

OPIOIDS

Treating an Illness, Ending a War



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TABLE OF CONTENTS

Executive Summary	5
I. Background	7
II. Sources of the Crisis	8
III. Responses to the Crisis	13
IV. Lessons from Previous Drug Crises	17
V. Recommendations	22

EXECUTIVE SUMMARY

More people died from opioid-related deaths in 2015 than in any previous year. This record number quadrupled the level of such deaths in 1999. Unlike the heroin and crack crises of the past, the current opioid emergency has disproportionately affected white Americans—poor and rural, but also middle class or affluent and suburban. This association has boosted support for preventative and treatment-based policy solutions. But the pace of the response has been slow, critical components of the solution—such as health insurance coverage expansion and improved access to medication-assisted treatment—face resistance, and there are growing efforts to revamp the failed and costly War on Drugs.

This report examines the sources of the opioid crisis, surveys health and justice policy responses at the federal and state levels, and draws on lessons from past drug crises to provide guidance on how to proceed.

The War on Drugs did *not* play a major role in ebbing past cycles of drug use, as revealed by extensive research and the reflections of police chiefs. In 2014, the National Research Council concluded:¹

The best empirical evidence suggests that the successive iterations of the war on drugs—through a substantial public policy effort—are unlikely to have markedly or clearly reduced drug crime over the past three decades.

Growing public awareness of the limited impact and devastating toll of the War on Drugs has encouraged many policymakers and criminal justice practitioners to begin its winding down. The number of people imprisoned nationwide for a drug offense skyrocketed from 24,000 in 1980 to a peak of 369,000 in 2007.² It has since declined by nearly one-quarter, reaching approximately 287,000 people in the most recent count.³

The lessons from past drug crises and the evidence base supporting a public health approach can guide policymakers as they seek an end to the current opioid crisis. Recommended strategies include:

END OVERPRESCRIBING OF OPIOIDS

A key step in tackling the opioid crisis is to reverse the historically unprecedented and internationally anomalous rate at which U.S. physicians are prescribing opioids. To address overprescribing:

- Align physicians' prescribing practices with the Centers for Disease Control and Prevention's (CDC) guidelines to ensure adequate consideration of risks and proper dosage.
- Revise health insurance policies to increase access to medications that carry a lower risk of addiction or dependence, and non-drug treatments.
- Improve the use of drug monitoring programs at the state level to identify problematic prescribing practices among physicians and support patients who need treatment for an opioid use disorder.
- Address illegal opioid sales by wholesale companies.

EXPAND ACCESS TO TREATMENT FOR DRUG USE DISORDERS

Policymakers should close the treatment gap for both the general and incarcerated populations, and ensure investment in *effective* forms of treatment.

- Continue to expand health insurance coverage so that people can access healthcare and mental health services that assist in preventing and treating opioid

use disorder. Lack of health insurance and the expense of treatment were the top-ranked reasons why people who wanted treatment for a substance use disorder did not receive it in 2015.⁴

- Improve enforcement of the Mental Health Parity and Addiction Equity Act to increase health insurance coverage of treatment for substance use disorder. Lowering barriers to receiving medication-assisted treatment, as recommended by the American Medical Association, would enable more people to access what the CDC, National Institute on Drug Abuse, and the World Health Organization consider the most effective form of treatment for opioid use disorder.⁵
- Prioritize drug treatment in communities and not in the criminal justice system, while ensuring that those who are brought into the system receive effective treatment. The federal Bureau of Prisons, state prisons, and local jails should follow the recommendation of the President's Commission on Combating Drug Addiction and the Opioid Crisis to increase access to medication-assisted treatment, particularly using methadone or buprenorphine.⁶

REDUCE OVERDOSE DEATHS

While use-reduction policies are important to mitigating the opioid crisis, it is also critical to reduce the harms caused by opioid use disorder.

- Broadly expand access to and training for administering naloxone to prevent overdose deaths.
- Implement supervised consumption sites and syringe service programs to reduce the spread of infectious diseases and overdose deaths among heroin users.
- Educate individuals who are using opioids on the risks of mixing substances.

END THE DRUG WAR

Policy makers and criminal justice professionals should continue to significantly reduce the use of incarceration for all drug types and eliminate the collateral consequences imposed on people with drug convictions.

- Given the evidence that incarceration of drug users and sellers is not an effective remedy for substance use disorder, significantly reduce the number of people incarcerated for possessing or selling drugs of all types.
- To address the harms caused by the more punitive response to past drug crises and by ongoing enforcement, ensure that people with felony drug convictions are not barred from federal benefits such as the Supplemental Nutrition Assistance Program and federal student aid.

I. BACKGROUND

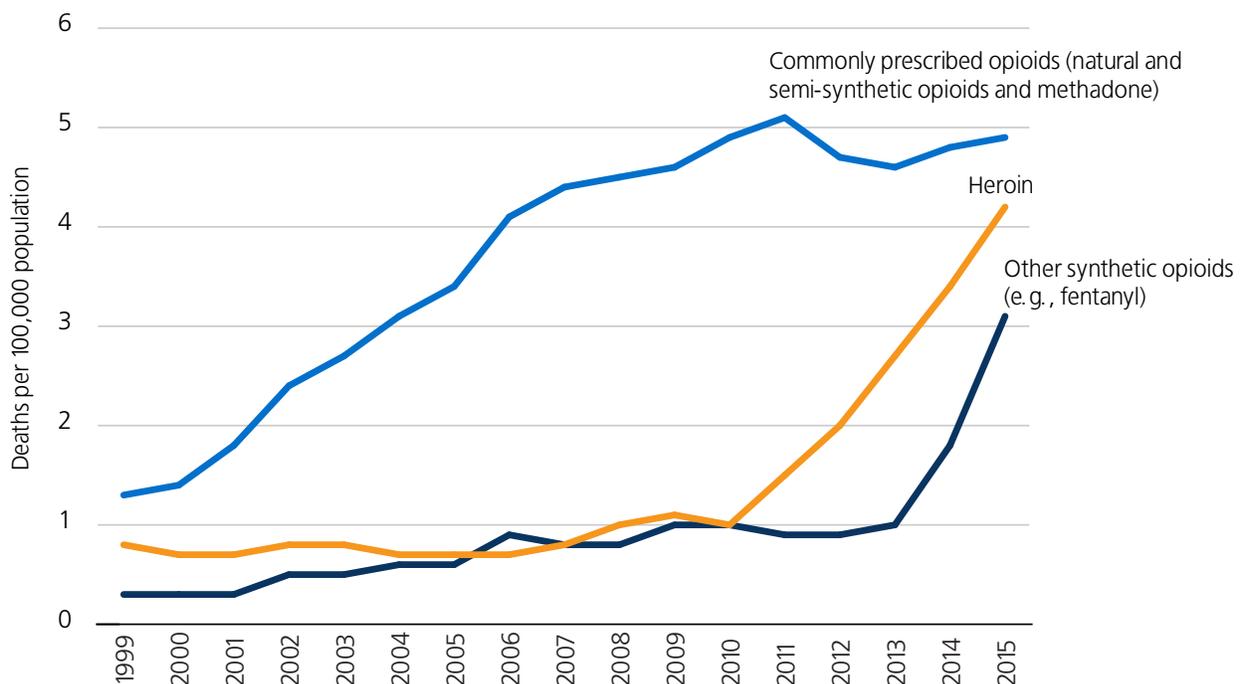
Driven largely by the accelerating opioid crisis, 64,000 people in the United States are estimated to have died from a drug overdose in 2016.⁷ This represents a 21% increase from the previous year, when drug overdose deaths had already outpaced deaths from car accidents and gun homicides, combined.⁸ Opioids, which include prescription pain relievers, heroin, and illegally-manufactured fentanyl, have been involved in nearly two-thirds of drug overdose deaths in recent years.⁹ In 2015, the most recent year for which finalized data are available, 33,000 people died of an opioid overdose—more than any other year on record and quadruple the level in 1999.¹⁰

According to the CDC, two related trends have been driving the opioid overdose crisis:¹¹ 1) A 16-year increase in deaths from prescription opioid overdoses, which remain at a high level but whose growth has begun to slow in recent years, and 2) A recent surge in fatal

overdoses from heroin and synthetic opioids such as fentanyl. **In 2016, overdose deaths from heroin and synthetic opioids such as fentanyl exceeded those from prescription opioids.**¹²

Many more people remain at risk of a fatal overdose, as revealed by estimates of the large number who were identified as having an opioid use disorder or who reported misusing opioids. In 2016, 2.1 million people met the criteria for an opioid use disorder: 1.8 million related to a prescription pain reliever and 600,000 related to heroin (for some the disorder involved both drugs).¹³ This total exceeded the number of people with methamphetamine- and cocaine-use disorders combined by 35%.¹⁴ That same year, 11.8 million people reported having misused opioids during the year: 11.5 million had misused pain relievers—in a way not directed by a doctor—and 948,000 had used heroin.¹⁵

Figure 1. Overdose deaths involving opioids, 1999-2015



Source: Centers for Disease Control and Prevention, Multiple Cause of Death Files 1999-2015 on CDC WONDER Online Database. Available at: <http://wonder.cdc.gov/mcd-icd10.html>.

Note: Using age-adjusted rates and the following ICD-10 Codes: T40.1 (Heroin), T40.2 (Other opioids), T40.3 (Methadone), T40.4 (Other synthetic narcotics). Deaths involving more than one type of opioid are included in the rates for each category

II. SOURCES OF THE CRISIS

The dramatic increase in opioid overdose deaths in the United States has paralleled the booming legal market in prescription opioids such as hydrocodone and oxycodone, known by brand names including Vicodin, OxyContin, and Percocet.¹⁶ The CDC reports that legal sales of opioid pain relievers in 2010 were four times those in 1999.¹⁷ In 2015, 97.5 million people aged 12 or older used, or misused, pain prescription relievers in the previous year, representing 36% of the population.¹⁸ As the *Associated Press* observes, “Most U.S. drug epidemics over the past two centuries were sparked by pharmaceutical companies and physicians pushing products that gradually proved to be addictive and dangerous.”¹⁹ Understanding how this statement applies to the current opioid crisis can help to expedite its end.

As described below, the origins of the opioid crisis lie in physicians’ greater willingness to rely on an expedient treatment for pain, whose harm was downplayed and efficacy was exaggerated by drug manufacturers. These factors, combined with lack of effective government oversight and limited access to treatment services, as well as skewed incentives created by health insurance providers, fueled the opioid crisis. While recent efforts have curbed prescription opioid use, the pace of the reversal has been slow and some people with untreated opioid use disorder have turned to heroin.

PHYSICIANS, DRUG MANUFACTURERS, AND PATIENT ADVOCATES

Responding in part to the demands of pain management advocates, some of whom were backed by pharmaceutical companies, doctors began increasingly prescribing opioids in the 1990s.²⁰ During this period, a group of advocates who sought to improve pain management founded the Pain as the Fifth Vital Sign movement to increase treatment for patients with chronic pain, which the National Institute of Health defines as any pain lasting more than 12 weeks.²¹ Viewing pain as a vital sign just like blood pressure, heart rate, respiratory rate

and temperature, advocates wanted healthcare professionals to end its under-treatment.²² Major campaigns by the Veterans Health Administration²³ and the Joint Commission on Accreditation of Healthcare Organizations²⁴ led to the creation of standards for consistent monitoring and treatment of pain,²⁵ which helped solidify the idea that pain is a fifth vital sign.

Several pharmaceutical companies such as Purdue Pharma, maker of OxyContin, saw this growing movement as an economic opportunity. They underplayed the risks associated with opioids and gave misleading information to doctors about the effectiveness of these drugs.²⁶ For example, pharmaceutical representatives would promote opioids at conventions and seminars by citing a one-paragraph letter written by Dr. Hershel Jick and Jane Porter to the *New England Journal of Medicine*, which stated that “despite widespread use of narcotic drugs in hospitals, the development of addiction is rare in medical patients with no history of addiction.”²⁷ Despite the fact that Jick and Porter were only examining hospitalized patients whose treatments were supervised by medical staff, their letter was widely cited and misrepresented to encourage the use of opioids.

For doctors, prescribing opioids became a fast and easy way to treat patients, a process that Dr. Anna Lembke of Stanford University calls the “Toyotaization of medicine.”²⁸ Doctors began prescribing products like OxyContin and Percocet in large numbers, although evidence shows that opioids are not more effective than non-opioid treatments in treating chronic pain.²⁹

HEALTH INSURANCE PROVIDERS

Health insurance policies encouraged the overprescribing of opioids by limiting access to pain medications with a lower risk of addiction or dependence while providing easy access to less costly generic opioid medications. In addition, as described later in this section, they

exacerbated the crisis by restricting mental health coverage and treatment for substance use disorder.

Preliminary findings from the Department of Health and Human Services (HHS) suggest there are fewer restrictions on opioids than on less addictive, non-opioid medications and non-drug treatments, such as physical therapy.³⁰ For example, United Healthcare places morphine in the lowest-cost drug coverage tier, while Lyrica—a non-opioid brand-name drug that treats nerve pain—is placed in the most expensive tier. Yet the Drug Enforcement Administration (DEA) places morphine in a higher category for abuse and dependence than other lower-risk pain medications.

Government-run insurance programs and workers' compensation laws also contributed to overprescribing of opioids. Like private insurers, Medicare and Medicaid have made it more difficult to prescribe non-addictive medication such as lidocaine patches, as well as Butrans—a painkilling skin patch that contains the less-risky opioid buprenorphine—than the more addictive opioids. Medicare requires patients to get prior approval for lidocaine, while almost every plan covers common opioids and very few require prior approval. Moreover, while under the Affordable Care Act Medicaid is required to cover physical therapy, "the generosity of the benefit varies by state."³¹ Finally, in certain states workers' compensation laws have created incentives for physicians to overprescribe. In Illinois, doctors can prescribe and sell drugs directly to injured workers, through "physician dispensing," which has led to some doctors overprescribing opioids that can be sold at a higher than average price.³²

FEDERAL ENFORCEMENT: SHORTCOMINGS AND SUCCESSES

Congress and the Department of Justice have been slow to address the overprescribing of opioids. Several former DEA supervisors claim that members of Congress, influenced by pharmaceutical companies, helped pass a law that weakened enforcement of wholesale companies that distributed drugs to pill mills and doctors, clinics, or pharmacies that were prescribing or dispensing drugs inappropriately or for non-medical reasons.³³

With such a surplus of pills, opioids began being diverted and misused by patients and non-patients. People

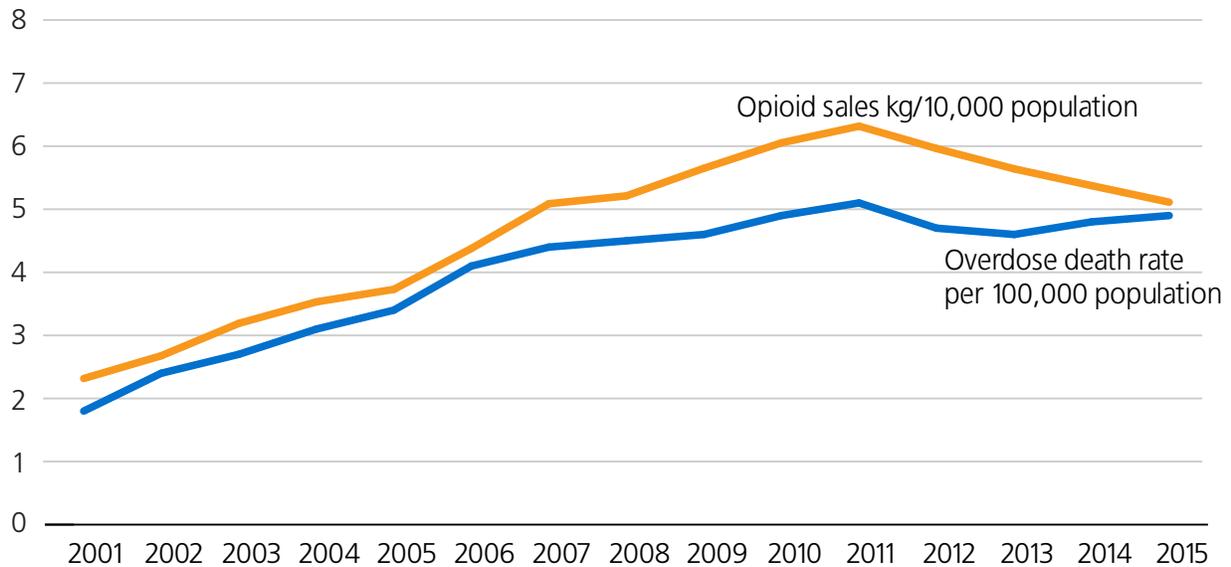
without prescriptions grew dependent on these highly addictive substances as they obtained pills with or without consent from family members or friends, or sometimes bought them from those who had prescriptions.³⁴ Among people aged 12 or older who misused pain relievers in 2016, about 6 out of 10 indicated that the main reason was to relieve physical pain (62%), 13% reported wanting to feel good or get high and 11% sought to relax or relieve tension.³⁵ According to a 2017 report from the National Research Council, "Lack of economic opportunity, poor working conditions, and eroded social capital in depressed communities, accompanied by hopelessness and despair," have been the underlying structural determinants of the misuse of opioids and other substances, and substance use disorder.³⁶ Factors like these have led Carl Hart, professor of Psychology at Columbia University, to argue that the "diseased brain" perspective on addiction has overshadowed consideration of "psychosocial determinants" of addiction, such as employment status, racial discrimination, and neighborhood characteristics.³⁷

62% of people who misused pain relievers in 2016 said that the main reason was to relieve physical pain.

As opioid prescription rates proliferated, so did cases of fatal overdoses from these drugs. Overdose deaths involving prescription opioids increased from 1.3 deaths per 100,000 people in 1999 to 4.9 deaths per 100,000 people in 2015.³⁸

But recent efforts to reduce overprescribing and misuse of prescription opioids have helped to stem the growth of overdose deaths from these drugs. The DEA, working along with local law enforcement, started cracking down on pill mills in Florida in 2010, a state well-known for its high rate of overprescribing. Known as Operation Pill Nation, this crackdown suspended the medical licenses of healthcare providers responsible for prescriptions that were misused or diverted to others for non-medical use. The Florida crackdowns continued until 2012,³⁹ and since then, the DEA has continued efforts in other states such as Arkansas, Alabama, Louisiana, and Mississippi.⁴⁰ Pharmaceutical companies have also sought to deter misuse of opioids by developing pills that are difficult to crush and snort or

Figure 2. Commonly prescribed opioid sales and overdose deaths, 2001-2015



Source: Centers for Disease Control and Prevention, Multiple Cause of Death Files 2001-2015 on CDC WONDER Online Database. Available at: <http://wonder.cdc.gov/mcd-icd10.html>; Drug Enforcement Agency, ARCOS Retail Drug Summary Reports, 2001-2015. Available at https://www.deadiversion.usdoj.gov/arcos/retail_drug_summary/index.html; Von Korff, M., et al. (2008). De Facto Long-term Opioid Therapy for Non-Cancer Pain The Clinical Journal of Pain, 24(6), Pgs. 521–527; U.S. Census Bureau, Intercensal Population Estimates for the United States, 2000-2016. Available at <https://www.census.gov/en.html>.

Note: Age-adjusted death rates are based on the following ICD-10 Codes: T40.2 (Other opioids) and T40.3 (Methadone). Sales are of codeine, fentanyl, hydrocodone, hydromorphone, meperidine, methadone, morphine, and oxycodone to pharmacies, hospitals, and practitioners standardized to morphine milligram equivalents following method outlined in Paulozzi, L.J., Jones, C.M., Mack, K.A., Rudd, R.A. (2011, November 4). Vital Signs: Overdoses of Prescription Opioid Pain Relievers --- United States, 1999–2008. Morbidity and Mortality Weekly Report, 60(43), Pgs. 1487-1492.

inject.⁴¹ Efforts like these have produced modest improvements:

- National retail opioid prescribing rates peaked in 2010, at 782 morphine milligram equivalents (MME) per capita, then declined to 640 MME per capita in 2015—an 18% decline, but a rate that is still three times as high as in 1999.⁴²
- Deaths from the most commonly prescribed opioid pain relievers peaked in 2011, at 5.1 deaths per 100,000 people, and declined to 4.9 per 100,000 in 2015—a 4% reduction.⁴³

But overdose deaths from heroin and synthetic opioids have tripled since 2011, with fatalities from each of these drug categories exceeding those from prescription painkillers in 2016.⁴⁴ These drugs offer greater—though unpredictable—potency, lower price, and greater accessibility than prescription opioids.⁴⁵ Although some observers have associated the spike in heroin and synthetic opioid deaths with the reduced supply of prescription opioids,⁴⁶ CDC researchers state: “There is no evidence that policies designed to reduce inappropriate opioid prescribing are leading to these increases.”⁴⁷

“There is no evidence that policies designed to reduce inappropriate opioid prescribing are leading to increases in heroin and synthetic opioid deaths.”

– CDC researchers

In most states, heroin use was already increasing before the implementation of these reforms, and in states such as Florida, researchers have found that the reduction in overdose deaths from prescription opioids far outnumbered the increase in heroin deaths.⁴⁸ One study found that while some people in Florida may have switched from prescription to alternative opioids:⁴⁹

the effect of such a switch was limited: 668 fewer opioid analgesic overdose deaths occurred in 2012, compared with 60 more heroin deaths. Heroin deaths fluctuated widely during 2003–2012, so other factors might be involved. Moreover, other states that did not experience declines in prescription opioid deaths have reported increases in heroin overdose deaths during 2010–2012.

As Dr. Wilson M. Compton, Deputy Director of the National Institute on Drug Abuse, has written with colleagues, “heroin market forces, including increased accessibility, reduced price, and high purity of heroin appear to be major drivers of the recent increases in rates of heroin use.”⁵⁰ Still, the recent uptick in heroin and synthetic opioid overdose deaths underscores the need not just for preventative measures but also for expansion of effective drug treatment for those with opioid use disorder.

THE TREATMENT GAP IN THE GENERAL POPULATION

The opioid crisis is exacerbated by the gap between the number of people who seek treatment for an opioid use disorder and the number who receive it. When it comes to substance use disorders in general, few people in the United States receive professional treatment: an estimated 10.6% of those with drug or alcohol use disorders received treatment at a specialty facility in 2016.⁵¹ A similar proportion (10.8%) of people with opioid use disorders received professional treatment in 2015.⁵² One study found that just 21.5% of people with opioid use disorder received *any* treatment between 2009 and 2013—including non-professional treatment such as through self-help groups.⁵³ Surveys reveal that while nearly half of people with substance use disorder did not seek out professional treatment because they were not ready or did not want it, one-third did not do so because they lacked health care coverage or could not afford the cost.⁵⁴ As described below, even people with health insurance or in treatment programs often struggle to access medication-assisted treatment with methadone or buprenorphine, which combined with professional counseling and behavioral therapy is the most effective treatment for dependence on heroin and other illicit opioids.⁵⁵

As recognized by the World Health Organization: “In the context of high-quality, supervised and well-organized treatment services ... [methadone or buprenorphine] interrupt the cycle of intoxication and withdrawal, greatly reducing heroin and other illicit opioid use, crime and the risk of death through overdose,” and are a tool in the prevention and care of HIV/AIDS.⁵⁶ As the Substance Abuse and Mental Health Services Administration

explains, these treatment programs, which may last from a few months to a lifetime, provide “a safe and controlled level of medication to overcome the use of an abused opioid,” and have no adverse effects on a person’s intelligence, mental capability, or physical functioning, while enabling full recovery.⁵⁷

Lack of health insurance coverage has been a major driver of the treatment gap. Professor Richard G. Frank, a health economics professor at Harvard Medical School, explains that those most affected by opioid use disorder “are also the least likely to have coverage for and access to adequate treatment options.”⁵⁸ His analysis of the 2015 National Survey on Drug Use and Health reveals that among U.S. residents aged 18 to 64, those with incomes below the federal poverty level (FPL) were 47% more likely to have an opioid use disorder than the non-poor (those with incomes above 200% of the FPL).⁵⁹ In addition, Frank estimates that prior to the Affordable Care Act (ACA), over a third of U.S. residents aged 18 to 64 with incomes at or below 200% of the poverty rate lacked health insurance coverage—over

three times the uninsured rate of people above that income level.⁶⁰

The Affordable Care Act has significantly improved these disparities in access to

treatment, although the ACA has been targeted for repeal and 18 states have not expanded Medicaid’s reach.⁶¹ Roughly 220,000 people with opioid use disorder have gained insurance coverage as a result of the ACA.⁶² Nationwide, Medicaid expansion is estimated to have increased the treatment rate for low-income people with substance use disorder from 8.8% to 9.7%.⁶³ Medicaid expansion under the ACA has dramatically increased the number of people receiving treatment for a substance use disorder in states including Kentucky and West Virginia, and has enabled treatment centers in New Hampshire to expand capacity.⁶⁴ While treatment rates for people with opioid use disorder have yet to increase at a statistically significant level nationwide, people are increasingly turning to professional treatment and relying on insurance to do so.⁶⁵

Dr. Thomas R. Frieden, who led the CDC during the Obama Administration, has indicated that currently “it is easier for most patients to get opioids than treatment for addiction.”⁶⁶ For example, medication-assisted treatment is covered by Medicare when it is deemed

“It is easier for most patients to get opioids than treatment for addiction.”

medically necessary and if it is provided in an inpatient or outpatient Medicare-certified treatment service. Coverage for MAT under Medicaid varies state by state, and is subject to rules about prior authorization or medical necessity.⁶⁷ “Hardest-hit states like West Virginia and Kentucky prohibit Medicaid coverage of methadone maintenance, while insurance preauthorization prevents low threshold access among privately insured patients,” write public health scholars Nabarun Dasgupta, Leo Beletsky, and Daniel Ciccarone.⁶⁸ The American Medical Association states that insurance requirements for patients to receive preauthorization to access MAT creates a barrier to treatment.⁶⁹

Another component of the treatment gap has been the shortage in the supply of treatment services. A 2015 study published in the *American Journal of Public Health* found that while the capacity to provide medication-assisted treatment with methadone or buprenorphine increased since 2003, there was not enough capacity to treat an estimated one million people with opioid use disorder in 2012.⁷⁰ Treatment capacity was lowest in states outside of the northeast. Overall, the study revealed an inadequate growth in the number of federally regulated opioid treatment programs which administer methadone and in the number of physicians who could, and would, use their waiver under the Drug Addiction Treatment Act of 2000 to prescribe buprenorphine. This gap between capacity and demand help to explain why many drug treatment facilities have had waiting lists of weeks or months.⁷¹

THE TREATMENT GAP IN THE CRIMINAL JUSTICE SYSTEM

The treatment gap persists among people who are entangled in the criminal justice system, with few receiving structured and professional treatment services. The Bureau of Justice Statistics reports that 58% of people in state prisons and 63% of those serving jail sentences between 2007 and 2009 reported having a drug use disorder in the year prior to their admission.⁷² These levels were over 10 times as high as that of the general population, after statistically standardizing to match these populations by sex, race/ethnicity, and age.⁷³ But only about one-quarter of incarcerated people who had a drug use disorder reported participating in *any* drug treatment program while serving a sentence in prison or jail.⁷⁴

Moreover, less than one-fifth of people with drug use disorders received *professional* treatment while incarcerated, including treatment in a special residential facility, professional counseling, placement in a detoxification unit, or use of a maintenance drug.⁷⁵ Others receiving drug treatment participated in programs such as a self-help group, peer counseling, or education programs. As Columbia University’s National Center on Addiction and Substance Abuse has noted, adjunct services such as mutual support/peer counseling and drug education “are unlikely to create lasting behavioral changes among those in need of addiction treatment.”⁷⁶

Table 1. Rate of drug treatment since prison or jail admission among incarcerated people with drug use disorder

Criminal justice environment	Any drug treatment	Professional drug treatment
Jails (sentenced)	22%	14%
State prisons	28%	15%
Federal prisons	49%	17%
Probation or parole supervision	35%	30%

Note: Federal prison data is from 2004, professional drug treatment rate among those under community supervision is from 2006, and other data are from 2007–2009. Drug treatment rates are since admission to jails and prisons and in the past year for those under community supervision.

Sources: Bronson, J., Stroop, J., Zimmer, S., & Berzofsky, M. (2017). Drug Use, Dependence, and Abuse Among State Prisoners and Jail Inmates, 2007-2009. Retrieved from <https://www.bjs.gov/content/pub/pdf/dudaspi0709.pdf>; Mumola, C.J., Karberg, J.C. (2006). Drug Use and Dependence, State and Federal Prisoners, 2004. Retrieved from <https://www.bjs.gov/content/pub/pdf/dudsfp04.pdf>; Sung, H.-E., Mahoney, A. M., & Mellow, J. (2011). Substance Abuse Treatment Gap Among Adult Parolees: Prevalence, Correlates, and Barriers. *Criminal Justice Review*, 36(1), 40-57.

In fact, the vast majority of prisons and jails around the country fail to provide methadone and buprenorphine, despite evidence of their effectiveness.⁷⁷ Notably, the Bureau of Prisons does not have an established medication-assisted treatment program in its prisons, though it has conducted a field trial to provide this treatment to individuals in the final months of their incarceration and had planned in 2016 to expand medication-assisted treatment in its reentry facilities.⁷⁸ The lack of effective drug treatment in prisons and jails interrupts the recovery process for people on medication-assisted treatment and endangers individuals with opioid use disorder, whose lowered tolerance during a period of incarceration elevates their risk of fatal overdose upon release.⁷⁹

III. RESPONSES TO THE CRISIS

Over the past decade the federal government has responded to the opioid crisis by increasing spending to expand access to naloxone and evidence-based treatment, pursued both preventative and punitive legislation, and created a task force to study different methods to combat the crisis. State responses have varied as well, from increasing access to naloxone for family and friends of individuals at risk of overdose to passing legislation that would allow a seller to be charged with homicide if a sale resulted in a fatal overdose.

FEDERAL RESPONSES

The Obama Administration and the 114th Congress sought to address the crisis as a public health issue when it passed the Comprehensive Addiction and Recovery Act (CARA) and instructed physicians to follow the CDC's prescribing guidelines. Within its first ten months, the Trump Administration declared a public health emergency, created a commission to study ways to combat the crisis and reversed charging and sentencing policy reforms that the Department of Justice initiated during the previous administration.

Opioid Policy During the Obama Administration

During the Obama Administration, both the president and Congress proposed treating the opioid crisis as a public health problem by urging physicians to reduce opioid overprescribing and by passing proactive legislation. In an August 2016 letter, Surgeon General Dr. Vivek Murthy urged physicians to combat the opioid crisis by following the CDC's prescribing guidelines, educating themselves on how to treat pain safely and effectively, and screening patients for opioid use disorder and connecting them to evidence-based treatment when needed. Dr. Murthy added: "We can shape how the rest of the country sees addiction by talking about and treating it as a chronic illness, not a moral failing."⁸⁰ The CDC prescribing guidelines state that using opioids to treat chronic pain should not be the first option nor a

routine treatment. Doctors should discuss and weigh risk factors with patients, and if they choose to prescribe opioids, they should start with a low prescription dosage, and prescribe no more than needed for acute pain.⁸¹ President Barrack Obama echoed Dr. Murthy by saying, "We can't fight this epidemic without eliminating stigma....This is an illness, and we've got to treat it as such."⁸²

The Obama Administration obtained modest additional spending in the federal budget to support its efforts to combat the crisis. The White House committed \$116 million and requested \$1.1 billion in new budget spending⁸³ from Congress to support evidence-based treatment, increase the number of physicians who can prescribe buprenorphine to treat opioid use disorder,⁸⁴ and acquire naloxone for states—a medication that counteracts an overdose.⁸⁵ The Affordable Care Act, President Obama's signature legislative achievement signed into law March 2010, helped to increase access to healthcare, mental health services, and professional treatment for opioid use disorder. The law also extended the provisions of the Mental Health Parity and Addiction Equity Act of 2008 to individual health insurance policies, requiring that insurers provide equal coverage for mental and physical illness—a provision that has required ongoing efforts to address noncompliance.⁸⁶

Additionally, Congress passed new legislation meant to address and counteract the crisis. In July 2016, President Obama signed CARA into law. CARA allows for the expansion of drug misuse prevention and education efforts, increases availability of naloxone to first responders and evidence-based treatment to incarcerated individuals, launches medication-assisted treatment (MAT) and intervention demonstration programs, and strengthens state-level prescription drug monitoring programs.⁸⁷ It authorized \$181 million each year in new funding to combat the crisis, though funds must be appropriated each year by Congress. Lastly, President Obama signed the 21st Century Cures Act in December 2016, which provides grants to states to

provide treatment for individuals with opioid use disorder and encourages courts to direct individuals suffering from substance use disorders to treatment instead of incarceration.⁸⁸

Opioid Policy During the Trump Administration

During its first ten months, the Trump Administration and the 115th Congress have declared a public health emergency, studied the opioid crisis, sought to repeal the Affordable Care Act, and proposed increasing prison terms for the sale of synthetic opioids.

In March 2017, the Trump Administration created the Commission on Combating Drug Addiction and the Opioid Crisis, led by New Jersey Governor Chris Christie, to study ways to combat the opioid crisis. In its final report issued November 2017, the commission recommended “comprehensive action,” including:⁸⁹

- Regulating the health insurance industry to disincentive overprescribing of opioids
- Increasing access to MAT
- “Ensuring life-saving access to affordable health care benefits” for people with substance use disorder
- Aggressively enforcing the Mental Health Parity and Addiction Equity Act
- Increasing training for doctors who prescribe opioids
- Increasing data sharing among state-based prescription drug monitoring programs
- Equipping all law enforcement officers with naloxone
- Expanding drug courts and creating stronger penalties for selling fentanyl.

The commission did not identify new funding to combat the crisis, but recommended creating block grants for states.⁹⁰ In its interim report issued July 2017, the commission had stated that its “first and most urgent” recommendation was for President Donald Trump to immediately declare the opioid crisis a national emergency, which would allocate billions of federal dollars to the issue.⁹¹ In October 2017, President Trump directed the Department of Health and Human Services to declare the opioid crisis a *public health* emergency. The directive, which does not allocate a significant

amount of additional funds, implements changes such as rolling back a rule preventing Medicaid funding from being used for drug treatment in large inpatient facilities, while leaving in place the restriction on Medicaid funds for treatment in jails and prisons.⁹² The President also committed to “really tough, really big, really great advertising” to deter drug use among youth, despite the limited efficacy—and potential “boomerang effect”—of such programs in the past.⁹³

The Trump Administration and members of Congress have also pursued measures to repeal the ACA. Repealing the ACA would have significant ramifications on accessibility to treatment for individuals suffering from opioid use disorder, leaving roughly 220,000 such individuals without insurance coverage, and leaving many with private insurance plans that no longer cover treatment for opioid use disorder.⁹⁴ Medicaid expansion also assists individuals in paying for naloxone to prevent overdoses.⁹⁵ The CBO and the Joint Tax Committee estimate the number of uninsured would increase by 17 million in 2018 and increase to 27 million by 2020 with the passage of the Obamacare Repeal Reconciliation Act of 2017 and the elimination of the ACA’s expansion of eligibility for Medicaid and subsidies for insurance purchased through the marketplaces.⁹⁶ Such a change would reduce access to healthcare and mental health services that assist in preventing opioid use disorder.

Attorney General Jeff Sessions and members of Congress are also taking a more punitive approach to this crisis. In May 2017, Sessions reversed former Attorney General Eric Holder’s charging guidance and called for prosecutors to pursue the harshest penalty possible in all federal cases, not just the most serious.⁹⁷ While speaking at a police academy in Ohio in August 2017, Sessions said, “We must not capitulate intellectually or morally to drug use. We must create a culture that is hostile to drug abuse.”⁹⁸ In addition to targeting drug sellers, Sessions has also launched an Opioid Fraud and Abuse Detection Unit comprised of 12 prosecutors who will target pharmaceutical companies and doctors who are profiting from the crisis.

In Congress, Senators Dianne Feinstein (D-CA) and Chuck Grassley (R-IA) introduced the Stop the Importation and Trafficking of Synthetic Analogues (SITSA) Act of 2017 (S1327) which creates a new category of controlled substances, known as Schedule

A. The new category would include substances that have a structure similar to a pre-existing controlled substance. The legislation would apply existing criminal penalties for sellers and manufacturers of Schedule III substances to sellers and manufacturers of Schedule A substances.⁹⁹ The bill would also increase the power of the Attorney General to ban a wide array of synthetic drugs.¹⁰⁰ The House Judiciary Committee passed a similar version of the bill (H.R.2851) in 2017.¹⁰¹

STATE RESPONSES

State responses to the opioid crisis include expanding access to naloxone and drug treatment, limiting prescriptions, increasing penalties for use and sale of opioids, and charging sellers with homicide when a sale results in an overdose death.

Treatment and Prevention

States are working to combat the opioid crisis with an emphasis on prevention and treatment through measures including:

Increasing access to naloxone:

- West Virginia passed legislation in 2015 that allowed emergency responders, medical personnel, and family and friends of individuals with opioid use disorders to administer naloxone.¹⁰²
- Pennsylvania will allocate \$5 million from the 2017-2018 budget to provide naloxone to first responders.¹⁰³
- As of 2015, 38 states including Alabama, Idaho, and Kentucky had third-party prescription laws allowing family members or friends of individuals with opioid use disorder to be prescribed naloxone.¹⁰⁴

Limiting prescriptions:

- Kentucky passed legislation (HB 333) in 2017 that created a three-day limit on certain narcotic prescriptions, such as OxyContin.¹⁰⁵
- New Jersey passed legislation (SB 3) in 2017 that reduced maximum prescribed quantity of opioids from 30 days to five days.¹⁰⁶
- Arizona Governor Doug Ducey signed an executive order limiting the supply of prescription opioids to seven days.¹⁰⁷

- Massachusetts and eight other states passed legislation limiting the supply of prescription opioids to seven days.¹⁰⁸

Expanding treatment accessibility:

- New Jersey passed SB 3 in 2017 which mandates that insurers cover 180 days of treatment without preauthorization.¹⁰⁹

Punishment

Despite broader efforts to reform sentencing for drug offenses, state lawmakers and prosecutors are also increasing already harsh penalties to combat the opioid crisis by:

Increasing penalties for use and sale:

- Louisiana passed legislation in 2014 that increased the penalty for repeat offenses of selling heroin from 50 to 99 years in prison. The mandatory minimum sentence for a first-time conviction of the drug was increased from five to 10 years.¹¹⁰
- Kentucky passed legislation (HB 333) in 2017 that increased penalties for selling heroin, carfentanil, and fentanyl.¹¹¹ The prison sentence for a first-time heroin sale was increased from 1-5 years to 5-10 years, with delayed parole eligibility, and the sentence for sharing any amount of heroin became five to 10 years.¹¹²
- Maryland passed HB 539 in 2017 which increased penalties for fentanyl and other controlled substances.¹¹³
- Florida state legislators imposed a mandatory three-year sentence for possession of four or more grams of fentanyl and a mandatory 15-year sentence for possession of 14 or more grams.¹¹⁴

Charging sellers with homicide:

- Florida passed legislation (CS/HB 477) in 2017 that allows prosecutors to charge individuals who sell heroin, fentanyl, or carfentanil that leads to a fatal overdose with first-degree murder, though there are questions about whether or not the death penalty would be allowed for those convicted.¹¹⁵

- Maryland prosecutors charged six accused sellers with murder in August 2017 after six overdoses on drugs such as fentanyl, heroin, and carfentanil.¹¹⁶ The seriousness of the original charges will likely result in a more severe penalty even if these individuals are ultimately convicted of lesser offenses.
- Massachusetts prosecutors are considering charging individuals who sold an opioid that led to a fatal overdose with homicide and manslaughter, with sentences ranging from five years to life.¹¹⁷ In addition, Governor Charlie Baker proposed that drug sales resulting in death be treated as manslaughter with a mandatory minimum of five years and a maximum of life.¹¹⁸

IV. LESSONS FROM PREVIOUS DRUG CRISES

Earlier drug crises, involving heroin in the 1970s and crack cocaine in the 1980s and 1990s, elicited an even less compassionate response from both policymakers and the media. Rather than applying a medical or public health framework, these drug crises were framed as failures of individuals' moral character, were believed to fuel crime and to therefore require criminal justice interventions. Policymakers' bias and lack of empathy toward the affected populations likely shaped this punitive emphasis. "When the perception of the user population is primarily people of color, then the response is to demonize and punish," explains Marc Mauer.¹¹⁹ Yet, as described below, the War on Drugs produced limited benefit at great financial and human cost, especially among urban communities of color. Growing awareness of these facts has encouraged policymakers and criminal justice practitioners to slowly wind down the drug war. One result has been a 22% percent decline in the number of people imprisoned for a drug offense since 2007, when U.S. prisons held their greatest number of people with drug convictions.

POPULATIONS AFFECTED BY CURRENT AND PAST DRUG CRISES

Unlike the heroin and crack crises of the past, the current opioid emergency has disproportionately affected white Americans—both rural and poor, but also suburban and middle class or affluent. The disproportionate impact of opioids on whites is reflected in several measures of the current crisis:

- A 2014 study published in the journal *JAMA Psychiatry* found that 90% of recent heroin users entering treatment programs in the previous decade had been white, while "whites and nonwhites were equally represented in those initiating use prior to the 1980s."¹²⁰

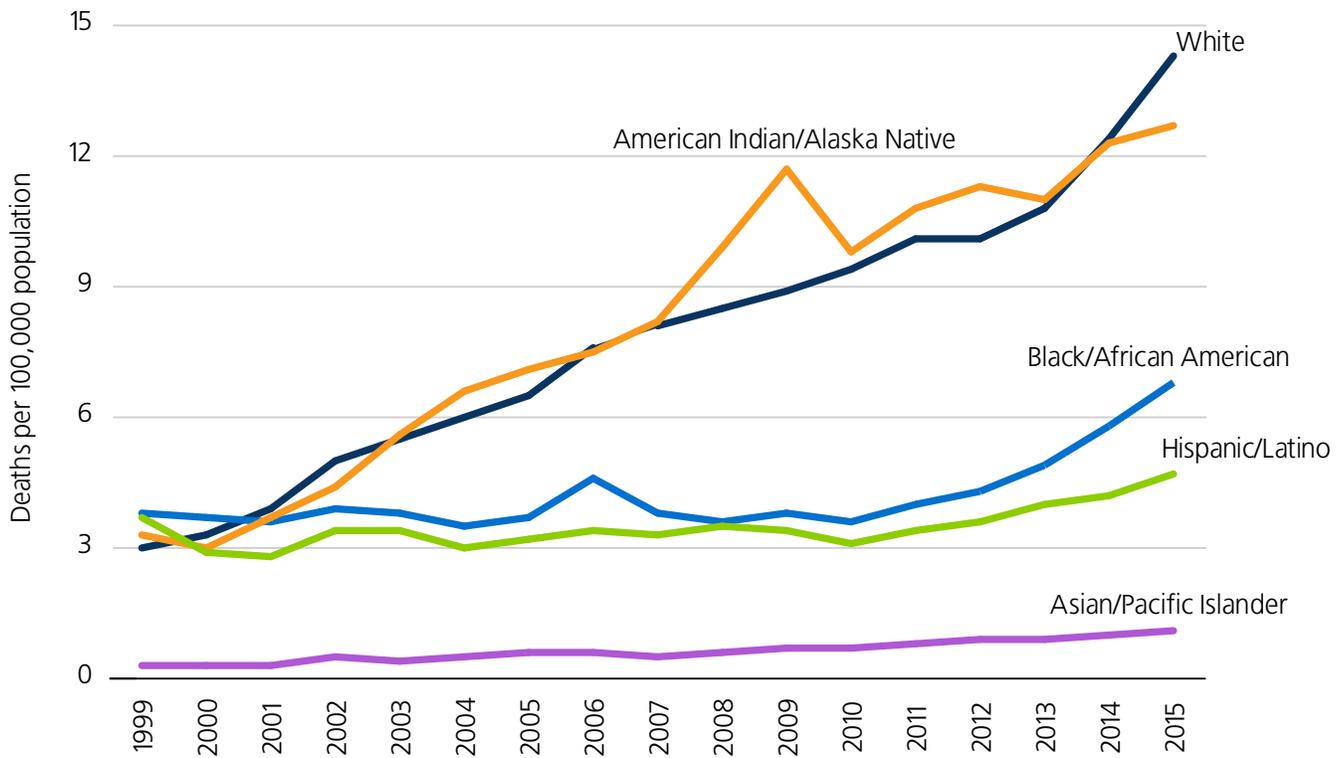
- In 2015, the prevalence of opioid use disorder among whites was 88% higher than that of African Americans, and 42% higher than that of Hispanics.¹²¹
- Finally, while recent opioid overdose deaths have risen for whites, blacks, and Hispanics, they have increased to a far greater extent for whites. The Kaiser Family Foundation's analysis of CDC data reveal that in 2015, non-Hispanic whites accounted for 82% of opioid overdose deaths, while comprising 62% of the U.S. population.¹²² Though they have largely been overlooked in the public debate and framing of this crisis, it is important to note that Native Americans have had a higher rate of opioid overdose deaths than whites in recent years.¹²³

In contrast, even though whites comprised the majority of heroin and crack users in the past, rates of crack usage for blacks exceeded those among whites during parts of the 1980s and 1990s—though not nearly at the disproportionate levels at which blacks in urban areas were arrested and incarcerated.¹²⁴ Both enforcement responses and media portrayals of these past drug crises largely focused on urban communities of color.

Bias and inequality are, ironically, part of the reason that people of color have not been impacted by the opioid crisis as much as whites. Due to differential access to healthcare services and to bias in healthcare settings, black and Latino patients have been and remain under-treated for pain. For example, a 2008 *JAMA* study found that people of color were less likely to receive opioids for pain in emergency departments compared to whites.¹²⁵ These disparities have helped to prevent higher levels of opioid use disorder among people of color.

Bias and inequality also help to explain the greater willingness of the public and policymakers to apply a

Figure 3. Opioid death rate by race, 1999-2015



Source: Centers for Disease Control and Prevention, Multiple Cause of Death Files 1999-2015 on CDC WONDER Online Database. Available at: <http://wonder.cdc.gov/mcd-icd10.html>.
 Note: Using age-adjusted rates and the following ICD-10 Codes: T40.0 (Opium), T40.1 (Heroin), T40.2 (Other opioids), T40.3 (Methadone), T40.4 (Other synthetic narcotics), T40.6 (Other and unspecified narcotics). Hispanics / Latinos are included only in the Hispanics / Latinos category.

public health framework to the current opioid crisis than to drug use disorders in the past. Researchers have shown that when white Americans associate crime with people of color, they are more supportive of punitive criminal justice policies.¹²⁶ Not only does the association of this drug crisis with whites help to promote treatment and prevention as policy responses, so too does the greater proximity of white Americans to the policymaking process. As a 2016 article in the *New York Times* describes:¹²⁷

the growing army of families of those lost to heroin—many of them in the suburbs and small towns—are now using their influence, anger and grief to cushion the country’s approach to drugs, from altering the language around addiction to prodding government to treat it not as a crime, but as a disease....Their efforts also include lobbying statehouses, holding rallies and starting nonprofit organizations, making these mothers and fathers part of a growing backlash against the harsh tactics of traditional drug enforcement.

The proximity of the opioid crisis to people in power was especially evident during the 2016 presidential election, when GOP candidates sought to highlight their connection to the broad reach of the opioid crisis, and substance use disorder in general. During their campaigns, Donald Trump, Ted Cruz, Jeb Bush, Chris Christie, and Carly Fiorina all recounted their personal experience with children, family, or close friends who struggled with or died from various forms of substance use disorder.¹²⁸

While the opioid crisis’s association with whites has to some extent mitigated punitive policy responses, experts caution that this does little to prevent the development of “one drug policy for white users and another for black users.”¹²⁹ This is because drug enforcement and incarceration patterns have long failed to reflect drug consumption and sales patterns. Data from the United States Sentencing Commission reveal that in 2016, whites comprised just 17% of the 2,826 people who received a federal prison sentence for a heroin offense, while blacks and Hispanics made up 82% of this group.¹³⁰ In addition, while whites made up

a majority (55%) of the 547 federal prison sentences for selling oxycodone in 2016, blacks accounted for 32%.¹³¹ While nearly all of these sentences were for drug sales, rather than possession, many studies suggest that drug users generally purchase drugs from people of the same race or ethnicity as them.¹³²

More generally for all illicit drugs, while people across racial and ethnic lines use drugs at roughly similar rates and tend to buy drugs from people of the same race or ethnicity, 56% of people serving time in state and federal prisons for drug offenses are black or Latino—nearly double their share of the US population.¹³³ This discrepancy exists even for police enforcement of marijuana possession: A 2013 ACLU report found that despite comparable rates of reported marijuana use, blacks were arrested for marijuana possession at 3.7 times the rate of whites nationwide.¹³⁴

MEDIA COVERAGE

“There is a clear double standard in the visual framing of the opioid crisis,” writes Michael Shaw in the *Columbia Journalism Review*.¹³⁵

Photos of the opioid crisis in media reports tend to depict well-lit spaces, stress domesticity, and emphasize close-knit communities. In contrast, pictures of past urban drug problems tended to depict nighttime scenes on seedy streets or portrayed individuals interacting with the police, courts, or jails—often using starker black and white photography. In content and in visual framing, media coverage of the current opioid crisis portrays it as an outside threat and focuses on treatment and recovery, while stories of heroin in the 1970s and crack-cocaine in the 1980s focused on the drug user’s morality.

“The racial bias is inescapable,” writes Shaw, attributing the “kinder and gentler” tone around the opioid crisis to its disproportionate impact on suburban and rural whites while earlier periods of heroin and crack use were seen as problems affecting low-income people of color. These differences in coverage likely reflect and help to shape differences in preferred policy solutions to these problems.

LESSONS LEARNED FROM THE WAR ON DRUGS

The responses to earlier drug crises are well known. After President Richard Nixon declared that “America’s public enemy number one in the United States is drug abuse,” the federal government, states, and localities dramatically ramped up law enforcement and punishment for the next three decades, while allocating limited resources to prevention and treatment.¹³⁶ Years after working as one of Nixon’s top aides, John Ehrlichman revealed that the administration was specifically using the drug war to target African Americans and the anti-war left: “We knew we couldn’t make it illegal to be either against the war or black, but by getting the public to associate the hippies with marijuana and blacks with heroin, and then criminalizing both heavily, we could disrupt those communities.”¹³⁷

“There is widespread agreement that addicted persons should be offered treatment services rather than prosecution.”

— Police Executive Research Forum

The rate of drug arrests grew by 162% from 1980 to 2006, with nearly 1.9 million arrests made for drug law violations in that final peak year—more than for any other offense.¹³⁸ The racial disparity in drug arrests

reached a peak in 1989, with black Americans four times as likely as whites to be arrested for a drug offense—a disparity that was “unrelated to relative rates of drug use and the limited available evidence on drug dealing.”¹³⁹ Moreover, drug arrests were more likely than in the past to result in imprisonment, and mandatory-minimum and “truth-in-sentencing” laws prolonged prison terms.¹⁴⁰ As a result of these policy changes, the number of people imprisoned nationwide for drug offenses skyrocketed from 24,000 in 1980 to a peak of 369,000 in 2007.¹⁴¹

Yet the War on Drugs did not play a major role in ebbing cycles of drug use. Following a comprehensive review of research, a 2014 report by the National Research Council concluded: “The best empirical evidence suggests that the successive iterations of the war on drugs—through a substantial public policy effort—are unlikely to have markedly or clearly reduced drug crime over the past three decades.”¹⁴² *New York Times* reporter Timothy Egan’s assessment of the nationwide crack crisis in 1999 illustrates how this drug ran its course

Figure 4. State prison population with drug convictions

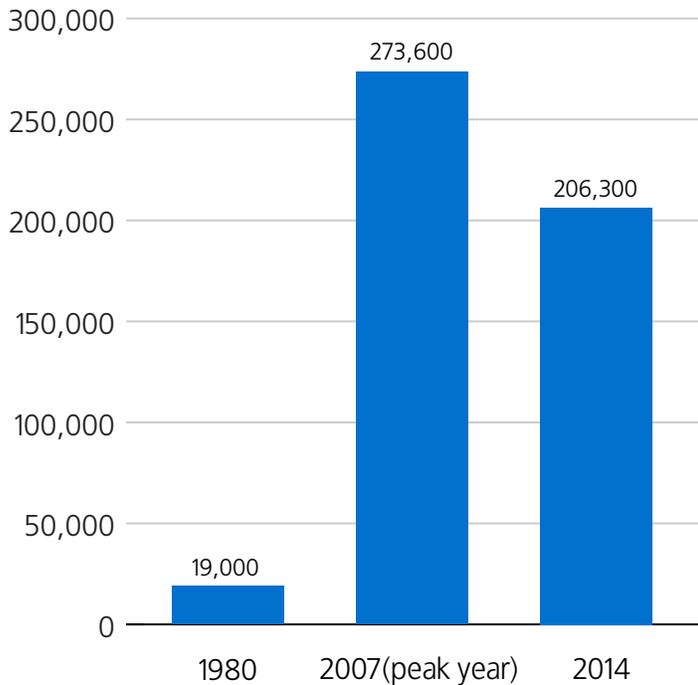
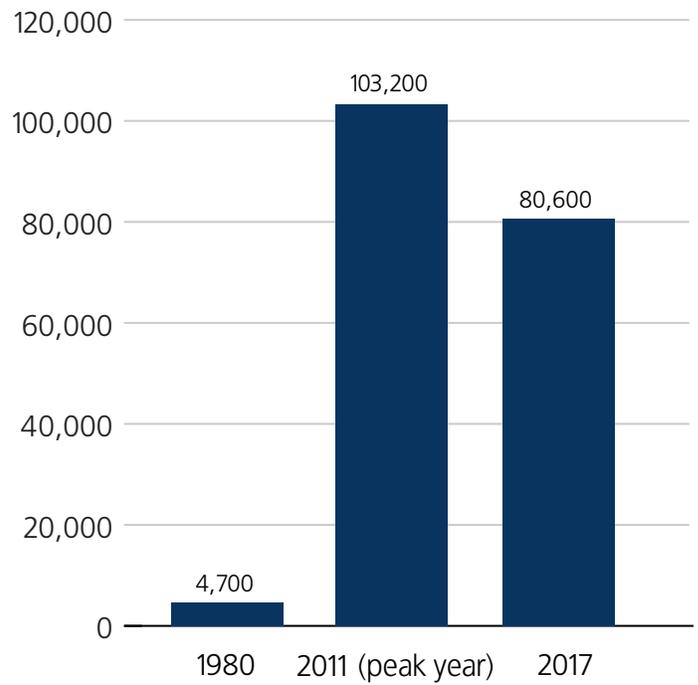


Figure 5. Federal prison population with drug convictions



Source: Bureau of Justice Statistics *Prisoners Series* and the Federal Bureau of Prisons as detailed in notes 141, 152, and 155.

for reasons other than criminal justice interventions. Egan compares the crack crisis with a fever. “It came on strong, appearing to rise without hesitation, and then broke, just as the most dire warnings were being sounded.”¹⁴³ As they aged, crack users eventually desisted from using the drug, and younger people spurned the drug upon seeing its devastating effects—in what is known as the “younger sibling” effect.¹⁴⁴ Aggressive law enforcement did not deter longtime users from the drug or eliminate adaptable drug markets, as revealed by anecdotes of police chiefs, surveys of past users, and comparisons across cities. For example, Egan notes that while declining crack use in New York City coincided with a massive buildup of arrests, Washington D.C. outpaced New York’s decline in cocaine use among young residents even though D.C. police reduced drug arrests in some years. Nevertheless, as Michael Tonry has argued, “the most intrusive laws and the cruelest penalties tend to be enacted *after* intolerance [toward the drug] has reached its peak and when drug use is already falling.”¹⁴⁵

Despite its limited benefits, the War on Drugs has levied an extraordinarily high economic and social toll—disproportionately on low-income communities of color and with lifelong consequences on employment and access to housing, education, and federal benefits.¹⁴⁶ Growing recognition of these consequences has informed recent reforms in law enforcement and sentencing. White House Drug Czar Gil Kerlikowske began to question the “War on Drugs” language in 2009, stating: “Regardless of how you try to explain to people it’s a ‘war on drugs’ or a ‘war on a product,’ people see a war as a war on them.... We’re not at war with people in this country.”¹⁴⁷ By 2014, the majority of Americans supported easing criminal punishment for drug offenses.¹⁴⁸ While still extraordinarily high and largely for possession rather than sales, the number of drug arrests declined by 17% between 2006 and 2016, to just under 1.6 million.¹⁴⁹ In 2017, following a conference with 150 officials from across the country, the Police Executive Research Forum reported, “There is widespread agreement that addicted persons should be offered treatment services rather than prosecution.”¹⁵⁰

Nearly all states and the federal government have reformed their criminal justice policies in recent years, and several states have dramatically downsized their prison populations, largely by reducing the number of people imprisoned for drug offenses.¹⁵¹ In fact, the number of people serving state prison sentences for drug offenses fell by 25% from a peak level of 274,000 in 2007 to 206,000 in 2014, the most recent year for which data were available.¹⁵² These reforms have occurred alongside improvements to public safety. For example, New York City has dramatically reduced misdemeanor and felony drug arrests, the number of people incarcerated for drug offenses, and its violent crime rate at the same time.¹⁵³

Prior to and during Obama's presidency, several branches of the federal government also worked to reduce excessive incarceration for federal drug offenses.¹⁵⁴ These reforms helped to reduce the number of people serving federal prison sentences for drug offenses by 22%, from a peak of 103,000 people in 2011 to 81,000 in September 2017.¹⁵⁵ Lastly, during this period of nationwide decarceration, racial and ethnic disparities in imprisonment have declined for both men and women.¹⁵⁶

V. RECOMMENDATIONS

To end the opioid crisis, policymakers can turn to several evidence-based approaches to prevent and treat opioid use disorder. As described below, these efforts include policies to reduce opioid use—by ending the overprescribing of opioids and expanding access to effective treatment for substance use disorder—as well as harm-reduction measures that seek to reduce overdose deaths among people with substance use disorder. Given that incarceration of drug users and sellers is not an effective remedy for substance use disorder, policymakers and criminal justice professionals should continue to reduce the number of people incarcerated for drug offenses, rather than ratchet up enforcement and penalties for using or selling opioids.¹⁵⁷

Since incarceration is not an effective remedy for substance use disorder, policymakers should continue to reduce the number of people incarcerated for drug offenses, rather than ratchet up enforcement and penalties for using or selling opioids.

Effectively ending the opioid crisis requires pursuing public health measures including:

ENDING OVERPRESCRIBING OF OPIOIDS

A key step in tackling the opioid crisis is to reverse the historically unprecedented and internationally anomalous rate at which U.S. physicians are prescribing opioids.

“If we change prescribing practices, we can change the face of the epidemic,” said former Surgeon General Vivek Murthy, regarding the overprescribing of opioid painkillers in 2016.¹⁵⁸ Ending overprescribing requires

educating physicians on proper dosages and prescription quantities, improving insurance and pharmacy policies, increasing the number and use of drug monitoring programs at the state level, along with other reforms described below.

To combat overprescribing, physicians should comply with the Center for Disease Control and Prevention’s recommendations about opioids prescription for acute and chronic pain, while ensuring that they do not exacerbate racial disparities in pain treatment. The CDC recommends that physicians ensure benefits outweigh risks, such as addiction, since opioid use is one of the strongest risk factors for heroin addiction. Additionally, when prescribing opioids, physicians should begin with a low dosage and only prescribe for the number of days the pain is expected.¹⁵⁹ There is limited research supporting long-term use of opioids to treat chronic pain, though research does support short-term use of opioids for acute pain.¹⁶⁰ The CDC also recommends that physicians set realistic goals for pain and function with patients and only consider opioid therapy when improvement with pain and function outweigh the risks associated with the medication, and that they re-evaluate benefits and risks one to four weeks after treatment begins.¹⁶¹

Insurance companies and pharmacies should implement policies to reduce overprescribing and prevent misuse of opioids. Private insurance plans, as well as Medicare and Medicaid, should increase access to medications that carry a lower risk of addiction or dependence, as well as non-drug treatments, such as physical therapy.¹⁶² Pharmacies can also play a role by limiting the dosage quantity for opioid prescriptions as well as requiring pharmacists to discuss the risks associated with the medication with patients. Starting February 2018, CVS will limit the number of opioid prescriptions to seven days for certain conditions and require pharmacists to discuss the risk of addiction, secure storage, and proper

disposal with patients.¹⁶³ In an effort to curb overprescribing, insurance company Cigna will stop covering the cost of the Purdue Pharma's OxyContin and will instead offer an alternative oxycodone from Collegium Pharmaceuticals, a company that has committed to reducing opioid overuse.¹⁶⁴

States should continue to utilize drug monitoring programs to identify patients who are at risk of an opioid use disorder and should evaluate the practices of workers' compensation programs. According to the CDC, prescription drug monitoring programs (PDMPs) are among the most promising methods of reducing opioid prescriptions, informing clinical practice, and assisting patients who may be at risk of an opioid use disorder—although research findings have been mixed.¹⁶⁵ Currently, the District of Columbia and 49 states have legislation that authorizes the use of drug monitoring programs as well as functional drug monitoring programs in place.¹⁶⁶ States should ensure that drug monitoring programs are up-to-date and easy to use, allowing providers to analyze a patient's prescription drug history and make informed decisions prior to prescribing opioid painkillers.¹⁶⁷ The CDC recommends physicians check PDMPs once every three months and prior to prescribing an opioid.¹⁶⁸ Regulators and physicians should use PDMPs to direct people misusing opioids to treatment and ensure that they do not “undermine trust between people with substance use problems and their providers, pushing vulnerable patients away from getting help at a time when they need it most.”¹⁶⁹

Additionally, states need to analyze the data and practices of workers' compensation programs to identify and diminish overprescribing. In Ohio, workers' compensation programs are being reformed to combat overprescribing. New rules state that reimbursement for opioid prescriptions can be denied if physicians are suspected of overprescribing and the Ohio Bureau of Workers is allowed to provide treatment for workers who developed an opioid use disorder after getting injured.¹⁷⁰

Drug companies must also be held accountable for their role in the crisis and federal law enforcement should prioritize ending illegal overselling in the prescription drug supply chain. The attorneys general of forty-one states have opened an investigation into

whether drug manufacturers and distributors deceived physicians and patients about the addictive nature of prescription opioids.¹⁷¹ Congress, instead of inhibiting enforcement against wholesale companies that made potentially illegal opioid sales to retail outlets, should work to curb this practice. The federal government should also continue to reduce the number of opioids that manufacturers are permitted to produce.¹⁷²

EXPANDING ACCESS TO TREATMENT FOR DRUG USE DISORDERS

Policymakers should close the treatment gap for both the general and incarcerated populations, and ensure investment in *effective* forms of treatment.

Increasing treatment rates for people with opioid use disorder in the general population requires continuing to expand health insurance coverage and ensuring coverage for MAT, in particular. Policymakers and criminal justice professionals should continue to end reliance on incarceration as a remedy for substance use disorder, and recognize that it is often not an effective means of reducing the supply of illicit drugs. They should also increase rates of *effective* drug treatment among those who do enter the criminal justice system.

General Population

To combat the opioid crisis, policymakers will need to ensure that people with opioid use disorder can access MAT—particularly methadone and buprenorphine—through their health insurance policies and they will need to expand the supply of treatment services. The CDC, the National Institute on Drug Abuse (NIDA), and the World Health Organization (WHO) all recommend increasing access to MAT in conjunction with behavioral counseling, because it is the most effective form of treatment for dependence on heroin and other illicit opioids.¹⁷³ Medication-assisted treatment, using methadone or buprenorphine, reduces an individual's need to use opioids as well as potentially mitigates withdrawal symptoms.¹⁷⁴ Methadone and buprenorphine are considered “essential medicines” by the WHO.¹⁷⁵ Naltrexone, another treatment medication, is best for individuals who have already withdrawn from opioids and hope to prevent relapse.¹⁷⁶ Dr. Nora Volkow, the director of NIDA, explains that MAT “decreases risk of

relapse – significantly. Second, MAT has also been shown to be effective in preventing infectious diseases like HIV. Third, medication-assisted therapy has been shown to be effective in preventing overdoses.¹⁷⁷ While access to MAT using methadone or buprenorphine has increased since 2003, there was still not enough capacity to treat approximately one million individuals with an opioid use disorder in 2012.¹⁷⁸

Given that lack of health care coverage is a major barrier to people receiving treatment for opioid use disorder, ending the opioid crisis requires preserving and expanding the increased rates of health insurance coverage achieved by the ACA. Health insurance coverage gives people access to healthcare and mental health services that serve as both preventative measures against opioid use disorder and as treatment. Between 2014 and early 2017, an estimated 1.6 million uninsured people with substance use disorders gained Medicaid coverage in 31 states and the District of Columbia under the ACA.¹⁷⁹ While the number of uninsured has declined, 18 states have yet to expand health care coverage through the ACA, and the law has faced repeated challenges.¹⁸⁰

Insurance plans should also improve access to effective treatment for opioid use disorder by meeting their legal obligations to adequately cover drug treatment costs and by removing prior-authorization requirements. The Trump opioid commission has recommended aggressively enforcing the Mental Health Parity and Addiction Equity Act, to ensure that coverage of treatment for substance use disorder and mental health illnesses are equitable with other medical care.¹⁸¹ Patrick Kennedy, the lead sponsor of the law and member of the Trump opioid commission, has called for “proactive enforcement of the law rather than the complaints-driven system that is currently in place,” and advocates recommend placing the burden of proof for compliance on insurers rather than on patients.¹⁸² States should also work with Medicaid and other insurance companies to provide coverage for and increase accessibility to MAT.¹⁸³ This can be done through Medicaid expansion and ending treatment preauthorization requirements. Cigna and Anthem, two insurance companies, reached separate agreements with New York Attorney General Eric Schneiderman that ended prior-authorization requirements making treatment much more accessible for individuals on their insurance plans.¹⁸⁴

Population in the Criminal Justice System

While people should ideally receive drug treatment in their communities, lawmakers and criminal justice professionals should ensure that incarcerated individuals with a substance use disorder receive effective treatment during their confinement. President Trump has endorsed the goal of “making addiction treatment available to those in prison.”¹⁸⁵ As described earlier, among people with drug use disorders, only between 14% – 17% of those serving jail, state, or federal prison sentences received professional treatment since their admission, including treatment in a special residential facility, professional counseling, placement in a detoxification unit, or use of a maintenance drug.¹⁸⁶ Reducing the number of people unnecessarily incarcerated would free up funds to dramatically increase participation rates in forms of drug treatment that have been shown to “create lasting behavioral changes.”¹⁸⁷

The Bureau of Prisons, with its large proportion of people serving drug sentences, should serve as a model in this area and end its resistance to medication-assisted treatment by following the Trump opioid commission’s recommendation to allow people in its prisons to access MAT.¹⁸⁸ Medication-assisted treatment, strongly endorsed by the CDC, NIDA, and WHO, does not produce a high and as NIDA explains regarding one form of MAT—buprenorphine—diversion for illicit use “is uncommon; when it does occur it is primarily used for managing withdrawal.”¹⁸⁹ States and counties should also be allowed to use federal financial participation (FFP)—the federal government’s contribution to Medicaid services—to collaborate with Medicaid providers to identify and treat those who were receiving community-based treatment prior to their incarceration.¹⁹⁰

Policymakers and criminal justice practitioners should also ensure that drug courts, which are intended to reduce incarceration levels for people with substance use disorder, are relying on effective forms of treatment and that treatment plans are not imposing unnecessary criminal convictions on their participants. According to Physicians for Human Rights, drug courts “routinely fail to provide adequate, medically-sound treatment for substance use disorders, with treatment plans that are at times designed and facilitated by individuals with little to no medical training.”¹⁹¹ Recent

reports have revealed that sales representatives for Alkermes, the manufacturer of Vivitrol, a monthly injection of naltrexone, may have persuaded judges to favor that drug even in cases in which it is inappropriate or ineffective, just as the company's lobbyists have done with some lawmakers.¹⁹² Judges are not trained medical professionals, which is why drug courts should follow the recommendation of the Substance Abuse and Mental Health Services Administration and the National Association of Drug Court Professionals that they provide all three medications approved by the Food and Drug Administration (FDA) to participants: methadone, buprenorphine, and naltrexone.¹⁹³ Though all three drugs are FDA-approved, NIDA states that naltrexone does not treat withdrawal symptoms like methadone and buprenorphine and should not be used with patients who have not yet detoxified.¹⁹⁴

To ensure that they are making a meaningful dent into mass incarceration, drug courts should focus on two key goals.¹⁹⁵ First, prioritize serving prison-bound cases, those in which the defendant would likely be sentenced to prison in the absence of a treatment intervention. Second, as is being done in some drug courts, establish admission criteria that include non-drug cases in which substance use disorder appears to be a causative factor contributing to criminal offending.

REDUCING OVERDOSE DEATHS

While use-reduction policies are important to mitigating the opioid crisis, it is also critical to reduce the harms caused by opioid use disorder.

Federal, state, and local policies should expand access to and training for administering naloxone to prevent overdose deaths.¹⁹⁶ The United States should also follow the lead of countries like Germany, Denmark, and Canada and implement supervised consumption sites to prevent overdose deaths among opioid users.¹⁹⁷

States should continue to work with stakeholders, such as advocates and pharmacies, to pass legislation that would expand access to naloxone to individuals with substance use disorder and those around them, first responders, police officers, and pharmacies. Administering naloxone to an individual who is experiencing an overdose can reverse the overdose and prevent death. Though naloxone has been a prescription medication, all 50 states and the District of Columbia

now have naloxone access laws.¹⁹⁸ Access laws vary state by state, with some allowing pharmacists to dispense naloxone without a prescription and others have increased accessibility to first responders.¹⁹⁹ The Police Executive Research Forum reported that 63% of police chiefs in its membership now employ trained officers to administer and carry naloxone.²⁰⁰ Naloxone access laws can also allow friends and relatives of people with opioid use disorder to access to naloxone through "third-party prescribing." Thirty-six states and the District of Columbia have given physicians immunity from criminal prosecution for prescribing, dispensing, or distributing naloxone to individuals other than a patient with a substance use disorder, though risk of prosecution is low.²⁰¹ Pharmacy chains such as CVS and Walgreens are also working to improve access and availability by having the medication available in their stores nationwide.²⁰²

Opioid overdose deaths could be further averted by continuing to expand third-party prescribing, which would require altering pharmacy regulations in several states, training those around opioid users on how to respond to an opioid overdose, and persuading people to not use heroin while alone.²⁰³ In addition, to combat overdose deaths for individuals being released from jails and prisons, these institutions should implement a take-home naloxone program similar to the National Naloxone Programme in Scotland which is associated with a 36% reduction in opioid-related deaths in the first four weeks following release from prison.²⁰⁴

To minimize the harm caused by heroin use, localities around the United States should create supervised consumption sites and syringe service programs, and educate individuals who are using opioids on the risks of mixing substances. There is need for greater public awareness that using alcohol or benzodiazepines, a type of drug typically used to treat anxiety, in conjunction with an opioid increases risk of hospitalization or death.²⁰⁵ Policymakers should also expand syringe services programs, which provide sterile syringes free of cost, HIV and Hepatitis C prevention materials, referral to substance use disorder treatment, and counseling.²⁰⁶

Supervised consumption sites are also a critical harm-reduction tool: in these facilities, individuals can legally use pre-obtained drugs with facility-provided sterile injection equipment under medical supervision. Years of research and evaluation show that these programs

are effective in reducing the number of overdose deaths and other adverse health, economic, and social consequences of drug use, while increasing drug treatment enrollment.²⁰⁷ In one study of a Vancouver safe injection site, overdose deaths near the site decreased by 35% in the two year period after its opening.²⁰⁸ Many cities around the world—in countries including Germany, Spain, and Canada—have operational supervised consumption sites.²⁰⁹ No supervised consumption sites are currently in operation in the United States. However, Seattle, Washington is currently trying to begin a three-year supervised consumption site pilot program.²¹⁰ San Francisco, Philadelphia, New York City, and Massachusetts are also considering the use of supervised consumption sites.²¹¹

ENDING THE DRUG WAR

Policy makers and criminal justice professionals should continue to significantly reduce the use of incarceration for all drug types and eliminate the collateral consequences imposed on people with drug convictions.

At the local and state level, this would include continuing to scale back arrests for drug offenses and implementing sentencing reforms, as many states have already begun doing.²¹² At the federal level, this would include making the Fair Sentencing Act of 2010 retroactive, so that people convicted prior to this law benefit from its sentencing reductions for crack cocaine offenses. In addition, to ameliorate the harms caused by the more punitive response to past drug crises and by ongoing enforcement, state and federal policymakers should ensure that people with felony drug convictions are not barred from federal benefits such as the Supplemental Nutrition Assistance Program and federal student aid.²¹³

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