

Ending the Opioid Crisis: A Practical Guide for State Policymakers

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Introduction

The opioid addiction and overdose epidemic is receiving increasing attention throughout the United States. Yet despite growing efforts to curb the crisis, overdose death rates continue to climb.

Drug overdose is now the leading cause of death in the United States among people under age 50¹ and, since 2010, opioid-related death rates have risen across virtually all demographic groups and in almost every state in the nation.²

In 2016, there were 11.8 million people, ages 12 and older, who reported misusing opioids (heroin or prescription pain medication) in the past year and 2.1 million who met the clinical criteria for an opioid use disorder. Opioid misuse and addiction have taken a significant toll on older adults³ and on adolescents as well. Nearly one million 12-17 year olds report that they misused opioids in the past year and 153,000 are addicted to them.⁴ We have to do more to address this public health crisis.

In December 2015, The National Center on Addiction and Substance Abuse published a comprehensive guide to assist policymakers at all levels of government in improving how we address substance use and addiction in the United States. This publication, [*Guide for Policymakers: Prevention, Early Intervention and Treatment of Risky Substance Use and Addiction*](#), drew on an extensive body of scientific research to describe what works best to prevent and reduce all forms of addictive substance use -- tobacco, alcohol, illicit drugs, and controlled prescription drugs -- and addiction. It included policies and practices relevant

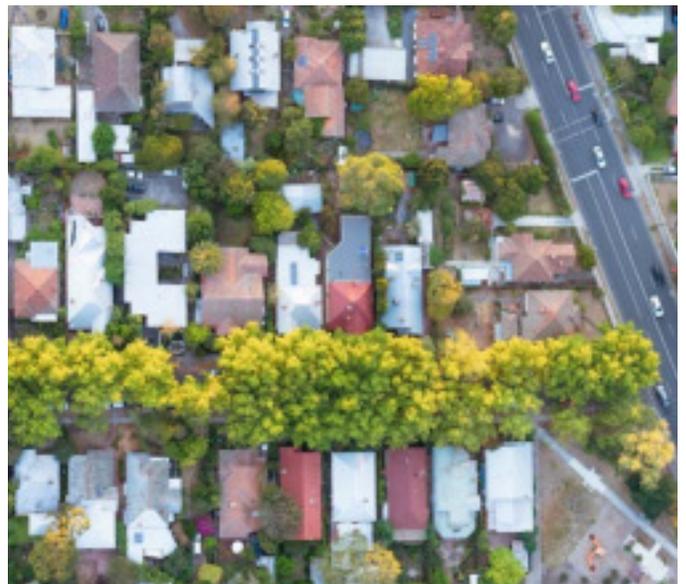
to those working within the key social systems most directly affected by substance use and addiction and for which carefully considered initiatives could produce the most significant results: health care, education, and justice. It offered resources and references for deeper examination of the issues and practical recommendations for ensuring that best practices in addiction prevention, early intervention, treatment, disease management, and recovery support are implemented effectively across the United States.



Although the opioid crisis was well under way at the time of its publication, the *Guide* addressed substance use and addiction more broadly, and it presumed a significant role for policymakers at all levels of government to take reasonable action to address substance use and addiction -- the primary preventable public health problems that our nation faces.

However, since its publication, significant political changes at the federal level of government have threatened to upend our nation's recent turn toward a public health approach to addressing addiction in the United States. That approach, which prioritizes the implementation of science-based prevention, early intervention, treatment, and disease management strategies to address substance use and addiction, is now under threat. Plans to repeal and replace the Affordable Care Act (also known as Obamacare) and fundamentally change the structure of the Medicaid program and slash its funding could lead to the elimination of insurance coverage for millions of people in need of costly addiction treatment. Plans to revive the ineffective strategies of the decades-old "War on Drugs" via a criminalization approach to addiction could eviscerate the painstaking efforts to educate the public, law enforcement, and health professionals that addiction is a treatable disease, which responds best to health-based interventions rather than to punitive actions. Plans to cut funding to key organizations and agencies that have been leading the charge to research and employ best practices for preventing, reducing, and treating substance use and addiction threaten to tie the hands of those most qualified and most dedicated to finding and implementing effective solutions to the current drug epidemic.

Although the opioid crisis is a national issue, individual states bear the brunt of its burden. States pay the enormous expenses of untreated addiction (in costs related to criminal justice, health care, education, social welfare, public safety, and lost productivity). Our Center's analysis found that approximately 15.7 percent of total state spending goes toward substance use and addiction; 94 percent of that amount is spent on addressing the consequences of substance use and addiction rather than on prevention, treatment, or research.⁵



It has become clear that states cannot wait for the federal government to act to end this epidemic. In their city streets, suburban schools, rural towns, hospital emergency rooms, jail cells, and funeral homes, states are seeing firsthand that they cannot arrest and imprison their way out of this problem. At the same time, they are inundated with guidelines and recommendations from government agencies, professional associations, and local organizations. Many of these have critically important suggestions for addressing the problem, but some are behind the curve in addressing the current manifestation of the crisis or are not applicable to how it is playing out in an individual state or locality.

For example, curtailing physicians' prescribing practices and mandating prescription drug monitoring programs (PDMPs) certainly have proven successful in curbing the unbridled opioid prescribing that many argue got us into this crisis in the first place. They are necessary components of any comprehensive effort to address the problem, particularly since the majority of individuals who begin to use heroin started out misusing prescription opioids.⁶ However, reducing the supply and availability of addictive prescription drugs is not sufficient. A significant portion of opioid-related addiction, overdose, and death is now related to the use of heroin and deadly synthetic opioids like fentanyl and carfentanil, which are not being prescribed by physicians nor monitored through PDMPs. Rather, these illicit drugs often are cheaper and more accessible than prescription opioids and the more potent and deadly versions of them increasingly are mixed into heroin, cocaine, and other drugs surreptitiously, without the knowledge or awareness of those who use them. These drugs are now the major driving force behind the growing number of opioid overdose deaths.⁷

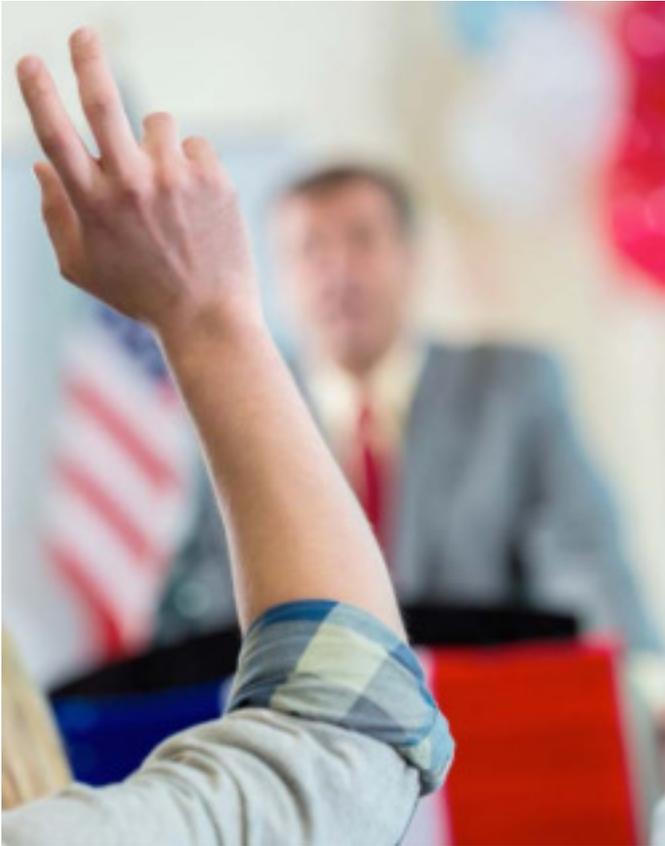
It is understandable for communities that are watching their families and neighbors laid waste by this epidemic to want to react in a forceful manner, locking up the "bad guys" and laying blame at the feet of parents, schools, physicians, law enforcement, and politicians. Nevertheless, as is true of any complex problem, there is no one simple solution or magic bullet. What is needed is a set of solutions that bridges the profound gap between what existing research demonstrates to be effective and the practices that are currently in use. This gap is due in part to decades of marginalizing addiction as a social, moral, or criminal problem rather than addressing it with interventions and treatments that match the responses given to other health conditions.

There are many actions states can take to address the opioid epidemic -- and the larger public health crisis of addiction -- without having to depend on support from the federal government. Many good resources are available to guide states in taking action.⁸ Several

states have convened working groups, developed action plans, and issued specific recommendations to address the opioid epidemic (e.g., Connecticut,⁹ Maryland,¹⁰ Massachusetts,¹¹ North Carolina,¹² Rhode Island,¹³ Virginia,¹⁴ and Wisconsin,¹⁵ among others).

In April 2017, our Center and the State Legislative Leaders Foundation (SLLF) co-hosted a policy summit, [*Addressing the Opioid Crisis in America: Strategies that WORK!*](#) The summit convened our nation's top state legislative leaders as well as key researchers and practitioners in the field of addiction to discuss the challenges of opioid addiction, how best to address them, and what some states are doing to respond. Discussions at the summit revealed the need for a concise resource for states to learn how they can implement concrete and effective strategies to prevent, reduce, treat, and manage opioid use, opioid addiction, and their tragic consequences.

The intent of this publication, *Ending the Opioid Crisis: A Practical Guide for State Policymakers*, is to cull proven and promising strategies from a range of evidence-based resources to offer a clear and concise set of actions that states can take. Its aim is to help state policymakers understand what a public health approach looks like and how best to implement one. It seeks to arm policymakers with the information they need to replace misinformation and stigma with research-based facts and practical, health-based solutions. Finally, it offers examples of data-informed and treatment-focused programs and initiatives on the state and local levels that can serve as models for states seeking to provide their citizens evidence-based prevention, early intervention, treatment, disease management, and recovery support. These examples are not all-inclusive and most have not been rigorously evaluated for effectiveness, but they do hold promise in their approach to the problem. There are states that are emerging as leaders on this issue and we encourage state policymakers to learn from one another in adopting and implementing successful approaches.



It is important to note that this guide is not a comprehensive review of the actions states are taking to address this crisis. Like our *Guide for Policymakers*, this guide is not meant to be a complete account of all effective policies and programs that have been considered or implemented to address the opioid epidemic, but rather a set of recommendations that can help guide states to take effective action in managing and ending it.

We encourage states to implement the recommendations in this guide and to examine the resources and illustrative examples provided to learn about the strategies that other states have employed and perhaps model their own initiatives on those examples. We challenge states to commit to adopting a comprehensive public health approach and evidence-based prevention and treatment practices. States that make this investment will not only be able to overcome the current opioid epidemic but will be in a better position to prevent and, if necessary, face future drug crises.

What is a Public Health Approach to the Opioid Crisis?

The hallmark of a public health problem is that it occurs frequently throughout a population and can be prevented through population-based interventions designed to modify individual behaviors, reduce exposure to harmful influences, and detect and treat people who are at risk of or already suffering from the problem. Classic examples of public health problems are communicable diseases such as tuberculosis and polio; modern examples are HIV/AIDS, obesity, and now the opioid crisis. A public health approach to such problems addresses both individual and underlying social, environmental, and economic determinants of the problem and aims to improve the health, safety, and well-being of those affected by it.¹⁶ Interventions must span the continuum from prevention and early intervention to treatment, disease management, and recovery support, and they must be based in scientific evidence.

Key Elements of a Public Health Approach, According to a Recent Surgeon General's Report

- “Define the problem through the systematic collection of data on the scope, characteristics, and consequences of substance misuse;
- Identify the risk and protective factors that increase or decrease the risk for substance misuse and its consequences, and the factors that could be modified through interventions;
- Work across the public and private sector to develop and test interventions that address social, environmental, or economic determinants of substance misuse and related health consequences;
- Support broad implementation of effective prevention and treatment interventions and recovery supports in a wide range of settings; and
- Monitor the impact of these interventions on substance misuse and related problems as well as on risk and protective factors.”¹⁷

Key Objectives for States Aiming to Address the Opioid Crisis

Years of research by our Center has led us to some key conclusions regarding how best to address addiction in the United States. Many of these are presented in our own reports and white papers and in those of other organizations and agencies concerned with this critical issue. Broadly speaking, states should prioritize the objectives of:

- ✓ **Adopting a public health approach** as outlined in our [Guide for Policymakers: Prevention, Early Intervention and Treatment of Risky Substance Use and Addiction](#), which offered specific recommendations and examples of how to adopt a comprehensive public health approach to addressing addiction in the realms of health care, criminal justice, and education. These recommendations recently were affirmed and elevated by [Facing Addiction in America: the Surgeon General's Report on Alcohol, Drugs, and Health](#).
- ✓ **Investing in the implementation of comprehensive, evidence-based addiction prevention and treatment initiatives**, as identified in our report, [Addiction Medicine: Closing the Gap between Science and Practice](#), with the goal of expanding treatment accessibility, ensuring quality care, and reducing the stigma associated with addiction.



- ✓ **Creating targeted prevention and treatment interventions** to reduce the initiation of substance use and the risk of addiction among young people, as addressed in our report, [Adolescent Substance Use: America's #1 Public Health Problem](#).
- ✓ **Unequivocally promoting the use of medication-assisted treatment (MAT) for opioid use disorders** and removing barriers for patients seeking to obtain this treatment. This includes addressing stigma, training and encouraging more providers to offer MAT, and removing restrictions imposed by insurance companies.
- ✓ **Expanding and maintaining insurance coverage for addiction treatment**, which is essential for increasing treatment access and providing evidence-based care. Unfortunately, as demonstrated in our report, [Uncovering Coverage Gaps: A Review of Addiction Benefits in ACA Plans](#), many states have not fully implemented the provisions of the Affordable Care Act (ACA) that are most pertinent to addressing this epidemic. Regardless of what happens at the federal level, states should ensure that their citizens have insurance coverage and that the plans sold in their state, as well as their Medicaid programs, provide comprehensive coverage for evidence-based addiction screening, intervention, and treatment.

Fundamental Steps States Must Take to Change the Course of the Opioid Crisis

Regardless of the specific action being taken, any state initiative to address opioid misuse and addiction should be held up to the following procedural standards to ensure that resources are well allocated and not wasted; that the impact is measurable, beneficial, and sustainable; and that the action results in improved and saved lives:

- ✓ **Conduct a needs assessment** to determine the exact nature and scope of the problem in the state, the population groups most affected by it, the availability of existing resources, and the gaps between needs and available resources. It is not advisable to put programs or policies into place without first ensuring that they will address the specific state's needs with regard to opioids. The National Governors Association produced a useful [policy development tool or road map](#) to help states implement targeted strategies to address the opioid crisis.
- ✓ **Implement a comprehensive approach** that addresses the problem from all angles: prevention, overdose reduction, treatment and recovery support, and criminal justice reforms. If states put all their resources into only one of these areas, they will not make a significant dent in the problem.
- ✓ **Utilize data-informed and evidence-based practices** when designing and implementing policies and programs. Sometimes what sounds like a good idea is not actually effective and may even be counterproductive. A very large body of research already exists documenting what works best with regard to opioid misuse prevention,

overdose reduction, addiction treatment, and criminal justice initiatives. Reinventing the wheel or making policy or programmatic decisions without consulting this evidence can result in wasted resources and, more importantly, wasted time. This is an emergency and we should not be experimenting with unproven strategies when we already know which actions have the best chance of working.

- ✓ **Evaluate the results of all initiatives, strategies, and interventions.** In the rush to end the opioid crisis, many states are putting into place policies and programs without an infrastructure for determining whether they work. As part of any state strategy, a rigorous and science-based evaluation should be planned, funded, and implemented to ensure that the practices that are put into place actually produce beneficial, long-term outcomes.
- ✓ **Provide adequate funding and resources** to ensure that all programs and policy initiatives have the financial support they need to be well implemented and to produce real results. The funding should be commensurate with the size and scope of this problem and with the recognition of the numerous short- and long-term costs to society of failing to address this crisis. States should invest wisely the federal dollars they receive through recent legislation to address this epidemic as well as state tax money.¹⁸ They should use their considerable leverage to ensure that all programs within the state that receive any state funding are addressing the opioid problem in a manner that reflects the evidence, as described in this guide and other credible resources.

Conclusions

To make significant and meaningful progress in ending the opioid crisis, all states must work to accomplish several basic goals, each of which is addressed in this guide along with specific recommended actions:

- ✓ **Prevent opioid misuse and addiction**
- ✓ **Reduce overdose deaths and other harmful consequences**
- ✓ **Improve opioid addiction treatment**
- ✓ **Improve addiction care in the criminal justice system**

Now, more than ever, it is important for states to assume the role of adopting a public health approach to the opioid crisis, and to addiction more generally. States can build on the momentum at the federal level to implement a public health approach to the problem, using the funds that have been made available to them through recent landmark pieces of legislation, including the Comprehensive Addiction and Recovery Act (CARA) and the 21st Century Cures Act.¹⁹

Each state faces unique challenges in tackling this problem and must tailor their responses accordingly. To be successful, a collaborative approach is necessary in which all stakeholders have a significant say in the strategy, significant responsibility for implementing its components, and significant accountability for monitoring and demonstrating its effectiveness. Policies, programs, and initiatives should not be developed and implemented on the basis of intuition, anecdote, emotion, or political expediency. Instead, they should be informed by data and evidence. They should be designed to ensure that we bring an end to this devastating epidemic via a compassionate approach based in good science and health-based solutions, rather than a combative approach based in fear, stigma, shame, and despair. We've been operating under the latter frame of mind for decades to no avail. Let's try something new.

The National Center on Addiction and Substance Abuse's *Ending the Opioid Crisis: A Practical Guide for State Policymakers* was prepared by Lindsey Vuolo, JD, MPH, Associate Director of Health Law and Policy; Tiffany John, LMSW, Research Associate; and Linda Richter, PhD, Director of Policy Research and Analysis, with the assistance of Emily Feinstein, JD, Director of Health Law and Policy. Many staff members contributed to the development and preparation of this guide, but we would especially like to thank Jennie Hauser; David Man, PhD, MLS; Jason Besser, MPP; and Robyn Oster, BA. Andrea Roley, BA; Hannah Freedman, BS; and Elizabeth Mustacchio, MBA, managed the communications, marketing, and distribution activities.

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While many individuals contributed to this effort, the opinions and recommendations expressed herein are the sole responsibility of The National Center on Addiction and Substance Abuse. ■

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Prevent Opioid Misuse and Addiction

The undeniably best way to avoid the costly consequences of opioid misuse and addiction is to invest in effective prevention and early intervention to reduce its incidence.

Effective prevention is comprised of public education and awareness that helps to reduce the appeal of addictive substances; evidence-based addiction prevention programming; and laws, regulations, and policies that reduce the availability and accessibility of opioids and other drugs, particularly to young people. The use of screenings and early interventions to identify individuals who are at risk for or already using addictive opioids is essential for preventing opioid misuse from progressing to addiction.

Parents are on the front lines and are most influential in preventing youth substance use. Therefore, state resources must be allocated to educating parents about opioid misuse and addiction and about how to help ensure that their children do not go down the dangerous path of addictive substance use.



After parents, professionals in the health care, education, justice, and other social service sectors -- particularly those who come into contact with young people -- should be properly trained to engage effectively in prevention and early intervention efforts. They should be well equipped to educate the populations they serve about opioid misuse and addiction, identify risky use or signs of addiction, know how to respond when such cases are identified, and participate in strategies to reduce the availability and accessibility of these addictive substances.¹

Effective prevention employs a comprehensive approach to target all addictive substances and all influences on or determinants of the use of those substances. However, due to the current opioid epidemic, these methods should be supplemented by measures that specifically target opioids.

An Effective and Comprehensive Approach to Prevention

- Implement Effective Public Education/Awareness Campaigns
- Ensure that Schools and Communities Implement Effective Prevention Initiatives
- Reduce Availability of and Accessibility to Addictive Opioids
 - Prescription Drug Monitoring Programs (PDMPs)
 - Safe Prescribing Initiatives for Pain Management
 - Prescription Drug Take-Back Programs
- Implement Effective Professional Training in Addiction Care
- Screening, Brief Intervention, and Referral to Treatment (SBIRT)

Implement Effective Public Education/Awareness Campaigns

Public education and awareness campaigns have a successful history of raising awareness of emerging and growing public health problems.² Such campaigns are critical for improving understanding about the risks of substance use and how to avoid those risks, informing the public about useful resources and treatment options, and reducing stigma, which can dissuade people from seeking help.

Recommendations for States to Implement Effective Public Education/Awareness Campaigns

- Develop prevention campaigns based on consumer research and evidence-based prevention strategies.
- Educate the public about the nature of risky substance use and addiction (e.g., the higher risk associated with use at a young age, the consequences of use) and how best to prevent and treat it.
- Invest in public education and awareness campaigns that are instructive in terms of concrete steps parents can take to help protect their children.



RESOURCES [Partnership for Drug Free Kids](#) has many resources of this nature for parents that states can use.

- Use data to identify the most pressing issues within a particular state and the populations or groups most at risk, and target the campaigns accordingly.
- Frame addiction as a chronic medical disease that can be treated effectively with medication and behavioral health services (medication-assisted treatment, or MAT).³
- Create separate, targeted campaigns for people who already engage in opioid misuse to communicate specific urgent safety concerns (e.g., the high risk of overdose from fentanyl, transmission of blood-borne diseases).⁴
- Design campaigns to reduce rather than promote stigma⁵ via a variety of mediums to communicate messages (e.g., television/radio public service announcements, social media, websites, billboards, brochures, posters).
- Evaluate the impact of these campaigns through credible and independent research, and adjust their messaging and implementation accordingly.



Examples of State Public Education/ Awareness Campaigns*



COLORADO

[Take Meds Seriously](#)



GEORGIA

[Generation RX project](#)



MASSACHUSETTS

[Stop Addiction Before it Starts](#)



NEW HAMPSHIRE

[Anyone Anytime](#)



NEW MEXICO

[Heroin and Opioid Prevention and Education \(HOPE\)](#)



NEW YORK

[Combat Heroin](#)
[HealingNYC: I Saved a Life](#)



NORTH DAKOTA

[Prevention Resource and Media Center](#)



PENNSYLVANIA

[Stop Opiate Abuse](#)



RHODE ISLAND

[Prevent Overdose Rhode Island](#)



UTAH

[Use Only as Directed](#)



VIRGINIA

[VaAware](#)



WISCONSIN

[Dose of Reality](#)

Ensure that Schools and Communities Implement Effective Prevention Initiatives

Addiction is a disease that often originates with substance use in adolescence. As such, adolescence is *the* critical period of risk for both initiation of substance use and for experiencing its harmful consequences. Addictive substances directly affect students' functioning and increase the risk of cognitive impairment, poor academic performance, and school dropout.⁶ Since young people spend the majority of their time at school, academic institutions have significant leverage -- and a significant responsibility -- to influence and manage the substance-related attitudes and behavior of their students. This includes helping to prevent use, intervening early with students already engaged in substance use, and linking those with addiction to effective treatment. Prevention programs also should involve parents and families, especially those of higher-risk students, because parents generally have the most influence over their children when it comes to substance use-related decisions and behaviors and because families embody many of the risk and protective factors that most strongly predict youth substance use and addiction.

* The examples listed here and in subsequent sections of this and the remaining chapters are provided to illustrate how some states have implemented a program or policy consistent with one of the broader recommendations presented in the section. Inclusion of these examples does not constitute an endorsement of the policy or program or any conclusion regarding its effectiveness.

Research supports the need for funding, designing, and implementing school- and community-based prevention programming that includes evidence-based initiatives to reduce risk factors and bolster protective factors, as well as protocols for screening students for early signs of risk. Many existing school- and community-based programs lack the intensity or comprehensiveness needed to be effective. Existing programs and initiatives that do not meet standard scientific criteria for effectiveness should be modified or replaced with those for which effectiveness has been documented in controlled research studies. The priority should be to direct scarce resources toward scientifically supported prevention efforts.



RESOURCES [Blueprints for Healthy Youth Development](#) and the [National Registry of Evidence-based Programs and Practices \(NREPP\)](#) are sources for finding evidence-based prevention programs.

Schools should take a health-based approach rather than a punitive approach to substance use prevention and intervention. Punitive policies that result in removing students from academic, social, health, and other support services should be avoided because they can exacerbate risk factors and increase the chance that students will develop problems. Although students should be held accountable for their choices and behavior, the emphasis should be on safeguarding students' short- and long-term health and safety rather than depriving them of pro-social activities and opportunities.

States play a vital role in shaping school- and community-based prevention efforts, through both standards they set and the funding from federal and state revenue that they give to schools and communities. The U.S. Centers for Disease Control and Prevention (CDC) is providing funding to states to support prevention efforts through its [Prevention for States](#) and [Data-Driven Prevention Initiative](#) programs. The funding helps states advance and evaluate their actions to address opioid misuse and overdose.⁷

Recommendations for States to Ensure that Schools and Communities Implement Effective Prevention Initiatives

- Require schools to deliver evidence-based prevention approaches.
- Encourage schools to maintain a health and wellness, rather than a punitive, focus with regard to student substance use and addiction.
- Comprehensively address the full range of risk factors known to increase substance use (e.g., poor coping skills, trauma, family history of substance use, peer substance use, psychiatric symptoms or disorders like depression and anxiety) and the protective factors known to decrease risk (e.g., academic opportunities and achievement, family and peer support, a nurturing school or community environment).



- Address all addictive substances as well as co-occurring health (including mental health) conditions.
- Ensure that prevention initiatives are sensitive to age, gender, sexual orientation, and racial, ethnic, religious, or cultural group.
- Ensure that prevention initiatives are implemented with fidelity and carried out by trained prevention specialists.
- Include a special focus on children and adolescents who are most vulnerable to substance use initiation and to the addicting effects of drugs.
- Use school websites to provide drug education and helpful resources to students and parents.⁸
- Have school athletic programs focus on risks of opioid use and misuse among student athletes.⁹
- Use state/local taxes to fund prevention efforts.

Examples of State School- and Community-Based Prevention Initiatives



CALIFORNIA

Getting Results: A web-based collection of resources for California school districts to use in implementing research-based strategies for alcohol, tobacco, and other drug prevention programs.



COLORADO

Rise Above Colorado: A collaboration between the Colorado Meth Project and the Partnership for Drug-Free Kids that uses public education strategies and community outreach to influence young people's perceptions about substances with the goal of reducing use.



MARYLAND

A [toolkit](#) developed by the Maryland State Department of Education provides several resources to educate students, parents, and educators about addiction; how to deter students from using drugs; and how to access needed services.

Maryland law now requires the development and implementation of drug prevention in public schools to students in grades 3-12. The program must include instruction related to opioid addiction and prevention, including education on fentanyl.¹⁰ The state also now requires state-funded colleges and universities to provide heroin and other opioid addiction prevention and awareness education to incoming students.¹¹



MASSACHUSETTS

Project Here: A public-private initiative that provides substance use prevention programming to all public middle school students and mobile device content for students, teachers, and parents around substance use prevention.



MICHIGAN

Michigan Model for Health: A comprehensive health education program for students in grades K-12 that uses age-appropriate and skill-based learning modules to address several health concerns students face, including substance use. Research shows that students participating in the curriculum had greater knowledge about substance use, more negative attitudes toward substance use, and stronger drug refusal skills.*¹²



NEW YORK

The New York State Office of Alcoholism and Substance Abuse Services (OASAS) has a set of prevention guidelines for implementing prevention programs in the state. OASAS guidelines are based on prevention research focused on risk and protective factors and include an OASAS approved [Registry of Evidence-based Programs for Prevention](#), available to state providers.¹³

* This curriculum is nationally recognized by registries such as the Collaborative for Academic, Social and Emotional Learning (CASEL) and SAMHSA's National Registry of Evidence-Based Programs and Practices.



Reduce Availability of and Accessibility to Addictive Opioids

Reducing the availability of addictive substances is critical for reducing their use. A notable example is tobacco. The greatest decline in smoking in our country occurred in conjunction with policy initiatives and strict government regulations aimed at restricting the sale and marketing of cigarettes and the locations in which they can be used.

With regard to opioid addiction, effective enforcement of laws aimed at curtailing the illegal drug trade can have an impact on the availability and accessibility of heroin and potent synthetic drugs that have no known medical value. However, when it comes to the misuse of prescription opioids, other means are necessary

to curtail their supply and availability. Millions of people rely on prescription pain relievers, and these medications are invaluable in medical treatment. Yet, their over-prescription during the past few decades has contributed to an abundance of such medications within easy reach of just about every individual in the United States, and their ready accessibility has contributed to their misuse and to the growing opioid epidemic. In fact, in the majority of cases, the misuse of prescription opioids precedes the use of heroin and other illicit opioids.¹⁴ Several initiatives have been put into place throughout the United States to try to rein in the supply of such medications and help assure that they are being used only by people for whom they were prescribed for a legitimate medical purpose and that they are being used as directed.

Prescription Drug Monitoring Programs (PDMPs)

The overprescribing or inappropriate prescribing of opioid medications profoundly increases the risk of opioid misuse and addiction and overdose deaths. Prescription drug monitoring programs (PDMPs) are state-run electronic databases used to track the prescribing and dispensing of controlled prescription drugs to identify suspected misuse, doctor shopping, or diversion.* These programs can be designed to reduce the misuse of controlled prescription drugs and identify individuals who may benefit from treatment, while permitting the enforcement of federal and state laws in a manner that is least disruptive to medical and pharmacy practice. Currently, PDMPs are operating in 49 states and Washington D.C. On July 17, 2017, the governor of Missouri, the only state without an operating PDMP, signed an executive order to create a PDMP.¹⁵ Still, evidence suggests that these programs are significantly underutilized by health care providers¹⁶ due to a variety of factors, including the cumbersome nature of accessing the system and privacy concerns. As of June 2016, 26 states require prescribers to use the PDMP before prescribing opioids;¹⁷ this requirement is essential for realizing the potential of this tool to affect prescribing practices and opioid misuse. The state-by-state patchwork of PDMP programs and policies also makes coordination between states difficult, which can undermine the ability to prevent cross-state doctor shopping and diversion.

Although the use of PDMPs alone will not solve the opioid crisis, particularly as more and more people are moving from misusing prescription opioids to illicit opioids, PDMPs are certainly a critical part of any comprehensive strategy to reduce opioid misuse and its devastating consequences.

Recommendations for States to Reduce Availability of and Accessibility to Addictive Opioids with Prescription Drug Monitoring Programs

- Adopt best practices for the design and implementation of PDMPs.



RESOURCES [The National Alliance for Model State Drug Laws \(NAMSDL\)](#) provides numerous resources for states related to PDMPs.¹⁸

[Shatterproof](#) defined the critical elements of state legislation for PDMPs and offered 12 guiding practices to maximize their effectiveness.¹⁹

The [Institute for Behavioral Health, Heller School for Social Policy and Management at Brandeis University and The Pew Charitable Trusts](#) published a report identifying key evidence-based practices to increase prescriber utilization of PDMPs.²⁰

[The Prescription Drug Monitoring Program Training and Technical Assistance Center](#), a partnership between The Bureau of Justice Assistance and Brandeis University, seeks to improve the effectiveness of PDMPs by promoting best practices and providing resources and support to various stakeholders.

* Doctor shopping is when patients obtain controlled prescription drugs from several doctors for the purpose of misusing those drugs and diversion is when drugs are diverted or sidetracked from their lawful (medical) purpose to illicit use.

¹ As of July 2017, the details of the PDMP were still being worked out.

Examples of State Prescription Drug Monitoring Program (PDMP) Initiatives That Have Been Subject to Evaluation



KENTUCKY

The first state to mandate comprehensive use* of PDMPs in 2012,²¹ Kentucky saw a 26 percent decrease in overdose hospitalizations related to prescription opioids between 2011 and 2013.²²



MAINE

Maine Diversion Alert is a statewide program for medical and law enforcement professionals that alerts health care providers if a patient has been arrested for diverting or misusing prescription drugs. This tool is intended to help prescribers determine if a patient is likely to misuse or divert prescription medications and to adjust patient care accordingly. In one study, 84 percent of study participants credited the Diversion Alert program for improved opioid prescribing practices, and 52 percent reported having identified at least one at-risk patient as a result of the program.²³



NEW YORK

One of the first states to mandate prescribers' use of a PDMP prior to issuing any Schedule II, III, or IV prescription drug, New York found that increased PDMP utilization was associated with a 75 percent reduction in opioid prescriptions and doctor shopping during the first year of mandated use.²⁴



OHIO

In 2011, Ohio implemented pain clinic regulations and required prescribers to review PDMP data. Between 2010 and 2015, per capita opioid prescribing decreased by 85 percent.²⁵



OKLAHOMA

Oklahoma implemented the first PDMP to offer real-time data reports[†] to help pharmacists and physicians make timely clinical decisions when prescribing opioids. Drug-related overdoses decreased from 807 in 2011 to 578 in 2012.²⁶

Safe Prescribing Initiatives for Pain Management

Prevention of opioid misuse and addiction requires that opioid medications for pain management are prescribed and administered appropriately with the aims of both helping to control patients' pain and reducing the risk of misuse. Physicians who are unaware of the risk of misuse and diversion of certain controlled prescription medications may inadvertently facilitate their occurrence by prescribing inappropriately, inadequately monitoring patients' outcomes to determine whether they are improving with treatment, or failing to determine whether patients are receiving prescriptions for medications from multiple sources (i.e., "doctor shopping"). Uninformed or negligent prescribing of controlled prescription medications can result in a surplus of prescription drugs in medicine cabinets and elsewhere that is easily accessible to young people seeking to misuse them or to adults seeking to divert them for self-medication or illicit purposes. Excessive prescribing also conveys to patients of all ages, and young people in particular, that controlled prescription medications are safe.

* When states first began implementing PDMP mandates, prescribers had to use subjective judgments, such as checking the PDMP only if the prescriber believed the patient might be doctor shopping. States found these requirements to be ineffective and instead mandated PDMP queries that applied to all initial controlled substance prescriptions -- substances in Schedule II, III, or IV categories -- or certain circumstances such as when prescribing to a new patient. Comprehensive mandates apply to all prescribers and, at a minimum, to all initial opioid prescriptions issued to patients.

[†] Pharmacies submit data to state PDMPs along a range of time intervals, from daily to monthly. However, "real-time" data reports are uploaded and transmitted in under five minutes. Having more timely data capitalizes on the utility of the PDMP and reduces the chances that providers will not have access to important patient information. Oklahoma is currently the only state to offer real-time data reports.

All prescribers should be required to receive specialized education and training in prescribing and administering controlled prescription drugs, monitoring patients who take these drugs, and identifying cases of misuse and diversion. Research-based professional guidelines should be used to inform best practices in preventing misuse and diversion and health professionals should be trained in how to implement these recommended prescribing practices. As of July 2016, 22 states have adopted prescribing guidelines.²⁷ Imposing limits on the number of opioids that can be prescribed for acute pain is another strategy used to help prevent misuse and diversion.

Recommendations for States to Reduce Availability of and Accessibility to Addictive Opioids with Safe Prescribing Initiatives for Pain Management

- Adopt professional guidelines on opioid treatment for chronic pain as the state’s prescribing guideline.²⁸
 - Utilize the Centers for Disease Control and Prevention’s (CDC) [Guideline for Prescribing Opioids for Chronic Pain](#). Several states are adopting the CDC’s prescribing guideline in their Medicaid program.²⁹
- Educate and train health professionals in safe prescribing.
 - Mandate education and training in pain management, safe prescribing, and addiction for all prescribers of controlled substances (physician assistants, nurses, physicians, dentists, oral surgeons, and veterinarians).
- Pass laws to impose limits on the number and amount of opioids that can be prescribed.

Examples of State Safe Prescribing Initiatives for Pain Management



KENTUCKY, NORTH CAROLINA, OREGON AND WISCONSIN

Adopted prescribing guidelines based on the [CDC’s guidelines](#).³⁰



CONNECTICUT

Imposes a seven-day limit for first time prescriptions for adults and for all prescriptions for minors.³¹



MASSACHUSETTS

Requires prescribers of controlled substances to be trained in pain management; risks associated with opioid medications; identifying risk factors for substance use disorders; counseling patients about side effects, proper storage and disposal of prescription medications; appropriate prescription quantities; and overdose prevention.³²

Imposes a seven-day limit for first time prescriptions for adults and for all prescriptions for minors.³³



NEW JERSEY

Requires training for health care providers on responsible prescribing practices; opioid alternatives for pain management; and risks of opioid misuse, addiction, and diversion.

Has a five-day limit for initial prescriptions of opioids for procedures that cause acute pain.³⁴



NEW YORK

Requires course work or training in pain management, palliative care, and addiction for providers who prescribe controlled substances.³⁵

Limits initial opioid prescriptions for acute pain to a seven-day supply; other prescriptions are limited to a 30-day supply.³⁶



NORTH CAROLINA

[Project Lazarus](#) is a community-based public health prevention model based in Wilkes County that achieved a decrease in the rate of opioid-related overdose deaths by, among other things, providing one-on-one provider education and continuing medical education programs.³⁷



RHODE ISLAND

Limits initial opioid prescriptions for acute pain to a maximum of 30 morphine milligram equivalents per day, with a maximum of 20 doses per prescription.³⁸



VERMONT

Imposes opioid limits based on level of pain and age of the patient.³⁹

Prescription Drug Take-Back Programs

Disposing of unused, unwanted, or expired prescription medications is an important part of reducing the accessibility of addictive prescription opioids and helping to ensure public safety. Research suggests that about 61 percent of prescribed medicines are not consumed.⁴⁰ It is important that prescription drugs get disposed of properly to reduce the risk of unintentional use, misuse, or overdose. When thrown in the trash, these medications can still be retrieved and diverted, and flushing them can contaminate the water supply. Medicine take-back programs are a safe way to dispose of most types of medications and reduce the supply and accessibility of addictive opioid medications that potentially may be misused or diverted.⁴¹

Recommendations for States to Reduce Availability of and Accessibility to Addictive Opioids with Prescription Drug Take-Back Programs

- Install drug collection boxes and utilize mail-back programs for receiving and disposing of unwanted prescription drugs.⁴²
 - Permit authorized pharmacies, law enforcement facilities, and other venues to implement these programs.
- Enact a mandatory drug take-back program.



RESOURCES The Network for Public Health Law has an [issue brief](#) on mandatory drug stewardship (drug take-back) programs in states and municipalities in the United States.⁴³



Examples of State Prescription Drug Take-Back Programs



CALIFORNIA

Seven counties and the city of San Francisco have passed local laws and ordinances mandating that pharmaceutical companies that manufacture certain medications fund their disposal.*⁴⁴



MAINE

Maine launched a drug-take back program that features a public and private collaboration to set up drug-take back stations. [MedReturn Drop Boxes](#) are stationed in a way that allows anyone to return unused medications anonymously. The coalition also holds take-back events and posts drop box locations on its website.



MASSACHUSETTS

In 2017, Massachusetts became the first state to require manufacturers to finance safe disposal of medications.⁴⁵



NEW YORK

In May 2017, the New York State Department of Environmental Conservation (DEC) launched a pilot pharmaceutical take-back program and will purchase medication collection boxes for participating pharmacies to install on site. It also will cover all costs associated with transportation and disposal of medications for two years.⁴⁶

In 2015, New York passed legislation allowing manufacturers, distributors, reverse distributors, treatment programs, hospitals/clinics with an on-site pharmacy, and retail pharmacies to apply directly to the Drug Enforcement Administration (DEA) for registration as a "Collector." This replaced a prior rule requiring the Commissioner of Health to designate sites for disposal.⁴⁷



PENNSYLVANIA

The [Pennsylvania Prescription Drug Take-Back Box Program](#) established over 580 take-back locations in 67 counties.⁴⁸



WASHINGTON

Two counties passed local ordinances requiring manufacturers to finance safe disposal of medications.⁴⁹



WISCONSIN

In 2016, Milwaukee, in partnership with the Milwaukee Metropolitan Sewerage District and CVS Pharmacy, launched the first public-private drug mail-back program. This two-year pilot program allows city residents to dispose of unused medications in pre-paid envelopes addressed to local police departments.⁵⁰ Wisconsin's [Dose of Reality](#) website provides information on mail-back programs and drug take-back days and locations.

* *Alameda, California's Safe Drug Disposal Ordinance*: Alameda was the first jurisdiction to pass a law requiring manufacturers to pay for drug take-back programs. Manufacturers are required to set up disposal kiosk sites throughout the county and promote the program through educational and outreach materials.

Implement Effective Professional Training in Addiction Prevention Care

Investing in the education and training of professionals who are best positioned to help prevent the initiation and misuse of opioids is essential for reducing opioid misuse and addiction. It also is incumbent upon professionals providing public services (e.g., health, education, justice, social welfare) to know how to address these problems effectively because they often are in contact with individuals who are at risk for or already engaging in the risky use of addictive substances, as well as those who have addiction. Professionals who do not provide direct addiction-related services but who come into contact with significant numbers of individuals who engage in risky substance use or who may have addiction should have a level of knowledge that surpasses that of the lay public about these issues and how to address them.



Recommendations for States to Implement Effective Professional Training in Addiction Care

- Educate and train health professionals in the predictors of risky substance use and addiction; prevention, intervention, treatment, and management options; co-occurring conditions; and special population and specialty-care needs.
 - Require training for all health care providers, including physicians, physician assistants, nurses and nurse practitioners, dentists and clinical mental health professionals (psychologists, social workers, counselors). Core competencies include understanding what constitutes risky substance use, the harms of such use to health and safety and the importance of reducing risky use; the causes and correlates of addiction; how to screen for risky substance use; and how to conduct brief interventions and refer to specialty treatment, when necessary.⁵¹
 - Mandate education and training in these topics for all providers as a condition of licensure and continuing education (CE) credits.⁵²
 - Include addiction prevention in accreditation standards for health care organizations.
- Educate non-health professionals -- including educators, law enforcement and other criminal justice personnel, legal staff, and child welfare and other social service workers -- about risky substance use and addiction.

Examples of State Actions to Implement Effective Professional Training in Addiction Care



CONNECTICUT

Due to the number of caregivers involved in the child welfare system who receive medication-assisted treatment (MAT), the Department of Children and Families collaborated with the Department of Mental Health and Addiction Services and the Judicial Branch to create a statewide training initiative, *Medication-Assisted Treatment Education Sessions*, to bolster knowledge of MAT across the child welfare, treatment, and justice systems. As of 2016, 261 individuals were trained throughout the state.

The Workforce Development Collaborative with the Department of Children and Families, Department of Mental Health and Addiction Services, Judicial Branch, the Connecticut Women's Consortium, and Advanced Behavioral Health offer trainings for staff working with substance-involved families to increase access to care and limit court involvement.⁵³



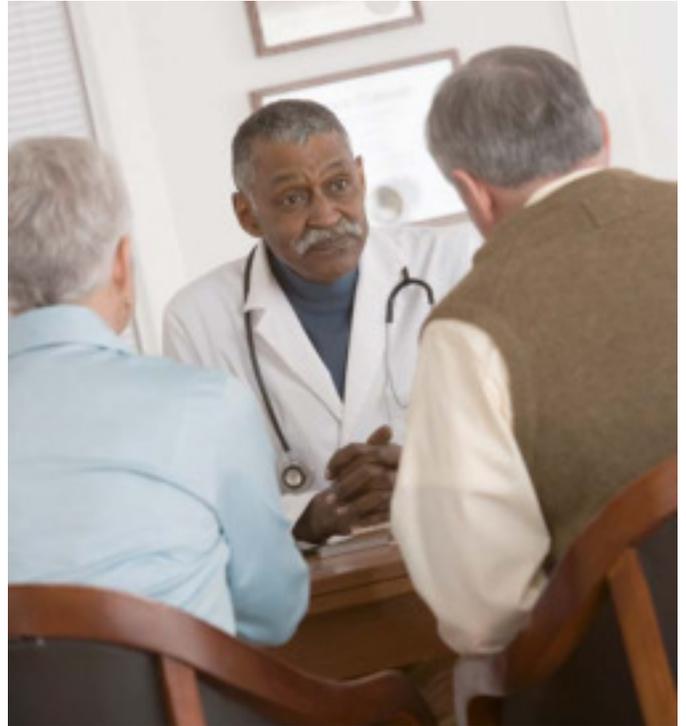
MASSACHUSETTS

The Department of Elementary and Secondary Education's *Guidance on School Policies Regarding Substance Use Prevention* instructs school districts to provide guidance around substance use, including training for faculty and staff. Training includes recognizing early warning signs and behaviors related to substance use and understanding how to provide referrals for treatment and/or additional services.⁵⁴



NEW JERSEY

Professional Development Requirements in Statute and Regulations require public school teachers to complete training in substance use and addiction. Training includes prevention, recognizing symptoms and behavioral patterns, appropriate intervention strategies, and treatment options for students showing signs of substance misuse.⁵⁵



Implement Effective Screening, Brief Intervention, and Referral to Treatment (SBIRT) Initiatives to Reduce Opioid Misuse and Addiction

Health care professionals should be provided with resources and incentives to identify substance-related problems and address them early. Screening and early intervention should be incorporated into routine health care practice and health services offered through schools, justice systems, and social services programs. Providing screening and brief interventions in routine health care practice is particularly effective because people tend to be more receptive to health messages once they are in a health care setting. Individuals who screen positive for risky substance use, such as opioid misuse, should be referred to a trained health professional for intervention, diagnosis, treatment, and disease management.

Recommendations for States to Implement Effective SBIRT Initiatives to Reduce Opioid Misuse and Addiction

- Establish a state SBIRT program and educate, train, and incentivize health care professionals to understand the predictors of risky substance use and addiction, particularly with regard to opioids, and to address these conditions in their practices.



RESOURCES The Substance Abuse and Mental Health Services Administration (SAMHSA) funds 32 [State Cooperative Agreements](#) for SBIRT programs.*⁵⁶

The National Institute on Drug Abuse has a useful resource guide, [Screening for Drug Use in General Medical Settings](#).

- Cover SBIRT in states' Medicaid programs and essential health benefits (EHB) benchmark plans. Several states have activated SBIRT Medicaid codes.⁵⁷



RESOURCES SAMHSA provides several resources on reimbursement for SBIRT.⁵⁸

- Screen students in schools to identify youth at risk for substance use or addiction and refer those in need to brief interventions or treatment.
- Support health care systems that provide SBIRT services. ■

Examples of State Actions to Implement Effective SBIRT Initiatives to Reduce Opioid Misuse and Addiction



CONNECTICUT AND MASSACHUSETTS

Project ASSERT (Alcohol & Substance Abuse Services, Education, and Referral to Treatment) is an emergency department program in New Haven, CT⁵⁹ and Boston, MA⁶⁰ where non-clinician health promotion advocates provide SBIRT services.



MASSACHUSETTS

Legislation signed in March 2016 requires all public schools to conduct verbal screenings of students for substance use problems.⁶¹



NEW YORK

The National Center on Addiction and Substance Abuse, in partnership with Northwell Health and the New York State Office of Alcoholism and Substance Abuse Services (OASAS), has incorporated SBIRT into Northwell's primary care practices and emergency departments.⁶² A main goal of the project is to build a sustainable model for incorporating SBIRT into health care settings that can be replicated throughout New York State.

* Cooperative agreements are a type of contract between state and federal agencies that allow a federal agency to provide assistance with a degree of participation and oversight.

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Reduce Overdose Deaths and Other Harmful Consequences

Throughout the nation, states are seeing an unprecedented number of their citizens die from opioid overdoses.

In 2015, there were 33,091 reported opioid overdose deaths in the United States -- 15,281 related to prescription opioids and 12,989 related to heroin. Opioid overdose deaths accounted for the majority (63.1 percent) of the 52,404 drug-related overdose deaths that year.¹ That is more than 90 deaths every day from opioids, including prescription pain relievers, heroin, and the synthetic opioid fentanyl, which can be 50 times more potent than heroin.² Unofficial estimates show continued increases in overdose death rates for 2016.³

These deaths are largely avoidable thanks to naloxone (Narcan® or Evzio®), a prescription medication that reverses the effects of overdose from illicit and prescription opioids and that is relatively easy to administer. It is estimated that there are 30 nonfatal overdoses for every fatal overdose.⁴ Yet, despite the existence of this life-saving tool, significant barriers to accessing naloxone have limited its reach and the number of people who could have been saved as the opioid crisis continues to worsen. Recent findings from a 2015 national survey of senior staff at alcohol and other drug agencies indicate that cost, stigma, liability concerns, and prohibitions against third party prescribing are ongoing obstacles to naloxone access in states across the nation.⁵ Other challenges include the need for multiple doses of naloxone to reverse overdoses from synthetic opioids (e.g., fentanyl) and the rising cost of the medication.⁶



Still, all states have implemented a law or developed a pilot program to expand access to naloxone, such as by allowing first responders and lay persons to administer it to someone who has overdosed.⁷ Naloxone administration by laypersons has averted tens of thousands of overdose deaths.⁸ The majority of states also have adopted Good Samaritan laws, which protect individuals from civil or criminal liability (for drug possession and/or administration of the medication) when administering naloxone or alerting authorities about a suspected overdose.⁹ Some of these laws are comprehensive and provide broad protection, whereas other states' laws are more limited.¹⁰ A recent analysis of national data found that the adoption of such laws is associated with a 9 to 11 percent reduction in opioid overdose deaths and does not contribute to an increase in the misuse of prescription opioids.¹¹

An Effective and Comprehensive Approach to Reducing Opioid Overdose Deaths and Other Harmful Consequences

- Increase Access to Naloxone
- Implement Syringe Exchange Programs (SEPs)
- Monitor and React Rapidly to Emerging Drug Trends



Increase Access to Naloxone

An opioid overdose can occur just about anywhere -- in the home, at a school or place of employment, in a store, or out on the street. The more readily available naloxone is, the greater the chance of a successful overdose reversal and of saving a life.

Naloxone should be distributed at all points of contact with individuals who may use opioids and be at risk of overdose. These include the more obvious locations, like opioid treatment programs (OTPs), outpatient and residential treatment centers, detoxification facilities, emergency departments, syringe exchanges, and criminal justice settings and reentry programs. The timing of distribution in these settings is critical; the times of highest risk of overdose are upon an individual's release from treatment or criminal justice confinement back into the community. Less obvious but necessary locations for the distribution of naloxone include schools, workplaces, community centers, health clubs and gyms, public transportation venues, pharmacies, and even in lockboxes on street corners.

Ensuring access to naloxone requires funding for the life-saving drug. Every state's Medicaid program covers naloxone, and 26 states include at least one of the formulations on their preferred drug lists.¹² Medicaid can also be used to purchase naloxone kits for laypersons.¹³ Since 2014, there have been roughly 11,500 overdose reversals due to Medicaid-financed

naloxone.¹⁴ Some state and local agencies, such as health departments and law enforcement agencies, use their budgets to purchase naloxone.¹⁵ Naloxone can also be purchased by public/private partnerships and through reimbursement from private insurance companies.¹⁶ Finally, states purchase naloxone with funding from federal grants through the Substance Abuse and Mental Health Services Administration's (SAMHSA) Substance Abuse Prevention and Treatment (SAPT) block grants, the Comprehensive Addiction and Recovery Act (CARA), the 21st Century Cures Act, the Comprehensive Opioid Abuse Program (COAP), the Byrne Justice Assistance Grants Program, High Intensity Drug Trafficking Area (HIDTA) grants, and the COPS Anti-Heroin Task Force (AHTF) Program.¹⁷



Despite its life-saving potential, naloxone is not a treatment for opioid addiction.

It is a stopgap measure to help an individual who is in immediate danger of dying. On its own, it will not resolve the opioid epidemic or reduce opioid use and addiction. Individuals receiving naloxone due to an overdose must immediately be connected to effective addiction treatment. Yet, this is not happening; a recent study found that only 33 percent of individuals who experience a heroin overdose and 15 percent of individuals who experience a prescription opioid overdose receive evidence-based treatment for opioid addiction following the overdose.¹⁸



Recommendations for States to Increase Access to Naloxone

- Model the availability and accessibility of naloxone on public access defibrillation laws. These laws make automated external defibrillators (AEDs) available in a wide variety of locations for use by the public in the event of a sudden cardiac arrest, without liability concerns.¹⁹
- Conduct aggressive outreach to at-risk populations and their families.²⁰
- Train all law enforcement and first responders to administer naloxone and supply them with an adequate supply of the medication.
- Allow laypersons (family and friends) to obtain and administer naloxone, and provide them with appropriate training.
- For those states that have not yet done so, adopt a Good Samaritan law to protect first responders and laypersons from civil or criminal liability for responding to a suspected overdose, and prescribers and dispensers from liability for prescribing, dispensing, or distributing naloxone to a layperson.²¹ For those states that have implemented such a law, raise awareness about its existence (e.g., via a media campaign) and conduct trainings with law enforcement and prosecutors to ensure the law is properly enforced.²² As of June 2017, 40 states and the District of Columbia have adopted some form of a Good Samaritan law.²³
- Allow organizations not otherwise permitted to dispense prescription medications to obtain, store, and dispense naloxone.²⁴ This includes syringe exchange programs.²⁵
- Permit third party prescribing of naloxone, so that prescriptions can be written directly to caregivers, family members, or friends who may witness and assist a person who is at risk of opioid overdose. As of August 2016, 44 states allow for third party prescribing.²⁶
- Allow pharmacists to dispense naloxone with a standing order,^{*} collaborative practice agreement,[†] or under the pharmacist's prescriptive authority.²⁷ As of August 2016, 42 states allow for standing orders and five states allow some pharmacists to prescribe naloxone on their own authority.²⁸
- Educate pharmacists about the risks of overdose so they can counsel patients to whom they dispense opioid medications.²⁹
- Require the prescribing of naloxone along with any prescription for a controlled opioid medication.
- Create a centralized naloxone procurement and distribution process at the state level and negotiate with manufacturers for a competitive pricing agreement.³⁰
- Require insurers to reimburse for naloxone for individuals with opioid addiction and for their families.³¹
- Include a formulation of naloxone on the state's Medicaid Preferred Drug List and use Medicaid reimbursement to purchase naloxone kits for laypersons.³²
- Implement a unified reporting mechanism for naloxone administration to track non-fatal overdoses (i.e., successful overdose reversals).³³
- Ensure access to treatment and follow-up services after naloxone administration.³⁴

* The prescription of a medication to a person with whom the prescriber does not have a prescriber-patient relationship and in which the prescriber authorizes the provision of medication to any person who meets predetermined criteria.

† Collaborative practice agreements are formal relationships between a pharmacist and another health care provider to specify what additional services can be provided that are normally beyond the scope of the pharmacist.

Examples of Promising State Initiatives to Increase Access to Naloxone*



CALIFORNIA AND NEW YORK

Include all injectable forms of naloxone on their Medicaid Preferred Drug Lists.³⁵



ARIZONA

Arizona's Medicaid program purchases naloxone kits for use in overdose reversal by laypersons.³⁶



MARYLAND

The Department of Health and Mental Hygiene's *Maryland Overdose Response Program* provides overdose response training and, upon completion, certificates for individuals to obtain naloxone without a prescription, pursuant to the state's standing order.³⁷ A recent change to the law permits pharmacies to dispense naloxone to individuals even if they have not obtained the trainings. This essentially makes naloxone available over-the-counter.³⁸

A provision of Maryland law directs each county board to establish a policy to require schools to store naloxone and authorizes school nurses or other professionals to administer naloxone at school.³⁹ State-funded universities also must store naloxone.⁴⁰

Baltimore City directed one of the most aggressive opioid overdose prevention campaigns in the country, training over 8,000 people to use naloxone in high-risk areas including jails, public housing, bus shelters, street corners, and markets. One program, [Staying Alive](#), educates individuals who use drugs about overdose prevention and trains them to use naloxone. As of June 30, 2016, the program has trained 17,514 individuals.⁴¹

Maryland's Medicaid program purchases naloxone kits for use in overdose reversal by laypersons.⁴²



MASSACHUSETTS

Massachusetts' *Overdose Education and Naloxone Distribution (OEND) Program* is a joint collaboration among the Department of Public Health Commissioner's Office, the Office of HIV/AIDS, and the Bureau of Substance Abuse Services. It provides overdose response training to individuals who are likely to experience or witness an overdose.⁴³

Massachusetts Ambulance Trip Reporting Information System (MATRIS) is being used to collect Emergency Medical Services (EMS) data related to opioid overdoses and naloxone administrations.⁴⁴

Massachusetts requires hospitals to complete a substance use evaluation prior to discharging a patient who has experienced an overdose.⁴⁵ Patients are notified of the findings of the evaluation, including recommendations for treatment options and level of care determination. Upon discharge, the patient is notified of local and statewide treatment options and providers.



NEW MEXICO

New Mexico passed legislation requiring all local and state law enforcement agencies to equip officers with naloxone.⁴⁶

New Mexico's Medicaid program purchases naloxone kits for use in overdose reversal by laypersons.⁴⁷

* The examples listed here are provided to illustrate how some states have implemented a program or policy consistent with one of the broader recommendations presented in the section. Inclusion of these examples does not constitute an endorsement of the policy or program or any conclusion regarding its effectiveness.



OHIO

Ohio's *Project DAWN (Deaths Avoided With Naloxone)* is an opioid overdose education and naloxone distribution program. It seeks to ensure that naloxone is provided to those who are at the greatest risk of overdose. The program dispenses naloxone through walk-in sites, emergency department and inpatient units, primary care clinics, a jail program, and all MetroHealth pharmacies.⁴⁸

Ohio's Medicaid program purchases naloxone kits for use in overdose reversal by laypersons.⁴⁹



OKLAHOMA

Oklahoma Naloxone Project is a partnership between the state's Department of Health and the Department of Mental Health and Substance Abuse Services that provides naloxone training to EMS and Emergency Medicine Residents' Association (EMRA) agencies as well as volunteer fire departments.



PENNSYLVANIA

The Pennsylvania Opioid Overdose Reduction Technical Assistance Center operates OverdoseFreePA.org in collaboration with Pennsylvania communities and other partner organizations. The publicly funded website serves as a "town square" for communities within the state to obtain and share materials and resources related to the opioid epidemic, including detailed information on where to obtain naloxone and real time data on overdose deaths.



RHODE ISLAND

Rhode Island's *Anchor ED Program* helps individuals who overdosed and were brought to an emergency department (ED) by connecting them with a certified peer recovery coach. The coach helps facilitate treatment and recovery services, provides education about overdose and obtaining naloxone, and offers additional services to family members.⁵⁰

Rhode Island offers training in overdose prevention and response to individuals who use opioids, their families and friends, addiction treatment program staff, community coalitions, human services providers, correctional staff, first responders, prescribers, and pharmacists through its Medicaid program.⁵¹

Rhode Island requires commercial insurers to cover naloxone, including third party prescribing.⁵²

Rhode Island's Board of Pharmacy approved a Collaborative Practice Agreement for naloxone, which allows pharmacists with specialized training to provide naloxone to eligible participants, along with overdose education and the opportunity for follow up between the patient and pharmacist.⁵³



TEXAS

Texas Overdose and Naloxone Initiative (TONI) is a statewide partnership among law enforcement, pharmacies, academic institutions, political leaders, non-profits, and private businesses that uses an evidence-based "train the trainers" model to teach lay audiences about overdose prevention, essentially enabling any community member to be a "first responder" in the event of an overdose.⁵⁴

Implement Syringe Exchange Programs (SEPs)

Individuals who use injection drugs are at an increased risk of contracting HIV/AIDS and other blood-borne diseases, such as hepatitis C. Community-based programs known as syringe exchange programs (SEPs), needle exchange programs (NEPs), or needle-syringe programs (NSPs) are designed to provide these individuals with access to clean needles, reduce unsafe needle sharing, and help reduce the risk of disease transmission. These programs often operate in conjunction with other services as part of a comprehensive approach to HIV prevention.⁵⁵ Ensuring access to clean syringes through these programs has been associated with reduced HIV transmission, reduced risk of contracting hepatitis C, and cost savings due to lowered treatment costs.⁵⁶ Some programs also provide referrals to addiction treatment facilities. According to a study by researchers at our Center, SEPs that incorporate mobile outreach and medication-assisted treatment (MAT) can help boost treatment access.⁵⁷

Historically, state laws criminalized the distribution and possession of clean syringes, but many states have amended their laws to remove these restrictions. In January 2016, Congress ended a ban on federal funding to SEPs. Although federal funds still cannot be used for the syringes themselves, they can be used for program expenses, including staffing, transportation, counseling, outreach, and referral to treatment.⁵⁸ SEPs can serve an important role in helping states reduce the incidence of HIV and hepatitis C and helping individuals with opioid use disorder access and engage in treatment.

Recommendations for States to Implement Syringe Exchange Programs (SEPs)

- Enact or change legislation to authorize the distribution of sterile syringes and provide access to state funding for SEPs.
- Require SEPs to educate participants about overdose prevention, provide training in the use of naloxone, and facilitate treatment access and entry.



Examples of Promising State Initiatives to Implement Syringe Exchange Programs (SEPs)



DELAWARE

In 2016, Delaware passed legislation authorizing a statewide SEP that provides referral and linkages to drug treatment.⁵⁹ The legislation was preceded by a pilot program, initiated in 2007 in the city of Wilmington, which successfully reduced the rate of HIV and enrolled 894 people into treatment.⁶⁰



INDIANA

In April 2017, Indiana passed legislation allowing counties and municipalities to operate SEPs without state approval.⁶¹



KENTUCKY

In 2015, Kentucky enacted legislation allowing local health departments to establish Harm Reduction and Syringe Exchange Programs.⁶² The SEPs provide linkages to treatment for addiction, HIV, and hepatitis.⁶³



MARYLAND

In 2016, a state law created Opioid-Associated Disease Prevention and Outreach Programs, which can be established by local health departments and community-based organizations with approval from the Department of Health and Mental Hygiene.⁶⁴



NEVADA

In April 2017, Nevada became the first U.S. state to implement a vending machine program for clean syringe exchange. These machines are available to clients of a program run by the Las Vegas Harm Reduction Center, and are accessed by entering a client ID number. Twice a week, clients are able to access the kits, which include sterile syringes, alcohol wipes, safe sex supplies, and a sharps disposal box.⁶⁵



NORTH CAROLINA

Legislation passed in July 2016 permits government and non-government organizations to operate SEPs, which distribute naloxone and provide consultations or referrals to addiction treatment.⁶⁶

Monitor and React Rapidly to Emerging Drug Trends

Increasingly, synthetic opioids are being introduced into communities that are struggling to get a handle on the opioid crisis, which mostly had been driven by the misuse of commonly prescribed opioid medications and the use of heroin. These drugs, including fentanyl and carfentanyl, are many times stronger than morphine or heroin and can be fatal even after ingestion of or exposure to tiny doses. Drug checking services monitor and analyze the purity of illicit drugs on the market and identify new or lethal versions of these drugs. If this information is shared in a timely fashion with public health professionals and law enforcement in a state or jurisdiction, the public and first responders can be warned and given appropriate tips for how to avoid the drug or what to do if someone is exposed to it. The CDC's [Enhanced State Opioid Overdose Surveillance Program](#) provides funding to states to enhance surveillance activities and share information among stakeholders.⁶⁷

Recommendations for States to Monitor and React Rapidly to Emerging Drug Trends

- Encourage partnerships between crime labs and public health officials to report real time data on overdoses to help identify and disseminate timely information on the presence of synthetic opioids in the community. This will help public health officials spot emerging overdose trends and inform first responders on the appropriate dosage of naloxone and how best to protect themselves against exposure to potentially deadly substances.⁶⁸
- Adequately fund such efforts to ensure timely and effective responses to new and emerging threats. ■

Examples of State Initiatives to Monitor and React Rapidly to Emerging Drug Trends



NEW JERSEY

The Drug Monitoring Initiative (DMI), operated by the New Jersey State Police Regional Operations Intelligence Center, works in partnership with many other agencies to collect and share information related to drug seizures, overdoses, and public health. The DMI seeks to provide law enforcement and public health officials with better information about emerging drug trends so they can work to develop policies and practices to reduce harm and protect the community.⁶⁹

Additional Resources on State Naloxone Laws and Opioid Overdose



RESOURCES

- [National Conference of State Legislatures, *Drug Overdose Immunity and Good Samaritan Laws*](#)
- [The Network for Public Health Law, *Legal Interventions to Reduce Overdose Mortality: Naloxone Access and Overdose Good Samaritan Laws*](#)
- [Prescription Drug Abuse Policy System, *Naloxone Overdose Prevention Laws and Good Samaritan Overdose Prevention Laws*](#)
- [Substance Abuse and Mental Health Services Administration \(SAMHSA\), *Sample State-Level Logic Models to Reduce the Non-Medical Use and Related Consequences of Opioids*](#)
- [SAMHSA, *Opioid Overdose Prevention Toolkit*](#)
- [Shatterproof, *Broader Access to Naloxone*](#)

Additional Resource on Syringe Distribution Laws



RESOURCES

- [The Policy Surveillance Program, *Syringe Distribution Laws*](#)

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Improve Opioid Addiction Treatment

Most individuals who receive addiction treatment do not receive evidence-based care or do not receive it in sufficient intensity and duration to promote long-term recovery. Individuals with substance use disorders who receive inadequate care often relapse, which perpetuates the perception that addiction is untreatable.¹

In a 2012 report, *Addiction Medicine: Closing the Gap Between Science and Practice*, our Center identified the services that comprise evidence-based care for addiction. These include:

- Comprehensive assessment to develop a treatment plan that is individualized and tailored to meet the patient's needs and that identifies co-occurring physical and mental health conditions;
- Stabilization/detoxification as a precursor to treatment; detoxification alone *does not* constitute treatment and must be followed by ongoing evidence-based care;
- Pharmaceutical and/or psychosocial therapies,* in the appropriate treatment setting (i.e., level of care);
- Chronic disease management (following a course of treatment); and
- Comprehensive support services.



To identify the appropriate treatment setting for a patient, experts have developed scientifically validated patient placement tools to assist treatment programs, government programs, insurers, and other organizations in appropriately matching patients' needs to specific treatment services and to determine the appropriate level of care (e.g., inpatient, outpatient, residential). The American Society of Addiction Medicine (ASAM) developed the [ASAM Criteria](#), which contain guidelines for patient placement and define services and levels of care. The New York State Office of Alcoholism and Substance Abuse Services (OASAS), in collaboration with our Center, developed the [Level of Care for Alcohol and Drug Treatment Referral \(LOCADTR\)](#), a web-based tool that determines the most appropriate level of care using factors such as patient risk factors and resources. States can require the use of such tools to help ensure that patients receive the appropriate level of care that will meet their treatment needs.

Since addiction is a chronic disease, it is also essential to provide long-term disease management, involving psychosocial and/or pharmaceutical interventions, following a course of treatment to prevent relapse and promote recovery. Recovery services play an important role in chronic disease management and in helping to support individuals sustain recovery and acclimate to a healthy, addiction-free life.

Although the responsibility for providing treatment rests primarily with the health care system, state policymakers have significant leverage to help increase access to quality treatment and ensure that individuals with addiction receive the full range of quality services they need.

* For the treatment of opioid addiction, medication-assisted treatment (MAT), which involves a combination of FDA-approved medications and psychosocial therapies (or counseling), is most effective. However, even medication alone has proven to be an effective treatment and to significantly reduce rates of overdose deaths.

An Effective and Comprehensive Approach to Improving Opioid Addiction Treatment

- Increase Treatment Capacity and Help Patients and Families Find Quality Addiction Care
- Increase the Availability of Medication-Assisted Treatment (MAT)
- Improve the Quality of Addiction Care
- Improve Insurance Coverage for Addiction Care
- Provide Comprehensive Recovery Support Services Following Treatment

Increase Treatment Capacity and Help Patients and Families Find Quality Addiction Care

Patients and their families frequently are unable to find treatment when they need it. This may be due to a lack of available treatment slots for individuals seeking help and/or a lack of knowledge about how and where to go for help. States must determine whether they have adequate capacity to meet the treatment needs of their citizens, work to expand that capacity if it is not sufficient, and then implement effective strategies for ensuring that patients and their families are able to access effective treatment if needed.

Checklist to Determine Treatment Capacity

1. *Determine the Prevalence of Substance Use Disorders in Your State*

- ✓ Does your state have a mechanism for accurately measuring all forms of substance use, including opioids, and rates of addiction among your citizens (of all ages) and for reporting the results in an easily accessible manner?

2. *Determine the Existing Resources in Your State for Treating Opioid Addiction*

- ✓ How many treatment facilities are licensed/certified to provide addiction treatment in your state?

- ✓ How many opioid treatment programs (OTPs) are operating in your state?
 - ✓ Do OTPs offer only methadone or do they also provide other FDA*-approved medications for opioid addiction treatment (naltrexone, buprenorphine)?
 - ✓ How many providers in your state hold [Drug Addiction Treatment Act of 2000 \(DATA 2000\) waivers](#) to prescribe buprenorphine? How many hold waivers for higher patient limits?
 - ✓ How many treatment facilities are for-profit?^{1 2}
 - ✓ Are there areas of the state where treatment is not accessible (e.g., does not meet the state's network adequacy requirements)?
 - ✓ Are people going to other states to obtain treatment?
 - ✓ Do patients and providers report wait times to enter treatment (i.e., wait lists)?
 - ✓ Are treatment facilities integrated with other health care services, including mental health care?
- ### 3. *Determine Whether Existing Treatment Resources Have Enough Funding*
- ✓ What is the rate of Medicaid participation among existing treatment facilities/providers?
 - ✓ What are the Medicaid reimbursement rates for addiction treatment services?
 - ✓ Does Medicaid reimbursement cover wrap-around services that are reimbursable under Medicaid waivers and necessary to treat addiction and sustain recovery?
- ### 4. *Determine Whether Existing Treatment Resources Have Capacity To Treat More People*
- ✓ What are the barriers to increasing treatment entry and how can they be overcome?

* U.S. Food and Drug Administration

¹ If treatment facilities are for-profit, they are not likely to accept Medicaid and are less likely to be accessible to low-income individuals.



One major reason for the lack of available treatment is the shortage of physicians trained to address addiction, and the limited number of those who have specialized in addiction medicine. This presents a significant barrier to integrating addiction care into the health care system. All physicians should be trained to identify symptoms of addiction using established screening instruments, know how to diagnose addiction using evidence-based assessment tools, have the ability to conduct brief interventions for those at risk for addiction, and know where and how to refer patients in need of treatment to quality addiction care. Addiction medicine physicians and addiction psychiatrists are two medical specialties with advanced training in addiction. These addiction medicine specialists have the capability to provide expert consultation to other physicians and health professionals, provide evidence-based treatment for more acute cases of the disease, and have the training and skills to recognize and treat the psychiatric and physical complications associated with addiction.*³ Investing in the education and training of health professionals who are best positioned to help prevent the initiation and continued use of addictive substances is critical for addressing the opioid crisis.

Recommendations for States to Increase Treatment Capacity

- Require all health care professionals in your state to receive training in addiction care.
 - All medical schools, residency training programs, and non-physician health professional training programs that receive state funding should be required to educate and train health care providers to identify and diagnose substance use and addiction and provide necessary referrals for patients needing treatment.⁴ Medical schools/residency training programs should offer training in the sub-specialty of addiction medicine.
 - All physicians, in order to be licensed to practice medicine in the state, should be required to receive training in addiction care, including the provision of medication-assisted treatment (MAT).
 - Providers authorized to prescribe controlled substances (e.g., physicians, nurse practitioners and physician assistants) should be required to complete MAT training as a condition of licensure.
 - Use a loan forgiveness program as an incentive to encourage medical professionals to serve as addiction treatment providers in your state for a designated period of time.⁵
 - Use telehealth training models to train providers who practice in rural or underserved areas in addiction care.

* Addiction specialists are addiction medicine physicians and addiction psychiatrists who hold either subspecialty board certification in addiction medicine.

Examples of State Actions to Expand the Addiction Treatment Workforce*



MASSACHUSETTS

The state's four medical schools agreed to adopt core competencies and train all medical students in prevention, treatment, and management of substance use disorders.⁶

Massachusetts established core competencies to train advanced practice nurses, physician assistants, and community health center clinicians in the prevention and management of prescription drug misuse.⁷



MICHIGAN

As part of the *Medicaid Innovation Accelerator Program*, the state conducted an inventory of addiction treatment services across all levels of care (e.g., residential, partial hospitalization, outpatient) to identify existing services. The state will continue to identify provider capacity for delivering services by utilizing state licensing and claims/encounter data to inform potential state interventions, including identifying residential providers who are not currently accepting Medicaid or expanding addiction residential treatment capacity.⁸



NEW JERSEY

The *Addiction Training and Workforce Development Initiative* aims to create a competent and diverse workforce by expanding alcohol and other drug counselor training, developing an addiction workforce career path, and increasing the number of workers in the field. The Division of Mental Health and Addiction Services will contract with partners to provide scholarships for college coursework or addiction training.⁹



NEW MEXICO

Project ECHO (Extension for Community Health Outcomes) is a provider educational tool that connects a specialist with other health care professionals through interactive video conferencing for case-based learning, enabling primary care providers to treat patients with complex conditions in their own communities.¹⁰



RHODE ISLAND

Brown University's medical school and the Rhode Island Department of Health created a comprehensive addiction medicine/psychiatry curriculum that spans the four years of medical school, providing training in screening, brief intervention, and referral to treatment (SBIRT); naloxone administration; pain management; management of co-occurring conditions; and the use of buprenorphine for opioid addiction treatment.¹¹



WISCONSIN

University of Wisconsin School of Medicine has a program to train physicians in addiction prevention, treatment, and management. Selected as a national model program by the American Board of Addiction Medicine, it was one of the first programs nationwide to provide training to physicians in addiction medicine.¹²

Even when treatment slots are available, patients and their families frequently do not know how to access care or where to turn for help. Our Center created a comprehensive [guide](#) to help individuals with addiction and their families identify effective, quality treatment options.

* The examples listed here are provided to illustrate how some states have implemented a program or policy consistent with one of the broader recommendations presented in the section. Inclusion of these examples does not constitute an endorsement of the policy or program or any conclusion regarding its effectiveness.

How to Find Quality Addiction Treatment

It can be overwhelming to know where to start if you need to find treatment for addiction. It is not a quick or easy process. The National Center on Addiction and Substance Abuse has created a step-by-step guide, [Guide to Finding Quality Addiction Treatment](#), to help people navigate the vast amount of available information -- and misinformation -- about finding addiction treatment and the questions that may arise along the journey.

Recommendations for States to Help Patients and Families Find Quality Addiction Care

- Create a call line and a statewide database of quality treatment providers and facilities for providers and the public seeking local and available treatment services.¹³
- Establish crisis treatment centers to help patients obtain immediate access to the appropriate level of care.

Examples of State Actions to Help Patients and Their Families Find Quality Addiction Care



MARYLAND

In 2018, Maryland will create crisis treatment centers that will be available 24 hours per day, 7 days per week to perform assessments and determinations regarding the needed level of care, and connect individuals with immediate care.¹⁴

Maryland will create a Health Crisis Hotline to assist callers with obtaining a screening assessment and referral to care.¹⁵



MASSACHUSETTS

Massachusetts Behavioral Health Access (MABHA) bed finder is a website designed to help health care providers identify available treatment capacity in mental health and addiction treatment programs and facilitates.

[Faster Paths to Treatment](#) is a collaborative program of the Boston Medical Center, the Massachusetts Department of Public Health, and the Boston Public Health Commission. As an opioid urgent care and assessment center, it provides detoxification, treatment, and aftercare services.¹⁶



NEW HAMPSHIRE

New Hampshire's Department of Health and Human Services' [Statewide Addiction Crisis Line](#) is a 24-hour resource in which trained professional counselors assist in identifying emergency care, treatment programs, support groups, transitional and sober housing, MAT services, and recovery supports.¹⁷



NEW JERSEY

[New Jersey's Division of Mental Health and Addiction Services](#) created an online, searchable directory of treatment services as well as a 24-hour hotline.



RHODE ISLAND

Rhode Island requires its Department of Health to develop a strategy to maintain a real-time database of available inpatient and outpatient services (by January 2018).¹⁸

Increase the Availability of Medication-Assisted Treatment (MAT) for Opioid Addiction

Medication-assisted treatment (MAT) -- the combination of psychological/behavioral therapy and FDA-approved medications (i.e., methadone, buprenorphine, naltrexone) -- is the most effective means of treating opioid use disorders and preventing opioid overdose.¹⁹ MAT is also cost effective; every dollar spent on it realizes an estimated \$1.80 in societal savings.*²⁰

Despite its proven effectiveness, fewer than ten percent of patients with opioid addiction receive MAT.²¹ Some of the medications used in MAT are subject to numerous federal regulations that reduce their accessibility. For example, methadone can only be dispensed in licensed opioid treatment programs (OTPs) -- specialized clinics to which patients have to report daily to receive their medication, while buprenorphine and injectable naltrexone can be provided in a physician's office. Providers who prescribe buprenorphine must receive a special waiver (i.e., DATA 2000 waiver) from the Drug Enforcement Administration (DEA), and are subject to reporting requirements and a limit on the number of patients that can be treated at one time. The third FDA-approved medication, naltrexone, is not a controlled substance and therefore not subject to special regulatory restrictions, but it is underutilized, and the injectable form (Vivitrol®) can be prohibitively expensive.

Although increasing the availability of MAT depends in large part on federal law with regard to federal requirements around the prescribing and administration of opioid addiction medications, there are actions states can take to help ensure that individuals with an opioid use disorder receive the full range of behavioral and pharmaceutical treatments they need.

Recommendations for States to Increase the Availability of Medication-Assisted Treatment (MAT) for Opioid Addiction

- Review state regulations related to opioid treatment programs (OTPs).
 - Eliminate or modify any state regulation that unnecessarily limits access to MAT for individuals with an opioid use disorder.
- Cover MAT in state Medicaid programs. Providing Medicaid reimbursement for MAT increases the availability of this life-saving treatment.²² The more treatment providers rely on Medicaid for payment, the more likely they are to offer pharmaceutical therapy, such as buprenorphine, for opioid addiction.²³
 - Increase the number of OTPs²⁴ and include reimbursement for OTPs in the state's Medicaid program.



RESOURCES The American Association for the Treatment of Opioid Dependence (AATOD) has developed a [strategy](#) and [webinars](#) to help states obtain Medicaid reimbursement for OTPs.

- Make MAT available in more treatment venues.
 - Make all FDA-approved medications for opioid addiction available at OTPs, many of which currently administer methadone only.²⁵
 - Encourage hospitals to initiate MAT in emergency departments following an opioid overdose, and encourage a warm hand-off[†] to treatment.²⁶
 - Provide necessary incentives and supports to primary care providers who prescribe buprenorphine.

* "Societal costs" include criminal activity and work productivity.

[†] A "warm hand-off" is when the provider offers the patient a face-to-face introduction to the behavioral health/addiction treatment specialist instead of providing the patient with the name and contact information of the specialist and relying on the patient to make the introduction.

- Encourage more health care providers to offer MAT.
 - Hold trainings on MAT for all health care professionals, including but not limited to addiction treatment providers.
 - Provide DATA 2000 waiver training in medical schools.²⁷
 - Encourage physicians who already hold DATA 2000 waivers to apply for waivers for increased patient limits.*²⁸
 - Change the state scope of practice laws to permit nurse practitioners and physician assistants to prescribe buprenorphine, which is now permitted under federal law.²⁹

Examples of State Actions to Increase the Availability of Medication-Assisted Treatment (MAT) for Opioid Addiction



CONNECTICUT

Yale Hew Haven Hospital launched an innovative buprenorphine program to initiate treatment for opioid addiction in the emergency department (ED), following an overdose, instead of providing a referral to treatment. The Yale team provides brief counseling, buprenorphine and connects patients to primary care following an overdose.³⁰ Patients initiated on buprenorphine in the ED and who continued to receive buprenorphine in a primary care setting were significantly more likely to remain in treatment than those who only received a brief intervention or referral to treatment in the ED.³¹



MARYLAND

Maryland law requires health care facilities to have a provider who is trained and authorized (has a DATA 2000 waiver) to prescribe FDA-approved medications for opioid addiction (MAT).³²



MISSOURI

Missouri offers *Medication Assisted Recovery Specialist*, a 40-hour hybrid live/online training program that covers a variety of topics related to addiction and MAT. The program has been completed by nearly 800 addiction counselors, nurses, doctors, and peer supporters.³³



NEW YORK

New York law requires training in MAT for certified addiction counselors.³⁴



RHODE ISLAND

Brown University, in partnership with the Rhode Island Department of Health, implemented addiction training for medical students that meets the requirements for the DATA 2000 waiver training so that students can obtain a waiver to prescribe buprenorphine upon graduation.³⁵



VERMONT

Vermont's *Care Alliance for Opioid Addiction* employs a "Hub and Spoke" model, which focuses on expanding access to MAT for individuals with an opioid use disorder while also creating a framework for integrating treatment services through a managed care approach. The model is comprised of "hubs" -- methadone treatment programs, and "spokes" -- a team of outpatient providers that prescribes buprenorphine. The hubs and spokes also provide home health care services to patients, including clinical care coordination. This model increased the state's capacity to provide MAT by more than 40 percent from January 2013 through July 2014, and helped to retain patients in treatment.³⁶



VIRGINIA

Virginia's Department of Health and its Department of Medical Assistance Services host training sessions on addiction treatment that include the DATA 2000 waiver training for physicians, nurse practitioners, and physician assistants who want to prescribe buprenorphine.³⁷



WISCONSIN

Wisconsin reduced state regulations on OTPs to align with federal regulations.³⁸

* One study showed that even a small increase (ten percent) in the number of physicians that received waivers to increase their limit to 100 patients significantly increased buprenorphine prescriptions (by 45 percent). There was no statistical increase in buprenorphine prescriptions related to an increase in the number of physicians with waivers for treating 30 patients.

Improve the Quality of Addiction Care

Historically, the addiction treatment system has been marginalized and not integrated with the mainstream health care system. As a result, addiction care has not benefitted from the medical advancements that have improved the quality of care and treatment of other chronic diseases. To improve the quality of addiction treatment, it needs to be well integrated with the health care system. Such integration will also help improve the treatment of other health conditions. Individuals with addiction often suffer from co-occurring mental and physical health conditions, which need to be treated concurrently with addiction, typically via a medical approach, to achieve the best and most sustainable outcomes.³⁹ Yet, as of 2016, only 50 percent of addiction treatment facilities provided comprehensive mental health assessments and diagnoses.⁴⁰ There are many ways states can change the addiction treatment system and integrate it with the health care system to help improve the quality of care.

Quality Assurance

Due to the historical separation of addiction care from mainstream health care, addiction treatment providers are not subject to the same level of regulatory oversight as other health care providers. While they are subject to state licensing requirements, these requirements typically are set by state agencies that are charged with overseeing addiction services rather than agencies responsible for regulating health care facilities. Our Center's review of licensing and certification requirements for addiction treatment facilities and programs found that the nature and extent of these regulations vary significantly among states, and that certain addiction treatment programs (e.g., many state-run and religious programs) are exempt entirely from state regulation.⁴¹

In some addiction treatment facilities throughout the country, especially those that are not well funded or adequately reimbursed through Medicaid, the staff that is primarily responsible for patient care is comprised largely of addiction counselors who have lived experience with addiction and a passion for addressing the disease, but variable (and often inadequate) levels of education and training in evidence-based treatments for addiction. Workforce development and professional standards and training are needed to improve the understanding and implementation of medical and evidence-based approaches to addiction treatment, and adequate funding is required for facilities to ensure that treatment services are provided by more highly-credentialed staff.

Chronic Disease Management

The addiction treatment system, in its current form, is not designed to treat addiction as a chronic disease. While the high rates of relapse for addiction are comparable to other chronic diseases, inadequate or ineffective treatment interventions may be a contributing factor to many instances of relapse.⁴² The usual approach to treatment involves brief, episodic interventions rather than a model based on long-term disease management, as is required of chronic health conditions.⁴³ Care should be modeled on the system of treatment for other chronic diseases, where patients receive services in primary care and more complex and severe cases are referred to a specialty care system.

Tailored Treatment

The addiction treatment system, in its current form, largely takes a 'one-size-fits-all' approach. Treatment is most effective when it is tailored to the individual needs of the patient and when it is responsive to a patient's need to move along the treatment continuum from more intensive to less intensive (or from less intensive to more intensive) care settings during a course of treatment. A comprehensive, integrated care system allows patients to receive the treatment that is tailored to their unique needs, within the level of care that is most appropriate. Unfortunately, many treatment systems are not comprehensive or integrated to allow for such movement along the treatment continuum. Care should also be person-centered and a treatment plan should be developed in a collaborative process between providers, the patient, and the patient's family.⁴⁴



Ease of Access

The addiction treatment system, in its current form, largely does not take into account that addiction affects the parts of the brain associated with motivation, decision-making, risk/reward assessment, and impulse control. Due to these motivational and cognitive deficits, as well as other social and environmental challenges common among those with addiction, the window of opportunity to get people motivated to engage in treatment can be narrow and shifting. Therefore, a "no wrong door approach" is needed to ensure that patients can be engaged in appropriate treatment regardless of the setting or time in which they demonstrate a willingness to pursue and receive care.



Value-Based Reimbursement

The current fee-for-service insurance reimbursement system does not create incentives for high quality treatment. As the entire health care system moves toward value-based care, new reimbursement methodologies are needed. Value-based models, in which billing and payments are determined on the basis of outcomes achieved rather than services rendered by a health care provider, reflect fairer compensation for addiction treatment services and can incorporate accountability for providing quality care. States can promote valued-based payment arrangements that incentivize quality care for addiction treatment by developing standards for good treatment and including quality metrics for those standards in the state's Medicaid contract.

There are many ways for states to improve the quality of care for patients with opioid or other substance use disorders.



Recommendations for States to Improve the Quality of Addiction Care

- Use state funding leverage to ensure that addiction treatment services are evidence-based and well integrated into the mainstream health care system.
 - States should require that routine screening and brief interventions be provided by trained professionals in all agencies* that receive public funding. Patients who screen positive for risky substance use or a potential diagnosis of addiction should be connected with a trained health professional for diagnosis, intervention, treatment, and disease management.
 - States should require that all state-funded hospital emergency departments screen all patients for substance use disorders, provide appropriate interventions -- including medication-assisted treatment (MAT) -- to those who screen positive, and develop a treatment plan and/or “warm hand-off” to a treatment program for each patient that screens positive.⁴⁵ States should provide necessary resources and incentives, such as increased reimbursement rates, to help hospitals create sufficient capacity to provide such services.
 - As a condition of receipt of public funds, states should require that facilities that provide addiction treatment services utilize evidence-based treatment approaches and employ a multidisciplinary team of health professionals and individuals with addiction experience to provide support services.⁴⁶ States should increase public funding so that facilities can provide such services.
- As a condition of reimbursement, contracts between public insurers and treatment providers should require that treatment be provided, supervised, or managed by qualified health care professionals; that providers utilize evidence-based addiction care services; and that treatment facilities generate positive and measurable patient outcomes.
- States should require discharge planning from state-funded or state-licensed hospitals and treatment facilities to ensure continuity of care, disease management, and support services.
- States should adopt value-based payment methodologies to improve care and incorporate addiction treatment into these payment arrangements.
- States should adopt [Medicaid health homes](#) to provide comprehensive care coordination for Medicaid recipients with chronic health conditions. These models strengthen care by coordinating physical and behavioral health services and long-term services and supports.^{† 47}
- As a condition of reimbursement, states should establish benchmarks for providing quality care and develop metrics that can be used for quality reporting and for holding providers accountable.⁴⁸

* Including educational, mental health, developmental disabilities, child welfare, housing, juvenile justice, and adult corrections services.

† While health home models vary across states, all provide the following core services: comprehensive care management, care coordination, health promotion, comprehensive transitional care and follow up, individual and family support, and referral to community and social support services. They also offer provider education and training in evidence-based addiction treatment.

- Use state leverage to license health care providers and develop clinical standards for licensed facilities to ensure that addiction treatment services are evidence-based and integrated into the mainstream health care system.
 - Subject all addiction treatment facilities and programs to the same mandatory licensing processes as other health care facilities. As a condition of licensure, all facilities and programs providing addiction treatment should be required to adhere to established minimum standards for accreditation.

Such accreditation standards should require:

- 1) an addiction physician specialist to serve as medical director;
- 2) individual providers to be credentialed in their field of practice;
- 3) facilities to provide evidence-based treatment for addiction, tailored to the patient and his/her co-occurring conditions; and
- 4) all facilities to collect and report comprehensive quality assessment data, including process and outcomes measurements related to screening, intervention, treatment, and disease management.⁴⁹

- States should encourage integrated care for mental health, substance use disorders, and physical health conditions, which are best addressed in an integrated manner. There are a range of options to improve integration -- from coordinated care among separate providers to the use of integrated licenses to treat co-occurring disorders. Any legal or regulatory requirements that create barriers to integrated treatment for co-occurring conditions should be eliminated.

Examples of State Actions to Improve the Quality of Addiction Care



CALIFORNIA

California's [*Drug Medi-Cal Organized Delivery System Pilot Program*](#) is a voluntary program that requires participating counties to provide access to a full continuum of addiction treatment services modeled on the ASAM Criteria.⁵⁰



CONNECTICUT

The Connecticut Department of Mental Health and Addiction Services' [*Performance Measurement System*](#) captures data on performance measures from addiction treatment providers.⁵¹



MARYLAND

The Maryland Hospital Association must conduct a study, by December 1, 2017, to identify opportunities and assess barriers to providing a comprehensive treatment continuum to patients who present at a hospital with a substance use disorder. By 2018, Maryland will require hospitals to establish a protocol for discharging patients who have been treated for an overdose or have been identified as having a substance use disorder.⁵²



MICHIGAN

Michigan's [*Integrated Dual Disorders Treatment \(COD:iDDT\) model*](#) offers combined integrated mental health and substance use interventions in the same setting, with the same team of clinicians, and using a consistent treatment approach and philosophy.



NEW HAMPSHIRE

New Hampshire's [*Building Capacity for Transformation*](#) is a performance-based funding initiative focused on integrating physical and behavioral health care, expanding mental health and addiction treatment capacity, and improving care coordination in the Medicaid program.⁵³

**NEW YORK**

New York law requires discharge planning from treatment facilities to ensure a continuum of care.⁵⁴

New York State is transitioning its behavioral health services from a fee-for-service to a Medicaid managed care payment structure.⁵⁵ The redesign focuses on integrating physical and behavioral health. New York state-based partners, including our Center, provide technical assistance and learning communities to behavioral health agencies to ensure that providers have the necessary tools and knowledge to successfully transition to the new system.⁵⁶

**OREGON**

Oregon operates 15 [Coordinated Care Organizations \(CCOs\)](#) on a pay-for-performance basis in its Medicaid program. These networks of payers, providers, and community organizations collaborate to prevent and manage chronic conditions. CCOs can obtain incentive payments for meeting benchmarks or showing improvements in incentive metrics. The CCOs report on metrics relating to screening, brief interventions, and referral to treatment (SBIRT); treatment initiation; and treatment engagement.⁵⁷

**PENNSYLVANIA**

Pennsylvania's *Integrated Care Management Program* awards incentive payments to providers treating individuals with serious persistent mental illness and addiction, based on incremental improvements in performance measures related to treatment initiation, medication adherence, emergency room use, hospital readmissions, and utilization of inpatient care.⁵⁸

**RHODE ISLAND**

Rhode Island's *Alexander Perry & Brandon Goldner Act*, requires hospitals to provide comprehensive discharge planning for patients with substance use disorders.⁵⁹

Rhode Island's [Centers of Excellence \(COE\)](#) help individuals with addiction access comprehensive treatment in a timely manner. The COEs, which are certified by the state, provide evaluations, treatment, and referrals. The COEs' multi-disciplinary staff provides patient-centered care. They can provide FDA-approved medications on-site and serve as a resource for community-based providers.

**VERMONT**

The Hub and Spoke providers in Vermont's [Care Alliance for Opioid Addiction](#) are required to meet standards on quality improvement and care coordination based on the National Committee for Quality Assurance (NCQA) Specialty Practice and Patient-Centered Medical Homes (PCMH) standards. This is one of the first times these standards are being used for addiction treatment.⁶⁰

**VIRGINIA**

Virginia aligned its definitions of community-based treatment services with the ASAM Criteria. The state requires that providers meet the ASAM Criteria to participate in the state's Medicaid program.⁶¹

In connection with Virginia's [Addiction Treatment Services Delivery System Transformation](#), the Department of Medical Assistance Services collects data from Medicaid managed care and behavioral health organizations on addiction treatment quality measures, which are used to improve quality processes.⁶²

**WASHINGTON**

Washington legislation requires the Department of Social and Health Services and the Health Care Authority to develop outcome-based behavioral health performance measures, which are used in Medicaid contracts and reported on a public website.⁶³

Improve Insurance Coverage for Addiction Care

A critical means of increasing access to the full spectrum of quality addiction care is the provision of comprehensive insurance coverage. Comprehensive coverage entails providing incentives to health care professionals (e.g., adequate training, reimbursement, and supports) to offer addiction care services -- from prevention and early intervention to treatment and disease management -- and removing the critical barrier of cost that prevents many patients from obtaining the services they need. Among patients with a perceived need for treatment, inability to pay due to lack of insurance coverage is cited as one of the top reasons for not receiving care.⁶⁴ It is essential that patients have health insurance and that their health insurance includes coverage for evidence-based addiction treatment services.

Health Care Reform

In recent years, the focus of health care reform has been on the role of the federal government. In 2017, Congress developed several proposals to “repeal and replace” the Patient Protection and Affordable Care Act (i.e., ACA or “Obamacare”). Although none has yet passed the Senate, should any of the proposed bills become law, it is expected that millions of individuals with addiction would lose health insurance coverage, making it harder for them to access care. Further, some of the proposals seek to weaken requirements on insurers to cover addiction treatment (i.e., the EHB requirement, described below). With increasing uncertainty around the role of the federal government in enforcing health care reform and ensuring better coverage for addiction treatment, states have the opportunity and obligation to ensure that the insurance plans they regulate provide comprehensive coverage of evidence-based addiction care. Although states do not have jurisdiction over employer-sponsored insurance plans covered by the Employee Retirement Income Security Act (ERISA),⁶⁵ states regulate plans in the individual, small group, and large group insurance markets.



Federal Laws

While the ACA and the Mental Health Parity and Addiction Equity Act (MHPAEA) are two federal laws that provide important protections for individuals seeking addiction treatment covered by health insurance, states have primary authority to enforce these laws. The ACA requires many individual and small group plans to cover addiction services as one of the 10 Essential Health Benefits (EHB).⁶⁶ The ACA does not define the addiction care benefits that must be covered; instead, each state defines the benefits by identifying an [EHB benchmark plan](#), which establishes the minimum level of coverage for plans subject to the ACA in the state.⁶⁷ According to [a recent report by our Center](#), none of the 2017 EHB benchmark plans offered coverage of all of the critical addiction benefits; however, Minnesota, Missouri, and Washington D.C. selected EHB benchmark plans that provided the most details about their benefits and provided the most coverage. Selecting a benchmark plan with comprehensive coverage ensures that health care consumers who purchase individual and small group plans will have adequate coverage of evidence-based treatment for addiction.⁶⁸ While there may be concern that requiring coverage would increase premium costs, such fears are unfounded; at least one recent analysis shows that removing requirements for plans to cover addiction benefits would do little to reduce premium prices while significantly increasing out-of-pocket costs for individuals who require such services.⁶⁹

MHPAEA, which applies to most but not all insurance products, requires plans that offer addiction care benefits to cover such benefits on par with coverage of other medical benefits.⁷⁰ Specifically, the law prohibits insurers from placing limitations on addiction treatment services that are more restrictive than the limitations placed on comparable medical or surgical care. State insurance regulators have primary enforcement responsibility for MHPAEA for plans under their jurisdiction. State attorneys general also have enforcement authority in some states. Enforcing MHPAEA requires monitoring health insurance plans' compliance with the law and creating channels for people to report MHPAEA violations.



RESOURCES [ParityTrack](#) monitors state legislative, regulatory, and legal activities related to parity enforcement and compliance and develops model resources for policymakers.

State Laws

Aside from enforcing federal insurance laws, states have broad authority to improve coverage of addiction treatment benefits in state-regulated plans. In addition to or in the absence of a federal requirement to cover addiction treatment, states can mandate coverage of benefits through state law. Not only is this important to increase access to care, it is also important for consumer protection.

Medicaid

States also can improve access to addiction treatment through their Medicaid program. The important role of Medicaid in the provision of addiction treatment cannot be overstated. Medicaid is the largest payer of behavioral health services in the country.⁷¹ It pays for addiction treatment for one in four people who receive care.⁷² In fact, adults who have addiction and are Medicaid beneficiaries are more likely to receive addiction treatment than those with private insurance. Nevertheless, there is still a significant treatment gap; only 32 percent of Medicaid enrollees with opioid use disorder received treatment in 2015.⁷³ Because rates of addiction are higher among Medicaid recipients relative to the general population,⁷⁴ it is important to ensure that treatment providers participate with Medicaid.

For various reasons, many treatment facilities, including OTPs, do not accept Medicaid.⁷⁵ In 2016, only 62 percent of treatment facilities reported accepting Medicaid.⁷⁶

The ACA requires coverage of addiction treatment for the Medicaid expansion population.*⁷⁷ States can also use Medicaid waivers to improve coverage of addiction treatment for their state Medicaid beneficiaries.[†] In 2015, the Centers for Medicare and Medicaid Services (CMS) issued guidance allowing states to seek waivers from the Institutions for Mental Disease (IMD) exclusion, which prohibited federal matching funds for residential services provided in facilities with more than 16 beds.⁷⁸ This prohibition made it difficult for states to cover residential treatment in their Medicaid program. The 1115 waiver[‡] supports states' ability to provide more effective care to Medicaid beneficiaries with a substance use disorder, including the provision of treatment services not otherwise covered under Medicaid.⁷⁹ Under a home and community-based services waiver (i.e., Section 1915i waiver), states can offer case management, day treatment, partial hospitalization, and psychosocial rehabilitation services to individuals with mental illness or addiction.⁸⁰

Network Adequacy

In addition to providing comprehensive addiction care benefits, plans should be required to have an adequate number of in-network providers to help ensure that health plan members have timely access to covered benefits. People will only be able to access addiction services if their health plans contract with a sufficient number of providers who are trained to treat the disease.

* Medicaid expansion refers to the provision of the Affordable Care Act that expanded Medicaid eligibility to include all individuals under age 65 with incomes up to 133 percent of the federal poverty level. Individuals eligible for Medicaid under the expansion are covered by Alternative Benefit Plans which are required to cover the 10 Essential Health Benefits, including addiction treatment.

† For example, 1115 demonstration waivers to test policy innovations; 1915 waivers to expand Medicaid to cover low-income individuals not previously eligible for Medicaid; 1915(a)/(b) waivers for Medicaid managed care; and 1915(c),(i),(j),(k) waivers for home and community-based services and supports.

‡ Authorized by §1115 of the Social Security Act.

Recommendations for States to Improve Insurance Coverage for Addiction Care

- Require insurance plans to offer coverage for the full range of addiction care services.
 - Select an Essential Health Benefits (EHB) benchmark plan with comprehensive coverage of benefits for evidence-based addiction care.
 - Legislate a mandated benefit with services defined by a validated patient placement tool (e.g., ASAM Criteria, LOCADTR), including all FDA-approved medications for addiction treatment.
 - Require insurance plans to use a scientifically validated patient placement tool (e.g., ASAM Criteria or LOCADTR) when determining whether services are medically necessary.
 - Prohibit plans from imposing prior authorization and other restrictive treatment limitations on addiction care, including treatment admission and the provision of FDA-approved medications used in MAT, to help ensure immediate on-demand access to evidence-based care.⁸¹
 - Adopt network adequacy laws that define specific standards for measuring the adequacy of treatment workforce capacity within a network, such as acceptable travel times, distances, and appointment waiting times. These laws should also require insurance plans to maintain directories of in-network providers that are accurate and up to date. The best approach combines network adequacy laws with thorough network adequacy reviews and strongly enforced network adequacy requirements. States should also require plans to apply affordable cost-sharing requirements when services can only be obtained from out-of-network providers.
 - Confirm that the traditional Medicaid program covers the full range of addiction benefits.
 - Obtain a Medicaid 1115 waiver to provide comprehensive addiction treatment services in the state's Medicaid program. Under this waiver, states can also obtain an IMD exclusion to obtain federal funds to cover residential treatment services.⁸²
- Obtain a Medicaid home- and community-based services waiver (Section 1915c-k) to expand access to recovery support services for Medicaid beneficiaries.⁸³
- Provide sufficient resources to state insurance and Medicaid regulators to implement insurance parity laws (MHPAEA) and monitor compliance.
- Provide state attorneys general with the authority to enforce MHPAEA and investigate MHPAEA violations.



- Ensure that health care providers receive adequate reimbursement for administering the full range of addiction care services.
 - Create Medicaid reimbursement rates that compensate providers for all services associated with evidence-based addiction care, including screening, brief interventions, office visits, counseling, MAT, and wrap-around or recovery support services. Frequently review and adjust the reimbursement rates for addiction treatment to ensure that they reflect an adequate payment to providers for rendering treatment.
 - Eliminate state Uniform Accident and Sickness Policy Provision Laws (UPPLs), which allow insurance providers to deny coverage for the treatment of injuries sustained by a person who was under the influence of alcohol or other drugs at the time of the injury. These laws provide physicians with disincentives to screen patients for substance problems or document substance-involved injuries, thereby reducing the likelihood that those who are at risk will get the help they need. As of January 2016, 17 states have prohibited the use of UPPLs.⁸⁴

Examples of State Actions to Improve Insurance Coverage for Addiction Care



CALIFORNIA

California's network adequacy laws require insurers to provide an annual report describing the adequacy of the plan's addiction treatment network. To demonstrate network adequacy, the plan must have a sufficient number of licensed and appropriately trained addiction treatment providers with sufficient capacity to accept patients with a travel time of 30 minutes or less or a maximum travel distance of 15 miles from each covered person's residence or workplace. Networks also must provide the following treatment services: crisis intervention, stabilization, detoxification, outpatient mental health and substance use evaluation and treatment, psychological testing, outpatient services for monitoring drug therapy, partial hospitalization, and intensive outpatient treatment.⁸⁵

California's Department of Managed Health Care requires all plans under its jurisdiction to submit documentation of compliance with the parity law (MHPAEA). Insurers are required to submit detailed information about treatment limitations and plan design features, including comparisons of behavioral health coverage to medical and surgical coverage and comparisons of non-quantitative treatment limits.⁸⁶

California's Medicaid 1115 waiver (Medi-Cal 2020) includes the Drug Medi-Cal Eligibility and Delivery System, a pilot program available to counties seeking to provide evidence-based and integrated care to beneficiaries with addiction, including a continuum of care modeled after the ASAM Criteria.⁸⁷



COLORADO

Requires plans to meet network adequacy standards for providers that specialize in addiction care. To demonstrate network adequacy, plans must meet specific standards related to wait times for emergency, urgent, and routine care, as well as provider-to-enrollee ratios.⁸⁸



ILLINOIS

Requires its Medicaid plans to cover all FDA-approved medications (MAT) to treat addiction and prohibits the use of prior authorization, annual or lifetime limits, and other restrictive utilization management policies on such medications.⁸⁹

Requires insurers to use the ASAM Criteria when making medical necessity determinations.⁹⁰



MARYLAND

Prohibits prior authorization for FDA-approved MAT medications to treat opioid addiction.⁹¹

Maryland will conduct a study to determine whether Medicaid reimbursement rates reflect the actual cost of providing community-based behavioral health services. In 2019 and 2020, Maryland will increase the Medicaid reimbursement rate for licensed community providers by 3.5 percent.⁹²

Medicaid now covers residential treatment for individuals with addiction under Maryland's Medicaid 1115 waiver (Maryland Health Choice).⁹³



MASSACHUSETTS

Prohibits health plans from imposing prior authorization for addiction treatment services including: evaluation, early intervention, outpatient services including MAT, intensive outpatient and partial hospitalization, and residential and certain inpatient services rendered by state licensed or certified providers.⁹⁴ Health plans must also cover up to 14 days of acute treatment and clinical stabilization services without prior authorization.⁹⁵

Massachusetts' Medicaid 1115 waiver (MassHealth) expands treatment services for individuals with addiction, including home- and community-based services, residential services, and recovery support services.⁹⁶

**NEW JERSEY**

Prohibits the use of prior authorization for FDA-approved medications to treat addiction and for the first 180 days of medically necessary inpatient and outpatient addiction treatment provided at in-network facilities.⁹⁷

Limits the use of concurrent* and retrospective reviews.^{†98}

Requires insurers to use an “evidence-based and peer reviewed clinical tool,” designated by the state’s Department of Health, for medical necessity determinations.⁹⁹

New Jersey’s 1115 waiver expanded Medicaid services, including community supports, behavioral health services, and MAT, to individuals aged 18 and older who have a diagnosis for a mental health disorder and an opioid use disorder and an income up to 150 percent of the federal poverty level.¹⁰⁰

**NEW YORK**

Requires commercial plans to cover a five-day emergency supply of FDA-approved medications to treat addiction, without prior authorization.¹⁰¹

Medicaid managed care plans cannot require prior authorization for buprenorphine or injectable naltrexone (MAT medications).¹⁰²

Insurers are prohibited from imposing prior authorization and concurrent review for 14 days for inpatient treatment in a state-certified in-network facility, provided that the treatment is determined to be medically necessary pursuant to a scientifically validated patient placement tool.¹⁰³

Requires insurers to use LOCADTR, or another tool approved by the Office of Alcoholism and Substance Abuse Services (OASAS), to determine patient placement in treatment.¹⁰⁴

Utilizes the Medicaid 1115 waiver for adults aged 21 and older who have a significant behavioral health disorder and are enrolled in a Health and Recovery Plan (HARP).

A HARP is a type of integrated recovery model of managed care for physical health, mental health, and substance use services.¹⁰⁵

New York State’s Attorney General’s office has been a leader in enforcing parity. It has reached numerous settlements with insurance companies.¹⁰⁶ Recent settlements resulted in two national carriers dropping prior authorization requirements for FDA-approved medications used to treat opioid addiction.¹⁰⁷

**NORTH CAROLINA**

Utilizes the Medicaid Home and Community-Based Services waiver to provide treatment for youth with co-occurring substance use and mental health disorders.¹⁰⁸

**RHODE ISLAND**

The Rhode Island Health Insurance Commissioner entered into an agreement with four commercial health insurance carriers to end prior authorization for FDA-approved medications to treat opioid addiction.¹⁰⁹

Requires insurance plans to use the ASAM Criteria when developing benefits for addiction treatment.¹¹⁰

**VIRGINIA**

Requires Medicaid managed care plans and behavioral health organizations to use the ASAM Criteria when completing assessments, determining the appropriate level of care, and making recommendations for residential treatment length of stay.¹¹¹

Recently increased its Medicaid reimbursement rates for addiction treatment to align with the reimbursement rates set by commercial insurers.¹¹²

Medicaid now covers residential treatment under Virginia’s Medicaid 1115 waiver (Addiction and Recovery Treatment Services Delivery System Transformation).¹¹³

* A utilization management practice, whereby the insurance company evaluates whether a service continues to be medically necessary while the service is being rendered.

† A utilization management practice, whereby the insurance company evaluates whether a service was medically necessary after the service has been rendered.

Additional Resources for Improving Insurance Coverage for Addiction Care



RESOURCES

- [Centers for Medicare & Medicaid Services \(CMS\), *Technical Assistance Brief: Coverage and Delivery of Adult Substance Abuse Services in Medicaid Managed Care*](#)
- [State Health Reform Assistance Network, *Issue Brief - Medicaid: States' Most Powerful Tool to Combat the Opioid Crisis*](#)
- [The National Conference of State Legislatures \(NCSL\), *Insurance Carriers and Access to Healthcare Providers – Network Adequacy*](#)

Provide Comprehensive Recovery Support Services

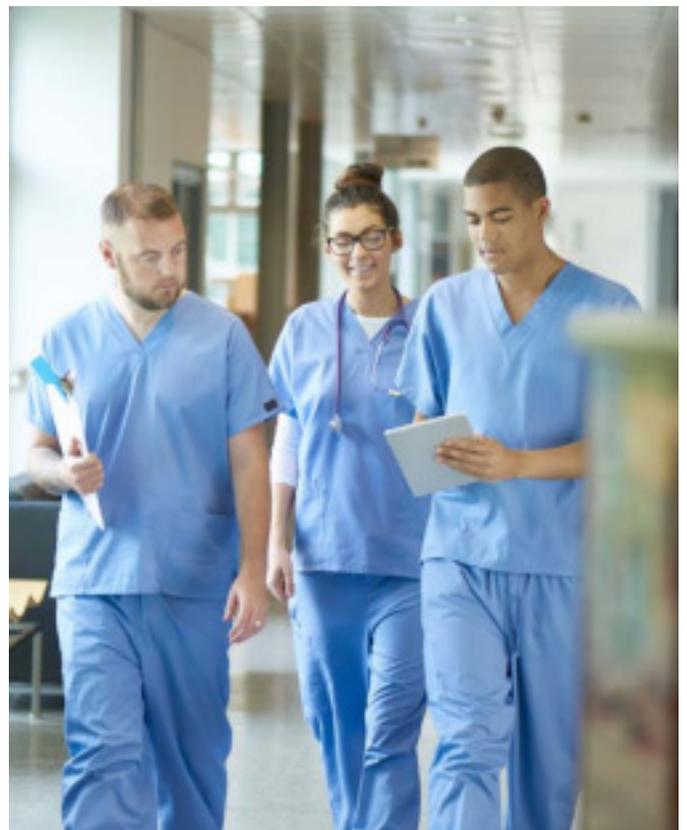
Chronic diseases, such as addiction, require long-term disease management following acute treatment to improve patient functioning, control symptoms, prevent additional diseases or co-occurring conditions, and reduce relapse.¹¹⁴ Chronic disease management addresses and mitigates the personal, psychological, and environmental risk factors for relapse.¹¹⁵ Recovery services play an important role in chronic disease management. Health care professionals and government agencies are increasingly encouraging the expansion of recovery services, which can be provided in schools, health care systems, recovery housing services, and community settings.¹¹⁶

Recovery Support

Recovery support includes mutual support services and auxiliary services. Mutual support programs, or self-help groups, allow individuals with addiction to seek and provide social, emotional, and informational support within a group of their peers. While these do not constitute treatment, they are often incorporated into formal treatment programs and can be an important part of chronic disease management. Mutual support groups include 12-step programs

such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) as well as other religious and secular programs.¹¹⁷ Individuals who attend AA or another 12-step program following treatment have about twice the rate of abstinence as those who do not participate in such groups or programs.¹¹⁸

Some mutual support programs are residential, such as recovery or sober living housing. These programs are not run by professionals and provide low-cost, substance-free housing to individuals attempting to establish or maintain sobriety.¹¹⁹ No formal treatment services are provided and residents may be mandated or strongly encouraged to participate in mutual support programs.¹²⁰ Individuals who live in a sober house and receive outpatient treatment have been found to show improvements in alcohol and other drug use, arrests, and employment.¹²¹ Often, recovery housing is not subject to government oversight. Recent news reports show that this can create an environment ripe for fraud and other criminal activity.¹²²



Peer supports also are an important tool to help individuals sustain recovery. Peer supports are provided by individuals who are in recovery and can share their own experiences and understanding of addiction with the people they serve. Peers can facilitate recovery, reduce health care costs, and help individuals engage with their communities and develop personal skills to achieve self-efficacy.¹²³ Peers should be considered part of the addiction treatment workforce, both in terms of training and licensing requirements and reimbursement by insurers for services rendered.

Recovery high schools provide recovery support services in an educational setting. Some limited studies show that they help students maintain abstinence, but they have not yet been well evaluated.¹²⁴ Several colleges also provide on-campus recovery support services to students with addiction. These programs have not been studied extensively, but limited evaluations have suggested that they may reduce substance use and improve academic performance.¹²⁵



RESOURCES Organizations, such as [Young People in Recovery](#), provide support and resources on the community level to young people in or seeking recovery.

Auxiliary Services

Patients who complete treatment successfully may find themselves facing relapse due to the anxiety of coping with other health problems, unemployment, childcare demands, homelessness, criminal justice, or other social, family, or economic problems.¹²⁶ Matching patients with the auxiliary services necessary to address these problems decreases the risk of relapse.¹²⁷ Patients who are matched to services for which they have a perceived need (e.g., childcare, vocational, housing, transportation) demonstrate better substance use and addiction outcomes.¹²⁸

Recommendations for States to Provide Comprehensive Recovery Support Services

- Use state leverage to support community recovery services and ensure their legitimacy.
 - Develop certification requirements to establish competencies/guidelines for individuals who provide peer supports.¹²⁹
 - Change insurance reimbursement rules to allow for coverage of peer support services.¹³⁰ As of 2015, 14 states cover some form of peer support services under Medicaid.¹³¹
 - Create a process to certify recovery housing.¹³²
 - Create permanent supportive housing to provide stability for individuals in recovery who are homeless or have inadequate housing.¹³³
 - Participate in federal programs, including those piloted by the United States Department of Agriculture (USDA), to provide transitional housing to individuals in recovery.¹³⁴
 - Support recovery high schools and colleges, which promote abstinence and help support students in their recovery. According to the [Association of Recovery Schools](#), as of August 2017, there are 40 recovery schools in 15 states in the United States.¹³⁵
- **RESOURCES** The [Association of Recovery in Higher Education](#) tracks collegiate recovery programs in colleges and universities across the country.
 - Provide recovery support services for parents involved with the child welfare system. ■



RESOURCES The [Association of Recovery in Higher Education](#) tracks collegiate recovery programs in colleges and universities across the country.

Examples of State Actions to Provide Comprehensive Recovery Support Services



ARIZONA

Arizona revised its Medicaid plan to include peer-delivered recovery supports across the full continuum of care for addiction services.¹³⁶



CONNECTICUT

[Connecticut Community for Addiction Recovery \(CCAR\)](#) organizes the recovery community and provides advocacy, education, and services. It has programs related to employment, housing, community centers, and young adult and family projects. Several states, including Idaho, New Hampshire, New Jersey, South Dakota, and Wisconsin have used CCAR's process to develop the foundation for a recovery community organization.



KENTUCKY

The [Sobriety Treatment and Recovery Team \(START\)](#) program provides services to families with parental substance use who have been referred to child welfare services. Social workers provide peer support and facilitate treatment and recovery services with the aim of keeping the family together. The program has demonstrated promise in helping mothers achieve sobriety, keeping families together, and cost-effectiveness. The program is expanding to pilot sites in other states.¹³⁷



MARYLAND

Pursuant to legislation, recovery residences must be certified and subject to inspection, and must participate in mandatory training.¹³⁸



MASSACHUSETTS

Massachusetts has a voluntary certification process for sober housing. State agencies can only refer clients to certified sober homes.¹³⁹



MISSOURI

Missouri requires peer recovery support specialists to be credentialed and to receive live training.¹⁴⁰

The Missouri [Coalition of Recovery Support Providers](#) is establishing certification standards for recovery housing.



NEW HAMPSHIRE

New Hampshire is participating in the U.S. Department of Agriculture's (USDA) *Contract for Deed* pilot project, which sells homes to non-profits at below-market rates to provide housing for homeless individuals in addiction recovery,¹⁴¹ and a project that provides rental assistance for tenants living in multi-family housing and participating in a drug court program.¹⁴²



RHODE ISLAND

Rhode Island's [Anchor ED! Program](#) is based in hospital emergency rooms and connects individuals who have experienced an overdose with certified peer recovery coaches who introduce recovery supports and resources.



VERMONT

The [Vermont Recovery Network \(VRN\)](#) is comprised of several of the state's recovery centers, which provide support and services for individuals in recovery. Additionally, a federally funded project of the VRN called [Pathways to Recovery](#) provides recovery supports and MAT-specific recovery groups for individuals receiving MAT through Vermont's Hub and Spoke system.

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Improve Addiction Care in the Criminal Justice System

Effectively addressing addiction should be a priority for our nation's criminal justice system (CJS). The majority of incarcerated adults in the United States are substance involved.*¹

Substance use and addiction are critical factors in the majority of criminal incidents, and failing to address them within the CJS is a key barrier to effective treatment, rehabilitation, and crime prevention and reduction.² Opioid addiction in particular disproportionately affects justice-involved individuals, and the risk of relapse and overdose deaths are high for those returning to the community after incarceration.³

There is a documented link between continued substance use, criminal activity, and recidivism: many individuals in the CJS who are substance involved re-engage in criminal behavior once they are released from jail or prison.⁴ National data show that three-quarters of individuals imprisoned for a drug-related offense are arrested for a new crime within five years of release.⁵ Left unaddressed, substance use and addiction cost the CJS billions of dollars. According to our Center's [report](#) on the cost of substance use and addiction to government, substance-related CJS costs -- including those associated with incarceration, probation, parole, juvenile justice, and criminal and family court -- account for an estimated 13 percent of total substance-related federal and state government spending.⁶ Despite these costs and the fact that governments are constitutionally required to provide health care to incarcerated individuals,⁷ an enormous

treatment gap persists.⁸ Only about ten percent of inmates receive addiction treatment services⁹ and, of those who do receive treatment, few receive evidence-based care.¹⁰

Criminal justice systems have a dual mission to protect public safety and the health and well-being of those involved in the CJS. Given the high rate of substance use and addiction among justice-involved individuals and the risks and costs associated with untreated addiction, providing effective, evidence-based addiction treatment should be a top priority. Health-based rather than punitive approaches should be used at every point of contact with the system, regardless of the severity of the infraction, to identify substance use and addiction and to respond appropriately.



* Defined as having a history of using illicit drugs regularly, meeting clinical criteria for addiction, having been under the influence of alcohol or other drugs when committing the crime, having a history of alcohol treatment, having been incarcerated for an alcohol or other drug law violation, having committed the offense to get money to buy drugs, or some combination of these characteristics.

The CJS has an opportunity to address opioid use and addiction at multiple points of contact with the system. These points range from pre-arrest during an individual’s initial engagement with law enforcement, to post-arrest when an individual may be connected with treatment interventions in lieu of incarceration or during incarceration, and finally during reentry into the community. Each approach presents unique opportunities, and intercepting at earlier points along the continuum will help to prevent further substance use and criminal activity. Therefore, states should provide multiple interventions within the CJS to ensure a comprehensive approach.

An Effective and Comprehensive Approach to Improving Addiction Care in the Criminal Justice System

- Provide Prevention and Early Intervention for At-Risk Groups
- Expand the Role of Law Enforcement in Addiction Care
- Implement and Support Diversion Programs
- Provide Evidence-Based Treatment within Jails and Prisons
- Provide Connections to Treatment and Support Services upon Reentry

Provide Prevention and Early Intervention for At-Risk Groups

Approximately 14 percent of 12th graders use addictive substances.¹¹ Initiation of any substance use prior to the age of 18 is a major risk factor for developing addiction.¹² Adolescents who use addictive substances often face a variety of risk factors including a family history of substance use and addiction, co-occurring mental health disorders, limited access to health care, low attachment to school, and poor self-regulation skills. These same factors increase the risk of criminal justice involvement as well.

Preventing substance use and providing timely and appropriate therapeutic interventions for those at risk for criminal involvement can improve health outcomes and reduce crime, recidivism, and prison overcrowding, and save taxpayer money.¹³

Unfortunately for many individuals, especially youth, opportunities for early identification and intervention of substance-related problems are missed, making the CJS the first point of contact with needed services. More adolescents in addiction treatment settings are referred by the criminal and juvenile justice systems (48.2 percent) than by any other source; only 4.7 percent are referred by a health care provider.¹⁴ Similar statistics highlight parallel challenges for the adult treatment-seeking population.¹⁵ Effectively addressing addiction before an individual comes into contact with the CJS should be a priority.

For more specific recommendations related to prevention, please see Chapter II.

Expand the Role of Law Enforcement in Addiction Care

Law enforcement can play a critical role in the effort to address addiction as a public health and safety issue rather than primarily as a criminal issue. Law enforcement professionals at all levels should be educated about addiction as a chronic health condition and be equipped with the knowledge and tools to intervene in a manner that facilitates connection to needed services. This is particularly relevant as police officers are frequently the first to respond to the scene of an overdose. Several communities have tailored outreach and engagement efforts specifically to their needs and, as of 2016, 153 police departments in 28 states have adopted no-arrest referral to treatment programs.¹⁶

Recommendations for States to Expand the Role of Law Enforcement in Addiction Care

- Train law enforcement and judicial professionals to address addiction as a public health and safety issue, rather than a criminal issue. They should be provided with tools to intervene with substance-involved individuals and those with co-occurring mental health conditions in a manner that assures they receive appropriate health care.
- Support law enforcement programs that connect individuals to intervention and treatment services.
- Support law enforcement programs that connect individuals to treatment following an overdose.

Examples of Promising Initiatives to Expand the Role of Law Enforcement in Addiction Care*



DELAWARE

The [HERO Help Program](#) was started in May 2016 and is a collaboration among the New Castle County Police Department, the Delaware Department of Justice, and the State Division of Substance Abuse and Mental Health. The program is a hybrid angel and diversion program. Eligible individuals may seek treatment in lieu of an arrest or may have charges dropped upon successful participation in treatment. The police also provide linkage to treatment for individuals who voluntarily seek help in obtaining treatment but who have not been arrested. Participants are also connected with case management to help them in their recovery.



ILLINOIS

[A Way Out](#) is a countywide collaborative program in Lake County in which participants can voluntarily contact law enforcement to be screened and fast-tracked into treatment. Participants can use a smartphone application where certified counselors are available 24/7 to conduct screening.



MARYLAND

[Stop, Triage, Engage, Educate and Rehabilitate \(STEER\)](#) of Montgomery County is one of the longer running pre-arrest diversion programs, consisting of a partnership between police and community treatment providers. The program administers evidence-based screening tools while in the field to help identify appropriate treatment options for individuals with substance use disorders.¹⁷



MASSACHUSETTS

In June 2015, the Gloucester Police Department pioneered the [Angel Project](#), an innovative program that allows citizens to turn in their drugs and drug paraphernalia to the police station, without fear of arrest, and receive help from volunteers (“angels”) who guide participants to detoxification and treatment. During the first year of the program, approximately 95 percent of those needing a referral were placed in treatment.¹⁸ [The Police Assisted Addiction and Recovery Initiative \(PAARI\)](#), a nonprofit organization, was formed to support local police departments that work with individuals with opioid addiction by providing resources to address the opioid epidemic. Such resources include information about how to have conversations with communities to help reduce stigma, connect people with treatment, encourage recovery, and distribute naloxone. Police departments that have adopted a program in conjunction with PAARI have experienced up to 25 percent reductions in substance-related crimes.¹⁹

The [Arlington Opiate Outreach Initiative](#) in Arlington is a community policing strategy predicated on the notion that recovery occurs in the community. Police officers provide outreach to individuals known to have addiction (based on overdose, criminal justice involvement, or referral), foster relationships with these individuals, and provide public education to address stigma.

* The examples listed here and in subsequent sections of this chapter are provided to illustrate how some states have implemented a program or policy consistent with one of the broader recommendations presented in the section. Inclusion of these examples does not constitute an endorsement of the policy or program or any conclusion regarding its effectiveness.

OHIO

Conversations for Change of Dayton is a partnership between the Dayton Police Department and East End Community Services aimed at exploring ways to address the opioid crisis. The program convenes meetings every few months to provide information to the community around topics of addiction, treatment options, and support services. Individuals with a substance use disorder are encouraged to attend and participate.²⁰

The [*Drug Abuse Response Team \(DART\)*](#) of the Lucas County Sheriff's Office in Toledo is an innovative program that connects law enforcement officers with individuals who have experienced an overdose and their families. Officers provide services to help people achieve recovery and follow program participants for two years.

TENNESSEE

[*Crisis Intervention Teams*](#) are partnerships of law enforcement, mental health, and addiction professionals and advocates. First developed in Memphis, this model of police-based crisis intervention training is designed to help individuals access needed care, reduce stigma, and promote problem solving rather than placement in the criminal justice system.

Implement and Support Diversion Programs

Historically, the criminal justice and addiction treatment systems operated independently. This has begun to change in recent years with the expanded use of diversion programs, such as alternative to incarceration (ATI) programs or drug courts, which provide more opportunities for individuals in the CJS to become engaged in treatment. Diversion may occur at any point before the point of arrest, at the time of arrest, before conviction, or post-plea.

Participants may be offered the chance to have charges dropped or sentences reduced upon successful completion of the program.²¹



Alternative to Incarceration (ATI) Programs

ATI programs are criminal justice innovations typically offered to defendants who can benefit from treatment instead of prison time. Such programs prioritize treatment, establish collaboration between justice authorities and treatment providers, and hold the justice-involved individual legally accountable for treatment compliance. Importantly, ATI programs have been found to reduce re-arrest and recidivism rates.²² The use of ATI has gained momentum in recent years as witnessed by a rapid expansion of drug courts, prosecutorial diversion programs, and treatment interventions supervised by probation and parole; the accumulation of evaluation studies demonstrating their efficacy;²³ and the emergence of advocacy coalitions* for treatment alternatives. Yet, despite the encouraging growth of diversion and treatment opportunities and evidence of their cost effectiveness, only a fraction of substance-involved individuals who are in the CJS have benefited from these programs. Barriers to greater adoption include a lack of knowledge or acceptance of addiction as a health condition, a dearth of qualified medical staff in the CJS, lack of insurance coverage for treatment, and limited community treatment programs and resources.²⁴

* Such as the Center for Community Alternatives (<https://www.cnysolidarity.org/directory/1495/center-for-community-alternatives/>), the New York City ATI/Reentry Coalition (<http://www.ati-ny.org/>), and the Texas Criminal Justice Coalition (<https://www.texascjc.org/alternatives-incarceration/>).

Drug Courts

Drug courts are a type of problem-solving court that operates under a public health model to address substance use and addiction. As a type of diversion program, they seek to engage individuals charged with a crime in addiction treatment instead of jail time. Individuals in drug courts typically have already been formally charged with a crime. In these types of courts, the judge takes a more active role than in traditional courts, while also taking a more rehabilitative and collaborative approach. A team of judges, prosecutors, defense attorneys, treatment providers, and court staff arrange for or provide treatment, monitoring, sanctions, and incentives. Drug courts have been shown to reduce recidivism rates by approximately 10 to 15 percent compared to traditional court or probation,²⁵ while saving an estimated \$5,680-\$6,208 per participant, on average.²⁶ To date, there are more than 3,000 drug courts in the United States.²⁷ Despite their considerable promise, to be effective, drug courts must provide evidence-based care for addiction, including medication-assisted treatment.

Medication-Assisted Treatment (MAT) in the Justice System

Initiation of MAT while incarcerated can increase the likelihood of engaging in aftercare upon release,²⁸ in turn decreasing re-arrest and recidivism rates.²⁹ MAT also reduces the risk of death for individuals with opioid addiction, both during incarceration and post-release, since overdose is a significant risk upon reentry for those whose opioid addiction had not been adequately treated or managed.³⁰ Despite the social, health, and economic benefits of providing MAT to individuals in the CJS, it has not been routine practice to do so.³¹

MAT should be incorporated as standard practice for individuals who are incarcerated and participants in drug courts and other ATI programs who have opioid use problems, including opioid addiction.

Drug courts that receive federal funding are prohibited from requiring participants to discontinue MAT,³² and some states are introducing similar laws.* Programs that do not allow the use of MAT during participation restrict access to a potentially life-saving evidence-based therapy for otherwise eligible justice-involved individuals with opioid addiction, and this practice may violate anti-discrimination laws. **Use of MAT should not prevent someone from participating in or completing their drug court or other justice requirements.**

The following organizations have endorsed the use of MAT in the CJS: American Correctional Association;³³ American Society of Addiction Medicine;³⁴ National Commission on Correctional Health Care;³⁵ National Governors Association;³⁶ National League of Cities and National Association of Counties;³⁷ and the President's Commission on Combatting Drug Addiction and the Opioid Crisis.³⁸

Recommendations for States to Implement and Support Diversion Programs

- Adopt diversion programs to encourage low-level, non-violent offenders to seek addiction treatment.
- Require or encourage drug courts to implement evidence-based practices in addiction care, including MAT.
- Eliminate mandatory sentencing, which prevents the possibility of alternative sentencing programs and/or parole.
- Invest funds in drug courts and improve access to quality treatment for the criminal justice population.

* In September 2015, New York Governor Andrew Cuomo signed legislation to prohibit the removal of defendants with opioid addiction from judicial diversion programs (drug courts) based on their use of MAT. This legislation will prohibit drug court judges from forcing defendants with opioid addiction to terminate their use of MAT as a condition of participation in diversion programs (N.Y. Crim. Proc. § 216.05).

Examples of Promising Initiatives to Implement and Support Diversion Programs



GEORGIA

Georgia provided \$11.6 million in funding for drug courts for arrestees with mental health and substance use disorders and made a \$5.7 million investment in residential treatment services using savings from criminal justice system reform.³⁹



MARYLAND

Maryland appropriated \$2 million in state funding to expand drug courts in 2019.⁴⁰



MASSACHUSETTS

Massachusetts undertook an initiative to expand drug courts and enhance and standardize drug court practices.⁴¹ In 2014, the Massachusetts Center of Excellence (COE) for Specialty Courts was founded to provide trainings, evaluation, and assistance to drug courts to adopt and implement evidence-based practices.⁴²

The [Jail Diversion Program](#) in Arlington is both a diversion and crisis intervention initiative, operating under a formal agreement between law enforcement and mental health agencies. Clinicians accompany police responding to calls and work to provide alternatives to arrest, booking, and jail for nonviolent offenses due to a mental health or substance use issue. The program expanded to operate in 13 counties, and between fiscal years 2012 and 2013, 73 to 92 percent of cases were diverted into treatment.⁴³



NEW YORK

Central New York Drug Court: Approximately 70 percent of Central New York's drug court participants have opioid use disorder. The court allows for all forms of MAT medications and requires that all participants receiving these medications attend accompanying counseling from state-licensed

programs. While most participants are not on MAT when they enter the drug court, they receive both an assessment from a court case manager and a referral for an additional assessment at a state licensed facility to determine MAT eligibility.⁴⁴

[Drug Treatment Alternatives to Prison \(DTAP\)](#) in Kings County was established in 1990. It is the first prosecution-run program in the nation to divert felony offenders into residential drug treatment programs instead of incarceration. Participants receive clinical screenings and assessment and residential treatment for 15-24 months. Upon completion, participants are able to have their charge dismissed from their record. Our Center conducted a five-year evaluation of DTAP and found that more than half (52.6 percent) of participants graduated from the program. Compared to the control group, graduates were 33 percent less likely to be rearrested and 87 percent less likely to return to prison.⁴⁵

A Road Not Taken (ARNT) is a jail-based diversion program at Rikers Island in New York City for drug court participants and inmates eligible for drug treatment instead of continued incarceration. The program provides cognitive behavioral therapy, motivational interviewing, and therapeutic community treatment in daily group meetings and biweekly individual sessions. Upon completion of the program, participants are linked to community services for continued treatment. Program participants were found to be less likely to be re-arrested within a year after release.⁴⁶



OHIO

The [Addiction Treatment Program \(ATP\)](#), launched in 2014 as part of a comprehensive strategy to address prescription opioid and heroin addiction, offers treatment, including MAT, to participants with alcohol and/or opioid addiction. During the first phase, past-month drug use decreased by 69 percent. The program is expanding into additional counties and currently is under evaluation.

**OREGON**

[Sanctions Treatment Opportunities Progress \(STOP\) Drug Court](#) in Multnomah uses both incentives and sanctions to encourage compliance. Each time a participant appears in a court, the team reviews treatment progress, attendance, participation, and urinalysis results. A ten-year evaluation showed significantly reduced recidivism for drug court participants up to 14 years after drug court entry compared to eligible offenders who did not participate, and the incidence of re-arrest was reduced by nearly 30 percent.

**SOUTH DAKOTA**

South Dakota invested \$4 million in drug courts and in treatment for mental health and substance use disorders for probation and parole populations.⁴⁷

**TEXAS**

[Dallas Initiative for Diversion and Expedited Rehabilitation and Treatment \(DIVERT\)](#) is Texas's first established drug court. Participants receive inpatient or outpatient treatment, education about addiction, and vocational and educational support services.

**WASHINGTON**

[Law Enforcement Assisted Diversion \(LEAD\)](#) in Seattle is a pre-booking diversion program that seeks to improve public safety by allowing individuals charged with low-level drug offenses the opportunity to participate in community-based services instead of jail.⁴⁸ The program is a collaboration of law enforcement agencies, public officials, and community groups. Participants receive intensive case management to identify their service needs, including housing, health care, job training, and treatment. Evaluations from the University of Washington-Harborview Medical Center reported participants were 60 percent less likely to be arrested compared to those not in the program.⁴⁹ Further, secure housing and employment were associated with 17 percent and 33 percent fewer arrests, respectively.⁵⁰ LEAD has been replicated in Santa Fe, NM and in Albany, NY.



Provide Evidence-Based Treatment within Jails and Prisons

Evidence-based treatment is not standard practice within the criminal justice system. Only an estimated 16.6 percent of facilities offer addiction treatment in specialized settings segregated from the general prison population -- a practice that produces better outcomes with regard to substance use and post-release arrests.⁵¹ Few correctional facilities offer MAT.⁵² If medications for opioid addiction are provided in a correctional facility, it often is only for detoxification, pregnant women, or individuals who already were on methadone prior to incarceration.⁵³

Recommendations for States to Provide Evidence-Based Treatment within Jails and Prisons

- Require jails and prisons to provide evidence-based addiction treatment to incarcerated individuals with substance use disorders.
- Require the accreditation of prison- and jail-based treatment programs and providers through organizations such as the American Correctional Association (ACA), the Center for Substance Abuse Treatment (CSAT),* or the National Commission on Correctional Health Care (NCCCHC). Such accreditation should require adherence to best practice standards and include periodic performance reviews by independent experts.
- Change state policy to obtain Medicaid coverage for inpatient treatment for incarcerated individuals.⁵⁴
- Seek federal funding to develop and implement addiction treatment programs in state and local correctional facilities through the Residential Substance Abuse Treatment (RSAT) for State Prisoners program, which helps governments develop and implement addiction treatment programs in correctional and detention facilities as well as community-based aftercare services.⁵⁵
- Tailor treatment for special populations with substance use disorders, including incarcerated individuals with co-occurring mental health disorders, veterans, juveniles, women, parents, and repeat offenders. While evidence-based treatments for special populations are not opioid specific, treatment for substance use disorders should be tailored to address the unique needs of the individual receiving services.

* A division of the U.S. Department of Health's Substance Abuse and Mental Health Services Administration (SAMHSA).

Examples of Promising Initiatives to Provide Evidence-Based Treatment within Jails and Prisons



ARIZONA

Arizona changed its Medicaid policy to permit reimbursement for inpatient treatment for incarcerated individuals.⁵⁶



COLORADO

Medication Assisted Treatment Induction Program for Denver Probationers allows participants already on MAT to continue treatment and allows participants to be induced on methadone while in custody of the Denver County Jail.⁵⁷

Colorado changed its Medicaid policy to permit reimbursement for inpatient treatment for incarcerated individuals.⁵⁸



KENTUCKY

Kenton County Detention Center provides cognitive-behavioral therapy, intensive counseling, spiritual programming, and a naltrexone injection prior to release. Participants are connected to community outpatient services through pre-release treatment planning. The recidivism rate for those completing the program is reported to be less than ten percent.⁵⁹

Kentucky changed its Medicaid policy to permit reimbursement for inpatient treatment for incarcerated individuals.⁶⁰



MICHIGAN

Michigan changed its Medicaid policy to permit reimbursement for inpatient treatment for incarcerated individuals.⁶¹



NEW HAMPSHIRE

New Hampshire changed its Medicaid policy to permit reimbursement for inpatient treatment for incarcerated individuals.⁶²



NEW YORK

Key Extended Entry Program (KEEP) is an opioid treatment program (OTP) at Rikers Island Jail Complex. Established in 1987, KEEP was the first methadone treatment program offered in a correctional facility and it remains the largest jail-based opioid treatment program. The program is voluntary and individuals not in treatment during the time of arrest are eligible. Men and women with opioid use issues receive detoxification with methadone and/or maintenance with methadone or buprenorphine, as deemed clinically appropriate by medical staff. Participants are also offered individual and group psychosocial therapy while incarcerated. Upon release, counselors connect participants to community methadone programs. An evaluation study showed that the program resulted in overall cost savings and reduced recidivism.⁶³ Approximately 2,500 patients each year are connected to a methadone program upon reentry⁶⁴ and approximately 500 have been induced on buprenorphine.⁶⁵



RHODE ISLAND

Rhode Island provides MAT to inmates in its adult correctional institutions. The state has included \$2 million in the fiscal year 2017 budget to expand the use of MAT in state prisons. Previously, MAT was only given to individuals with sentences of less than 60 days. The expansion allows for access to treatment for six months to one year, along with additional treatment prior to release.⁶⁶ Recently, the state became the first unified correctional system in the U.S. to implement all three forms of MAT.⁶⁷

Provide Connections to Treatment and Support Services upon Reentry

Providing comprehensive pre-release planning and services for incarcerated individuals with substance use disorders -- such as treatment, recovery supports, health care, education, and vocational training -- is essential to ensure successful reentry, reduce the risk of overdose, and decrease recidivism. The leading cause of death among recently released former inmates is drug overdose.⁶⁸

Medicaid is an important tool that states can use to help justice-involved individuals gain access to addiction treatment upon release from prison or jail. Most incarcerated individuals are uninsured, making it difficult for them to access needed treatment.⁶⁹ Enrolling them in health insurance and facilitating their access to community-based care will yield better health outcomes and may reduce recidivism. One way to accomplish this is to suspend, rather than terminate Medicaid during incarceration. Terminating Medicaid eligibility can create gaps in health care access, especially following release when rates of relapse, overdose, and criminal recidivism are high.⁷⁰



Recommendations for States to Provide Connections to Treatment and Support Services upon Reentry

- Suspend rather than terminate Medicaid coverage during incarceration to facilitate access to treatment upon release.⁷¹ As of May 2016, 31 states and the District of Columbia have some form of policy to suspend Medicaid upon incarceration.⁷²
- Enroll people in Medicaid during all stages of criminal justice involvement and especially upon release.
- Provide services to help prevent post-release overdose, including MAT, overdose education, and naloxone.
- Offer transitional services to incarcerated individuals reentering the community, including treatment, recovery support, health care, education, vocational training, and family support.
- Reduce collateral consequences on justice-involved individuals by removing barriers to employment and public benefits.
 - Opt out of the federal policy in the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), which bans individuals with drug felony convictions from receiving federal benefits such as Temporary Assistance for Needy Families (TANF) and the Supplemental Nutrition Assistance Program (SNAP, formerly known as Food Stamps). Ensure access to these and other benefits (e.g., public housing, education assistance) for justice-involved individuals reentering the community if they have successfully completed their sentences and are making satisfactory progress in addiction treatment. As of August 2016, 43 states have lifted the ban on SNAP and 11 states have lifted the ban on TANF.⁷³
 - Support “Ban the Box Initiatives,” which remove questions about conviction history from employment applications so that applicants are judged more fairly and not subject to stigma based on their history with the criminal justice system.⁷⁴ ■

Examples of Promising State Initiatives to Provide Connections to Treatment and Support Services upon Reentry



COLORADO

Reentry Modified Therapeutic Community is a program for individuals with co-occurring mental health and substance use disorders who have been released from jail. Services include medication monitoring, case management, coordination with the legal system, linkage to recovery mutual support organizations, and enhanced therapeutic community treatment services. A randomized controlled trial showed that, compared to a control group, participants in the program had significantly greater declines in drug use, self-reported criminal activity, and contact with the justice system 12-months post-release.⁷⁵



MARYLAND

The *Maryland MAT Reentry Program*, modeled after the Washington County Detention Center program, combines addiction treatment, behavioral health counseling, and monthly injections of Vivitrol® (injectable naltrexone). Vivitrol® is administered in the jail within three months of release, and subsequent injections are provided by local health departments, community practitioners, or by the local detention center. Program participants without insurance are enrolled in Medicaid at release in order to pay for follow-up injections. To ensure successful reentry, each participant has a tailored post-release treatment plan that includes intensive addiction treatment and community support services, such as housing, mental health treatment, education, and employment assistance.⁷⁶



MASSACHUSETTS

Massachusetts' *Medication Assisted Treatment Reentry Initiative (MATRI)* provides pre-release treatment and post-release referral for inmates with opioid or alcohol addiction with the goal of providing comprehensive reentry services, including medication, counseling, and aftercare. Participants also receive Vivitrol® both pre-and post-release. If an individual is located in a facility without access to addiction treatment, he or she can be transferred to one with the appropriate services in order to participate in the program.⁷⁷

The Barnstable Sheriff's Department was one of the first to adopt Vivitrol® upon release. According to the Sheriff's Department, only 18 percent of participants have been rearrested in the county, and an estimated 40 to 45 percent have remained substance-free.⁷⁸



MISSOURI

Participants in St. Louis's drug courts are referred to the city's Vivitrol® centers for treatment. A 2011 pilot study of the St. Louis drug court (and two Michigan drug courts) demonstrated positive outcomes. Eight percent of participants given Vivitrol® were rearrested compared to 26 percent in the control group, and individuals who received Vivitrol® were 57 percent less likely to miss drug court sessions. The study estimated that keeping individuals from reentering the justice systems saves an estimated \$4,000-\$12,000 per person.⁷⁹



NEW YORK

Community and Law Enforcement Resources Together (ComALERT) in Brooklyn is a reentry program that provides addiction treatment and employment and housing services for individuals reentering the community. Participants are evaluated and assigned to a social worker and are mandated to individual and group therapy for outpatient addiction treatment. Participants also receive transitional employment opportunities, transitional housing, vocational training, and financial management and life skills courses.⁸⁰



PENNSYLVANIA

Pennsylvania's MAT pilot project gives participants a Vivitrol® injection prior to release, and participants continue to receive a monthly injection and cognitive behavioral therapy in the community. In order to implement the program, the PA Department of Corrections collaborated with social workers, medical staff, community corrections staff, probation and parole departments, and community treatment and service providers. The department also employed a MAT services coordinator to provide technical assistance and coordination for all of the partners.⁸¹



RHODE ISLAND

Rhode Island instituted a pilot program funded by the National Institutes of Health and operated by the state Department of Correction and Medicaid Program. Prior to release, individuals are provided with three counseling sessions and a Vivitrol® injection and are connected to a community provider for ongoing monthly injections.⁸²

Additional Resources on Reentry Services for the Substance-Involved Justice Population



RESOURCES

- [Kaiser Family Foundation, *State Medicaid Eligibility Policies for Individuals Moving Into and Out of Incarceration*](#)
- [The Urban Institute, *The Justice Reinvestment Initiative, Experiences from the States*](#)
- [National Institute of Justice, *Crime Solutions Database*](#)
- [Substance Abuse and Mental Health Services Administration \(SAMHSA\), *Reentry Resources for Individuals, Providers, Communities, and States*](#)
- [The Council of State Governments Justice Center, *Second Chance Act Grant Program*](#)
- [Legal Action Center, *Opting Out of the Federal Ban on Food Stamps and TANF*](#)



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