THE OPIOID CRISIS IN NEW YORK STATE: THE JOURNEY TO SOLUTIONS

A White Paper

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New York State, like the rest of the country, is facing an opioid crisis. Fatal and non-fatal overdoses have increased dramatically over the past several years and the incidence of addiction continues to grow. This paper, written by the Executive Committee of the New York State Psychological Association's (NYSPA) Division on Addictions, elaborates on the following select recommendations to help address the opioid crisis:

Recommendation #1: Provide evidence-based training and education about substance misuse for medical and mental health professionals and students.

Recommendation #2: Require prescriber and patient education about the risks of opioid-based pain medications.

Recommendation #3: Require health care providers to provide referrals to substance use treatment for opioid overdose survivors and patients coming out of emergency department visits, rehabilitation and detoxification facilities.

Recommendation #4: Integrate medical, psychological services and social interventions.

Recommendation #5: Offer referrals for non-pharmaceutical, evidence-based interventions for pain management.

Recommendation #6: Address opioid use in individuals in, and transitioning out, of the criminal justice system.

Recommendation #7: Respect the importance of a harm reduction framework for the entire continuum of care.

Introduction

Addiction is a biopsychosocial condition. Effective intervention must address all 3 components: medical, psychological and socio-cultural. Medically-based treatments are essential, as is training for physicians in prescribing practices as well as intervention and treatment. Evidence shows that opioids are not the most effective treatment for chronic pain, yet they have been prescribed at alarming rates, encouraged by the pharmaceutical companies that have profited from them. Physicians and other prescribers should be educated about effective alternatives. In addition, medical practitioners are frequently the first point of contact for opioid users, in the Emergency Department following an overdose or in a clinic or medical office. With proper assessment techniques, these contacts provide opportunities to identify substance misuse and engage clients in discussion about treatment options. Medical personnel should be trained to perform sensitive and comprehensive assessments of substance use. Asking the right questions or administering assessment tools in an open, non-judgmental and non-punitive manner significantly improves the chances of identifying and referring substance-misusing patients to treatment.

Medical treatment for opioid and other substance use disorders is crucial. Medically-assisted detoxification should be widely available followed by continuing medical care. Addiction is a long-term medical and psychiatric condition that requires care beyond withdrawal from physical dependence. Medication Assisted Treatment (MAT) has been shown to be effective in preventing relapse and enabling individuals to live functional, productive lives. These include opioid replacement medicines, such as buprenorphine and methadone, opiate antagonists like naltrexone or Vivitrol, and deterrents for other substances, such as antabuse or naltrexone for alcohol. Physicians should be well-versed in the use and effects of these medications, and referrals should be readily available. Additionally, it is important that all insurance, including Medicaid, cover these potentially life saving medications.

The psychological component in addiction is too often overlooked. Evidence for this lies in the frequency of relapse, even after withdrawal has been achieved and even when MAT is in place. Often at play is an underlying psychological condition that the individual is attempting to medicate with a substance; until that psychological condition is addressed, relapse is a risk. Although no single treatment intervention should be mandatory, effective evidence-based treatment should be offered. This would include not only MAT, but also counseling with licensed mental health providers who are substance use experts or Intensive Outpatient or Inpatient programs that include individual, group and family therapies and psychoeducation. In addition, psychologists, social workers and other mental health clinicians should be taught about substance use in their educational programs, with an emphasis on de-stigmatizing users, reducing the risk of shame and associated secrecy, and addressing underlying issues while working to reduce potential harm to users or others.

Finally, the socio-cultural circumstances of users must be attended to. The stress of homelessness, poverty, incarceration and other adverse circumstances contributes to substance misuse and relapse. The New York State legislature has a tremendous opportunity to impact these socio-cultural challenges. For example, Housing First, a model of addressing homelessness that provides for housing before sobriety or other criteria such as participation in treatment has been shown to reduce substance misuse as well as homelessness itself. Once safely sheltered, people are more likely to access services, especially if these are made available, but not mandated, in the housing environment. New York State has some, but not enough, facilities like these.

The criminal justice system is another area that provides ample opportunity for the State to address the opioid crisis. The incarceration of low level drug offenders has not been shown to be an effective deterrent to use and actually increases vulnerability for both incarcerated users as well as their family members. Drug courts and Diversion programs offer a solution to this problem. In addition, offering MAT and substance use counseling to inmates with substance use disorders, while incarcerated and upon discharge, should be mandatory at all state prison facilities.

In addition to the above suggestions which address both the long-term and short-term needs of addicted individuals in our state, an immediate life saving intervention would be the wide spread availability of naloxone to interrupt an overdose. Similarly, Good Samaritan laws that allow 911 calls to be made in case of overdose without risking arrest should not only be in place, but be widely publicized so that individuals witnessing an overdose have no hesitation to call for help even if they themselves are using.

This paper represents the expertise and recommendations of some of the top addiction psychologists in the state with extensive collective experience treating a range of substance users, from impoverished or homeless patients in city hospitals to executives and professionals in private practice. With a comprehensive approach that incorporates these suggestions, New York State can significantly reduce the frequency of opiate overdose and death, impact the consequences of rampant substance misuse in our state, and in the process become a model for other states to follow.

Recommendation #1: Provide evidence-based training and education about substance misuse for medical and mental health professionals and students

The Problem: The Substance Abuse and Mental Health Services Association reports that 8.4% of the US population (20.2 million people), have a substance use disorder (SUD).[1] Over one quarter of the general population report binge drinking in the past month, and almost 10% of the general population have used an illicit substance in the past month.[1] Approximately 1.8 million people in the US have opioid use disorders (OUD) related to opioid painkillers, while 626,000 individuals have heroin-related OUDs.[1] In spite of this prevalence, *less than 1%* of those who report substance misuse receive drug and alcohol treatment. Many untreated individuals who misuse substances do make contact with medical and mental health practitioners; unfortunately, many of these providers are not adequately trained to assess and refer individuals to drug and alcohol treatment, creating failed opportunities to provide help and treatment guidance.

Medical providers have a great deal of access to the substance using population in emergency rooms, primary care clinics, or inpatient units, as people who misuse substances are at higher risk for medical problems. Studies have shown, however, that only about one-third of people who present for medical care are asked about their drug or alcohol use.[2] Lack of training in assessing and recommending treatment for substance misuse can lead to inadequate patient care. ER nurses have indicated self-reported frustration with the lack of training on SUDs in nursing schools.

Lack of education on SUDs is often associated with stigmatization of this population, as well. Substance-using patients are often characterized as “manipulative” and not truly deserving of care because of their “choice” to use. More education and collaboration with other providers has been shown to improve the therapeutic attitude toward substance using clients.[3]

A variety of screening instruments have been specifically developed to help medical providers make brief, accurate assessments of substance misuse for patients presenting with medical issues (ex: CAGE or AUDIT). Being trained on these instruments and in Motivational Interviewing, an empirically-validated approach to substance misuse that supports behavioral change, has been shown to decrease substance use in primary care settings. Brief interventions by a primary care provider (PCP) have been shown to reduce patient substance use and may prevent substance use from escalating.[1]

Lack of substance use training is also a common problem in mental health counseling, social work, psychology and psychiatry training programs.
This has been reinforced by a long-standing separation between the mental health and addiction fields, with many addiction treatment centers being staffed only by people in recovery from substance misuse themselves, or by paraprofessionals. There are high incidences of comorbidity between substance abuse and other mental health disorders, however. For example, the presence of a drug or alcohol problem doubles the odds of

having a mood disorder, PTSD, or other anxiety disorders.[4] SAMHSA recommends the need for integrative care that addresses both substance misuse and mental health issues, suggesting a vital opportunity for mental health professionals to be involved in SUD treatment.

The Solution: In order to achieve this goal, medical and mental health graduate training programs should provide training about substance misuse, drug and alcohol assessment and evidence-based SUD treatment practices that have been shown to be effective in improving patient outcomes. Hospitals and mental health clinics should likewise provide training and education around substance misuse, and ongoing credentialing could be dependent on such trainings.

Recommendation #2: Require prescriber and patient education about the risks of opioid-based pain medications.

The Problem: To a significant extent, the opioid epidemic in the United States is an iatrogenic effect of changes in prescribing practices around the treatment of pain over the past two decades. Previously, opioids were prescribed almost exclusively for either short-term use, such as following surgery, or for terminal, painful illnesses, such as cancer. In 1992, 88% of physicians surveyed said that prescribing opioids for chronic pain was not a "lawful and generally acceptable medical practice."[5] They recognized the high potential for addiction and deleterious side effects as patients became tolerant and would require increasingly larger doses, and that patients who wanted to stop the opioids would be exposed to the agony of opioid withdrawal.

As a result of an astonishingly compelling campaign led by Purdue Pharma, the maker of Oxycontin, however, physicians reversed course and came to believe that the use of opioids for common chronic pain syndromes was both safe and effective. Pain was highlighted as the "5th Vital Sign," and doctors were provided with misleading information suggesting that people with "legitimate pain" wouldn't develop a tolerance to and cravings for opioids. In addition, the *New England Journal of Medicine* published a piece that stated that the risks of addiction from the long-term use of opioids was "inconsequential," and the FDA-approved labeling for Oxycontin stated that "addiction to opioid analgesics in properly managed patients with pain has been reported to be rare."

The medical community was convinced. If opioids were safe and effective for chronic pain patients and would not cause the addiction that had been considered inevitable when used by other populations, why would a well-meaning physician deprive his or her patient of opioids for pain relief? Unfortunately, as we now know, this paradigm shift was based on erroneous data and created a vast amount of opioid dependence, opioid use disorders and, eventually, profound suffering and death. Much of this has been worsened by the transition to heroin, as prescription opioid users unable to obtain or afford prescription opioids sought cheaper, more accessible alternatives. This transition also introduced other potential dangers associated with impurities, such as fentanyl, inconsistencies in potency, and risks associated with IV injection. At the present time

there are approximate 2 million Americans who are opioid dependent. How do we prevent the next two million people from become opioid-dependent as a result of misguided prescribing patterns?

The Solution: Since the tragic consequences of the overprescribing of prescription opioids are now well known, a variety of measures have been put in place to impact prescribing practices in the medical community. The Federal government has made some pain medications more difficult to misuse, and has reclassified some opioids to a different classification schedule, placing restrictions on prescribers. State governments have created Prescription Drug Monitoring Programs (PMPs) that force providers to check databases that show what medications their patients have received before prescribing opioids (in NYS the PMP is known as I-STOP). New regulations specify the duration of new opioid prescriptions and dictate the frequency of face-to-face encounters for patients receiving long-term opioid therapy.

These measures, and others, have had some impact on opioid prescribing practices, but we have a long way to go. None of these measures truly focus on the need for improved provider training and education, as well as patient education, about the dangers of long-term opioid use. Unfortunately, not enough attention has been given to helping providers understand the complexity of addiction, the need to investigate patients' addiction histories and the use of non-opioid pain management strategies as alternatives.

Two recent studies that focus on the effectiveness of non-opioid pain management highlight how far removed the overprescribing of opioids is from evidence-based practice. One study found that the combination of acetaminophen and ibuprofen was as effective as opioid/acetaminophen combinations (oxycodone, hydrocodone and codeine).[6] Another found that for patients with chronic back, knee or hip pain, opioid patches (Vicodin, oxycodone and fentanyl) were no more effective than non-opioid medication.[7] Given this data, and taking into account the array of evidence-based interventions for pain that do not rely on medication (e.g., physical therapy, biofeedback, psychological approaches, etc.), it is clear that a sea change must occur in the way that health care providers think about, treat and especially prescribe for pain.

It is also critical that the public receive similar messaging and education. No patient with chronic pain goes to a medical office eager to become addicted to a potentially life-threatening medication. Only when the prescriber and the consumer both understand that the treatment for pain need not include the risks of addiction and death can an adequate response to this aspect of the opioid epidemic be said to be in place.

Another vital public component of public education around opioids includes stressing the importance of and guidance for appropriately disposing of all unused opioid medications. Unused prescription opioids in homes provide opportunities for other family members, notably teenagers, to become initiated into using opioids because of their easy access. Increasing public and practitioner awareness about the prevalence and impact of fentanyl in heroin and other substances should also be part of public

education, as the unexpected presence of this substance has contributed to recent waves of overdoses.

Recommendation #3 : Require health care providers to provide referrals to substance use treatment for opioid overdose survivors and patients coming out of emergency department visits, rehabilitation and detoxification facilities.

The Problem: Opioid Use Disorders (OUD) require ongoing care to ensure long-term recovery and positive outcome. Many patients with OUD, however, are currently touching the health care system only for Emergency Department (ED) visits or brief treatment (detoxification and rehabilitation), resulting in significant risk for overdose and death following discharge. Both fatal and non-fatal opioid overdoses have increased across the United States in recent years. According to the CDC, for example, ED visits for opioid overdose increased by 29.7% from 2016 to 2017.[8] Moreover, increases were seen across most demographic groups and geographic regions of the country, demonstrating that this issue is pervasive throughout the United States and reflecting an alarming worsening of the opioid epidemic.

Additionally, according to the National Institute on Drug Abuse, medical detoxification alone does little to treat opioid use disorders and may actually increase the risk of fatal overdose if patients do not engage in additional treatment after discharge. The reason is that following discharge from detox, tolerance for opioids is decreased, leaving individuals more vulnerable to overdose upon resumption of opioid use. Despite this information, a minority of patients released from ER, detox and rehab actually engage in ongoing care, including engagement in MAT. Even though MAT is an evidence-based standard of care for OUD treatment, engagement rates tend to be low. Only 15 to 33 percent of overdose survivors receive buprenorphine, naltrexone or methadone within six months of an overdose.[9] In addition, preventing relapse through lasting behavioral changes, and addressing the multifaceted mental health issues that frequently contribute to relapse, typically require ongoing therapeutic intervention via counseling or psychotherapy with qualified clinicians. People who have experienced one overdose are at significantly higher risk for additional overdoses. The failure to assist patients in enrolling in outpatient substance abuse care following overdose and detox/rehab demonstrates a breakdown in the continuum of care and can lead to significant loss of life.

The Solution: Increasing awareness of the chronic nature of opioid use disorders and encouraging patients with OUD to enroll in ongoing care is imperative to reduce overdose deaths. Non-fatal overdoses provide a critical window of opportunity during which people with opioid use disorders have been shown to be more willing to consider making positive changes and during which healthcare professionals may successfully intervene to refer patients to ongoing treatment.

A timely referral and “warm hand-off” to treatment following a non-fatal overdose and after detox or rehabilitation can prevent future opioid overdoses and death. ED, detox and rehabilitation staff should be mandated to provide a referral at the time of time of

discharge. This referral should include a brief session with a staff member who can present treatment options and help the patient connect to a treatment provider. Providers should be reimbursed for these brief but important visits. Results are increased if the patient can receive a first dose of methadone or buprenorphine. Future overdoses can be prevented with successful referrals to counseling and MAT. Coordinated action between EDs, rehab and detox programs, addiction treatment providers, and community-based organizations can prevent opioid overdose and death.

Recommendation #4: Integrate medical, psychological services and social interventions.

The Problem: Problematic and addictive alcohol and drug use is a biopsychosocial disorder. As such, both our conceptualization of the problem and our approaches to treating it will be more effective if we remain anchored in these dimensions: medical, psychological and socio-cultural.

Problematic substance use is complex. There are frequently arrays of emotional problems that not only precede the addiction, but also stem from it or are co-occurring. Inner pain and suffering play a well-known role in the onset and maintenance of addiction. Trauma and self-hatred often underlie and drive problematic drug and alcohol use. There are additional psychological consequences as the alcohol and drug use takes on a life of its own, as the individual approaches or crosses the line into addiction.

The Solution: Ensure access to comprehensive care that includes access to mental health professionals trained to address substance use in the context of broader psychological issues. Psychological approaches must work on two fronts. They must empower people to not only understand how their addiction works, but have strategies and tools to regain control of their lives and re-claim their freedom from substances. There is a profound need for in-depth psychotherapies and cognitive, behavioral, experiential, and existential therapeutic techniques and interventions. Thankfully, evidence-based interventions such as Relapse Prevention, Cognitive-Behavioral Therapy, the Community Reinforcement Approach, Mindfulness-Based Interventions, Motivational Interviewing, Contingency Management, as well as trauma-focused therapies and psychodynamic psychotherapies that can each play an important role in a comprehensive approach to addiction treatment.

Recommendation #5: Offer referrals for non-pharmaceutical, evidence-based interventions for pain management.

The Problem: Patients and treatment providers alike are in need of education and information regarding evidenced-based alternatives to opioids for pain management. Providers who are prepared with accurate and current information about the spectrum of pain management techniques are better able to educate and guide patients about pain management options; however, many providers currently feel ill-prepared to counsel patients regarding pain.

The Solution: A cultural transformation around understanding pain and pain management is necessary. Specifically, we recommend:

- expanding and redesigning clinical education programs to include non-pharmacological interventions for pain management,
- improving education for clinicians and increasing the number of health professionals with advanced expertise in pain care,
- enhancing public education about pain and treatment options for consumers.

The inclusion of non-pharmaceutical interventions as a component of a larger, integrated care plan has been shown to be effective in both the management of pain and the reduction of opioid use for the management of pain.[10] A comprehensive pain management program may focus on restoring function in addition to treating pain. A number of pain clinics and larger medical systems, such as Kaiser Permanente, have successfully employed multifaceted treatment approaches and integrated medical teams to address pain management and reduce the use of opioids. Non-pharmaceutical interventions include alternative approaches such as mindfulness meditation; biofeedback; hypnosis, behavioral interventions such as Acceptance and Commitment Therapy (ACT) and Mindfulness Based Stress Reduction (MBSR), and medical marijuana for relief of chronic pain.

Psychoeducation

Psychoeducation provides individuals with accurate information about the pharmacology of prescription medication and the science behind the action of opioids. Psychoeducation should include the risks of opioid use, facts about the reduced efficacy of opioids in the treatment of long-term pain, and the addictive potential of long-term opioid use.

Psychoeducation should also include information about the biopsychosocial construction of pain. Helping patients to understand the psychological contribution to pain may help them see how non-pharmaceutical methods of managing pain can be effective, with far less risk than opioid use. Information regarding alternative interventions can be disseminated by primary care physicians, psychiatrists, clinics, hospitals, treatment centers, rehabilitation centers, outpatient and inpatient SUD programs, and other mental health care providers.

Meditation and Mindfulness Training

Meditation is a practice of concentrated focus upon a sound, object, visualization, the breath, movement, or attention itself. Mindfulness is a "mental state achieved by focusing one's awareness on the present moment, while calmly acknowledging and accepting one's feelings, thoughts, and bodily sensations."[11] Numerous studies have demonstrated the positive health benefits of meditation, including lowered levels of chronic pain.[12] Mindfulness practices orient people toward the acceptance of pain as opposed to fighting against pain, helping them better manage pain instead of attempting to extinguish pain, which may not be achievable.

Hypnosis

Hypnosis is an evidence-based treatment alternative to opioid pain management described as “a set of techniques designed to enhance concentration, minimize one's usual distractions, and heighten responsiveness to suggestions to alter one's thoughts, feelings, behavior, or physiological state.”[13] Hypnosis has been found to be an effective component of a pain management program to treat both chronic and acute pain. With the exception of a minority of patients who are resistant to hypnotic interventions, hypnosis has been found to be an effective option to manage pain.[14] One of the benefits of hypnosis is that it has been found to alter psychological components of pain that may even have an effect on severe pain.[14]

Additionally, incorporating hypnosis into a pain management regimen is also less expensive than medication management, and superior to standard care.[15,16] Hypnosis has also been associated with better overall outcome after medical treatment and greater physiological stability.[15] Patients who undergo hypnosis report higher rates of satisfaction than those treated by other means, per surgeons and other health care providers.[13]

Medical Cannabis

There is growing empirical evidence to support the efficacy of cannabinoid use in treating chronic pain. Meta-analyses have provided moderate, but significant evidence supporting the use of cannabinoids to treat and provide relief of neuropathic pain, chronic pain and multiple sclerosis spasticity.[17,18] Importantly, researchers are also beginning to investigate and demonstrate that cannabinoid use in the treatment of chronic pain also results in the reduction in opioid use. In one such study, medical cannabis use was associated with a 64% decrease in opioid use, use of fewer medications with fewer medication side effects, and an improved quality of life (45%).[19] With this growing evidence for both symptom relief and reduction of opioid use, cannabinoids may be an effective alternative to opioid use for pain management.

Biofeedback

Biofeedback instructs participants in the practice of relaxation exercises that fine-tune an individual’s ability to control different physiological responses. Several different relaxation exercises are used in biofeedback therapy, including:

- Breathing retraining: focusing on calming, diaphragmatic breathing.
- Progressive muscle relaxation: alternately tightening and then relaxing different muscle groups
- Guided imagery: concentrating on a specific image to focus the mind, which brings about increased relaxation
- Mindfulness meditation: focusing thoughts and letting go of negative emotions

Physical Therapy, Exercise, Stretching
A physical therapist can design a program including exercise, strength training and stretching to help improve physical function and consequently decrease physical pain.

Acceptance and Commitment Therapy (ACT)
ACT is a behavioral intervention that targets ineffective control strategies and experiential avoidance of unwanted emotions. ACT helps the individual to clarify and commit to values in daily life.[20] People learn to stay in contact with and tolerate unpleasant emotions, sensations, and thoughts, including negative thoughts associated with pain. Patients learn to stop fighting against these experiences.

Public education, outreach and PSA advertising to promote public awareness of non-pharmaceutical alternatives to opioids for pain management is also essential to curb the perspective that opioids are the best option for chronic and acute pain. Outcomes improve with patient education regarding pain and the potential consequences related to one's choices of pain management.[10] A menu of options can inform consumer decisions relative to his or her unique circumstances and needs. Education must also help those who are in pain to recognize that their beliefs about pain can substantially impact outcome. Concerns about discussing pain with providers can also be addressed. Through this process, patients can be empowered to play a more active role in their pain management decisions.

Recommendation #6: Address opioid use in individuals in, and transitioning out, of the criminal justice system.

The Problem: People who are involved in the criminal justice system have extraordinarily high rates of addiction. The Bureau of Justice calculates that 58% and 63% of prison and jail inmates suffer from a SUD.[21] By comparison, the prevalence rate of substance dependence in the general U.S. population is 9%.[1] Inmates who suffer from addiction are also much more likely to have histories of trauma and co-occurring psychiatric disorders, which complicate recovery. Those recently released from incarceration are especially vulnerable to the ravages of addiction, and face a staggering likelihood of fatal overdose. An often-cited study in Washington State calculated that the recently released are more than 129 times more likely to die from an opioid overdose than the general population.[22]

New York State has been a forerunner in the development of successful criminal justice interventions to combat the opioid crisis. In 2015 it pioneered the *nation's first* overdose education and naloxone distribution (OEND) program within a state correctional system. Through an innovative collaboration between NY DOH and the Harm Reduction Coalition, New York State Department of Corrections and Community Supervisions Program now educates all individuals who are soon-to-be released from state correctional facilities about the dangers of opioid use, particularly after periods of

confinement, and provides naloxone training to them and their families. The program also equips each individual with a naloxone kit free of charge at the time of release. As of July 2017, naloxone training and kits have been available in all 54 of New York's prisons. More than 6,000 formerly incarcerated individuals have been trained and received kits with fourteen documented incidents of naloxone administration in the community following release.[23]

Despite this groundbreaking work in overdose prevention, New York State remains deeply ill-equipped to address the addiction treatment needs of its incarcerated individuals. Only three jails in the entirety of New York State (George Motchan, Nassau County and Rikers) currently offer methadone treatment. Upon entering most jails or prisons in New York State any stabilizing, MAT regimens begun before incarceration are abruptly discontinued. The notion persists that incarceration alone—and the abstinence it potentially imposes—will treat a substance use disorder, despite overwhelming evidence to the contrary. The lack of medication-assisted treatment options within the NYS correctional system is devastating and, given the disproportionately high rates of overdose following release, often fatal. Decades of research have demonstrated that relapse is exceedingly common during post-incarceration, fueled by the multiple stressors of re-integration into the community: ex-offender stigma, housing and employment challenges, to name a few.

The failure to effectively treat addiction in prisons is deeply troubling given what we know about incorporating medication-assisted treatment into the criminal justice system. Individuals who receive buprenorphine or methadone treatment combined with counseling while incarcerated are more likely to continue medication and engage in community-based treatment upon release than those who received counseling alone.[24,25] In one study, starting buprenorphine while incarcerated meant engaging in treatment more quickly after release (3.9 days versus 9.2 days) and staying in community treatment longer (20.3 weeks versus of 13.2). The benefits of integrating medication-assisted and psychological treatment during prison stays stand in stark contrast to what research has shown about what untreated opioid addiction in prisons looks like upon release: high rates of recidivism, incarceration and risk for HIV/Hep B and Hep C transmission.[26]

An estimated 200,000 opioid users (between 24-36% of all opioid users) pass through the criminal justice system. Because of this, the courts represent an untapped potential for fighting the opioid crisis. With its more than 2,700 active sites nationwide, the drug court treatment model is one such arena carrying tremendous possibility. Drug courts are specialized court calendars or dockets that are tasked with reducing recidivism and drug abuse by diverting nonviolent offenders to treatment services in conjunction with court supervision. Unfortunately, drug courts are woefully in need of standardization and upgrading. In a nationally-representative sample of drug courts, a 2012 survey found that although 98% reported opioid-addicted participants, only a little more than half (56%) of drug courts offered medication-assisted treatment options such as methadone or buprenorphine.[27]

Without addressing the needs of the opioid users entering and exiting the criminal justice system, our chances of successfully addressing the opioid epidemic are destined to fail.

The Solution: New York State must implement a comprehensive, multi-pronged screening and treatment approach for tackling opioid addiction in its prisons and jails.

We must offer integrated MAT *and* mental health services to every incarcerated individual with an opioid use disorder. Treatment must be individualized to the unique needs of each inmate, meaning traditional MAT approaches such as methadone and buprenorphine should be considered alongside Vivitrol, an extended-release version of naltrexone. Vivitrol may be particularly advantageous for preventing overdoses in individuals who are soon to be released. Importantly, evidence-based mental health screening and treatment services must always accompany MAT to successfully address not only opioid use-specific issues, but other psychiatric disorders which often underlie and maintain drug use problems.

Rhode Island provides a recent example of this untapped potential for saving and transforming lives. In 2017 Rhode Island's Department of Corrections established an innovative program to screen and treat opioid use disorder using MATs. A recently published study in *JAMA Psychiatry* on the program reported "large and clinically meaningful reduction in post- incarceration deaths." Whereas individuals recently released from incarceration comprised 14.5% of all overdose deaths in Rhode Island in 2016, this number dropped to 5.4% in 2017.[28]

Coordinating prison and post-release treatment services is of life-and-death importance. The transition period from incarceration to community life is a pivotal one, which is already fraught with a great deal of stressors for former inmates. Thus the prison's mental health system must extend into this transition period, connecting individuals with evidence-based treatment options within their communities is essential.

In order to achieve their tremendous potential, evidenced-based standards and training for drug courts are imperative. As a blueprint, the National Association of Drug Court Professionals has compiled a 10-point set of best-practices that are based upon empirical research. These standards provide thresholds of effective, evidence-based treatment and criteria for monitoring and evaluation of drug court procedures and outcomes. Furthermore, an accompanying educational initiative that includes training on the evidence-based models of addiction care and the de-stigmatizing of MAT is essential.

Recommendation #7: Respect the importance of a harm reduction framework for the entire continuum of care.

The Problem: Many of the strategies detailed above will take time to implement and may not have the immediate impact on saving lives that our communities desperately

need now. In contrast, Harm Reduction strategies can have an immediate effect in the community for those individuals who are currently using opioids and are at risk for overdose and death. Harm Reduction strategies include immediate medical interventions that can save lives as well as psychological and social strategies that ease the entry into treatment and allow for intervention earlier in an addictive process, often before full-blown addiction and overuse has set in.

Harm Reduction is an umbrella term for a set of principles and a wide range of interventions that: 1) reduce the immediate risk of death (e.g., opiate-related overdose), 2) make it less likely that individuals will contract serious medical diseases (e.g., AIDS, hepatitis C, endocarditis), 3) encourage safer alternatives to current use as part of the process of change, and 4) facilitate therapeutic relationships that help those with drug and alcohol problems gradually move toward a state of abstinence or non-addictive use.

A central problem in the current drug treatment system is that it places an emphasis on pursuing abstinence as a requirement to enter and remain in treatment. While this paradigm of care was created with the best of intentions, it fails to meet the needs of great numbers of people who are wrestling with problematic substance use and addiction. Many people are not ready or willing to consider abstinence, and therefore do not enter treatment. The concept of waiting until they "hit bottom" and are ready to stop using entirely can mean increased death and certainly entails increased harm. Furthermore, this approach is not in tune with contemporary research findings that support evidence-based clinical practices today.

Harm Reduction principles and interventions also align with the pubic health conceptualizations of primary, secondary and particularly tertiary prevention. While primary prevention measures hope to prevent the initiation of substance use, secondary prevention measures involve treatment for those who are misusing substances, and tertiary prevention approaches aim to limit and contain the negative consequences of substance use and minimize related suffering.

The Solution: Implement the following Harm Reduction recommendations that provide an immediate opportunity to save the lives of those people who are currently using opioids:

1. Make naloxone/Narcan widely available and easy to obtain for all at-risk individuals.

All first-responders should be equipped with naloxone, and it should be made readily available in all shelters, prisons, clinics and other facilities where overdoses are likely to occur. Family members and friends of users should also be allowed and encouraged to keep naloxone at hand without fear of legal repercussions.

2. Increase access to clean needles and syringe exchange programs, and create supervised consumption sites throughout NYS.

These programs have proven effective in other countries and can greatly reduce the risks of illness and death experienced by users in New York State, in addition to removing IV substance users from the streets and exposing them to increased opportunities for supportive treatment.

In addition, these programs have been shown to reduce long-term costs associated with substance use and, contrary to concerns, do not increase substance use in the surrounding communities, do not increase drug related crime and do not increase initiation of injection substance use.

3. Eliminate the requirement for a goal of abstinence to obtain treatment. Provide treatment opportunities even for those who are not ready to embrace abstinence as a goal.

Although alcohol and drug use is ultimately destructive to most people's lives, use often begins as self-medication for underlying issues and is frequently the best solution the user has found despite the devastating consequences. For this reason, many people are ambivalent about giving up their use, even when they have become concerned about it. Harm Reduction principles allow people to enter treatment with the goal of reducing harm of their use, even if they are not willing at first to relinquish it totally. This might mean using less, using differently, getting clean needles, not driving when drunk, etc. These interventions can have immediate life saving effects. It can allow people to enter treatment even when they are ambivalent, explore their ambivalence and frequently arrive at a goal of abstinence rather than keeping them out of treatment all together. A Harm Reduction framework "meets people where they are" as unique individuals in unique social circumstances and accepts them into treatment, engaging them collaboratively around their motivation and positive change goals.

Additional Recommendations

Clearly a consistent, concerted, ongoing and multifaceted approach will be required in order to have a meaningful impact on the opioid epidemic. The specific recommendations highlighted above would be a good start, but to fully address the opioid epidemic the following recommendations are also worthy of consideration.

1. Prescribing Practices

The critical importance of a drastic change in prescribing practices for pain relief cannot be underestimated, as described above. As noted, there are approximately two million Americans who go to sleep every night addicted to opioids, and tragically some of them do not wake up the morning. It's imperative that those individuals receive appropriate treatment for their addiction, and equally important that our medical system stops adding to their number. While this process has begun in the medical system, the following recommendations are designed to address both aspects of the problem.

A. Mandate the widespread implementation of brief screening methods (e.g., SBIRT) in primary care to identify and address substance misuse in its early stages
B. Create and enforce models of reasonable, safe opioid prescribing
C. Expand suboxone prescribing privileges among MDs, Physician Assistants and Nurse Practitioners
D. Establish quantity limits on initial and ongoing opioid prescriptions, and require periodic, in person follow up visits for patients receiving long-term opioid therapy
E. Require health care providers to offer to prescribe buprenorphine, naltrexone and naloxone to all overdose patients and those coming out of rehabilitation and detox facilities
F. Provide access to Medication Assisted Treatment (MAT; methadone, buprenorphine, and naltrexone) to all persons struggling with opioid use disorders, regardless of income or insurance
G. Work to educate and de-stigmatize MAT within the medical community and the general population

2. Non-Pharmaceutical Interventions

Lack of clarity about pain, pain treatment and addiction have been primary drivers of the opioid epidemic. Western medicine's treatment of pain has always been primarily pharmacological, with often disastrous results. Similarly the "brain disease" model of addiction has led to an increasing tendency to view a biopsychosocial illness in predominantly medical terms. It is important to recognize that both pain and addiction are complex problems that require complex and multifaceted solutions. The following recommendations are designed to address these issues.

A. Mandate adequate insurance coverage for evidence-based, non-opioid pain management interventions
B. Require insurance coverage for evidence-based psychotherapies for substance misuse by providers trained to utilize a biopsychosocial approach to address the trauma and co-occurring disorders that often accompany substance misuse

3. Social Interventions

Long-term strategies for combating the current opioid epidemic and ensuring that we prevent as many new episodes of opioid addiction as possible requires a citizenry that is more resilient and can access resources towards overall psychosocial well-being. People also need to be more educated about strategies that will make a difference in their own families and communities. For example:

A. Expand "Good Samaritan" laws to shield citizens who assist overdose victims
B. Increase access to social institutions for young people (e.g., extended school days, implement programs such as Midnight Basketball, Big Vision)

C. Increase educational, employment and housing opportunities in at-risk communities.

Conclusion

We believe that a solution to the opioid epidemic is attainable. We look forward to working with our colleagues in government, healthcare, education, law enforcement and other arenas to create a comprehensive approach that reduces the frequency of opiate overdose and death in New York State and serves as a model that other states can benefit from.

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