The show will be filmed in a panel format, with free discussion between the show host and other panelists. This discussion guide is not to be considered a script. The information and resources provided in this discussion guide are provided to assist panelists in show preparation. The questions identified in each panel section will be asked by the show host. Panelists will respond to questions asked by the host, and they will also comment and add to information presented by other panelists in a discussion format. Panelists will bring their own keen anecdotal experiences to the show in addition to discussing ongoing research in the field.

Show Description: According to the Centers for Disease Control and Prevention, the number of overdose deaths involving opioids has quadrupled since 1999. More than six out of ten drug overdose deaths involve an opioid and more than 91 Americans die every day from an opioid overdose. This show features federal, state and local programs that are effectively addressing the opioid epidemic, such as SAMHSA’s State Targeted Response to the Opioid Crisis Grants that aim to increase access to treatment, reduce unmet treatment needs, and reduce opioid overdose related deaths through the provision of prevention, treatment, overdose rescue (narcan) and recovery activities for opioid use disorder. Panelists include political representatives across the country who have succeeded in implementing creative strategies to tackle this widespread problem and can speak about the critical next steps our communities can take.

4 Substance Abuse and Mental Health Administration. State Targeted Response to the Opioid Crisis Grants. (December 14, 2016). SAMHSA’s State Targeted Response to the Opioid Crisis Grants aims to increase access to treatment, reduce unmet treatment need and reduce opioid overdose related deaths through the provision of prevention, treatment and recovery activities for opioid use disorder. From https://www.samhsa.gov/grants/grant-announcements/ti-17-014 (accessed September 16, 2017).
Segment 1: Understanding Opioid Use Disorder

Key Questions:

1. What are opioids? How are they typically used and what are the risks?
2. What is opioid use disorder and how is it different from opioid misuse?
3. Opioid misuse is now a public health emergency. How prevalent is opioid use disorder and how much have the numbers been going up?
4. How many deaths occur each year from opioid overdose and who’s most at risk for overdose?
5. Opioids have been around for a long time. What’s fueling this crisis?
6. Why is it important to understand the risks of overprescribing opioids?
7. What is the prevalence of opioid use disorder among persons with behavioral health conditions?

Answers:

1. What are prescription opioids? How are they typically used and what are the risks?


- Opioids are a class of drugs chemically similar to alkaloids found in opium poppies.
- A number of opioids are prescribed by doctors to relieve pain. These include hydrocodone, oxycodone, morphine, and codeine. While many people benefit from using these medications to manage pain, prescription drugs are frequently diverted for improper use.


- Pharmaceutical fentanyl is a synthetic opioid pain reliever, approved for treating severe pain, typically advanced cancer pain. It is 50 to 100 times more potent than morphine. It is prescribed in the form of transdermal patches or lozenges and can be diverted for misuse and abuse in the United States. However, most recent cases of fentanyl-related harm, overdose, and death in the U.S. are linked to illegally made fentanyl. It is sold through illegal drug markets for its heroin-like effect. It is often mixed with heroin and/or cocaine as a combination product—with or without the user’s knowledge—to increase its euphoric effects.
- Heroin is an illegal opioid. Heroin use has increased across the U.S. among men and women, most age groups, and all income levels.
- Heroin is typically injected but is also smoked and snorted. When people inject heroin, they are at risk of serious, long-term viral infections such as HIV, Hepatitis C, and Hepatitis B, as well as bacterial infections of the skin, bloodstream, and heart.
- Anyone who takes prescription opioids can become addicted to them. In fact, as many as one in four patients receiving long-term opioid therapy in a primary care setting struggles with opioid addiction. Once addicted, it can be hard to stop.
- Taking too many prescription opioids can stop a person’s breathing—leading to death.

2. What is opioid use disorder and how is it different from opioid misuse?


- [Opioid use disorder is defined as] a problematic pattern of opioid use leading to clinically significant impairment or distress, as manifested by at least two of the following, occurring within a 12-month period:
  1. Opioids are often taken in larger amounts or over a longer period than was intended.
  2. There is a persistent desire or unsuccessful efforts to cut down or control opioid use.
3. A great deal of time is spent in activities necessary to obtain the opioid, use the opioid, or recover from its effects.
4. Craving, or a strong desire or urge to use opioids.
5. Recurrent opioid use resulting in a failure to fulfill major role obligations at work, school, or home.
6. Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids.
7. Important social, occupational, or recreational activities are given up or reduced because of opioid use.
8. Recurrent opioid use in situations in which it is physically hazardous.
9. Continued opioid use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.
10. Tolerance, as defined by either of the following:
   a. A need for markedly increased amounts of opioids to achieve intoxication or desired effect.
   b. A markedly diminished effect with continued use of the same amount of an opioid.
      Note: This criterion is not considered to be met for those taking opioids solely under appropriate medical supervision.
11. Withdrawal, as manifested by either of the following:
   a. The characteristic opioid withdrawal syndrome (refer to Criteria A and B of the criteria set for opioid withdrawal).
   b. Opioids (or a closely related substance) are taken to relieve or avoid withdrawal symptoms.
      Note: This criterion is not considered to be met for those individuals taking opioids solely under appropriate medical supervision.


• Substance Use Disorder is defined as meeting criteria for illicit drug or alcohol dependence or abuse.
• Opioid misuse refers to the use of heroin or the misuse of prescription pain relievers. Misuse of prescription pain relievers is defined as use in any way not directed by a doctor, including use without a prescription of one's own; use in greater amounts, more often, or longer than told; or use in any other way not directed by a doctor.

3. Opioid misuse is now a public health emergency. How prevalent is opioid use disorder and how much have the numbers been going up?


• National Survey on Drug Use and Health (NSDUH) estimates suggested that, in 2016, 91.8 million (34.1%) or more than one-third of U.S. civilian, noninstitutionalized adults used prescription opioids; 11.5 million (4.3%) misused them. In 2015, 1.6 million (0.7%) had an OUD. Among adults with prescription opioid use, 12.2% reported misuse and 15.1% of misusers reported a prescription OUD.


• In 2016, approximately 11.8 million people aged 12 or older misused opioids in the past year. This number represents 4.4 percent of the population aged 12 or older. About 891,000 adolescents aged 12 to 17 misused opioids in the past year. This number corresponds to 3.6 percent of adolescents misusing opioids in the past year.
[In 2015] Of the 7.7 million people aged 12 or older who had a past year SUD related to their use of illicit drugs... 2.0 million people had a disorder related to their misuse of prescription pain relievers.

Deaths caused by opioid overdose “increased from 1.4 to 7.0 deaths per 100,000 population” between 1999 and 2015.


CEA estimates that in 2015, the economic cost of the opioid crisis was $504.0 billion, or 2.8 percent of GDP that year. This is over six times larger than the most recently estimated economic cost of the epidemic.

4. How many deaths occur each year from opioid overdose and who’s most at risk for overdose?

The crisis in opioid overdose deaths has reached epidemic proportions in the United States (33,091 in 2015), and currently exceeds all other drug-related deaths or traffic fatalities. These data from the CDC are expected to rise even higher for 2016.

From 1999 onwards, overdose deaths due to prescription opioids rose incrementally and consistently outpaced annual heroin death rates. Heroin overdose deaths remained relatively low from 1999 onwards, and then escalated 4-fold from 2010-2015. Data from death certificates in 2015 revealed a disproportionate rise from the previous year in deaths attributable to fentanyl/analgos (72.2%) and heroin (20.6%), with prescription opioid-related deaths rising minimally (2.6%). The overall death rate was higher for prescription opioids, but the most recent data show minimal increases in deaths involving prescription overdoses, while an increasing proportion now involves synthetic opioids, mainly fentanyl.

Residents in rural areas have relatively high rates of opioid overdoses, but they face substantial barriers to OUD treatment, including a shortage of mental/behavioral health providers.

The risk of overdose resides primarily, but not exclusively, among those harboring a medical diagnosis of an OUD. Of six risk markers (sex, age, race, psychiatric disorders, SUDs, urban/rural residence), SUDs have the strongest association with drug overdose death, followed by psychiatric disorders, white race, 35-44 year age group, and male sex.

Opioid-related death rates are higher among those who had recently been released from prison, those who doctor-shop and receive opioid prescriptions from multiple pharmacies, and those who consume prescription opioids in combination with other scheduled medications, particularly benzodiazepines.

Contamination of the heroin supply with fentanyl is currently driving recent increases in opioid-related overdose deaths. Reports from individual states in 2016 and 2017 confirm this emerging trend, as heroin and/or fentanyl currently account for more than 50% of the overdose deaths in specific states.

Preliminary estimates of U.S. drug overdose deaths exceeded 60,000 in 2016 and were partially driven by a fivefold increase in overdose deaths involving synthetic opioids (excluding methadone), from 3,105 in 2013 to approximately 20,000 in 2016.
5. **Opioids have been around for a long time. What’s fueling this crisis?**


- Triggered by excessive prescribing of opioids since 1999, the current crisis is being fueled by several factors that did not exist in the 20th century: the advent of large scale production and distribution of pure, potent, orally effective and addictive opioids; the widespread availability of inexpensive and purer illicit heroin; the influx of highly potent fentanyl/fentanyl analogs; the transition of prescription opioid misusers into use of heroin and fentanyl; and the production of illicit opioid pills containing deadly fentanyl(s) made by authentic pill presses.
- Aggressive promotion of an oxycodone brand from 1997-2002 led to a 10-fold rise in prescriptions to treat moderate to severe noncancer pain, and increases in prescribing of other opioids. Subsequently, the highest strengths permissible was increased for opioid-tolerant patients, likely contributing to its misuse.
- The expectation of eliminating a patient’s pain as an indication of successful treatment, and seeing pain as the fifth vital sign, which has been stated by some medical professionals as unique to the United States, was cited as a core cause of the culture of overprescribing in this country that led to the current health crisis.
- Sales of prescription opioids in the U.S. nearly quadrupled from 1999 to 2014, largely paid for by insurance carriers. It is estimated that 1 out of 5 patients with non-cancer pain or pain-related diagnoses are prescribed opioids in office-based settings. From 2007 to 2012, the rate of opioid prescribing steadily increased amongst specialists more likely to manage acute and chronic pain (pain medicine [49%], surgery [37%], physical medicine/rehabilitation [36%]).

6. **Why is it important to understand the risks of overprescribing opioids?**


- Overall, the risk of transition from medical use for pain relief to dependence is especially high for opioids, especially with longer use, and high doses.
- Overprescribing is still considered a driver of increases in opioid-related consequences, addiction, overdose, and infections, as it sustains nonmedical use of prescription opioids.
- In an analysis of more than 4,400 patients entering drug treatment for opioid abuse, of individuals initially exposed to opioids through a physician's prescription to treat pain, 94.6% had used a psychoactive substance non-medically prior to or coincident with their opioid prescription... It highlights the need for clinicians to screen patients for prior drug use histories and judicious monitoring of and intervention with these at-risk patients prior to or during opioid prescribing.


- Physician prescribing patterns, patient drug diversion (selling, sharing, or using medications prescribed for another person), and doctor shopping behaviors have all contributed to the ongoing opioid overdose epidemic. For example, evidence indicates that chronic pain patients with substance use disorders are prescribed opioids more often than other individuals with chronic pain, with the trend increasing over time. Also, a study in two health systems found opioid prescription rates for older persons, particularly older women, to be higher over time than for other individuals with long-term chronic pain.


- The amount of opioids prescribed in the US peaked in 2010 and then decreased each year through 2015. However, prescribing remains high and vary widely from county to county.
• Taking opioids for longer periods of time or in higher doses increases the risk of addiction, overdose, and death.
• Healthcare providers have an important role in offering safer and more effective pain treatment.

7. **What is the prevalence of opioid use disorder among persons with behavioral health conditions?**


• In 2015, of the 9.8 million adults with serious mental illness, 1.5 million, or 15.6%, misused opioids in the past year. This also equates to “one in seven adults with serious mental illness in the past year were past year misusers of opioids.”


• The high prevalence of comorbidity between drug use disorders and other mental illnesses does not mean that one caused the other, even if one appeared first. In fact, establishing causality or directionality is difficult for several reasons. Diagnosis of a mental disorder may not occur until symptoms have progressed to a specified level (per DSM); however, subclinical symptoms may also prompt drug use, and imperfect recollections of when drug use or abuse started can create confusion as to which came first. Still, three scenarios deserve consideration:
  1. Drugs of abuse can cause abusers to experience one or more symptoms of another mental illness. The increased risk of psychosis in some marijuana abusers has been offered as evidence for this possibility.
  2. Mental illnesses can lead to drug abuse. Individuals with overt, mild, or even subclinical mental disorders may abuse drugs as a form of self-medication. For example, the use of tobacco products by patients with schizophrenia is believed to lessen the symptoms of the disease and improve cognition (see "Smoking and Schizophrenia: Self-Medication or Shared Brain Circuitry?").
  3. Both drug use disorders and other mental illnesses are caused by overlapping factors such as underlying brain deficits, genetic vulnerabilities, and/or early exposure to stress or trauma.
Segment 2: Opioid Use Disorder: Everyone’s Problem

Key Questions:

1. How does opioid use disorder impact families, communities, and society?
2. What are the risk factors behind America’s increasing heroin related deaths?
3. What is illicit fentanyl and how does this factor into so many more deaths?
4. How important is improving public awareness of opioid use disorder and what topics should awareness campaigns focus on?
5. What states or cities have been successful in targeting areas and populations of greatest need or crisis and why have their efforts been successful?
6. This is a multifaceted problem without a single solution. Which groups, agencies, and communities need to be involved to fully address this growing problem in our country?

Answers:

1. How does opioid use disorder impact families, communities, and society?


- “Addiction impacts each member of a family, affecting each member differently, but the most vulnerable are children. Children whose parents have an OUD may be neglected or even require removal to foster care. The developing fetus is vulnerable to substance use by the pregnant mother, as drugs readily cross the placenta and enters fetal blood circulation. The opioid epidemic has impacted many states with increases in the number of children who have entered foster care due to parental drug use. Child welfare agencies have seen an increase in their 81 caseloads and are burdened with limited resources, e.g., funds to support drug treatment or parenting classes and community-based support for these children.”


- Friends and family members often suffer when a loved one has a substance use disorder. This may be due to worry about the loved one experiencing accidents, injuries, negative social and legal consequences, diseases, or death, as well as fear of the loved one engaging in destructive behavior, such as stealing, manipulating, or being verbally or physically aggressive. Consequently, a number of mutual aid groups have emerged to provide emotional support to concerned significant others and families and to help them systematically and strategically alter their own unproductive behaviors that have emerged in their efforts to deal with the substance use problems of their affected loved one.


- Drugs can hurt not only the person taking them, but everyone connected to the person:
  - husbands, wives, boyfriends, girlfriends
  - teens and children
  - babies
  - other family members and friends

- Drug use can hurt people at any age, from any financial, racial/ethnic, or education background. When you or a loved one uses illegal drugs or misuses prescription drugs, everyday life can feel out of control.
2. **What are the risk factors behind America’s increasing heroin related deaths?**


- Research has identified several factors that place people at increased risk for heroin use. Examples include the following:
  - Personality characteristics, such as cynicism, or a high level of anger toward self and others, are associated with heroin being the “drug of choice.”
  - Early onset of tobacco and other drug use has been associated with past-year heroin use, heroin initiation, and opiate use.
  - History of poly-drug use, especially combined inhalant and marijuana use, is linked to past year heroin use.
  - Having ever been in jail or a detention center is associated with past-year heroin use.
  - Engaging in multiple delinquent behaviors (i.e., getting into serious fights at school or work, engaging in group fighting, carrying guns, selling illicit drugs, stealing, or attacking someone with intent to seriously injure) makes someone more likely to have engaged in past-year heroin use.
  - Ability to access heroin-using social networks makes a person more likely to have used heroin in the past six months.
  - Having experienced a history of child abuse (sexual, physical or emotional) is associated with heroin initiation, past-year heroin use, and the number of years of lifetime heroin use.
  - Dropping out of school, participating in delinquent behaviors, or having a history of foster care placements increases the chances of past-year heroin injection use.
  - Experiencing depression or having a network of injecting drug users increases the likelihood of engaging in injection heroin use.

- Once a person has begun using heroin, additional factors place them at risk for overdose. Some examples include the following:
  - Being homeless and having a long history of injection drug use increases the likelihood of experiencing a nonfatal heroin overdose during a lifetime.
  - Using heroin in a public space or residing in a large city has been associated with an increase in overdose death.
  - Recently injecting drugs, being incarcerated, poly-drug use, testing positive for hepatitis, or having witnessed an overdose increases risk of past-year nonfatal overdose.
  - Decreases in the cost of heroin and increases in availability are associated with increased heroin overdose hospitalizations.

3. **What is illicit fentanyl and how does this factor into so many more deaths?**


- The severity of the opioid crisis has intensified with the introduction of highly potent illicit synthetic opioids into the market. Manufactured in clandestine laboratories without regulation or pharmaceutical standards, illicit synthetic opioids are increasingly implicated in overdose fatalities. The most common varieties are fentanyl, which is 50-100 times more potent than morphine, and carfentanil, which is 10,000 times more potent than morphine. These drugs appear in heroin, MDMA, and cocaine, and are also sold as counterfeit prescription pills.
• There’s a new heroin on the street far more potent than the usual that people who are addicted to heroin have come to know and expect. This heroin is laced with fentanyl—a prescription painkiller used to treat the severe pain of cancer. Drug dealers are in a competitive business and like other entrepreneurs they look for ways to distinguish their product and make it something people will seek, including by increasing the potency of the heroin they sell. Unfortunately this has resulted in the deaths of dozens of people who cannot tolerate it. Within minutes of using this contaminated heroin they lose consciousness, breathe ever more slowly until they finally stop—and die.

• These days we’re seeing a spike in the numbers of accidental deaths among heroin users who may die because their heroin is mixed with fentanyl or other contaminants, or because they use it in combination with other substances like alcohol, benzodiazepines and prescription pain medicine.


• Fentanyl is a synthetic opioid 50-100 times more potent than morphine.

• Illicitly manufactured fentanyl partially explains the rapid increase in opioid overdose deaths in the United States since 2013.

4. How important is improving public awareness of opioid use disorder and what topics should awareness campaigns focus on?


• A national prevention strategy with a comprehensive public health mass media campaign supported by evidence-based prevention programs is timely and essential. The goals would include: (a) universal drug prevention messages, as current or past SUDs predispose individuals to misusing opioids, and polysubstance use disorders are common; (b) youth-directed messages, as they are more susceptible to addiction and other adverse consequences; (c) prevention messages specific to opioids, to include patient and family education on what opioids are, the hazards of opioids, safeguarding of prescription medications, and disposing of unused pills; (d) the common hazards of illicit and prescription opioids; and (e) availability of treatment resources. Media campaigns are commonly used to deliver preventive health messages and to shape healthy behaviors and attitudes.

• There are several successful state, local government and grassroots media campaigns aimed at providing drug-related public education or assistance in locating appropriate help for children. During the first Commission meeting on June 16, 2017, the Commission heard about one such campaign from the Partnership for Drug-Free Kids, who have worked with national and local media partners, as well as private sector partners like Google and Facebook, to run public service announcements that inform parents on available help for their loved ones. Similarly, Commission Chairman Governor Christie has implemented a media campaign in New Jersey around opioid addiction and a help hotline and website.


• “Health care has multiple roles to play in changing the trajectory of the opioid crisis in the communities they serve, including limiting the supply of prescription opioids in circulation, raising awareness of the risk of opioid addiction, identifying and treating opioid-dependent individuals, and collaborating closely with community efforts.”
• Raising awareness of the risk of opioid addiction among providers, patients, and families is one of the four tasks for health care providers to address the opioid crisis in their communities.

• Raising awareness involves:
  o Identifying and educating those patients at greatest risk for addiction.
  o Educate all patients and their families about the risks of prescription opioids, elevating the danger of prescription opioids equivalent of non-prescription opioids, such as heroin.


• Prevention programs and interventions can have a strong impact and be cost-effective, but only if evidence-based components are used and if those components are delivered in a coordinated and consistent fashion throughout the at-risk period. Parents, schools, health care systems, faith communities, and social service organizations should be involved in delivering comprehensive, evidence-based community prevention programs that are sustained over time.

• To be effective, prevention programs and policies should be designed to address the common risk and protective factors that influence the most common health threats affecting young people. They should be tested through research and should be delivered continuously throughout the entire at-risk period by those who have been properly trained and supervised to use them. Federal and state funding incentives could increase the number of properly organized community coalitions using effective prevention practices that adhere to commonly defined standards. The research reviewed in this Report suggests that such coordinated efforts could significantly improve the impact of existing prevention funding, programs, and policies, enhancing quality of life for American families and communities.

5. What states or cities have been successful in targeting areas and populations of greatest need or crisis and why have their efforts been successful?


• Community leaders in Wilkes County, North Carolina, implemented Project Lazarus, a model that expands access to naloxone for law enforcement, emergency services, education, and health services, and reduced the county overdose rate by half within a year. North Carolina also passed a law in 2013 that implemented standing orders, allowing naloxone to be dispensed from a pharmacy without a prescription.

• In 2013, the State of Vermont implemented an innovative treatment system with the goal of increasing access to opioid treatment throughout the state. This model, called the “Hub and Spoke” approach, met this need by providing physicians throughout the state with training and supports for providing evidence-based buprenorphine treatment.


• In 2016, with funding from a SAMHSA Partnerships for Success (PFS) grant, the Healthy Tekoa Coalition invested in one prescription drug drop-off box. "We’re a tiny town, so we were lucky to have a pharmacy to place the Rx drop-off box in," says Harp, noting residents would be more comfortable bringing medications to their local pharmacy, rather than travelling to the sheriff’s office to do so. They were also fortunate that, despite a recent robbery, the pharmacist was willing to host the drop box for the good of the community. "She was willing to step up, knowing we’d have the support of the Whitman County Sheriff," Harp says.
Once a month, the sheriff agreed to make the one-hour drive back and forth to Tekoa to empty the drop box and transport the medications for incineration.


- In response to rising rates of opiate addiction across the state of Ohio, Governor John Kasich established the Ohio Governor’s Cabinet Opiate Action Team (GCOAT) in 2011. With involvement from Prevention Bureau Chief/NPN Molly Stone and others from the Ohio Department of Mental Health and Addiction Services (a Partnerships for Success 2014 grantee), the team was charged with reducing opiate addiction rates and overdose deaths across the state. Understanding the role of opioid over-prescribing as a key contributor to subsequent addiction and overdose, GCOAT focused its efforts on developing opioid prescribing guideline. To inform guideline development, GCOAT convened a 75-member task force comprising prevention professionals, doctors, dentists, nurses, and other healthcare providers. Together, the team created three sets of guidelines: to inform opioid prescriptions for emergency medicine, for chronic care management, and for acute care settings. Within two years, the task force produced the emergency medicine and chronic care prescribing guidelines. According to Andrea Boxill, Deputy Director of GCOAT, the process for developing these initial sets went relatively smoothly. “There was quick consensus on what do in the emergency room—don’t send people home with a script for 30 pain pills for a sprained ankle, for example. And it was easy to create thoughtful guidelines for people in chronic pain,” she explains.

- The GCOAT task force’s final set of acute care prescriber guidelines were launched in January 2016. Since then, Boxill has been working diligently with provider boards, hospitals and clinics, and healthcare organizations across the state to get them to adopt the guidelines. “I’m always on the lookout for new ways to connect with statewide provider boards, hospitals and clinics, and healthcare organizations to get them to adopt the guidelines,” she explains. “I ask them what they need to make using the guidelines easier and then we work on doing that for them.” Boxill is also an active member of Ohio’s SPF-PFS and SPF-Rx Advisory Committees: both provide forums for both learning about prescribing practices and sharing information about the guidelines. Reports published by the Ohio Automated Rx Reporting System (OARRS) show that user rates are steadily increasing, indicating that physicians are checking a patient’s prior prescriptions with greater frequency. Boxill has also been approached about creating a training video on the guidelines for use by the Ohio State Medical, Dental, and Veterinary Boards. At their request, she is working on tying the training video to the renewal of licenses for prescribing providers.


- After Indiana used an insurance access program to rapidly respond to a rural, opioid-related health crisis, the Indiana Department of Health reported that such a program opened the door to life changing medical treatment.


- Governor Chris Christie today announced that dozens of measures designed to combat America’s opioid crisis have been identified by The Governor’s Task Force on Drug Abuse Control, which was initiated by the Governor as part of his 2017 State of the State address...The Task Force, authorized when Governor Christie declared opioid addiction a public health crisis in February, made 40 recommendations involving education, prevention, intervention, treatment, recovery, and reentry.

- The state Department of Health (DOH) will revise critical EMT guidelines to permit first responders to carry 4 milligrams of Naloxone, or Narcan, equaling the amount civilians can obtain and doubling the current amount EMT’s are allowed to stock.
Among several other Task Force recommendations in progress is the expansion of New Jersey’s revolutionary Recovery Coach program, which helps ensure that individuals reversed with naloxone (or Narcan) learn about their options for treatment, and are encouraged to seek help. A Recovery Coach is an individual, often in recovery themselves, trained to provide support to someone who wakes up following an overdose. With first-hand experience overcoming addiction and arising from rock bottom, New Jersey Recovery Coaches work alongside the state’s other dedicated behavioral health professionals to help reclaim lives. In 2016, there were 1,243 reversals seen in the Emergency Departments by the Recovery Coaches. This program is growing to all 21 counties and will now assist people after treatment and/or incarceration, in addition to those in hospital emergency rooms.

6. This is a multifaceted problem without a single solution. Which groups, agencies, and communities need to be involved to fully address this growing problem in our country?


- Because substance use disorders often first come to light in the context of school, law enforcement, and employment, communities have many opportunities to expand the delivery of prevention and treatment services to include schools and school-based health care clinics, jails and prisons, and places of employment. Services provided in these settings can range from prevention education to SBIRT to treatment for substance use disorders. For example, law enforcement and emergency medical services in many communities are already collaborating in the distribution and administration of naloxone to prevent opioid overdose deaths. These efforts require a public health approach and the development of a comprehensive community infrastructure, which in turn requires coordination across federal, state, local, and tribal agencies. A number of states are developing promising approaches to address substance use in their communities.


- National experts discuss the opioid epidemic and provide resources for faith-based and community leaders and organizations to help with recovery and prevention during the opioid epidemic.


- The Commission urges Congress and the Administration to block grant federal funding for opioid-related and SUD-related activities to the states, where the battle is happening every day. There are multiple federal agencies and multiple grants within those agencies that cause states a significant administrative burden from an application and reporting perspective. Creating uniform block grants would allow more resources to be spent on administering life-saving programs. This was a request to the Commission by nearly every Governor, regardless of party, across the country.

- The Commission recommends that Department of Education (DOE) collaborate with states on student assessment programs such as Screening, Brief Intervention and Referral to Treatment (SBIRT). SBIRT is a program that uses a screening tool by trained staff to identify at-risk youth who may need treatment. This should be deployed for adolescents in middle school, high school and college levels. This is a significant prevention tool.

- The Commission recommends that HHS coordinate the development of a national curriculum and standard of care for opioid prescribers. An updated set of guidelines for prescription pain medications should be established by an expert committee composed of various specialty practices to supplement the CDC guideline that are specifically targeted to primary care physicians.


• The Commission recommends that federal agencies work to collect participation data. Data on prescribing patterns should be matched with participation in continuing medical education data to determine program effectiveness and such analytics shared with clinicians and stakeholders such as state licensing boards.
• The Commission recommends the Administration work with Congress to amend the Controlled Substances Act to allow the DEA to require that all prescribers desiring to be relicensed to prescribe opioids show participation in an approved continuing medical education program on opioid prescribing.
• The Commission recommends that HHS, DOJ/DEA, ONDCP, and pharmacy associations train pharmacists on best practices to evaluate legitimacy of opioid prescriptions, and not penalize pharmacists for denying inappropriate prescriptions.
• The Commission recommends U.S. Customs and Border Protection (CBP) and the U.S. Postal Inspection Service (USPIS) use additional technologies and drug detection canines to expand efforts to intercept fentanyl (and other synthetic opioids) in envelopes and packages at international mail processing distribution centers.
• The Commission recommends DOJ broadly establish federal drug courts within the federal district court system in all 93 federal judicial districts. States, local units of government, and Indian tribal governments should apply for drug court grants established by 34 U.S.C. § 10611. Individuals with an SUD who violate probation terms with substance use should be diverted into drug court, rather than prison.
• The Commission recommends the Federal Government partner with appropriate hospital and recovery organizations to expand the use of recovery coaches, especially in hard-hit areas. Insurance companies, federal health systems, and state payers should expand programs for hospital and primary care-based SUD treatment and referral services. Recovery coach programs have been extraordinarily effective in states that have them to help direct patients in crisis to appropriate treatment. Addiction and recovery specialists can also work with patients through technology and telemedicine, to expand their reach to underserved areas.
• The Commission recommends the National Highway Traffic Safety Administration (NHTSA) review its National Emergency Medical Services (EMS) Scope of Practice Model with respect to naloxone, and disseminate best practices for states that may need statutory or regulatory changes to allow Emergency Medical Technicians (EMT) to administer naloxone, including higher doses to account for the rising number of fentanyl overdoses.
Segment 3: Behavioral Health and Recovery Communities: Addressing Opioid Use Disorder

Key Questions:

1. What evidence-based treatments are available for opioid use disorder?
2. How does medication-assisted treatment (MAT) work and what are some misperceptions about MAT?
3. How do we enhance the capacity of healthcare providers to implement evidence-based treatments?
4. How do behavioral health and recovery communities partner with national, state, and local governments to address the opioid epidemic?
5. How can we expand access to naloxone and detox services in targeted areas? What barriers exist?
6. How can healthcare providers integrate peer support programs into treatment programs for opioid use disorder?
7. What are some ways to expand access of residential services for individuals with an opioid use disorder in targeted areas?

Answers:

1. **What evidence-based treatments are available for opioid use disorder?**


- Medication-assisted treatment (MAT) is an effective response to opioid use disorder. It is the use of medications, in combination with behavioral therapies, to provide a whole-patient approach to the treatment of substance use disorders. Individuals receiving MAT often demonstrate dramatic improvement in addiction-related behaviors and psychosocial functioning.
- *Methadone, Naltrexone, and Buprenorphine are used to treat opioid addiction.*


- The Brief Negotiation Interview (BNI) with Emergency Department (ED)-Initiated Buprenorphine is a program that seeks to increase treatment for ED patients with severe opioid use disorders. The BNI, which was developed in 2002 for problem alcohol use, was adapted for substance use orders in 2008, and further modified for opioid use disorders. Designed for use with ED patients 18 years of age or older who present with moderate-to-severe opioid use disorder, the program can be used in hospitals and other healthcare settings. It is designed to engage patients in treatment for opioid dependence and expand their access to medication-assisted treatment, and includes follow-up primary care management. Intended secondary effects include reductions in self-reported days of illicit opioid use and HIV-risk behaviors.”
- *NREPP’s evaluation found that* “This program is effective for reducing opioid use and disorders. The review of the program yielded strong evidence of a favorable effect.”


- Interim Methadone Maintenance, also known as Interim Maintenance or IM, is a substance use treatment that serves as a transition for opioid-dependent adults who are on waiting lists to be placed in comprehensive methadone treatment programs (MTPs). IM is intended to provide a safe way to engage patients, curb opiate craving, and prevent opiate withdrawal symptoms. The goal of IM is to help participants gain entry into MTPs and to encourage them to reduce their heroin use and other relevant outcomes by providing treatment when they choose to seek help.
• IM includes two program components: 1) A daily, individualized methadone dose administered to participants by a nurse; and 2) emergency counseling for up to 120 days. Federal regulations allow MTPs to provide IM to adults who seek treatment; however, in cases of limited program capacity, MTPs can provide treatment to those who are unable to be admitted to the program within 14 days. The regulations specify that 1) only public or nonprofit MTPs can provide IM; 2) counseling can be provided to patients receiving IM only during times of emergency or crisis (i.e., temporary loss of housing, relationship problems, serious medical problems); and 3) patients must complete drug testing. IM programs provide physical examinations and education about HIV prevention, but do not provide the full range of counseling and social services of MTPs, making them less expensive than MTPs.

• **NREPP’s evaluation found that** "This program is effective for improving receipt of mental health and/or substance use treatment. The review of the program yielded strong evidence of a favorable effect.

2. **How does medication-assisted treatment (MAT) work and what are some misperceptions about MAT?**


- Opioid agonist therapies with methadone or buprenorphine reduce the effects of opioid withdrawal and reduce cravings. They have been shown to increase retention in treatment and reduce risk behaviors that lead to transmission of HIV and viral hepatitis such as using opioids by injection.

- Medication-assisted treatment with extended-release injectable naltrexone reduces the risk of relapse to opioid use and helps control cravings. Extended-release injectable naltrexone is particularly useful for people exiting a controlled setting where abstinence has been enforced such as jail or residential rehabilitation or in situations where maintenance with an opioid agonist is not available or appropriate. People who misuse prescription opioids benefit from medication assisted treatment as much as people abusing heroin.


- MAT for patients with a chronic opioid use disorder must be delivered for an adequate duration in order to be effective. Patients who receive MAT for fewer than 90 days have not shown improved outcomes. One study suggested that individuals who receive MAT for fewer than 3 years are more likely to relapse than those who are in treatment for 3 or more years. Three medications are commonly used to treat opioid use disorders: methadone, buprenorphine, and naltrexone.

- The use of opioid agonist medications to treat opioid use disorders has always had its critics. Many people, including some policymakers, authorities in the criminal justice system, and treatment providers, have viewed maintenance treatments as “substituting one substance for another” and have adhered instead to an abstinence-only philosophy that avoids the use of medications, especially those that activate opioid receptors. Such views are not scientifically supported; the research clearly demonstrates that MAT leads to better treatment outcomes compared to behavioral treatments alone. Moreover, withholding medications greatly increases the risk of relapse to illicit opioid use and overdose death. Decades of research have shown that the benefits of MAT greatly outweigh the risks associated with diversion.

3. **How do we enhance the capacity of healthcare providers to implement evidence-based treatments?**


- Partnerships flexibly applied the Advancing Recovery model to promote the adoption of evidence-based treatments. Most sites achieved a measurable increase in the numbers of patients served with evidence-based practices, up from a baseline of virtually no use. Rates of adopting medication-based treatments were
higher than those for continuing care management. Partnerships used a menu of top-down and bottom-up strategies that varied in specifics across sites but shared a general process of incremental testing and piecemeal adaptation.

- Supported partnerships between providers and policymakers can achieve wider adoption of evidence-based treatment practices. Systems change unfolds through a trial-and-error process of adaptation and political learning that is unique to each treatment system. This leads to considerable state and local variation in implementation strategies and outcomes.


- People who provide medication-assisted treatment (MAT) services work in a range of prevention, health care, and social service settings. They include psychiatrists, psychologists, pharmacists, nurses, social workers, counselors, marriage and family therapists, peer professionals, clergy, and many others.

- Training a diverse and qualified behavioral health workforce is essential to meeting the nation’s needs. SAMHSA’s Division of Pharmacological Therapies provides the following training materials for MAT professionals:
  - Buprenorphine Training for Physicians
  - Opioid Prescribing Courses for Physicians
  - Webinars, Workshops, and Summits
  - Physician and Program Data
  - Publications and Research
  - Organizations that Support MAT

- Learn more about medication and counseling treatment.


- MATx empowers health care practitioners to provide effective, evidence-based care for opioid use disorders. This free app supports practitioners who currently provide medication-assisted treatment (MAT), as well as those who plan to do so in the future.

- MATx features include:
  - Information on treatment approaches and medications approved by the U.S. Food and Drug Administration for use in the treatment of opioid use disorders
  - A buprenorphine prescribing guide, which includes information on the Drug Addiction Treatment Act of 2000 waiver process and patient limits
  - Clinical support tools, such as treatment guidelines, ICD-10 coding, and recommendations for working with special populations
  - Access to critical helplines and SAMHSA’s treatment locators.

4. How do behavioral health and recovery communities partner with national, state, and local governments to address the opioid epidemic?


- Community coalitions are increasingly used as a vehicle to foster improvements in community health. Community coalitions differ from other types of coalitions in that they include professional and grassroots members committed to work together to influence long-term health and welfare practices in their community. Additionally, given their ability to leverage existing resources in the community and convene diverse organizations, community coalitions connote a type of collaboration that is considered to be sustainable over time.

- The federal government has increasingly used community coalitions as a programmatic approach to address emerging community health issues. Community coalitions are composed of diverse organizations that form
an alliance in order to pursue a common goal. The activities of community coalitions include outreach, education, prevention, service delivery, capacity building, empowerment, community action, and systems change. The presumption is that successful community coalitions are able to identify new resources to continue their activities and sustain their impact in the community over time. Given the large investment in community coalitions, researchers are beginning to systematically explore the factors that affect the sustainability of community coalitions once their initial funding ends.

- The Office of National Drug Control Policy (ONDCP) and the SAMHSA Center for Substance Abuse Prevention (CSAP) support Drug-Free Communities (DFC) Support Program grants, which were created by the Drug-Free Communities Act of 1997 (Public Law 105-20). The DFC Support Program has two goals:
  - Establish and strengthen collaboration among communities, public and private non-profit agencies, as well as federal, state, local, and tribal governments to support the efforts of community coalitions working to prevent and reduce substance use among youth.
  - Reduce substance use among youth and, over time, reduce substance abuse among adults by addressing the factors in a community that increase the risk of substance abuse and promoting the factors that minimize the risk of substance abuse.

- Long-term analyses suggest a consistent record of positive accomplishment for substance use outcomes in communities with a DFC grantee from 2002 to 2012. The prevalence of past 30-day use of alcohol, tobacco, and marijuana declined significantly among both middle school and high school students. The prevalence of past 30-day alcohol use dropped the most in absolute percentage point terms, declining by 2.8 percentage points among middle school students and declining by 3.8 percentage points among high school students. The prevalence of past 30-day tobacco use declined by 1.9 percentage points among middle school students, and by 3.2 percentage points among high school students from DFC grantees’ first report to their most recent report. Though significant, the declines in the prevalence of past 30-day marijuana use were less pronounced, declining by 1.3 percentage points among middle school students and by 0.7 percentage points among high school students.


- Health and Human Services Secretary Tom Price, M.D., today announced the availability of over $70 million over multiple years to help communities and healthcare providers prevent opioid overdose deaths and provide treatment for opioid use disorder, of which $28 million will be dedicated for medication-assisted treatment (MAT).

- The announcement followed a separate award of $485 million in grants in April 2017—provided by the 21st Century Cures Act— to all 50 states, the District of Columbia, four U.S. territories, and the free associated states of Palau and Micronesia for opioid abuse prevention, treatment, and recovery. Administered through the Substance Abuse and Mental Health Services Administration (SAMHSA), these funds will be made available through the following three grants:
  - Medication-Assisted Treatment and Prescription Drugs Opioid Addiction: Up to $28 million to 5 grantees to increase access of medication-assisted treatment for opioid use disorder. Medication-assisted treatment combines behavioral therapy and FDA-approved medication.
  - First Responders: Up to $41.7 million over 4 years available to approximately 30 grantees to train and provide resources for first responders and members of other key community sectors on carrying and administering an FDA approved product for emergency treatment of known or suspected opioid overdose.
  - Improving Access to Overdose Treatment: Up to $1 million over 5 years to one grantee to expand availability to overdose reversal medications in healthcare settings and to establish protocols to connect patients who have experienced a drug overdose with appropriate treatment.
Non-governmental organizations, community health centers, HIV service providers, substance abuse treatment providers, the medical community and public health organizations play a critical role in educating health care consumers and the general public about the risks associated with opioid misuse and abuse including overdose and the use of naloxone. The Department continues to support efforts to reduce barriers to the use of naloxone and opioid overdose prevention activities. State and local governments play a critical role through the public health system in preventing overdose deaths. [SAMHSA has] reached out to them to provide technical assistance and to help them strategize on best practices in overdose prevention and naloxone use.

Professional associations can be instrumental in setting workforce guidelines, advocating for curriculum changes in professional schools, promoting professional continuing education training, and developing evidence-based guidelines that outline best practices for prevention, screening and assessment, brief interventions, diagnosis, and treatment of substance-related health issues. For example, to help address the current prescription opioid crisis and overdose epidemic, associations should raise awareness of the most recent guidelines for opioid prescribing and commend the use of PDMPs by providers. Associations also should raise awareness of the benefits of making naloxone more readily available without a prescription and providing legal protection to physician-prescribers and bystanders (“Good Samaritans”) who administer naloxone when encountering an overdose situation.

The following programs have been funded through SAMHSA’s State Targeted Response to Opioid Crisis Grants and provide good examples of how behavioral health and recovery communities are partnering with state governments to address the opioid epidemic.


- **California’s MAT Expansion Project** complements other collaborative efforts California has implemented to expand MAT access and reduce opioid related deaths in California. The MAT Expansion project is expected to serve 20,892 over the two-year grant period. The goals of the project are to implement the Hub and Spoke model in various areas throughout California which will improve access to Narcotic Treatment Programs (NTPs), Medication Unites in counties with the highest overdose rates. The MAT Expansion Project will also increase the availability of buprenorphine statewide and increase MAT utilization for tribal communities.

- **Florida’s Opioid State Targeted Response Project** is designed to address the opioid crisis by providing evidence based prevention, medication-assisted treatment, and recovery support services. The four goals of this proposal include reducing opioid-related deaths, preventing prescription opioid misuse among young people, increasing the number of individuals trained to provide medication-assisted treatment and recovery support services, and increasing access to medication-assisted treatment among individuals with opioid use disorders.

- **Ohio’s Opioid STR Project** goals focus on building a community system of care (prevention, early intervention, treatment and recovery support) that emphasizes service integration between physical health care, emergency health care, behavioral health care, criminal justice, and child welfare. Strategies and
activities undertaken for this effort build upon Ohio’s on-going efforts to address the opioid epidemic and are designed to reduce overdose deaths and enhance the ability of individuals with opioid use disorder to receive treatment using evidence-based approaches. A three-pronged approach is adopted to operationalize the identified strategies and activities. This includes 1) department-directed strategies and activities focusing on counties of the state with highest opioid overdose deaths and treatment need, 2) department-directed strategies and activities to be deployed statewide, and 3) Alcohol, Drug Addiction and Mental Health Services (ADAMHS) Boards identified projects consistent with the goals and objectives of the Ohio Opioid STR Project. Ohio’s Opioid STR Project emphasizes evidence-based practices throughout the needed continuum of services and interventions: PAX Good Behavior Game and Botvin Lifeskills for primary prevention, Screening, Brief Intervention and Referral to Treatment (SBIRT) for early intervention, and Medication-Assisted Treatment (MAT) for opioid use disorder, using the ECHO model and other training methodologies to expand treatment capacity. Additional evidence-based practices include Sobriety, Treatment and Recovery Teams (START) for child welfare and Trauma Informed Care to address the vicarious trauma experienced by professionals in multiple systems and families who are facing the consequences of Ohio’s opioid epidemic on a daily basis.

- **The Texas Targeted Opioid Response (TTOR) program** will allow the Texas Health and Human Services Commission (HHSC) to expand prevention and treatment efforts that promote recovery and early intervention for populations identified as high risk for opioid use disorders (OUD). This program will enhance outreach and education for the public, provide training to enhance workforce, and target individuals at risk of developing OUDs, or a potential overdose, while increasing access to enhanced recovery oriented treatment. Based on available data, TTOR will focus on three populations at highest risk for OUD and its related consequences: people who live in major metropolitan areas; women who are pregnant and postpartum; and people who have a history of prescription opioid misuse or are at risk of developing an opioid issue (including persons being treated for chronic pain, veterans, and rural areas with high rates of abuse). The Texas Statewide Behavioral Health Strategic Plan (2017-2021) identified access to treatment, unmet treatment needs, fortifying re-entry services, and increasing recovery support services (RSS) as essential for behavioral health planning in Texas. TTOR will address the alarming opioid crisis trends by working in concert with this plan and augmenting it with a variety of additional activities for those at highest risk of OUD. Through a variety of community contracts, TTOR will serve approximately 14,710 persons over a two-year period. TTOR will partner with the state agency representatives on the Texas Statewide Behavioral Health Coordinating Council in addition to consumers, advocates, and provider members that serve on the Behavioral Health Advisory Council to ensure stakeholder input is incorporated and to coordinate and ensure efficient use of resources.

5. **How can we expand access to naloxone and detox services in targeted areas? What barriers exist?**


- In the interim report, the Commission recognized the importance of ensuring naloxone is made as widely available as possible to save lives. Consequently, the Commission recommended that all law enforcement in the United States be equipped with naloxone, model legislation be provided to states to allow naloxone dispensing via standing orders, and ‘Good Samaritan’ laws be enacted to empower the public to seek help.
- While there is not necessarily a naloxone supply shortage, price increases of the various forms of naloxone continue to create affordability issues, preventing state and local governments, as well as community organizations, from stocking naloxone at the levels necessary to rescue more people from overdose.
- To further ensure naloxone is made available when there is the greatest chance of an overdose, we must allow more first responders to be equipped with this life saving drug, including EMS personnel.
• The Commission recommends HHS implement naloxone co-prescribing pilot programs to confirm initial research and identify best practices. ONDCP should, in coordination with HHS, disseminate a summary of existing research on co-prescribing to stakeholders.


• SAMHSA is … working with its federal partners and state and local law enforcement to expand the safe administration of naloxone by first responders. SAMHSA is working with emergency medical service professionals to:
  o Identify any state or local laws that permit or restrict naloxone use by certain types of first responders
  o Advocate for their use of naloxone in emergency situations

• In an effort to save more lives from opioid overdose, SAMHSA published the Opioid Overdose Prevention Toolkit – 2014. The Toolkit equips communities and local governments with material to develop policies and practices to help prevent opioid-related overdoses and deaths. It also serves as a foundation for educating and training:
  o Communities
  o Prescribers of opioid pain medications
  o First responders
  o Patients who are prescribed opioid medications
  o Individuals and family members who have experienced an opioid overdose


• Some states have made it easier for law enforcement officers to access naloxone. For example, at least one state’s Board of Pharmacy (New York) streamlined the process through which law enforcement agencies can order the medication, allowing them to purchase naloxone directly from a wholesaler instead of receiving it from a retail pharmacy via a prescription from a health care provider. Other states have supported agreements between law enforcement overdose response programs and EMS agencies to handle purchasing and training. Other states have supported agreements between law enforcement overdose response programs and EMS agencies to handle purchasing and training.


• Providing naloxone kits to laypersons reduces overdose deaths, is safe, and is cost-effective. U.S. and international health organizations recommend providing naloxone kits to laypersons who might witness an opioid overdose; to patients in substance use treatment programs; to persons leaving prison and jail; and as a component of responsible opioid prescribing.

• Although the number of organizations providing naloxone kits to laypersons is increasing, in 2013, 20 states had no such organization, and nine had less than one layperson per 100,000 population who had received a naloxone kit. Among these 29 states with minimal or no access to naloxone kits for laypersons, 11 had age-adjusted 2013 drug overdose death rates higher than the national median.

6. **How can healthcare providers integrate peer support programs into treatment programs for opioid use disorder?**


• Peer support services are delivered by individuals who have common life experiences with the people they are serving. People with mental and/or substance use disorders have a unique capacity to help each other based on a shared affiliation and a deep understanding of this experience. In self-help and mutual support,
people offer this support, strength, and hope to their peers, which allows for personal growth, wellness promotion, and recovery.

- Research has shown that peer support facilitates recovery and reduces health care costs. Peers also provide assistance that promotes a sense of belonging within the community. The ability to contribute to and enjoy one’s community is key to recovery and well-being. Another critical component that peers provide is the development of self-efficacy through role modeling and assisting peers with ongoing recovery through mastery of experiences and finding meaning, purpose, and social connections in their lives.

- SAMHSA’s Recovery Community Services Program (RCSP) advances recovery by providing peer recovery support services across the nation. These services help prevent relapse and promote sustained recovery from mental and/or substance use disorders. For more information, visit SAMHSA’s What Are Peer Recovery Support Services? – 2009.

- Through the RCSP, SAMHSA recognizes that social support includes informational, emotional, and intentional support. Examples of peer recovery support services include:
  - Peer mentoring or coaching—developing a one-on-one relationship in which a peer leader with recovery experience encourages, motivates, and supports a peer in recovery
  - Peer recovery resource connecting—connecting the peer with professional and nonprofessional services and resources available in the community
  - Recovery group facilitation—facilitating or leading recovery-oriented group activities, including support groups and educational activities
  - Building community—helping peers make new friends and build healthy social networks through emotional, instrumental, informational, and affiliation types of peer support


- The MARS™ Project is a peer-initiated and peer-based recovery support project sponsored by the National Alliance of Medication-Assisted (NAMA) Recovery. Thanks to the Albert Einstein College of Medicine for providing space and for being supportive of our efforts, the original MARS™ Community was launched in 2005 with funding from a SAMHSA RCSP grant. In 2012, the Beyond MARS™ Training Institute was formed to replicate this model and implement MARS™ “satellite” programs across the United States. The growing MARS™ Community currently includes seventeen programs across the United States and two programs in Haiphong, Vietnam. We offer a wide range of training and technical assistance services.

- We help Medication-Assisted Treatment Programs develop a holistic approach that includes MAT education and a supportive peer community. We help drug-free programs to integrate medication-assisted treatment into their other services. We help anyone from any organization that is interested in promoting an effective approach to medication-assisted treatment and recovery efforts.

7. **What are some ways to expand access of residential services for individuals with an opioid use disorder in targeted areas?**


- Findings here suggest residential treatment may be helpful for emerging adults with opioid dependence. This benefit may be less prominent, though, among non-dependent opioid misusers. Randomized trials are needed to compare more directly the relative benefits of outpatient agonist-based treatment to abstinence-based, residential care in this vulnerable age-group, and to examine the feasibility of an integrated model.

• On September 15th, HHS announced its commitment of $144.1 million in funding to combat the opioid epidemic. This funding will be administered by the Substance Abuse and Mental Health Services Administration (SAMHSA) through six grant programs, and distributed among 58 city, state, and community organizations. Four of the grant programs were authorized in the Comprehensive Addiction and Recovery Act (CARA) of 2016, which helped fund efforts to prevent and treat opioid use disorder.

• [One of the grant programs directed at residential services is the] Services Grant Program for Residential Treatment for Pregnant and Postpartum Women –$49 million to expand services for women and their children in residential substance abuse treatment facilities, among other services.


• The Commission recommends HHS/CMS, the Indian Health Service (IHS), Tricare, the DEA, and the VA remove reimbursement and policy barriers to SUD treatment, including those, such as patient limits, that limit access to any forms of FDA-approved medication-assisted treatment (MAT), counseling, inpatient/residential treatment, and other treatment modalities, particularly fail-first protocols and frequent prior authorizations. All primary care providers employed by the above-mentioned health systems should screen for alcohol and drug use and, directly or through referral, provide treatment within 24 to 48 hours.

• Grant waiver approvals for all 50 states to quickly eliminate barriers to treatment resulting from the federal Institutes for Mental Diseases (IMD) exclusion within the Medicaid program. This will immediately open treatment to thousands of Americans in existing facilities in all 50 states. The Commission has been urged by every Governor, numerous treatment providers, parents, and non-profit advocacy organizations to eliminate the IMD exclusion within the Medicaid program. This component of the Social Security Act prohibits federal Medicaid funds from reimbursing services provided in an inpatient facility treating “mental diseases” (including SUDs) that have more than 16 beds. This exclusion makes states entirely responsible for Medicaid-eligible patients in inpatient treatment facilities, including patients undergoing withdrawal management in addiction treatment facilities rather than hospitals. The Commission members that serve as Governors, as well as individuals and organizations that treat Medicaid patients, are intimately aware of how the IMD exclusion impacts the ability to serve patients with severe SUDs that are best served in an inpatient setting. The Commission recognizes that legislation would be necessary to repeal the exclusion in its entirety. However, certainly after an emergency declaration by the President (and arguably even without it) the Department of Health and Human Services (HHS) Secretary would be empowered to immediately grant waivers to each state that requests one. This is the single fastest way to increase treatment availability across the nation.
Segment 4: Strategies and Resources for Prevention, Treatment and Recovery for Opioid Use Disorder

Key Questions:

1. What are some programs and resources on opioid use disorder available from SAMHSA and other Federal agencies for behavioral health practitioners, providers, and consumers?
2. What are some strategies to expand training to opioid use disorder prevention providers, law enforcement, and community members?
3. What's needed to enhance implementation of guidelines for prescribing and taking opioids for chronic pain?
4. What are some resources for safe and effective pain management?
5. How do we develop and expand recovery support services for individuals with an opioid use disorder?
6. What information can you share with people who are concerned that their loved ones may be misusing opioids?

Answers:

1. **What are some programs and resources on opioid use disorder available from SAMHSA and other Federal agencies for behavioral health practitioners, providers, and consumers?**

**Programs:**


- SAMHSA’s administration of the Opioid State Targeted Response grant program created by the 21st Century Cures Act, with the goal of increasing access to evidence-based treatment, reducing unmet treatment need, and reducing opioid overdose related deaths through the provision of prevention, treatment, and recovery services. Beginning in May 2017, SAMHSA awarded grants to all 50 states, territories, and six pacific jurisdictions totaling $485 million.
- SAMHSA has funded and provided online or in-person trainings for over 46,000 medical professionals on MAT for opioid use disorders.
- SAMHSA’s award in September 2017 of almost $46 million over five years to grantees in 22 states to provide naloxone and related resources to first responders and treatment providers.


- Launched in October 2016, the PDO grant program is intended to reduce the number of prescription drug/opioid overdose-related deaths and related adverse events among people ages 18 and older.
- The program provides the opportunity for states, selected tribes, and jurisdictions that receive SABG funding to train first responders and other key community sectors to prevent prescription drug/opioid overdose-related deaths and implement secondary prevention strategies, including the purchase and distribution of naloxone to first responders.


- Launched in October 2016, the SPF Rx grant program aims to raise awareness among healthcare practitioners and the community about the dangers of sharing medications and the risks of overprescribing to young adults.
The program provides an opportunity for states, tribes, and jurisdictions that have completed a SPF SIG/TIG to target the priority issue of prescription drug misuse. SPF Rx also aims to bring prescription drug misuse prevention activities and education to schools, communities, parents, prescribers, and their patients.

**Resources:**


- This toolkit offers strategies to health care providers, communities, and local governments for developing practices and policies to help prevent opioid-related overdoses and deaths. Access reports for community members, prescribers, patients and families, and those recovering from opioid overdose.


- A state-by-state directory for Medication-Assisted Treatment programs for opioid use disorder.


- The Opioid Overdose Toolkit provides communities and local governments with material to develop policies and practices to help prevent opioid-related overdoses and deaths. This toolkit contains resources and information for first responders, prescribers, patients, family members, and those who are recovering from opioid overdose.


- Prescription Drug Overdose: Prevention for States is a program that helps states combat the ongoing prescription drug overdose epidemic. The purpose of Prevention for States is to provide state health departments with resources and support needed to advance interventions for preventing prescription drug overdoses.


- This guideline provides recommendations for primary care clinicians who are prescribing opioids for chronic pain outside of active cancer treatment, palliative care, and end-of-life care. The guideline addresses 1) when to initiate or continue opioids for chronic pain; 2) opioid selection, dosage, duration, follow-up, and discontinuation; and 3) assessing risk and addressing harms of opioid use. This guideline is intended to improve communication between clinicians and patients about the risks and benefits of opioid therapy for chronic pain, improve the safety and effectiveness of pain treatment, and reduce the risks associated with long-term opioid therapy, including opioid use disorder, overdose, and death. CDC has provided a checklist for prescribing opioids for chronic pain ([http://stacks.cdc.gov/view/cdc/38025](http://stacks.cdc.gov/view/cdc/38025)) as well as a website ([http://www.cdc.gov/drugoverdose/prescribingresources.html](http://www.cdc.gov/drugoverdose/prescribingresources.html)) with additional tools to guide clinicians in implementing the recommendations.


- Department of Veterans Affairs Secretary Shulkin, in response to the Commission’s interim report release, immediately launched eight best practices for pain management in the VA health-care system. These guidelines included everything from alternatives and complimentary care, counseling and patient monitoring to peer education for front-line providers, informed consent of patients and naloxone distribution for Veterans on long-term opioid therapy.
Overdose Good Samaritan laws are policies that provide legal protections for individuals who call for emergency assistance (such as 9-1-1) in the event of a drug overdose. This may include protection from arrest and/or prosecution for crimes related to drug possession, drug paraphernalia possession, and other crimes. These laws are designed to encourage people to summon emergency assistance if they experience or witness a drug overdose. As of July 2017, 40 states and the District of Columbia have instituted Good Samaritan laws. Yet, lack of awareness and understanding of the protections these laws provide, as well as concerns about their limitations, may be limiting their effectiveness in encouraging overdose bystanders to call for help. These barriers may also prevent the criminal justice system from fully observing them.

2. What are some strategies to expand training to opioid use disorder prevention providers, law enforcement, and community members?

PCSS-O is a national training and mentoring project developed in response to the prescription opioid overdose epidemic. The consortium of major stakeholders and constituency groups with interests in safe and effective use of opioid medications offers extensive experience in the treatment of substance use disorders and specifically, opioid use disorder treatment, as well as the interface of pain and opioid use disorder. PCSS-O makes available at no cost CME programs on the safe and effective use of opioids for treatment of chronic pain and safe and effective treatment of opioid use disorder.

SAMHSA’s Center for the Application of Prevention Technologies (CAPT) has developed numerous resources to support the prevention of opioid misuse, including the non-medical use of prescription drugs (NMUPD) and heroin use. These resources include: practice-support tools, compiled data sources, archived webinars, video interviews, and grantee success stories.

“IRETA is a non-profit organization that works with national, state, and local partners to improve recognition, prevention, treatment, research and policy related to addiction and recovery.”

- Intended for: the substance abuse field (best practice treatment resources)
- Describes intervention implementation
Individual technical assistance available
- Provides information on fidelity measurement
- Provides guidance on staff training
- References related to EBPs


- DOL has established an apprenticeship program for [CHWs (community health workers)] and recovery coaches with standard competencies, a curriculum, educational training, and on-the-job learning components, and routinely provides grants to augment the workforce. Through this program, employers provide a stipend for entry-level CHWs to receive on-the-job learning, on-site supervision, and educational training with the intent to secure employment as a credentialed CHW. Once an apprentice completes the CHW certification program, his or her name is registered into a DOL database, issued a certificate of completion, and is considered certified. The Presidential Executive Order Expanding Apprenticeships in America published on June 15, 2017 encourages federal agencies to fund and provide other supports to expand the use of CHWs to provide critically needed services across the country. Health entities such as hospitals and primary care offices can also sponsor training and employment.

3. **What’s needed to enhance implementation of guidelines for prescribing and taking opioids for chronic pain?**


- This guideline provides recommendations for primary care clinicians who are prescribing opioids for chronic pain outside of active cancer treatment, palliative care, and end-of-life care. The guideline addresses 1) when to initiate or continue opioids for chronic pain; 2) opioid selection, dosage, duration, follow-up, and discontinuation; and 3) assessing risk and addressing harms of opioid use. This guideline is intended to improve communication between clinicians and patients about the risks and benefits of opioid therapy for chronic pain, improve the safety and effectiveness of pain treatment, and reduce the risks associated with long-term opioid therapy, including opioid use disorder, overdose, and death. CDC has provided a checklist for prescribing opioids for chronic pain (http://stacks.cdc.gov/view/cdc/38025) as well as a website (http://www.cdc.gov/drugoverdose/prescribingresources.html) with additional tools to guide clinicians in implementing the recommendations.


- A CDC “Morbidity and Mortality Weekly Report” published in July 2017 found that while prescriptions for opioid medications have decreased since 2010, substantial variation in opioid prescribing was observed at the county-level across the U.S., demonstrating “the need for better application of guidance and standards around opioid prescribing practices.”
- In the first Commission meeting, the Commission heard from various medical societies about the need to promote expanded implementation of the CDC opioid prescribing guideline. However, while many professional organizations encourage use of the CDC guideline, it is important to note the Commission received a substantial amount of correspondence from patients who currently use opioid medications for legitimate medical reasons and are worried about the guideline being too restrictive for their physicians to properly treat them. Clinicians have added their concerns about the CDC guideline, including the time required to discuss alternative forms of pain control, the difficulty in obtaining reimbursement for alternatives, how to address opioid tapering, and concerns with the prescribing guideline for specific forms of pain. Furthermore, it is important to point out that the CDC guideline is intended for primary care clinicians, who are treating patients for chronic pain in outpatient settings, and more latitude in decision
making should be given to physicians that have specialized training in pain management. The Commission also recognizes that the CDC guideline may not include specific recommendations regarding patient education and informed consent. Patients are often ill-informed about the risks of taking opioid analgesics and, therefore, are not able to balance the potential benefits of opioid analgesics with the associated risks.

- While progress has been made in training prescribers and fostering the adoption of prescribing guidelines such as the CDC guideline, the Commission has learned that not all states have adopted the guideline, not all physicians are aware of them, and sound opioid prescribing guidelines are far from universally followed. For example, while the CDC guideline, as well as guidelines from the VA and the Department of Defense (DOD), recommend clinicians use baseline and periodic urine testing as part of a comprehensive plan to ensure the safe and effective use of opioid therapies, not all states have placed sufficient emphasis upon the utility of medication screenings. In the current crisis, drug testing not only allows providers to assess proper use of prescribed medications in individual patients, but it would also be part of a broader solution in fighting the opioid crisis, as it can provide a snapshot of controlled prescription drugs and illicit drugs available in a community.

- Consequently, the Commission recommended in the interim report that medical education and prescriber education initiatives in proper opioid prescribing and risks of developing an SUD be mandated.

- Stakeholders important to the adoption of prescribing guidelines include public and private payers, medical and dental schools, physician and pharmacy groups, insurers, and health care associations. Medical associations have developed courses for proper opioid prescribing practices, with support from federal grants and made them available online for free. Federal agencies have also compiled lists of courses in compliance with the CDC guideline. It is imperative that all DEA registrants prescribing scheduled drugs develop proficiency in pain management and opioid prescribing. In recognizing that OUD is associated with or preceded by other SUDs, training on diagnosis and office-based treatment of addictions should also be implemented for all stages of professional activity, including medical school, residency, practicing clinicians, and all others legally permitted to prescribe scheduled drugs.

4. What are some resources for safe and effective pain management?


- Although prescription pain medications can be effective at treating certain types of pain, there are different treatment options and therapies available. Whether one approach is safer and more effective than another will depend on your unique situation.”

- This pain management sheet suggests alternate forms of pain management:
  - Acupuncture
  - Chiropractic
  - Cognitive behavioral therapy
  - Massage therapy
  - Meditation and relaxation
  - Physical therapy
  - Yoga


- This Treatment Improvement Protocol (TIP) is for primary care providers who treat or are likely to treat adult patients with or in recovery from SUDs who present with CNCP (Chronic noncancer pain). Given the prevalence of CNCP in the population, this audience includes virtually all primary care providers. Addiction specialists, psychiatrists, nurses, and other clinicians may find information here that will help them ensure that their patients with CNCP receive adequate pain treatment. By providing a shared basic understanding
of and a common language for these two chronic conditions, this TIP facilitates cooperation and communication between healthcare professionals treating pain and those treating addiction.


- More than 40 people die every day from prescription opioid-involved overdose. The CDC Guideline for Prescribing Opioids for Chronic Pain provides recommendations for safer and more effective prescribing of opioids for chronic pain in patients 18 and older in outpatient settings outside of active cancer treatment, palliative care, and end-of-life care.
- This online training series aims to help you apply CDC’s recommendations in your clinical setting through interactive patient scenarios, videos, knowledge checks, tips, and resources. You will gain a better understanding of the recommendations, the risks and benefits of prescription opioids, nonopioid treatment options, patient communication, and risk mitigation.


- Developed by NIDA and Medscape Education, with funding from the White House Office of National Drug Control Policy, these CME courses provide practical guidance for physicians and other clinicians in screening pain patients for substance use disorder risk factors before prescribing, and in identifying when patients are abusing their medications. The courses use videos that model effective communication about sensitive issues, without losing sight of addressing the pain.

5. How do we develop and expand recovery support services for individuals with an opioid use disorder?


- SAMHSA has delineated four major dimensions that support a life in recovery: health, home, purpose, and community. To recover, people need good access to affordable, accessible, and high-quality health and behavioral health care (health). Overcoming or managing one’s disease(s) or symptoms (for example: abstaining from use of alcohol, illicit drugs, and non-prescribed medications if one has an addiction, or accessing the appropriate clinical medical treatment for a mental illness), and—for everyone in recovery—making informed, healthy choices that support physical and emotional well-being, are essential to recovery. To recover, people also need a stable and safe place to live (home) and meaningful, productive, worthwhile activities (purpose). Activities such as having a job, attending school, volunteering, family caretaking, or pursuing creative endeavors—and the independence, income, and resources they bring—are necessary for people to fully participate in communities. Lastly, to recover, people need relationships and social networks, such as family and friends, that provide support, friendship, love, and hope (community).


- Recovery is supported by peers and allies. Mutual support and mutual aid groups, including the sharing of experiential knowledge and skills, as well as social learning, play an invaluable role in recovery. Peers encourage and engage other peers and provide each other with a vital sense of belonging, supportive
relationships, valued roles, and community. Through helping others and giving back to the community, one helps one’s self. Peer-operated supports and services provide important resources to assist people along their journeys of recovery and wellness. Professionals can also play an important role in the recovery process by providing clinical treatment and other services that support individuals in their chosen recovery paths. While peers and allies play an important role for many in recovery, their role for children and youth may be slightly different. Peer supports for families are very important for children with behavioral health problems and can also play a supportive role for youth in recovery.

- **Recovery is supported through relationship and social networks.** An important factor in the recovery process is the presence and involvement of people who believe in the person’s ability to recover; who offer hope, support, and encouragement; and who also suggest strategies and resources for change. Family members, peers, providers, faith groups, community members, and other allies form vital support networks. Through these relationships, people leave unhealthy and/or unfulfilling life roles behind and engage in new roles (e.g., partner, caregiver, friend, student, employee) that lead to a greater sense of belonging, personhood, empowerment, autonomy, social inclusion, and community participation.

- **Recovery involves individual, family, and community strengths and responsibility.** Individuals, families, and communities have strengths and resources that serve as a foundation for recovery. In addition, individuals have a personal responsibility for their own self-care and journeys of recovery. Individuals should be supported in speaking for themselves. Families and significant others have responsibilities to support their loved ones, especially for children and youth in recovery. Communities have responsibilities to provide opportunities and resources to address discrimination and to foster social inclusion and recovery. Individuals in recovery also have a social responsibility and should have the ability to join with peers to speak collectively about their strengths, needs, wants, desires, and aspirations.


- Training and technical assistance provided by Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS) aims to transform behavioral health systems. The goal is to provide a diverse array of nonclinical supports, support person-directed treatment, increase access to recovery supports, and expand the peer workforce. Recovery-oriented systems are developed with an understanding that long-term recovery happens in the community. Training and technical assistance is provided in a variety of formats, including consultations, virtual and in-person events and meetings, and online resources.


- A growing number of colleges and universities have established collegiate recovery programs (CRP). These programs offer support and assistance to students in recovery and to students seeking help for alcohol and other drug problems. To join, some CRP’s require treatment completion and/or a specified period of abstinence coupled with mutual aid participation while others are open to any student who believes they have an alcohol or other drug problem or who simply wishes to be part of a community for which alcohol or other drug consumption is not a part of social and recreational activities. Some CRPs provide a dedicated dorm or recovery residence for members and others do not.

- Ultimately, private sector employers are well positioned to play a central role in supporting the hiring and ongoing employment of those in recovery, identifying rules and laws that may impede hiring people in recovery, and increasing treatment access for employees with active addiction. Employment for those with past drug use is a critical part of the solution to this drug crisis. The State of Florida has decoupled felony convictions and eligibility for certain business or occupational licenses with great success, expanding access to the wide arrays of jobs with licensing requirements.
6. **What information can you share with people who are concerned that their loved ones may be misusing opioids?**


- A state-by-state directory for Medication-Assisted Treatment programs for opioid use disorder.


- SAMHSA’s National Helpline, 1-800-662-HELP (4357), (also known as the Treatment Referral Routing Service) is a confidential, free, 24-hour-a-day, 365-day-a-year, information service, in English and Spanish, for individuals and family members facing mental and/or substance use disorders. This service provides referrals to local treatment facilities, support groups, and community-based organizations. Callers can also order free publications and other information.


- Are you finding it difficult to stop using? If you’ve thought about cutting down or stopping, this site can help. If you are using narcotics, prescription pain medications, heroin, or any other opioid drug, this site has information about some of your treatment options and ways to locate a provider who can help.
- You can also watch videos of people who have been where you are. They found a way to succeed in recovery and reclaim their lives.