A Public Health and Safety Approach to Problematic Opioid Use and Overdose

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BACKGROUND ON INCREASING RATES OF OPIOID USE DISORDER AND OVERDOSE AS WELL AS INADEQUACY OF CURRENT RESPONSES

Rates of opioid use, dependence, and overdose in the United States are reaching epidemic-level proportions. Opioids are a class of drugs that include the illicit drug heroin as well as the legal prescription pain medications oxycodone (OxyContin™), hydrocodone (Vicodin™), codeine, morphine and others.[1] Between 1999 and 2010, sales, substance abuse treatment admissions, and overdose death rates related to prescription opioids increased simultaneously.[2] Sales in 2010 were four times those in 1999; the substance abuse treatment admission rate in 2009 was almost six times the rate in 1999; and the overdose death rate in 2008 was nearly four times the rate in 1999.[3] Moreover, from 1999 to 2011, consumption of hydrocodone more than doubled and consumption of oxycodone increased by nearly 500%.[4]

As state and federal lawmakers and law enforcement officials attempted to restrict access to prescription opioids, many opioid-dependent people transitioned to using heroin.[5] Ninety-four percent of opioid-addicted individuals who switched from prescription opioids to heroin reported doing so because prescription opioids "were far more expensive and harder to obtain."[6] As a result, beginning in 2010, heroin overdose fatalities began increasing rapidly across the country while fatal overdoses involving prescription opioids began to level off and even declined slightly between 2011 and 2013.[7] Deaths from heroin overdose nearly tripled from 2010 to 2013.[8]

The United States is, according to the Centers for Disease Control and Prevention, in the midst of the "worst drug overdose epidemic in history."[9] In 2015, drug overdoses accounted for over 52,000 U.S. deaths, including over 33,000 – the most ever – from misuse of opioids, typically in combination with other drugs.[10]

Where past opioid epidemics were seen primarily in terms of inner city African Americans getting addicted to heroin, the current epidemic is perceived, more correctly than not,[11] as disproportionately affecting white, middle class people getting addicted to pharmaceutical opioids.[12] The result, The New York Times has noted, is a "gentler drug war."[13] Republican legislators who long championed drug war policies now propose more humane responses. There has been a renewed emphasis, for example, on treatment, expanded access to the overdose antidote naloxone, the passage of Good Samaritan laws that offer protection to those calling for help during an overdose, and, recently, serious discussions of previously-taboo harm reduction interventions, such as supervised injection facilities. Nonetheless, drug war strategies persist. Use of the criminal justice system continues to dominate local, state and federal responses to increasing rates of opioid use disorder and overdose.

The Office of National Drug Control Policy has promoted prescription drug monitoring programs and coordinated federal-state crackdowns on pain physicians, patients and illicit sellers.[14] The Drug Enforcement Administration has aggressively investigated and prosecuted pain physicians for prescribing practices viewed as outside the scope of legitimate medical practice.[15] The Obama Administration has prioritized "law enforcement efforts to decrease pill mills, drug trafficking and doctor shopping" since 2011.[16] States have mirrored the federal

response to combatting prescription opioid misuse. Unsurprisingly, these responses have been wholly ineffective at reducing rates of opioid use or overdose. Moreover, as opioid-addicted people transition to the illicit heroin market, they are met with the same "arrest and incarcerate" policies that have been widely recognized as ineffective at reducing drug use, with high rates of relapse, recidivism and re-incarceration.[17]

Taking an approach focused on punishment in the face of the current crisis is misguided and further harms individuals and communities already struggling with opioid dependence. Indeed, criminalization has usurped attention to, and resources for, harm reduction and effective drug treatment services. Only 12% of opioid dependent individuals receive methadone – one of the most effective treatments for opioid use disorder.[18] A staggering 30 states in the country provide either no access to syringe exchange programs or provide limited access in only one or two cities in the entire state.[19] Though the importance of naloxone, the opioid overdose antidote, has received widespread national attention, the vast majority of overdose prevention programs receive no federal or state funding and are unable to provide the amount of naloxone required to adequately serve their clients. Because public health interventions are often not in place and remain vastly inaccessible, the opioid epidemic remains unchecked. We must now focus our attention on formulating and implementing policies that effectively mitigate the risks and negative consequences associated with opioid use, dependence, and overdose. And, we must make sure that they are applied equally to all communities.

Finally, our response must be tempered with the knowledge that the vast majority of people who have ever used opioids – whether prescription medications or heroin – never develop problematic use. The National Institute on Drug Abuse estimates that 23 percent of individuals who use heroin become dependent on it.[20] The Substance Abuse and Mental Health Services Administration recently published the results of the 2015 National Survey on Drug Use and Health, which found that over 87 percent of people who used prescription opioid pain relievers in the past year did not misuse them.[21] Thus, while we need to ensure that those with opioid use disorder and those who are at risk of overdose receive the effective treatment and services they need to mitigate the harms associated with their drug use, we must not widen the net and criminalize legitimate medical use of opioids, overstate the potential dangers of prescription opioid use and reduce access to needed pain medications, or stigmatize the people who use them.

A COMPREHENSIVE OPIOID DEPENDENCE AND OVERDOSE RESPONSE PLAN MUST INCREASE ACCESS TO EFFECTIVE TREATMENT, REDUCE HARMS, PREVENT FUTURE OPIOID MISUSE, AND DECREASE THE ROLE OF CRIMINALIZATION

In the sections that follow, DPA outlines a robust response plan focused on effective treatment, harm reduction, prevention, and reducing the role of criminalization to optimally address increasing rates of opioid dependence, overdose, and other negative consequences stemming from opioid use. Opioid use disorder is a complex issue, and there is no silver bullet for fixing the problem. Rather, a multifaceted, comprehensive approach rooted in science is needed. In taking some or all or the steps delineated in the plan, local, state, and federal policymakers can act to produce healthier, safer outcomes while avoiding failed strategies that drive people away from care and treatment and exacerbate racial disparities. This plan, however, is not intended to be comprehensive. Instead, it highlights high level policy proposals that have the greatest potential for across-the-board success in reducing opioid dependence and overdose and increasing access to effective treatment (for those that want or need it) and harm reduction services.

There are a host of other potential solutions whose viability depends entirely on the needs and resources of each state and locality and the unique factors that contribute to opioid use disorder and overdose trends in that state. As such, DPA's recommended interventions below should be coupled with respective state-level analysis of data and strategic plans developed by local task forces comprised of representatives from multiple state agencies as well as community members, public health, treatment, and medical experts, social service providers, law enforcement, the research community, insurance providers, and others. A recent strategic plan on addiction and overdose published by the Rhode Island Governor's Overdose Prevention and Intervention

Task Force is a prime example of developing interventions targeted to unique state dynamics as they relate to opioid dependence and overdose.[22]

INCREASE ACCESS TO CONVENTIONAL, EFFECTIVE TREATMENT AND EXPAND TREATMENT MODALITIES

The vast majority of people who use drugs, including opioids, never develop problematic drug use and so are not in need of treatment.[23] However, for those who do need treatment, access is lacking. Nearly 80 percent of people experiencing opioid dependence do not receive treatment because of limited treatment capacity, financial obstacles, social stigma, and other barriers to care.[24] Moreover, certain populations, including women, communities of color, and residents of rural areas, are even less likely to have access to treatment. A 2013 U.S. government study found that only 32 percent of treatment facilities in the U.S. have unique programs for women, and only 13 percent have special programs for pregnant or postpartum women.[25] Black and Latino people are less likely to have access to drug treatment than are white people.[26] The Office of National Drug Control Policy has noted that, ". . . much-needed [drug treatment] services may be less available to vulnerable populations, including racial and ethnic minorities like African Americans, Native Americans, Alaskans, [and] Asian American/Pacific Islanders."[27] Rural residents also face significant barriers to accessing treatment.[28] Only 10.7 percent of hospitals in rural areas, for example, offer substance abuse treatment services compared to 26.5 percent of metropolitan hospitals.[29] Expanding access to effective drug treatment for those who need it, and for all populations, is accordingly a key strategy to reducing the harms associated with prescription opioids and heroin.

Medication-Assisted Treatment

Medication-assisted treatment (MAT) refers to the treatment of opioid use disorder through the prescription of medications such as methadone and buprenorphine (Suboxone™), which block the effects of opioid use and prevent or relieve withdrawal symptoms and cravings.[30] Scientific research has established that MAT is a cost-effective intervention that increases patient retention in treatment and decreases drug use, transmission of infectious diseases, and criminal activity.[31]

After reviewing 941 studies, the National Institutes of Health Consensus Development Panel concluded that the safety and efficacy of methadone has been "unequivocally established."[32] Moreover, studies have shown buprenorphine to be at least as effective as methadone in sustaining treatment and maintaining abstinence.[33] Medication-assisted treatment is endorsed by the Institute of Medicine,[34] the National Academy of Sciences,[35] the National Institute on Drug Abuse,[36] the Office of National Drug Control Policy,[37] the United States Department of Health and Human Services,[38] the Center for Substance Abuse Treatment,[39] the CDC,[40] and the World Health Organization,[41] among others.

Despite widespread acceptance and support, however, access to MAT is severely limited by extensive federal and state regulations and restrictions. A scant 12 percent of individuals with opioid dependence receive methadone,[42] and only nine percent of substance abuse treatment facilities in the United States offer specialized treatment of opioid dependence with MAT.[43] Indeed, there is absolutely no access to methadone in North Dakota or Wyoming, and very limited access in other states.[44] Though buprenorphine avoids some of the burdensome regulations that govern access to methadone, over half the states (28) have less than 20 physicians that are certified to provide buprenorphine to 100 patients; 13 states have less than five eligible physicians.[45] Moreover, buprenorphine fails to reach many of the communities that need it: buprenorphine patients are more likely than methadone patients to be white, employed and college-educated.[46] Finally, methadone and buprenorphine are among the only medications that are routinely stopped upon incarceration. In a national survey of 40 state prison medical directors (having jurisdiction over 88% of the of U.S. state and federal prisoners), none offered methadone treatment to any population of opioid-dependent inmates other than pregnant women.[47] These results are consistent with a U.S. Department of Justice report

that found that less than 0.5% of state and federal prisoners who met drug dependence or abuse criteria received MAT.[48]

To increase access to MAT, DPA recommends consideration of the following proposals:

- Increase Insurance Coverage for MAT: Seventeen state medical plans under the Patient Protection and Affordable Care Act (ACA) do not provide coverage for methadone or buprenorphine for opioid dependence.[49] Moreover, the Veterans Administration's (VA's) insurance system has explicitly prohibited coverage of methadone and buprenorphine treatment for active duty personnel or for veterans in the process of transitioning from Department of Defense care.[50] As a result, veterans obtaining care through the VA are denied effective treatment for opioid dependence.[51] Insurance coverage for these critical medications should be standard practice.

- Establish and Implement Office-Based Opioid Treatment for Methadone: Currently, with a few exceptions, methadone for the treatment of opioid dependence is only available through a highly regulated and widely stigmatized system of Opioid Treatment Programs (OTPs). Moreover, several states have imposed moratoriums on establishing new OTPs that facilitate methadone treatment despite large, unmet treatment needs for a growing opioid-dependent population.[52] Patients enrolled in methadone treatment in many communities are often limited to visiting a single OTP and face other inconveniences that make adherence to treatment more difficult.[53] Initial trials have suggested that methadone can be effectively delivered in office-based settings[54] and that, with training, physicians would be willing to prescribe methadone to their patients to treat their opioid dependence.[55] Office-based methadone may help reduce the stigma associated with methadone delivered in OTPs[56] as well as provide a critical window of intervention to address medical and psychiatric conditions.[57] Office-based opioid treatment programs offering methadone have been implemented in California, Connecticut, and Vermont.[58]

- Provide MAT in Criminal Justice Settings, Including Jails/Prisons and Drug Courts: Individuals recently released from correctional settings are up to 130 times more likely to die of an overdose than the general population, particularly in the immediate two weeks after release.[59] Given that approximately one quarter of people incarcerated in jails and prisons are opioid-dependent,[60] initiating MAT behind bars should be a widespread, standard practice as a part of a comprehensive plan to reduce risk of opioid fatality. Jails should be mandated to continue MAT for those who received it in the community and to assess and initiate new patients in treatment. Prisons should initiate methadone or buprenorphine prior to release, with a referral to a community-based clinic or provider upon release. Vermont was the first state to pass legislation establishing a pilot project for the continued provision of MAT to its entire incarcerated population (both jails and prisons).[61] In addition, drug courts should be mandated to offer participants the option to participate in MAT if they are not already enrolled, make arrangements for their treatment, and should not be permitted to make discontinuation of MAT a criteria for successful completion of drug court programs. The Substance Abuse and Mental Health Services Administration will no longer provide federal funding to drug courts that deny the use of MAT when made available to the client under the care of a physician and pursuant to a valid prescription.[62] The National Association of Drug Court Professionals agrees: "No drug court should prohibit the use of MAT for participants deemed appropriate and in need of an addiction medication."[63]

- Offer Hospital-Based MAT[64]: Emergency departments should be mandated to inform patients about MAT and offer buprenorphine to those patients that visit emergency rooms and have an underlying opioid use disorder, with an appointment for continued treatment with physicians in the community. Hospitals should also offer MAT within the inpatient setting, and start MAT prior to discharge with community referrals for ongoing MAT.

- Assess Barriers to Accessing MAT to Increase Access to Methadone and Buprenorphine: A number of known barriers prevent MAT from being as widely accessible as it should be. The federal government needs to reevaluate the need for and effectiveness of the OTP model and make necessary modifications to ensure improved and increased access to methadone. And, while federal law allows physicians to become eligible to prescribe buprenorphine for the treatment of opioid dependence, it arbitrarily caps the number of opioid patients a physician can treat with buprenorphine at any one time to 30 through the first year following certification, expandable to up to potentially 200 patients thereafter.[65] Moreover, states need to evaluate additional barriers created by state law, including, among others, training and continuing education requirements, restrictions on nurse practitioners, insurance enrollment and reimbursement, and lack of provider incentives.

Effective Treatment Access, Standards of Care, and Quality of Treatment

There is wide consensus among experts that medical best practice requires that an individual struggling with opioid use disorder should have access to the full spectrum of behavioral, pharmacological, and psychosocial treatments. Effective treatment modalities also need to be available to people at all stages of the recovery spectrum. Barriers to effective treatment, gaps in provider education, and lack of standards of quality care, as well as the best methods and mechanisms to increase access to effective treatment and availability of different types of treatment, are best addressed on a state-by-state basis by experts representing the state's medical and healthcare community (physicians and nurses, medical universities and students, hospitals, etc.), insurance providers, treatment professionals, social workers, harm reduction providers, mental health professionals, and state and local government officials.

To increase access to effective treatment and enhance the quality of treatment provided, DPA recommends consideration of the following proposal:

- Create Expert Panel on Treatment Needs: States should establish an expert panel to address effective treatment needs and opportunities. The expert panel should evaluate barriers to existing treatment options and make recommendations to the state legislature on removing unnecessary impediments to accessing effective treatment on demand. Moreover, the panel should determine where gaps in treatment exist and make recommendations to provide additional types of effective treatment and increased access points to treatment (such as hospital-based on demand addiction treatment[66]). The expert panel must also set evidence-based standards of care and identify the essential components of effective treatment and recovery services to be included in licensed facilities, especially with regards to medication-assisted treatment, admission requirements, discharge, continuity of care and/or after-care, pain management, treatment programming, integration of medical and mental health services, and provision of or referrals to harm reduction services. The expert panel should identify how to improve or create referral mechanisms and treatment linkages across various healthcare and other providers. The panel should establish clear outcome measures and a system for evaluating how well providers meet the scientific requirements the panel sets. And, finally, the expert panel should evaluate opportunities under the ACA to expand coverage for treatment.

New Treatment Models

While medication-assisted treatment and other forms of evidence-based treatment have strong potential to benefit the vast majority of opioid-dependent people who need treatment, there is still a small group of people with opioid dependence who are "treatment refractory." In other words, despite their best effort and attempts, these individuals consistently fail to recover from opioid use disorder through existing treatment options. It is estimated that 15–25 percent of the most severely affected individuals with opioid dependence are not reached or retained by any current treatment.[67] Though this group is a small one, it is also one in which the negative health and social implications of long-term drug dependence are most pronounced. The effective treatment of

these individuals thus has a high relative potential to impact the harms, and costs, associated with drug dependence.

To provide effective treatment to all opioid-dependent persons who want it, including those for whom conventional treatment modalities have not been effective, DPA recommends consideration of the following proposal:

- Establish and Implement a Heroin-Assisted Treatment Pilot Program: Heroin-assisted treatment (HAT) refers to the administering or dispensing of pharmaceutical-grade heroin to a small and previously unresponsive group of chronic heroin users under the supervision of a doctor in a specialized clinic. The heroin is required to be consumed on-site, under the watchful eye of trained professionals. This enables providers to ensure that the drug is not diverted, and allows staff to intervene in the event of overdose or other adverse reaction. Permanent HAT programs have been established in the United Kingdom, Switzerland, the Netherlands, Germany and Denmark, with additional trial programs having been completed or currently taking place in Spain, Belgium and Canada.[68] Findings from randomized controlled studies in these countries have yielded unanimously positive results, including: 1) HAT reduces drug use; 2) retention rates in HAT surpass those of conventional treatment; 3) HAT can be a stepping stone to other treatments and even abstinence; 4) HAT improves health, social functioning, and quality of life; 5) HAT does not pose nuisance or other neighborhood concerns; 6) HAT reduces crime; 7) HAT can reduce the black market for heroin; and, 8) HAT is cost-effective (cost-savings from the benefits attributable to the program far outweigh the cost of program operation over the long-run).[69] States should consider permitting the establishment and implementation of a HAT pilot program. Nevada[70] and Maryland[71] have introduced legislation of this nature and the New Mexico Legislature recently convened a joint committee hearing to query experts about this strategy.[72]

- Evaluate the Use of Cannabis to Decrease Reliance on Prescription Opioids and Reduce Opioid Overdose Deaths: Medical use of marijuana can be an effective adjunct to or substitute for opioids in the treatment of chronic pain. Research published last year found 80 percent of medical cannabis users reported substituting cannabis for prescribed medications, particularly among patients with pain-related conditions.[73] Another important recent study reported that cannabis treatment "may allow for opioid treatment at lower doses with fewer [patient] side effects."[74] The result of substituting marijuana, a drug with less side effects and potential for abuse, has had profound harm reduction impacts. The Journal of the American Medical Association, for instance, documents a relationship between medical marijuana laws and a significant reduction in opioid overdose fatalities: "[s]tates with medical cannabis laws had a 24.8% lower mean annual opioid overdose mortality rate compared with states without medical cannabis laws."[75] Another working paper from the RAND BING Center for Health Economics notes that "states permitting medical cannabis dispensaries experienced a 15 to 35 percent decrease in substance abuse admissions and opiate overdose deaths."[76] There is also some emerging evidence that marijuana has the potential to treat opioid addiction, but additional research is needed.[77]

IMPLEMENT AND FUND COMPREHENSIVE HARM REDUCTION INTERVENTIONS

Safe Injection Facilities / Safe Drug Consumption Services

The negative health and social consequences of drug use remains staggeringly high in large part due to the failure to reach the most marginalized and high-risk drug users who, due to lack of housing and other supportive care, are forced to consume drugs in public spaces. Public drug use is associated with significantly higher rates of overdose, transmission of infectious diseases, and necessity of costly emergency care, as well as a variety of nuisance and safety issues, including improper syringe disposal and "open-air" drug consumption.[78] Safe injection facilities (SIFs) – also known as supervised or safe drug consumption services or drug consumption rooms – directly, and effectively, address these issues and engage otherwise hard-to-reach users in therapeutic

relationships.[79]

Safe drug consumption services are provided in legally sanctioned facilities that provide a hygienic space for people who use drugs to consume pre-obtained drugs under the supervision of trained staff. Staff members do not directly assist in consumption or handle any drugs brought in by clients, but are present to provide sterile syringes and injection-related supplies, answer questions on safe consumption practices, administer first aid if needed, and monitor for overdose. Staff also offer general medical advice and referrals to drug treatment, medical treatment, and other social support programs. There are approximately 100 such programs operating in 66 cities around the world in nine countries (Switzerland, Germany, the Netherlands, Norway, Luxembourg, Spain, Denmark, Australia and Canada).[80]

Key research findings on SIFs in other countries include: 1) SIFs reduce overdose deaths; 2) SIFs do not encourage additional drug use; 3) SIFs provide an entry to treatment and even abstinence; 4) SIFs reduce risky injecting and transmission of infectious diseases, including HIV, hepatitis C, and hepatitis B; 5) SIFs improve public order by reducing discarded syringes and public injecting; 6) crime is not increased in the areas in which SIFs are located; and 7) SIFs are cost effective.[81] Despite the compelling and uncontroverted evidence, however, no SIFs have been established in the United States to date.

To reduce overdose, transmission of infectious diseases, and nuisances associated with public injecting as well as to increase access to effective treatment, DPA recommends consideration of the following proposal:

- Establish and Implement Safe Drug Consumption Services: States and/or municipalities should permit the establishment and implementation of safe drug consumption services through local health departments and/or community-based organizations. California[82] and Maryland[83] have introduced legislation to establish safe drug consumption services, and the City of Ithaca, New York has included a proposal for a supervised injection site in their widely-publicized municipal drug strategy.[84] In Washington State, the King County Heroin an Prescription Opiate Addiction Task Force has recommended the establishment of at least two pilot supervised consumption sites as part of a community health engagement program designed to reduce stigma and "decrease risks associated with substance use disorder and promote improved health outcomes" in the region that includes the cities of Seattle, Renton and Auburn.[85]

Naloxone Access and Good Samaritan Reforms

Great progress has been made to increase access to the opioid overdose antidote naloxone, which immediately reverses an overdose and restores normal breathing within two to three minutes of administration without any potential for misuse or abuse, and to encourage the summoning of medical help in an overdose. Though, as of June 2016, all but three states (KS, MT, WY) have passed legislation designed to improve layperson naloxone access, and 36 states and the District of Columbia have passed "Good Samaritan" laws, these authorizations vary widely in the access and protections they actually provide.[86] Moreover, community-based programs that offer overdose prevention services to people who use drugs and their friends and family members – the people most likely to be present at the time of an overdose – have been under-resourced and urgently need appropriate support.

To curb opioid overdose deaths, DPA recommends consideration of the following proposals:

- Maximize Naloxone Access Points, Including Lay Distribution and Pharmacy Access, As Well As Immunities for Prescription, Distribution and Administration: Naloxone should be available directly from a physician to either a patient or to a family member, friend, or other person in a position to assist in an overdose, from community-based organizations through lay distribution or standing order laws, and from pharmacies behind-the-counter without a prescription through standing order, collaborative agreement,

or standardized protocol laws or regulations. Though some states, including California, New York, Colorado and Vermont, among others, have access to naloxone at each of these critical intervention points, many others only provide naloxone through a standard prescription.[87] Civil and criminal immunities should be provided to prescribers, dispensers and lay administrators at every access point. In addition, all first responders, firefighters and law enforcement should be trained on how to recognize an overdose and be permitted to carry and use naloxone. Naloxone should also be reclassified as an over-the-counter (OTC) medication. Having naloxone available over-the-counter would greatly increase the ability of parents, caregivers, and other bystanders to intervene and provide first aid to a person experiencing an opioid overdose. FDA approval of OTC naloxone is predicated on research that satisfies efficacy and safety data requirements. Pharmaceutical companies, however, have not sought to develop an over-the-counter product.[88] Federal funding may be needed to meet FDA approval requirements.

- Provide Dedicated Funding for Community-Based Naloxone Distribution and Overdose Prevention and Response Education: Few states provide dedicated budget lines to support the cost of naloxone or staffing for community-based opioid overdose prevention programs. The CDC, however, reports that, between 1996 and 2014, these programs trained and equipped more than 152,280 laypeople with naloxone, who have successfully reversed 26,463 opioid overdoses.[89] Without additional and dedicated funding, community-based opioid overdose prevention programs will not be able to continue to provide naloxone to all those who need it, and the likelihood of new programs being implemented is slim. A major barrier to naloxone access is its affordability and chronic shortages in market supply,[90] which overdose prevention programs, operating on shoestring budgets, can have a difficult time navigating.

- Improve Insurance Coverage for Naloxone: Individuals who use heroin and other opioids are often both uninsured and marginalized by the healthcare system.[91] States should insure optimal reimbursement rates for naloxone to increase access to those who need it most – users themselves.

- Provide Naloxone to Additional At-Risk Communities: People exiting detox and other treatment programs as well as periods of incarceration are at particularly high risk for overdose because their tolerance has been substantially decreased. After their period of abstinence, if they relapse and use the same amount, the result is often a deadly overdose. States should require overdose education and offer naloxone to people upon discharge from detox and other drug treatment programs and jails/prisons. The Substance Abuse and Mental Health Services Administration has declared that prescribing or dispensing naloxone is an essential complement to both detoxification services as well as medically supervised withdrawal.[92] Vermont passed legislation making naloxone available to eligible pilot project participants who are transitioning from incarceration back to the community.[93] In addition, there are other programs/studies that provide naloxone to recently released individuals on a limited basis, including in San Francisco, California, King County, Washington and Rhode Island.[94]

- Encourage Distribution of Naloxone to Patients Receiving Opioids[95]: Physicians should be encouraged to prescribe naloxone to their patients and opioid treatment programs should inform their clients about naloxone, if prescribing or dispensing an opioid to them. Pharmacists should similarly be encouraged to offer naloxone along with all Schedule II opioid prescriptions being filled, for syringe purchases (without concurrent injectable medication), and for all co-prescriptions (within 30 days) of a benzodiazepine (such as Valium™, Xanax™ or Klonopin™) and any opioid medication. The Rhode Island Governor's Overdose Prevention and Intervention Task Force found that offering naloxone to those prescribed a Schedule II opioid or when co-prescribed a benzodiazepine and any opioid would have reached 86% of overdose victims who received a prescription from a pharmacy prior to their death, and could have prevented 58% of all overdose deaths from 2014 to 2015.[96]

- Expand Good Samaritan Protections: "Good Samaritan" laws provide limited immunity from prosecution for specified drug law violations for people who summon help at the scene of an overdose. But, protection from prosecution is not enough to ensure that people are not too frightened to seek medical help. Other consequences, like arrest, parole or probation violations, and immigration consequences, can be equal barriers to calling 911. States with Good Samaritan laws already on the books should evaluate the protections provided and determine whether expansion of those protections would increase the likelihood that people seek medical assistance.

Sterile Syringe Access

Research has conclusively shown that sterile syringe access programs reduce the spread of HIV and viral hepatitis without increasing drug use, crime or unsafe discarding of syringes.[97] Moreover, syringe access programs also provide people who inject drugs with referrals to treatment, detoxification, social services and primary health care.[98] These programs are supported by every major medical and public health organization in the U.S. and the world, including the American Medical Association, National Academy of Sciences, CDC and World Health Organization.[99]

Despite the documented benefits of syringe access and widespread endorsement, however, these programs remain woefully inaccessible. Approximately half the states in the country have either no syringe exchange programs (14 states) or only have programs available in one or two cities in the entire state (12 states).[100] The result has been devastating for people in rural communities where opioid use is on the rise. Indeed, as of April 2015, there were 120 confirmed and 10 preliminary positive cases of HIV from the sharing of drug injection equipment in a *single county* in Indiana[101] and Kentucky has the highest rate of new hepatitis C cases.[102] The emergency response of both states included permitting syringe access programs, but the crises could have been avoided altogether had the programs been implemented earlier.

To significantly increase access to sterile syringes to both reduce the rates of infectious diseases and provide a gateway to social services and effective drug treatment, DPA recommends consideration of the following proposals:

- End the Criminalization of Syringe Possession: Syringes should be exempt from state paraphernalia laws in order to provide optimal access to people who inject drugs. Twenty-two states criminalize syringe possession.[103] Thus, even if there is a legal access point, such as pharmacy sales, paraphernalia laws still permit law enforcement to arrest and prosecute individuals in possession of a syringe. Public health and law enforcement authorities should not be working at cross-purposes.

- Reduce Barriers to Over-The-Counter Syringe Sales and Permit Direct Prescriptions of Syringes: While the non-prescription, over-the-counter sale of syringes is now permitted in all but one U.S. state, access is still unduly restricted.[104] States should evaluate the potential barriers to accessing syringes over-the-counter and implement measures to improve access. Moreover, doctors should be permitted to prescribe syringes directly to their patients, a practice few states currently permit.

- Authorize and Fund Sterile Syringe Access and Exchange Programs; Increase Programs: States should explicitly authorize and fund sterile syringe access and exchange programs, and states that have already authorized them should evaluate how to increase the number or capacity of programs to ensure all state residents – whether in urban centers or rural communities – have access to clean syringes, as well as evaluate any possible barriers to access such as unnecessary age restrictions.

Drug Checking

Increasingly, one of the risks of opioid and/or heroin use is that people who use these substances will

unknowingly acquire a drug that has been adulterated with far more potent synthetic opioids such as fentanyl.[105] While more common in heroin, there have been cases of counterfeit Xanax and Oxycodone tablets adulterated with fentanyl.[106] Adulterated substances lead to higher numbers of hospitalizations and fatal overdoses.[107]

To reduce the number of hospitalizations and fatal overdoses related to adulterated heroin or opioid products, DPA recommends consideration of the following proposal:

- Provide Free Public, Community-Level Access to Drug Checking Services: Technology exists to test heroin and opioid products for adulterants via GC/MS analysis, but it has so far been unavailable at a public level in the U.S. (aside from a mail-in service run by Ecstasydata.org). Making these services available in the context of a community outreach service or academic study would lower the number of deaths and hospitalizations and also allow for real-time tracking of local drug trends.

PREVENT OPIOID MISUSE

Drug use prevention and education programs should be based on rational, honest information and strategies that are scientifically evaluated, supportive rather than stigmatizing, and which promote resiliency among those at risk of developing problematic opioid use and readily offer avenues to care, effective treatment for those who need it, and harm reduction interventions.

To reduce demand for opioids and prevent future opioid dependence, DPA recommends consideration of the following proposals:

- Establish Expert Panel on Opioid Prescribing: Though the CDC has issued guidelines for prescribing opioids for chronic pain,[108] the guidelines are voluntary and are likely to exacerbate disparities in treatment that already exist. Research has shown, for example, that African Americans are less likely than whites to receive opioids for pain even when being treated for the same conditions.[109] Moreover, the CDC guidelines only address prescribing practices for chronic pain, not prescribing practices more broadly. States should accordingly establish an expert panel to undertake an assessment as to whether prescribing practices, such as co-prescriptions for benzodiazepines and opioids or overprescribing of opioids, have contributed to increased rates of opioid dependence, and, if so, the expert panel should develop a plan to address any such linkages as well as any treatment disparities. The plan must account for the potential negative effects of curtailing prescribing practices or swiftly reducing prescription opioid prescribing volume. A task force in Rhode Island found that while changes in opioid supply can have the intended effect of reducing availability of abuse-able medications, they have also been linked to an increase in transition to illicit drug use and in more risky drug use behaviors (e.g., snorting and injecting pain medications).[110] The plan must also account for chronic pain patients, particularly those already underserviced, and not unduly limit their access to necessary medications. Finally, to the extent prescribing guidelines are issued as part of the plan, they should be mandatory and applied across the board.

- Mandate Medical Provider Education: States should mandate that all health professional degree-granting institutions include curricula on opioid dependence, overdose prevention, medication-assisted treatment, and harm reduction interventions, and that continuing education on these topics be readily available.

- Develop Comprehensive, Evidence-Based Health, Wellness, and Harm Reduction Curriculum for Youth: State education departments, in conjunction with an expert panel consisting of various stakeholders that ascribe to scientific principles of treatment for youth, should develop a comprehensive, evidence-based health, wellness, and harm reduction curriculum for use in schools that incorporates scientific education on drugs, continuum of use, and contributors to problematic drug use (e.g., coping and resiliency, mental health issues, adverse childhood experiences, traumatic events and crisis), as well as how to

reduce harm (e.g., not mixing opioids with benzodiazepines). Education departments should also establish protocols and resources for early intervention, counseling, linkage to care, harm reduction resources, and other supports for students.

DECREASE THE ROLE OF CRIMINALIZATION

Policymakers are understandably alarmed at the opioid dependence and overdose crisis with which they are now confronted. The public is calling for help and solutions. Elected officials unfamiliar with, or resistant to, harm reduction, prevention and treatment interventions, however, are introducing punitive, counter-productive legislative measures in a misguided effort to reduce use and overdose fatalities. In particular, some states, including New York (AB 8616), Ohio (HB 270), and Virginia (HB 615, SB 66), are currently considering bills that would allow prosecutors to charge people who provide the drugs that ultimately contribute to an overdose death with homicide. Georgia (SB 384), Vermont (H 151, H 457), and Virginia (HB 277) all introduced bills in 2016 that would increase heroin penalties. Nine states are seeking to add the opioid fentanyl to Schedule 1, including Florida (SB 1528), Iowa (SF 2116), Kansas (HB 2540, SB 483), Kentucky (SB 115), Maryland (HB 3755, HB 3756), Mississippi (HB 1369), New Hampshire (HB 1634), Ohio (SB 237), and West Virginia (HB 4620). But, unlike the science-backed interventions detailed above, there is no existing evidence that indicates that further criminalizing opioids will achieve the goal of reducing opioid use or overdose fatalities.

Reducing the Role of the Criminal Justice System

It is widely accepted, both in the general population as well as the academic and scientific communities, that increased arrests or increased severity of criminal punishment for drug-related offenses do not, in fact, result in less use (demand) or sales (supply).[111] In other words, punitive sentences for drug offenses have no deterrent effect. Moreover, the distinction often made between "seller" and "user" is artificial. Though data evaluating the drug use history of people who sell drugs is scant, a 2004 Bureau of Justice report found that an astonishing 70% of people incarcerated for drug trafficking in state prison used drugs themselves in the month prior to the offense.[112]

Criminalizing people who sell and use drugs, including opioids, amplifies the risk of fatal overdoses and diseases, increases stigma and marginalization, and drives people away from needed treatment, health and harm reduction services.[113] Reducing the role of the criminal justice system is therefore critical to ensuring that people who use opioids are able to access the vital treatment and harm reduction services that improve outcomes and enhance quality of life for individuals, families and communities.

To ensure that opioid dependence is treated as a health issue and that criminalization and stigma do not cut off access to needed treatment and services, DPA recommends consideration of the following proposals:

- Establish Diversion Programs, Including Law Enforcement Assisted Diversion (LEAD): LEAD is a pre-booking diversion program that establishes protocols by which police divert people away from the typical criminal justice route of arrest, charge and conviction into a health-based, harm-reduction focused intensive case management process wherein the individual receives support services ranging from housing and healthcare to drug treatment and mental health services.[114] Municipalities should create and implement LEAD programs and states and the federal government should provide dedicated funding for such programs. Various other forms of diversion programs exist and can be implemented should LEAD prove unsuitable to a particular population or municipality.

  Decriminalize Drug Possession: Decriminalization is commonly defined as the elimination of criminal penalties for drug possession for personal use. In other words, it means that people who merely use or possess small amounts of drugs are no longer arrested, jailed, prosecuted, imprisoned, put on probation or parole, or saddled with a criminal record. Nearly two dozen countries have taken steps toward decriminalization (the best and most well-documented example is Portugal, which in 2001 eliminated

criminal penalties for low-level possession and use of all illicit drugs).[115] Empirical evidence from the international experiences demonstrate that decriminalization does not result in increased use or crime, reduces incidences of HIV/AIDs and overdose, increases the number of people in treatment, and reduces social costs of drug misuse.[116] All criminal penalties for possession of small amounts of controlled substances for personal use should be removed. Maryland recently introduced legislation to accomplish this reform.[117] Moreover, various other steps toward decriminalization have been taken in the United States. Twenty states and Washington, DC have reduced or eliminated criminal penalties for personal marijuana possession.[118] Four states – Connecticut, Utah, Maine and California – recently reclassified drug possession from a felony to a misdemeanor.[119] Since the passage of California's law, Proposition 47, more than 13,000 people have been released and resentenced – saving the state an estimated $156 million in incarceration costs averted, which is being reinvested in drug treatment and mental health services, programs for at-risk students in K-12 schools, and victim services.[120] Finally, states that have adopted 911 Good Samaritan immunity laws essentially decriminalize simple possession and other minor drug offenses at the scene of an overdose.

CONCLUSION

Ultimately, if we want to see comprehensive progress on reducing problematic opioid use and all of its associated social impacts, we simply cannot continue to rely on the status quo policy of criminalization. It has already proven a failure on all accounts, causing additional harms beyond those associated with opioid use itself. In addition to decriminalization efforts, policymakers need to evaluate the spectrum of potential harm reduction, effective treatment, and prevention interventions – all backed by rigorous science – and shift the focus of their efforts to implementing policies that actually have the power to save and improve lives.

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