiple Healthcare Sites: Comparison at Intake and 6 Months*, Madras, B.K. et al. *Drug and Alcohol Dependence*, 99(1–3), 280–295 (2009); *A Randomized Controlled Trial of Brief Cognitive-Behavioral Interventions for Cannabis Use Disorder*, Copeland, J. et al. *Journal of Substance Abuse Treatment*, 21(2), 55–64 (2001). Screening and brief interventions have been linked to reduced use of heroin, stimulants, marijuana, and other drugs (*The Effectiveness of a Brief Intervention for Illicit Drugs Linked to the Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) in Primary Health Care Settings,* Humeniuk et al. World Health Organization, 2008).

[11] An overview of evidence supporting the need for patient risk assessments is provided in the CDC Morbidity and Mortality Weekly report, *CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016* (March 18, 2016 / 65(1);1–49).

[12] Crisis Intervention Teams (CIT) were developed by the Memphis Police Department in partnership with the University of Memphis (Tennessee). CIT is based on community partnerships between law enforcement, mental health, and consumer organizations. Officers are trained to de-escalate crisis situations involving individuals experiencing a behavioral health crisis, and then directly connect the individual to appropriate treatment rather than jail. CIT training has been made available to law enforcement officers through support from the Alaska Mental Health Trust Authority and NAMI since 2001. Police departments in Anchorage, Juneau, and Fairbanks all have CIT-trained officers on duty. CIT can transform a community's response to day-to-day crises. It is most effective when officers participate voluntarily, and then are embedded in the patrol operations of the law enforcement agency. A comprehensive review of research into the effectiveness of CIT programs was published in 2008, and reported generally positive outcomes for officers and individuals. (*A Comprehensive Review of Extant Research on Crisis Intervention Team Programs*, Compton, M. et al. *Journal of the American Academy of Psychiatry Law*, 36:47-55 (2008).
Mental Health First Aid (MHFA) complements the more intensive CIT training by providing all officers and staff with a basic level of mental health awareness and understanding. CIT International and the National Council for Behavioral Health provide an overview of how MHFA and CIT can work together.

[13] Public Safety Assisted Addiction and Recovery Models are a relatively new endeavor, brought to national attention in 2015 by the Gloucester, Massachusetts police department. However, they are built upon the same community partnerships and principles proven effective by CIT models nationwide – training and equipping officers to divert people in need of treatment (in this case opioid use disorder treatment) to community resources rather than arresting them. The Police Assisted Addiction and Recovery Initiative, which includes more than 160 law enforcement agencies nationwide, coordinates information and resources related to these programs. They report a 25% reduction in addiction-related crimes in communities implementing this model. (PAARI Annual Report, June 2015- June 2016)

[14] Primary care providers are less able to coordinate care for patients with complex needs, including substance use disorders, if there is a lack of communication with specialist providers, hospitals, and social services organizations. (*Primary Care Physicians in Ten Countries Report Challenges Caring for Patients with Complex Health Needs,* Osborn, R. et al. *Health Affairs* (December 2015)). If primary care providers can easily connect with an up-to-date clearinghouse of information and referral supports from existing services, like Alaska 211 and Aging and Disability Resource Centers, that will facilitate the screening and referral of patients to treatment.

[15] Individuals experiencing chronic pain are also likely to experience mental health and substance use disorders. Chronic pain and addiction have many shared neurophysiological characteristics, and have similar physical, emotional, social, and economic effects on a person. Depression is also frequently found in patients with chronic pain. (*TIP54: Managing Chronic Pain in Adults with or in Recovery from Substance Use Disorders,* SAMHSA (2012)) The National Pain Strategy includes access to a "well trained behavioral health work force . . . to support the needs of patients who suffer from chronic pain, including those at risk who need mental health care and substance abuse prevention and recovery treatment." (National Pain Strategy Final Report, Interagency Pain Research Coordinating Committee, National Institutes of Health (March 18, 2016))

[16] "Substance use has complex biological and social determinants, and substance use disorders are medical conditions involving disruption of key brain circuits." *Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health* at 7-1 (2016). The American Society of Addiction defines addiction as "a primary, chronic disease of brain reward, motivation, memory and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social and spiritual manifestations. This is reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviors. . . Like other chronic diseases, addiction often involves cycles of relapse and remission. Without treatment or engagement in recovery activities, addiction is progressive and can result in disability or premature death."

[17] Medication assisted treatment (MAT) is promoted by the Substance Abuse and Mental Health Services Administration for the treatment of opioid and other substance use disorders. MAT combines medications and behavioral health treatment to help individuals achieve recovery. MAT is considered to be a highly effective treatment for opioid use disorders, given the impact opioids have on the human brain. Methadone, buprenorphine, and naltrexone are the approved medications for opioid use disorder treatment. These medications can help mitigate initial withdrawal symptoms and support abstinence over the long-term.

[18] An estimated 80% of individuals experiencing a substance use disorder also experience a mental health disorder (and vice versa). It is appropriate to assess patients to determine whether psychosocial treatment is indicated, and then coordinate with behavioral health providers to ensure the patient has access to appropriate clinical services.

[19] Health plans are required to provide parity in coverage of services for behavioral health under the Mental Health Parity and Addiction Equity Act of 2008.

[20] "Institutions of mental disease" (IMD) are defined as "a hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnoses, treatment, or care

of persons with mental diseases, including medical attention, nursing care, and related services." (42 USC §1396d(i)). IMDs serving adults age 21-64 are excluded from Medicaid reimbursement. (42 USC §1396d).

[21] An overview of the evidence and research on drug courts is available from the U.S. Department of Justice Office of Justice Programs (May 2016).

[22] Alaska Medicaid implemented prior authorization processes for extended release opioids in 2015 to help reduce the risk of patient dependence, overdose and death. Alaska Medicaid also has established therapeutic duplication measures, dosage and unit limits for opioid analgesics.

[23] Preventing HIV Infection Among Injecting Drug Users in High Risk Countries: An Assessment of the Evidence, Institute of Medicine (2006)
Evidence for the effectiveness of sterile injecting equipment provision in preventing hepatitis C and human immunodeficiency virus transmission among injecting drug users: a review of reviews, Palmateer, N. et al. *Addiction* (May, 2010)

[24] Benefits of peer support can include reduced substance use, increased treatment engagement, reduced risk behaviors, and improved maintenance of recovery. *Benefits of Peer Support Groups in the Treatment of Addiction,* Tracy, K. and Wallace, S. *Journal of Substance Abuse and Rehabilitation* (September 29, 2016).

[25] The Council of State Governments Justice Center National Reentry Resource Center provides an overview of research and evaluation of "what works" in re-entry programs.

City and Borough of Juneau
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DATE: February 26, 2018

TO: Jerry Nankervis, Chair, Assembly Committee of the Whole

FROM: Rorie Watt, PE, City Manager

Mila Cosgrove, Deputy City Manager

RE: Centennial Hall Management Update

Background:

At the 12/4/17 Committee of the Whole meeting, staff advised the Assembly that discussions were underway regarding the potential of entering into an agreement with the Juneau Arts and Humanities Council for operational management of Centennial Hall. We asked the Assembly for permission to evolve that issue with the understanding that prior to entering into such an agreement, details would be brought back to the full Assembly.

Conversations have been ongoing with the Juneau Arts and Humanities Council and Travel Juneau regarding what a management agreement might look like, and staff have been working internally to determine the best path forward to assure that the underlying interests of CBJ are met. The following issues were identified and are explained in greater detail below: expected results of a collaborative agreement, type of operational agreement and conceptual components, procurement path, personnel services impact, and physical plant impact.

Expected Results:

In order to determine if proceeding with an operational agreement is in the best interest of the CBJ and to determine what type of agreement is appropriate, it was necessary to identify what the expected results were of such an arrangement:

Fiscal: The facility could be run on at cost neutral to cost savings basis.
Operational: That joint management of Centennial Hall and the Juneau Arts and Culture Center would result in running Centennial Hall in a more efficient and effective manner, measured by the overall satisfaction of the user groups.
Economic Development: That joint management of Centennial Hall and the Juneau Arts and Culture Center would result in the ability to further the Assembly's Economic Development goals related to arts & culture as well as a travel destination for larger conventions and meetings.
Community Purpose: Centennial Hall should remain available to the community for emergency management purposes on the same basis as it is currently available and to the Governor and Legislature as needed to be responsive to our role as Alaska's Capital City.

Operational Agreement Options:

Two options exist for entering into an agreement for the JAHC to manage daily operations of Centennial Hall. CBJ could enter into a lease arrangement or a management agreement. The differences between the two are largely a balance between how much control over operations and how much liability CBJ wants to retain in regard to operations.

With a lease, CBJ has less management control and less liability for operations. With a management agreement, CBJ has more control over operations and retains greater liability. Currently the JACH leases the building that has become the JACC.

Because the concept of contracting the management of Centennial Hall is new, the Manager's Office believes it is in the best interest of the CBJ to enter into a management agreement rather than a lease. Doing so will allow the Manager's Office greater input in assuring that the expected results are met and assure the community that Centennial Hall continues to operate in way that assures the best interest of the community are being met.

The conceptual components of the management agreement are attached as an appendix to this memo. The details of a management agreement are largely operational and would be negotiated by the Manager's Office. This is similar to how other management agreement/contracts for services are handled, as an example, our contract with Care a Van services and Gastineau Humane Society.

Procurement Path:

The Manager's Office has met with the CBJ Purchasing Officer to determine how best to comply with the Purchasing Code. A determination has been reached that, given the unique nature and requirements of the agreement qualify for an MR which is an exemption to the competitive procurement process.

That finding is based on the concept that only the JAHC can provide unified management of both facilities and therefore a competitive process would be useless.

Personnel Services Impact:

Centennial Hall is currently staffed by 6 benefited employees (5.83 FTE), and 9 non benefited employees (.15 FTE) who serve on an on-call basis. In considering a decision to move forward with a management agreement there are two issues: the potential impact regarding PERS and the impact to the actual employees.

PERS: In considering PERS implications there are two potential impacts, a termination study and the potential of ongoing indebtedness payments. In determining if there is financial impact to employers, PERS considers whether a job class is being eliminated, the retirement tier of the employees in the positions to be eliminated, and the employer's reported salary floor for Calendar Year 2008.

A termination study is triggered when there is a reduction in force that may impact the projected future contributions of the positions to the defined benefit system (Tiers I – III) in a way that adversely impacts actuarial projections. The cost of such a study would be borne by CBJ and the anticipated cost is approximately $5,000. There are 5 positions in classifications unique to Centennial Hall. As all 5 incumbents are in the Tier IV retirement system a termination study will likely not be triggered. If a termination study was triggered, the actuary would identify a sum of money that would need to be paid to keep the retirement system whole for the loss of the positions. Again, given that the positions are Tier IV, the impact should be minimal.

The remaining benefited position is allocated to a job class with multiple incumbents across the city. Elimination of the Centennial Hall position will not trigger PERS implications.

The CBJ must also be aware that Alaska statute provides that staff reductions must not fall below the overall salary floor from 2008. The salary floor in 2008 was approximately $29.9 million and the 2016 PERS reported salary was $36.2 million. The salary reduction impact for this group is not close to the $6.3 million current gap, so going below the salary floor does not appear to be an issue.

Staff Impact: Every attempt will be made to absorb benefited staff into other positions within the organization. In the event that is not possible, staff will be laid off from their positions and have recall rights for a period of two years. It is also possible that displaced staff could be reemployed by JAHC to fulfill similar functions in the new organization.

Physical Plant Impact:

The terms of the management agreement would outline the specifics of routine maintenance, preventative maintenance and capital improvements. There is also the possibility of mutual benefit to the CBJ and JAHC as the JAHC pursues the construction of the new JACC. At that time, there may be additional efficiencies gained through the sharing of physical plant systems and other relevant connections.

Budget Impact:

The intent is a cost neutral to cost savings agreement. The Assembly should be aware that like many Departments, Centennial Hall's budget contributes "full cost allocation" (FCA) to compensate other Departments for services incurred. The costs funded by the FCA would be partially avoided, shifted or still incurred. Thus, the ultimate price negotiation will entail management of the appropriate allocation of these costs. A copy of the current budget for Centennial Hall is attached for reference.

Action requested:

After studying this issue and discussing the practical implications, we believe it is in the best interest of CBJ to pursue a management agreement with the JAHC that meets the conceptual guidance outlined in the attached agreement. As this represents a major shift in operational policy, we are seeking the approval of the Assembly to proceed in this direction. We believe that the community will be best served by this management concept.

Conceptual Management Agreement
CBJ/JAHC for operational Management of Centennial Hall
Assembly Committee of the Whole
February 26, 2018

Purpose

Throughout its history, Centennial Hall has been operated in the public interest to create positive economic impacts, to stimulate growth for Southeast Alaska, and to provide for the cultural enrichment of Juneau.

The purpose of entering into a management agreement is to:

- Increase use and facilitate greater coordination of event scheduling between Centennial Hall and the JAHC, and;
- Make it easier for users to book the facilities; and;
- To maximize operational efficiencies between the two facilities, and;
- In accordance with the Juneau Economic Development plan, operate the facility to foster enhanced economic development opportunities including conventions, meetings, trainings, and arts and culture events.

These goals are intended to lead to greater utilization of and a stabilization or reduction in public subsidies to Centennial Hall.

Scope of Services

CBJ shall contract for the management of all day to day operational decisions to the Juneau Arts and Humanities Council (JAHC) while retaining high level oversight of operational plans, budget, the facility and governance. As an example, JAHC will recommend a fee structure that must be approved by the Manager's Office.

Governance

JAHC will form a governance group comprised of representatives from CBJ, Travel Juneau, JEDC, Chamber of Commerce and commercial uses for the Hall. The purpose of this group will be to advise the JAHC on policy and operational issues associated with Centennial Hall and to forge a closer connection between these groups.

Physical Plant

Routine and reoccurring maintenance shall be the responsibility of the JAHC. Major projects and systems upgrades to Centennial Hall will be the responsibility of CBJ. CBJ will continue to provide basic outdoor maintenance and snow plowing services.

Revenues/Management Fees

JAHC shall be paid a management fee. The details are to be negotiated but the intent is that the cost to the CBJ be no more than the current cost with the goal of reducing general fund support.

Priorities of Use

Priorities of use will be subject to contract negotiations, but the parties tentatively agree that at a minimum, the following order of use shall be observed:

1. Emergency Use
2. Legislature & Governor
3. Full day, multi day events
4. Full day, single day events

Employment relationships

All staff will be employees of the JAHC. JAHC retains the right to subcontract out specific services.

Applicability of law

JAHC will comply with all applicable Federal, State and Local laws.

Reporting

JAHC will provide an annual budget, operating plan, and facility plan to the CBJ. In addition, JAHC will provide quarterly reports on revenues and expenses.

Term of Contract

We are considering a 5 year agreement with possibility of renewals thereafter. There will be options to terminate the contract for cause as well as for convenience.

PARKS AND RECREATION

COMPARATIVES FOR CENTENNIAL HALL (VISITOR SERVICES)

	FY16 Actuals	FY17 Amended Budget	FY17 Projected Actuals	FY18 Approved Budget	FY18 Adopted Budget
EXPENDITURES:					
Personnel Services	$ 542,900	587,400	545,000	593,900	597,200
Commodities and Services	558,400	602,600	544,200	601,700	501,800
Travel Juneau					
Hotel Tax Funding	815,500	-	-	-	-
Marine Passenger Fee Funding	310,000	-	-	-	-
Total Expenditures	**2,226,800**	**1,190,000**	**1,089,200**	**1,195,600**	**1,099,000**
FUNDING SOURCES:					
Charges for Services	3,800	2,000	4,700	2,000	2,000
Rental and Lease	356,500	335,300	355,400	335,300	335,300
Licenses, Permits and Fees	74,200	51,500	67,300	51,500	52,500
Fines and Forfeitures	2,700	1,000	2,500	1,000	1,000
Other Revenue	2,600	-	-	-	-
Support From:					
General Fund for Centennial Hall	27,000	178,700	37,800	171,500	73,900
Hotel Tax for Centennial Hall	568,700	621,500	621,500	634,300	634,300
Hotel Tax for Travel Juneau	815,500	-	-	-	-
Marine Passenger Fee for Travel Juneau	310,000	-	-	-	-
Total Funding Sources	**2,161,000**	**1,190,000**	**1,089,200**	**1,195,600**	**1,099,000**
FUND BALANCE:					
Beginning Available Fund Balance	389,000	N/A	N/A	N/A	N/A
Increase (decrease) in Fund Balance	(65,800)	N/A	N/A	N/A	N/A
End of Period Fund Balance	**323,200**	N/A	N/A	N/A	N/A
STAFFING	7.73	7.73	7.73	7.73	7.73

The Centennial Hall Division is a component of the General Fund. See the General Fund fund balance in the "Changes in Fund Balances" schedule.

(1) In 2002, the Assembly Finance Committee directed staff to transfer unexpended marine passenger fee funds, designated for specific projects and activities, to Waterfront Open Space Land Acquisition. Unexpended proceeds are returned to the Marine Passenger Fee Fund and appropriated to Waterfront Open Space Land Acquisition as part of the subsequent year budget process.

(2) Effective FY17, the Hotel Tax support to Travel Juneau will be presented as a Mayor and Assembly grant which is presented in the General Fund.

(3) Effective FY17, Visitor Services was moved from a Special Revenue fund to the General Fund and renamed Centennial Hall. Therefore, there is no longer a Fund Balance.

PARKS AND RECREATION

BUDGET HIGHLIGHT

The Parks & Recreation Department's FY18 Adopted Budget is a decrease of $152,800 (1.3%) from the FY18 Approved Budget.

The significant budgetary changes are:

FY18 Adopted Budget

- Personnel Services decreased $297,000 (4.3%) which is primarily composed of long-term staff turnover and the elimination of funding for positions at Treadwell Ice Arena and Aquatics. Personnel services for Treadwell were reduced by $19,100, Augustus Brown Pool was reduced by $30,000 and the Community Outreach Manager position funding of $82,000 in Areawide Recreation was not funded in FY18.
- Commodities and Services increased $144,200 (3.3%) due to an increase in contracted services and minimal increases across the Department in parking fees, telephone charges and bank card fees.

City and Borough of Juneau
Deputy Mayor's Office
155 South Seward Street
Juneau, Alaska 99801
Telephone: 586-5240| Facsimile: 586-5385

DATE: February 26, 2018

TO: Ken Koelsch, Mayor

FROM: Jerry Nankervis, Deputy Mayor

RE: Final Report, Mayor's Taskforce on Public Safety

Background:

On July 31, 2017, the Mayor's Taskforce on Public Safety was created and charged with:

1. Creating an inventory of what services the CBJ currently provides or has access to in the areas of Public Safety, Treatment for Drug and Alcohol abuse/Addiction, and reentry.
2. Making recommendations to the Mayor regarding options available to the CJB to combat and reverse the current crime trends, including what services may be added or enhanced to address the treatment of drug and alcohol abuse.

In addition to myself as Chair, members of the taskforce included: David Campbell, Deputy Chief JPD; Sherri Layne and Emily Wright, CBJ Criminal Prosecutors; Don Habeger, Community Coordinator for the Juneau Reentry Coalition; Bradley Grigg, Chief Behavioral Health Officer, Bartlett Regional Hospital; Terry Goff, General Manager Safeway; and Angie Kemp, District Attorney. Mila Cosgrove, Deputy City Manager was the staff liaison.

The Taskforce held 10 meetings between August 9, 2017 and January 30, 2018. During those meetings the Taskforce discussed what services were available in the community and generated and discussed ideas to define potential solutions to resolving the increasing crime and addiction issues in our community. Those ideas fit into three primary topic areas; staffing, diversion and treatment, and legislation.

Staffing:

There is a national shortage of people who are qualified and interested in serving as sworn Police Officers. Juneau's size and geographical isolation combine to limit the number of people who apply as sworn staff and meet hiring criteria. In addition, sworn staff participates in the 20 year retirement system which serves to qualify officers for retirement with a shorter career span than non public safety staff. While staffing numbers are always a moving target, currently out of the 55 sworn positions (including command staff), 8 are eligible for retirement now, 8 are eligible within the next 5 years, and 30 are more than 5 years out. There are 9 vacant positions.

Recruitment and Retention of Police Officers: Many ideas surfaced during the taskforce discussions that might have an impact on this area. In addition, the Assembly identified first responder recruitment and retention as a 2018 goal. The Taskforce's recommendation is to focus JPD command staff and Human Resource staff with generating strategies to more effectively recruit and retain sworn staff and to determine how to most effectively deploy the current staff given the current vacancies. Part of this discussion should include a discussion of whether the Assembly should support different retirement system options through the legislative process. There was a consensus in the group that it was too early to evaluate an increase in staffing due to the number of existing vacancies. Costs associated with this solution will be dependent on the strategies identified.

Create a Misdemeanant Probation Officer: Hire a staff person to serve as a Probation Officer for individuals working their way through the system with misdemeanor convictions. This function would take over where pre-trial services leaves off and help assure that misdemeanants follow through with probation conditions and have access to services. The cost of creating this level of staff would be approximately $125,000 which includes salary, benefits and training costs.

Support additional staff for the District Attorney's Office: Over the last 3 years, the local District Attorney's Office has lost a significant number of staff. This puts staff in the position of triaging what cases go forward for prosecution and generally impairs their ability to be as effective as needed. The Governor's submitted budget includes additional funding for the DA's Office. The CBJ Assembly should support additional funding for the DA's Office and specific funding for staffing in the Juneau/Southeast Office.

Treatment & Diversion:

According to staff from the CBJ Law Department and the District Attorney's Office, a significant majority of crime in the community is directly related to drug and alcohol addiction. Any effort to effectively identify and treat individuals with substance abuse disorders should have a positive impact on reducing crime in general and recidivism.

Coordinate meeting between Rainforest Recovery Center, Gastineau Human Services, and AK Department of Corrections: Issues to be addressed should include bed to bed protocols to allow incarcerated individuals or those who are ready for release to go directly into treatment. Also, anyone needing an addiction assessment should have access to one. CBJ may be able to reduce barriers to this by providing a small amount of grant funding to assure that addiction assessments are available to anyone in the criminal justice system who might need one. Anticipated cost is $10,000 - $25,000.

Create a separate residential treatment center for incarcerated individuals: Currently, individuals in the criminal justice system who need substance abuse treatment do not have ready access to such services. When treatment is provided as an alternative to incarceration, individuals are co-housed (at least locally) with individuals who have sought voluntary treatment. Having the populations mixed, particularly if the person who is getting treatment for diversion reasons is there just for diversion and not motivated to fully engage in treatment, can have an adverse impact on those who are there for voluntary reasons. In addition, a number of residential treatment centers, Rainforest Recover

included, tailor their programs for a period of up to 30 days. There needs to be a longer term, residential option available to the incarcerated population which will also allow more tailored service delivery.

Hire a contractor to conduct an analysis of service gaps: This contract could include substance abuse assessment and treatment options as well as gaps in other services that might benefit those making their way through the criminal justice system and help reduce recidivism. It is believed it may be possible to find grant funding to covers such an analysis.

In addition, a general assessment of treatment options in the community for those individuals who are not involved in the criminal justice system. As an example, there is a shortage of beds in the community for females who are transferring out of Rainforest into a supported environment. The ability to identify, and solve issues prior to individuals entering the criminal justice system is ideal.

Legislation:

There were several ideas for legislative "fixes" including stiffer penalties for heroin possession, sentence structuring that incentivizes treatment, changes to the public safety retirement system, and other related ideas. Bills will be introduced this legislative session that should be monitored and supported if appropriate. As an example, HB 171 is legislation that deals with education, training, and work programs in the Department of Corrections. It is also possible that there may be legislation introduced dealing with Heroin possession and distribution.

The consensus of the group was that SB 54 modified SB 91 and the new legislation should be given time to take effect prior to advocating for further changes.

Other:

A recommendation was made to pilot a program to put security cameras in high crime areas. JPD could weigh in on the best placement and the Law Department should weigh in on any associated legal issues associated with such placement.