THE STATE LEGISLATIVE LEADERS FOUNDATION

SLLF

Addressing the Opioid Crisis in America
Strategies that WORK!

April 6 – 8, 2017 New York, New York

SOME KEY POINTS from FRIDAY SESSIONS

9:00am	**Medication-Assisted Treatment for Opioid Addiction** Dr. Samuel Ball, CASA Paul Samuels, Legal Action Center Mark Parrino, AATOD Scott Breedlove, Missouri Credentialing Board
10:30am	**Creating Data-Driven Policy** Steve Kearney, SAS State and Local Government
11:00am	**Strategies for Increasing Access to Care** Peter Albert, BCBS of Vermont Dr. Stephen Korn, Anthem BCBS Hon. Ron Kim, NYS Assembly Hon. Linda Rosenthal, NYS Assembly
1:00pm	**Preventing Overdose Deaths** Sheriff John Tharp, Lucas County, Ohio Lieutenant Robert Chromik Jr, Lucas County, Ohio Dr. Gail D'Onofrio, Yale-New Haven Hospital
2:00pm	**The Politics of Addiction Treatment Reform** Gary Mendell, *Shatterproof* Hon. Helene Keeley, DE House of Representatives

SOME KEY POINTS from SATURDAY SESSIONS

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8:45am **Sentencing Alternatives and Approaches**
Natalie Walton-Anderson, Prosecutor, *LEAD*
Hon. Jan Jones, Georgia House of Representatives

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10:00am **A Personal Story of Addiction and Recovery**
Justin Luke Riley, Young People in Recovery

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Medication-Assisted Treatment

some key points from Friday's presentation:

MOST PEOPLE in need of treatment don't get it: only about 10% do, compared to about 70% of those who suffer from depression, for example. Patients may deny they have a problem; may wish to fix it on their own; may be concerned with the stigma of seeking treatment; treatment may not be locally available; a patient may not know how to find it; a patient may not be able to afford it. *We'd like to turn that 10% into 100%.*

And some things used as "treatments" are NOT EFFECTIVE BY THEMSELVES, for example detox, abstinence counseling, mutual support (12-Step) programs, and naloxone. *Effective treatment requires medication AND behavioral therapy.*

TREATMENT with MEDICATION is more than twice as effective as treatment without. But fewer than 20% of health providers include these medicines in their treatment. *That 20% needs to become 100%.*

FUNDING until about 10 years ago consisted of federal block grants, state appropriations, and client fees. This was unlike other areas of health care, and such funding varied with the political environment, varied with the economic environment, and didn't necessarily increase as need did.

FUNDING NOW consists of Medicaid (for poor or disabled persons) and commercial insurance. And parity of treatment benefits is required, compared to other medical conditions. These changes have hugely increased the number of people receiving care, but are in question in today's political climate. *Funding is crucial*.

MEDICAID and INCARCERATION: it is legal to suspend Medicaid payments while a patient is incarcerated, but some states go further and de-enroll such patients from the program. This becomes very harmful when patients are eventually released*. It is far better policy to keep such people on Medicaid, and even to enroll previously-unenrolled inmates as well.*

PRESCRIPTION DRUG MONITORING: 49 states have programs such that health providers can know of all prescription drugs prescribed for a patient. *This is essential.*

OPIOID TREATMENT PROGRAMS are essential hubs for treatment delivery, but we need far more of them. Only 1500 programs exist in the U.S. today. *We need more of them.*

IT TOOK 25 YEARS to get where we are today. *It will take some time to reverse this, but the task is urgent. (And you have more influence than most people.)*

Creating Data-Driven Policy

some key points from Friday's presentation:

Wilkes County, North Carolina knows a lot about chronic pain. Set into the foothills of the Appalachian Mountains, its residents perform PHYSICALLY-DEMANDING JOBS in the logging, textile, and farming industries.

And not long ago, the County had the highest rate of DRUG OVERDOSE deaths in the U.S., barring only two other counties.

Alarmed, officials created PROJECT LAZARUS to reduce overdoses and deaths from use of prescription opioid pain relievers. The project tries to enlist everyone in the community towards this end, through:

- REDUCING PRESCRIBING of OPIOIDS. Physicians get one-on-one training sessions regarding pain management, and regarding opioids; increasingly create pain agreements with patients; and increasingly check North Carolina's prescription drug monitoring program before prescribing.

- REDUCING EXCESS OPIOIDS in circulation: law enforcement agencies are encouraged to operate "medication take-back" programs.

- INCREASING AVAILABILITY of NALOXONE. Physicians are trained to prescribe naloxone to patients at high risk of overdose (14 risk factors have been identified). Patients watch a 20-minute DVD about overdose prevention and naloxone use, and then can fill their naloxone prescription at no charge.

- INCREASED TREATMENT of ADDICTION: local mental health centers have expanded their services.

- PUBLIC AWARENESS.

At the ROOT of opioid overuse is the huge problem of CHRONIC PAIN in America: long-term pain may impact more patients in the U.S. than heart disease, cancer, and diabetes *combined.* And the number of prescriptions written in response to this need is staggering. The CDC thinks that even in 2010, enough painkillers were prescribed to medicate *every adult American, around-the-clock, for a month.*

As prescribing has skyrocketed, so have deaths from overdoses. Such deaths rose FIVE-FOLD between 1990 and 2007.

But the measures listed above, and others, reduced the death rate from drug overdoses between 2009 and 2011*,* in Wilkes County*, by 70%.*

Strategies for Increasing Access to Care

some key points from Friday's presentation:

ONE INSURER has a task group that meets 3x/week to improve the effectiveness of care; it expects primary care providers to take the central role.

ANOTHER INSURER feels that OPIOID TREATMENT PROGRAMS make the best "case manager," and pays such programs a flat monthly amount to deliver (or arrange) all the elements of effective care. Those elements could include medication to stabilize the situation; daily or almost-daily visits by the patient; in-home visits, and other actions.

SOME PROVIDERS SUGGEST this sequence: research to identify the elements of best care; set up what you think will work; then get feedback from actual patients and providers; and *then* make adjustments as indicated. *(Rinse, repeat.)*

EXPECT UNFORESEEN PHENOMENA that are important to patient outcomes, and must be fixed. For example, one set of rules requires children to be elsewhere when a patient receives Methadone or a similar treatment. But if a single parent leaves their child in the car or at home alone, they might be violating child-endangerment laws. *Answer: this treatment program created a daycare center for patients.*

Other actions: Vermont created COMMUNITY COURTS, which have been sympathetic to the treatment-not-jail approach of today's providers. And an insurer discovered that charging co-pays for each daily visit was prohibitive for many patients, so altered their schedule to one small co-pay for a month of visits. *Seek feedback, then adjust.*

If insurers or providers tell you they're treating addiction WITH PARITY to other medical conditions, *verify that yourself.* And to put a human face on problems of addiction, see and show the films of BESS O'BRIEN.

New York State created a task force on opioid addiction, that made 25 RECOMMENDATIONS. One requires medication training for medical professionals; another requires monthly reports from counties, regarding addiction treatment. A third sets up supervised injection facilities to get people with addictions into a safer environment, and into a relationship with a medical professional. *A fourth would tax opioid prescriptions at a penny per milligram prescribed.*

OTHER RECOMMENDATIONS include requiring the court system, and medical providers, to record a patient's attempts to get into treatment, and the outcomes of those attempts. Another forbids opioid ads in public transit, and yet another prohibits direct-to-consumer ads for prescription drugs. *NY has a pretty good list of actions.*

Preventing Overdose Deaths

some key points from Friday's presentation:

The LUCAS COUNTY SHERIFF's OFFICE in Toledo, Ohio created a model Drug Abuse Response Team (DART). *They quickly decided they could not arrest their way out of this epidemic, so had better try treatment.*

The unit BEGAN WITH TWO OFFICERS, quickly added four more, then added even more from local jurisdictions. Local companies and organizations contributed money to help, then gave needed items, and even cars. *The community is grateful for the DART approach. Really, folks are beyond grateful.*

DART DEFINES SUCCESS as getting people into rehab, and through it. They achieve 74% success (give or take a point or two.) They follow their participants for two years; they're available 24 hours a day, 7 days a week, for crises. They know that relapse is part of recovery. *They never give up, ever.*

They learned they needed more rehab beds, and convinced the County to provide those. 11 treatment agencies cooperate with them, because DART doesn't step on other agencies' toes.

They never ask people to inform on others. But the community so appreciates the officers' commitment, and their priorities, that arrest-generating information has SKYROCKETED. *And community relations are so positive, many other policing issues have much improved.*

Their approach has been: compassion, commitment, and persistence. *And it works.*

The YALE-NEW HAVEN HOSPITAL EMERGENCY DEPARTMENT in Connecticut created a model program for Emergency Rooms. They used to treat just the overdose. Now they refer people to treatment, and prescribe suboxone. With suboxone prescribed, patients are twice as likely to be in treatment 30 days after their overdose, as without it. *And more than two-thirds of their addiction patients do enroll in treatment programs.*

They say, THINK OF ADDICTION AS BEING like this: you're driving down the street. A child runs out, in front of your car. Your entire desire is to stop your car. You hit the brakes. But the brakes don't work. You *cannot* stop your car.

That's how to understand addiction. So, we need Narcan everywhere: sitting with defibrillators, standing by in drones. *Because if you can't get someone through their overdose, you have no chance of beating their addiction.*

The Politics of Addiction Treatment

some key points from Friday's presentation:

Gary shared the story of two young best friends, Brian and Mikey. Brian and Mikey did all of the things that youngsters do, and often together. And then both became ill.

Mikey had access to evidence-based treatment; friends and neighbors offered their best wishes, brought cooked food, and held fundraisers. Mikey and his family were enfolded in a web of help and support.

Brian and his family tried hard to find evidence-based treatment for his condition. As thoroughly as they tried, they couldn't find any. Cooked food didn't arrive at the door, and neighbors didn't hold fundraisers. Brian faced his ailment without science-based treatment, and without a broad community of supporters.

Mikey got better. But Brian eventually researched "suicide notes" on his computer, wrote such a note, and took his life.

What led to the different outcomes? Mikey had been a patient; Brian had been an outcast. Mikey, you might guess, had had cancer. Brian had substance abuse disorder. And today, Brian is gone.

Brian died not just from a substance abuse disorder, but from *stigma* and its effects. Victims of addiction often are reluctant to seek treatment; practitioners are often reluctant to treat them; law enforcement and the courts can create barriers to treatment. *If we don't want people to die, reducing that stigma is crucial.*

SHATTERPROOF advocates 12 items for every state's policies regarding addiction. Try to enact 5 or so right away, and then more later. The items include:

- *Good Samaritan* laws, to reduce liability for those who try to help;
- *Naloxone* much more easily prescribed, so it is available when and where it is needed in order to save a life;
- *Prescriber Education,* so that we prescribe fewer pills;
- *Prescribing Guidelines* – see the CDC's list of 12 guidelines;
- *Prescription Drug Monitoring Programs* (PDMPs). 86% of opioids are prescribed without the doctor checking the patient's prescription history. Practioners *should* be required to consult such a database before prescribing Schedule IV drugs (now Schedule I, II, and III drugs are required); pharmacies *should* be required to upload their actions within a day, rather than within a week; and practitioners *should* be required to re-check the database every 3 months, rather than every year.

The Politics of Addiction Treatment

more key points from Friday's presentation:

Helene had advice for legislators: go back to your state, ASK A LOT of questions, research how things are *actually* getting done, and then fix the holes.

DO NOT assume that if treatment is available in your state, that things are necessarily functioning as they should.

Delaware went through a VERY methodical process, to assess what more they needed to do, and then to get it done. They gathered all sorts of data from various stakeholders, regarding different aspects of the problem, and the effectiveness of current actions.

In Delaware, they discovered they needed to:

- ensure that citizens got the "wrap-around" services they needed in order to succeed;

- add nurses, public health professionals, and other professionals to the State medical review board, which then had only doctors, and seldom held doctors responsible for substandard behavior;

- re-write State contracts with providers of medical and social services, to emphasize paying for results;

- eliminate the policy of many providers that patients must attempt (and fail at) outpatient treatment of their substance abuse, before receiving inpatient treatment. Very often, such a policy amounts to requiring that a citizen die before getting good treatment;

- assist citizens in appealing denial-of-coverage decisions by insurance companies. Otherwise, insurance companies were unlikely to really provide "parity of coverage" compared to other conditions;

- enact a needle exchange law, to reduce some of the dangers of intravenous drug use;

- enact a Good Samaritan law, to reduce legal jeopardy for those attempting to help a person in distress; and

- provide for broader and easier distribution of narcan, so that it is available when needed to save a life.

Sentencing Alternatives and Approaches

some key points from Saturday's presentation:

COSTLY, INEFFECTIVE, and UNJUST: that's how Seattle felt about its drug enforcement approach. So in 2011 it began a new approach, allowing officers to immediately direct some offenders to drug treatment, housing, or other services (rather than booking them into the criminal justice system.)

And Seattle feels that THIS APPROACH HAS WORKED. Regarding COST, money saved through fewer court appearances and fewer days in jail has been redirected to drug treatment and to other social services. Regarding EFFECTIVENESS, participants in the new approach have been nearly 60% less likely to re-offend than have non-participants. And regarding JUSTICE, Seattle continues to experience significant racial disparities in drug enforcement, but now officers are getting citizens into treatment rather than arresting them, so police-community relations are improved.

Seattle calls its program *Law Enforcement Assisted Diversion*, or *LEAD*. Other cities have begun SIMILAR PROGRAMS, for example Santa Fe, New Mexico, and Albany, New York. Many other cities are exploring the ideas. The program shows that even without state legislation, cities and counties can craft policies that choose to bypass the criminal justice system, while pursuing public safety and public health.

Offenders who qualify for the LEAD program, and choose to participate, must contact a case manager within a short time. In many cases, the case manager can give participants access to services which would otherwise be difficult to obtain.

The program recognizes that drug misuse is a complex problem. Case managers concern themselves with each participant's HEALTH, EMPLOYMENT, SOCIAL RELATIONSHIPS, and overall well-being, rather than exclusively tracking their sobriety or abstinence. As one former police chief said, "We know there may be relapses and falls. Our over-all philosophy is *harm reduction."*

Participants are generally eager for help and for treatment. Some participants, who get into treatment through Drug Court (another topic), ask to remain in treatment for longer than they were sentenced, knowing that longer is what they need in order to succeed. As one participant said, "Other programs want you to jump through so many hoops. But when a person got an addiction, you got to get them some help. LEAD helped me get back to my true self."

Presenter Natalie thinks of this as being like eyeglasses. We would think it absurd to expect ONE SET OF EYEGLASSES to work for everyone. But regarding drug recovery, the criminal justice system often seems to think in just that way.

Sentencing Alternatives and Approaches

more key points from Saturday's presentation:

Not long ago, Georgia decided it had a huge problem. Nearly ONE CITIZEN OF EVERY THIRTY was incarcerated.

In 2011, the state set up a TASK GROUP, of stakeholders from every level of government. The task group discovered that the rise in prison population was NOT RELATED to any increase in crime; it was related to decisions about who should go to prison, and for how long.

The task group tried to find solutions for Georgia's high incarceration rate: actions which would hold offenders accountable, while being fiscally sound, and effective in outcome.

They realized they needed to rethink who they were sending to prison, and for how long. And they took other actions:

- REMOVED the existing lifetime ban on foodstamp eligibility, for citizens convicted of a felony.

- REMOVED requirement on applications for state jobs, that felony convictions be listed.

- OPENED MORE DRUG COURTS, with a goal that every Georgia citizen with a drug offense, have access to a drug court. (In order gain treatment through a drug court, offenders must typically plead guilty to possession; be over 18 years old; and sign a treatment contract)

Jan noted that in order to reduce Georgia's incarceration rate, stakeholders had to be disciplined in their thinking, and even compassionate. They had to distinguish between the citizen-offenders they were "merely mad at, for their bad behavior, and those they have reason to be truly afraid of."

As a result of these actions, CORRECTIONS SPENDING has now DROPPED OUT OF the top 5 categories of State spending, and they have reduced their prison population.

In discussion, INDIANA'S recent EXPUNGEMENT law was noted: for various non-sex crimes, after a certain period of time with a clean record, a citizen can petition the court, and the judge SHALL expunge the conviction from the record.

And, BAIL REFORM in Connecticut was noted as an issue: poorer citizens often languish in jail because any bail amount is prohibitive, and then may plead guilty just to get out.

A Personal Story of Addiction and Recovery

some key points from Saturday's presentation:

Justin noted that he had been in many different recovery programs (without lasting success) by the time he was 17. But eventually, with much help from those who loved him, he was successful at staying drug-free. He is now married, has a daughter, runs an organization he founded, and is in graduate school. *Recovery can take many attempts.*

He believes in the RECOVERY EMPOWERMENT EFFECT. That is, the reality that when one of us, or the community, helps a substance abuser to recover, one is helping lots and lots of other people as well: all of the people who depend on that person, are touched by that person, or might someday be helped by that person. *Recovery is worth the effort.*

The principles that have helped *him* the most: believing in something larger than oneself, and serving others.

Justin founded a national organization, YOUNG PEOPLE in RECOVERY, which strives to help all young people to get the support they need in their recoveries.

That SUPPORT MIGHT INCLUDE stable employment, or secure housing, or entry to education. His organization encourages local chapters, all over the country, to create in their own localities the partnerships and working relationships needed to support young people trying to recover from substance abuse.

Justin evoked an image of his very little daughter, standing in front of a large obstacle, which she had never seen the likes of before. She knows that in a situation like that, she has only to hold out her hand to ask for help and guidance. She knows that her father or mother – who have *always* been there when she has encountered an obstacle – will then take her hand, and successfully guide her through whatever barrier has appeared.

She is confident that she will be supported, and guided, and will get past the obstacle.

Can we be there for *others* in our community, facing an obstacle they've never negotiated before, and which they can't guess how to surmount?

There can be many challenges within recovery, and the successful paths for different people may vary a good deal. But all of us have the power -- even if we've never had this challenge -- to empathize with people facing this task.

Justin asked all attendees to " believe the *best* of the community they're representing."