the **Access to Health Project**

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IDENTIFYING THE METRICS OF SUCCESS IN INTERDISCIPLINARY ADDICTION RESPONSE

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PREFACE

Building on its 2016 Interdisciplinary Symposium on the opioid epidemic, on October 27, 2017, Northwestern University Pritzker School of Law hosted an invitational roundtable entitled "Identifying the Metrics of Success in Interdisciplinary Addiction Response." The roundtable was convened to address the problem of the siloed nature of work in Chicagoland to curb the opioid epidemic. The event brought together a group of 35 actors from the Chicago area across disciplines, including primary care physicians, law enforcement, NGOs, public health officials, and others, to bridge the disconnect and work toward an interdisciplinary approach to cresting the arc of the opioid epidemic.

The full-day roundtable operated using the Chatham House Rule[1] and was organized in small breakout group sessions in the morning, followed by plenary sessions in the afternoon. The five breakout session topics included (1) prevention, (2) paying for the opioid crisis, (3) race, class, and gender within the response, (4) best practices in response, and (5) the metrics of success. A facilitator guided each breakout group in a cross-sector discussion on the stated topic. In the afternoon, participants came back together and shared with the larger group the takeaways from their breakout sessions. The full group then discussed the Chicago-area opioid epidemic in the context of the national public health emergency and the way forward. The day concluded with a public address by City of Chicago Corporation Counsel Edward Siskel entitled, "Step One – Admitting We Have a Problem: Leadership Responses to the Opioids Epidemic at Federal, State and Local Levels."

This white paper is largely derived from the roundtable.

[1] "Chatham House Rule," Chatham House: The Royal Institute of International Affairs, accessed November 15, 2017, https://www.chathamhouse.org/about/chatham-house-rule. The Chatham House Rule provides anonymity to speakers to encourage openness and the sharing of information.

EXECUTIVE SUMMARY

The United States has been experiencing an opioid epidemic for more than two decades, with no end in sight as opioid-related deaths continue to climb. Chicago and its surrounding counties have been particularly hard hit by the epidemic. In Chicago between 2015 and 2016, opioid-related overdose deaths – both illicit and prescribed – increased by 74%. Yet stakeholders have struggled to appropriately respond to the epidemic. A successful response to the opioid epidemic ultimately comes down to the development of a coordinated, interdisciplinary response, which is what this white paper and the preceding roundtable aims to initiate in the Chicago area. The expert roundtable identified three major components, with specific concerns under each, key to the Chicago-area response to the opioid epidemic: (1) prevention, (2) harm reduction, and (3) recovery.

In the area of prevention, a joint effort of addressing the social determinants of substance use disorder ("SUD") as well as decreasing the opioid supply is essential. While SUD is a neurological disease, like all diseases, social factors play a role in exacerbating (and bettering) its development. Thus, remedying the socio-economic factors of SUD like stress, trauma, lack of opportunity, and co-occurring mental and behavioral health disorders is an important preventative measure. Another crucial aspect of prevention is curbing the supply of opioid available to individuals through improved prescribing practices, targeted and tailored efforts of law enforcement, especially on large importers of fentanyl, and litigation against big pharmaceutical companies to decrease advertising.

Harm reduction, that is, diminishing the negative effects of opioid use, without actually decreasing opioid use, is the second fundamental piece of a Chicago-area response to the opioid epidemic. Major steps must take place to destigmatize not only substance use and SUD but also mental and behavioral health conditions that are often co-occurring with SUD. Concurrently, naloxone, the overdose reversing drug, must be made available to emergency response personnel, including police officers, primary care physicians, family and friends of drug users, as well as drug users themselves. Moreover, safe consumption facilities, where drug users can access clean, safe environments and the presence of health professionals, and a reevaluation of the criminal justice system's treatment of SUD are key components to harm reduction.

Recovery is perhaps the largest focus of the response to the opioid epidemic and has two major components. First, the response must increase the methods of getting people suffering from SUD to treatment. Methods such as universal screening, pre-arrest diversion, and post-arrest diversion in the form of, for instance, drug courts all function to identify SUD earlier and provide access to treatment for willing sufferers of SUD. The second component is the treatment itself. While many tend to focus solely on detox as a remedy, the roundtable notes that detox alone is not enough. Research shows that the best method for treatment is medication-assisted treatment ("MAT") combined with integrated mental health services as well as "wrap-around" social services such as employment, education, and housing services.

INTRODUCTION

For more than two decades, the United States has been experiencing an opioid crisis.[2] Yet the most recent data indicates we have not yet crested the arc of the epidemic: opioid-related overdose deaths are still on the rise.[3] In Chicago between 2015 and 2016, opioid-related overdose deaths – both illicit and prescribed – increased by 74%.[4] Indeed, the President only last month declared the opioid epidemic a national public health emergency.[5] It is clear that the country as a whole needs to take action.

Chicago and its surrounding counties have been particularly hard hit by the epidemic.[6] The most recent data show "[t]he rate of overdose deaths involving opioids in Chicago…was 50% higher than the national rate…in 2015."[7] In fact, "Cook County [alone] accounted for nearly 50 percent of the opioid overdose death in Illinois during 2016."[8] Importantly, Chicago's problem differs from the national epidemic in two ways: First, the vast majority of opioid-related overdose deaths involve heroin, not prescription opioids.[9] In fact, "[t]he rate of overdose deaths involving heroin in Chicago…was three times the rate in the United States."[10] Second, according to a new issue brief published by the Chicago Urban League, "[b]lack people make up approximately 32% of the population in Chicago but account for nearly half (48.4%) of all opioid deaths."[11]

This white paper forwards the position that interdisciplinary engagement at every level of the opioid response is imperative to successfully addressing the opioid epidemic in Chicago. Interdisciplinary engagement means formally and informally working across sectors on every

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[2] "Understanding the Epidemic," *Center for Disease Control and Prevention*, last updated August 30, 2017, https://www.cdc.gov/drugoverdose/epidemic/index.html.
[3] Rose A. Rudd et al. "Increases in Drug and Opioid-Involved Overdose Deaths—Untied States, 2010-2015," *Morbidity and Mortality Weekly Report* 65 (December 2016): 1445-1452, https://www.cdc.gov/mmwr/volumes/65/wr/mm655051e1.htm.
[4] Chicago Department of Public Health, *Epidemiology Report: Increase in Overdose Deaths Involving Opioids – Chicago 2015-2016*, October 2017: 1, https://www.cityofchicago.org/content/dam/city/depts/cdph/tobacco_alchohol_and_drug_abuse/2016ChicagoOpioidReport.pdf.
[5] Jenna Johnson and John Wagner, "Trump declares the opioid crisis a public health emergency," *Washington Post*, October 26, 2017, https://www.washingtonpost.com/news/post-politics/wp/2017/10/26/trump-plans-to-declare-the-opioid-crisis-a-public-health-emergency/?utm_term=.4850b4f1d8a9.
[6] Centers for Disease Control, National Center for Health Statistics, *Provisional Counts of Drug Overdose Deaths, as of 8/6/2017*, August 2017, https://www.cdc.gov/nchs/data/health_policy/monthly-drug-overdose-death-estimates.pdf; Chicago Department of Public Health, *Epidemiology Brief: Characterizing Opioid Use, Misuse, and Overdose in Chicago, IL 2015*, June 2017, https://www.cityofchicago.org/content/dam/city/depts/cdph/CDPH/Healthy%20Chicago/ChicagoOpioidBrief3_6162017.pdf.
[7] Chicago Department of Public Health, *Epidemiology Brief: Characterizing Opioid Use, Misuse, and Overdose in Chicago, IL 2015*, June 2017: 3, https://www.cityofchicago.org/content/dam/city/depts/cdph/CDPH/Healthy%20Chicago/ChicagoOpioidBrief3_6162017.pdf.
[8] State of Illinois Department of Human Services, *The Opioid Crisis in Illinois: Data and the State's Response*, May 2017: 2, http://www.dhs.state.il.us/OneNetLibrary/27896/documents/OpioidCrisisInIllinois_051617.pdf.
[9] Chicago Department of Public Health, *Epidemiology Brief: Characterizing Opioid Use, Misuse, and Overdose in Chicago, IL 2015*, June 2017: 3, https://www.cityofchicago.org/content/dam/city/depts/cdph/CDPH/Healthy%20Chicago/ChicagoOpioidBrief3_6162017.pdf.
[10] *Ibid*.
[11] Stephanie Schmitz Bechteler & Kathie Kane-Willis, "Whitewashed: The African American Opioid Epidemic," *The Chicago Urban League*, November 2017: 2, https://www.thechicagourbanleague.org/cms/lib/IL07000264/Centricity/Domain/1/Whitewashed%20AA%20Opioid%20Crisis%2011-15-17_EMBARGOED_%20FINAL.pdf.

policy and solution moving forward. While the policies examined here are ones that frequently appear in debates on addressing the opioid epidemic, the discussion below is unique in that it is derived from a convening of interdisciplinary stakeholders.

The white paper is divided into three major sections: (1) prevention, (2) harm reduction, and (3) recovery. Each section is further divided into subsections that outline a particular problem and an interdisciplinary solution. The white paper concludes with action items for next steps that stakeholders in the Chicago area can take to implement an interdisciplinary response.

PREVENTION

Prevention in the context of the opioid epidemic means counteracting the risk factors of developing a substance-use disorder ("SUD"). In this vein, targeting the socio-economic factors that make individuals more likely to use substances and to develop a SUD is an important first step to preventing further development of the epidemic as well as preventing others like it. At the same time, opioid availability – illicit and prescribed – contributes to the development of the epidemic. Therefore, efforts to curb the supply work to prevent the epidemic from advancing.

Socio-Economic Factors

As a general matter, "[t]he root causes of health include both the social determinants of health and structural inequities, or societal systems that unjustly benefit one population more than another."[12] The root causes of SUD are no different – SUD is a physical brain disease that, like any other disease, social determinants can exacerbate (or help).[13] While some aspects of SUD are difficulty to change, like genetics, other factors can be manipulated in attempts to prevent development of SUD.[14] Thus, a first step to prevention is addressing the socio-economic factors that lead people to use drugs in the first place and that make them especially vulnerable to developing SUD. The roundtable distilled three major areas for attention in seeking to prevent individuals from developing a SUD: (1) stress, (2) lack of opportunity, and (3) social isolation and mental health.

Stress: Trauma and Discrimination

Stress is a significant determinant of health, both mental and physical. [15] Importantly, stress stemming from trauma and "discrimination stress" are risk factors to developing a SUD. Trauma is an "extreme threat[] to a person's physical or psychological well-being."[16] People who have

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[12] Chicago Department of Public Health, *Healthy Chicago 2.0,* March 2016: 15, https://www.cityofchicago.org/content/dam/city/depts/cdph/CDPH/HC2.0Plan_3252016.pdf.
[13] Nora D. Volkow, George F. Koob, and A. Thomas McLellan, "Neurobiologic Advances from the Brain Disease Model of Addiction," *New England Journal of Medicine* (January 2016): 363-371, http://www.nejm.org/doi/full/10.1056/NEJMra1511480#t=article.
[14] *Ibid*.
[15] Peggy A. Thoits, Stress and Health: Major Findings and Policy Implications, Journal of Health and Social Behavior 51 (2010), http://journals.sagepub.com/doi/pdf/10.1177/0022146510383499.
[16] *Ibid*., S43.

experienced trauma are particularly vulnerable to developing a SUD.[17] Trauma related to "adverse childhood experiences" ("ACEs") in particular is "strongly related to development and prevalence of...substance abuse."[18] ACEs include "abuse, neglect, [and]…witnessing domestic violence."[19] In addition to childhood trauma, SUD is highly prevalent in people suffering from posttraumatic stress disorder ("PTSD"), "an anxiety disorder that may develop subsequent to exposure to a traumatic event."[20] In fact, those suffering from PTSD are 2-4 times more likely to suffer from SUD.[21] The veteran community is particularly vulnerable, as research indicates veterans "are at increased risk for developing both PTSD and SUDs."[22]

Discrimination is the "unfair or unjust treatment by others on the basis of one's gender, race-ethnicity, age, social class, sexual orientation, body weight, and other status characteristics."[23] Discrimination can be experienced through "major events such as being fired or refused a home loan" and through "repeated or chronic harassment, threats, or slights on the basis of one's social status."[24] Research shows that "discriminatory experiences are significantly associated with…poor health…psychological distress, anxiety disorder, and major depressive disorder, among other conditions, even when other life stressors are controlled."[25] As such, "discrimination stress adds to the disproportionate burden of stressors borne by lower status, disadvantaged group members in the United Sates."[26]

Addressing the root causes of trauma and discrimination is a key step in preventing further development of the opioid epidemic and of people with SUD as well as guarding against future epidemics. In addition, prevention involves developing individuals' "stress buffers," such as "a sense of control or mastery over life, high self-esteem, and social support."[27]

Lack of Opportunity

People with low opportunity – low income and unemployed individuals in particular – are at a higher risk of developing a substance-use disorder.[28] Relatedly, as mentioned above, people who experience discrimination are at a higher risk of developing a SUD. Structural inequalities, especially racism, affect the availability of economic opportunities as well as access to resources

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[17] Jenna L. McCauley et al., "Posttraumatic Stress Disorder and Co-Occurring Substance Use Disorders: Advances in Assessment and Treatment," *Clinical Psychology* 12, no. 3 (September 2012).
[18] Substance Abuse and Mental Health Services Administration, *The Role of Adverse Childhood Experiences in Substance Abuse and Related Behavioral Health Problems*, accessed on December 8, 2017: 1, https://www.samhsa.gov/capt/sites/default/files/resources/aces-behavioral-health-problems.pdf.
[19] *Ibid*.
[20] Jenna L. McCauley et al., "Posttraumatic Stress Disorder and Co-Occurring Substance Use Disorders: Advances in Assessment and Treatment," *Clinical Psychology* 12, no. 3 (September 2012).
[21] *Ibid*.
[22] *Ibid*.
[23] Peggy A. Thoits, Stress and Health: Major Findings and Policy Implications, Journal of Health and Social Behavior 51 (2010): S44, http://journals.sagepub.com/doi/pdf/10.1177/0022146510383499.
[24] *Ibid*.
[25] *Ibid*., S45.
[26] *Ibid*.
[27] *Ibid*., S46.
[28] Beth Han et al., "Prescription Opioid Use, Misuse, and Use Disorders in U.S. Adults: 2015 National Survey on Drug Use and Health," *Annals of Internal Medicine* 167, no. 5 (September 2017), http://annals.org/aim/fullarticle/2646632/prescription-opioid-use-misuse-use-disorders-u-s-adults-2015.

such as mental and physical health care.[29] Moreover, inequality, that is, distribution of wealth and status differences in social hierarchies, is related to higher rates of SUD.[30] Therefore, prevention includes addressing racial and economic inequalities in society to create more opportunities for marginalized communities.

Social Isolation and Mental Health

Social isolation is linked to higher rates of drug use.[31] Studies show that "social stress and isolation reliably increase drug intake whereas social enrichment reliable decreases drug intake."[32] Mental health issues increase a person's risk of developing a SUD.[33] Moreover, co-occurring mental health issues are found in a majority of patients with SUDs.[34] However, stigma related to mental illness and substance use creates a barrier that prevents individuals from seeking and receiving treatment. In addition, the stigma surrounding mental health and substance use can make it difficult to socialize or build social networks in one's community, compounding the issue of social isolation.

Prevention includes encouraging and building social networks, as well as destigmatizing and increasing access to care for mental illness and SUD. One potential route to prevent social isolation and mental health issues from driving opioid use is the use of technology to counteract social isolation. For instance, Lake County's Leading Efforts Against Drugs (LEAD) developed an app called "Text-A-Tip," which provides a "24/7 anonymous text communication system allows youths to reach out for immediate mental health assistance for themselves or a friend."[35]

Curbing Opioid Supply

While the socio-economic factors described above are part of what drive a person to use drugs – or make them especially vulnerable to developing a substance-use disorder – decreasing the opioid supply is another preventative method to stem the opioid epidemic. The roundtable distilled three concurrent strategies to bring down the opioid circulation in the country through: (1) law enforcement, (2) prescribers, and (3) litigation.

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[29] "Risk and Protective Factors," *Substance Abuse and Mental Health Services Administration*, last updated October 2 2015, https://www.samhsa.gov/capt/practicing-effective-prevention/prevention-behavioral-health/risk-protective-factors.

[30] Maria Szalavitz, "Yes, Addiction Does Discriminate," *The Fix*, November 1, 2011, https://www.thefix.com/content/economic-inequality-and-addiction8202.

[31] Justin C. Strickland and Mark A. Smith, "The Effects of Social Contact on Drug Use: Behavioral Mechanisms Controlling Drug Intake," *Experimental and Clinical Psychopharmacology*, 22, no. 1 (2014): 23-34, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3926100/.

[32] *Ibid*.

[33] "Treatment for Co-occurring Mental and Substance Use Disorders," *Substance Abuse and Mental Health Services Administration*, last updated September 20, 2017, https://www.samhsa.gov/treatment#co-occurring.

[34] United States White House, *The President's Commission on Combating Drug Addiction and the Opioid Crisis: Final Report*, November 2017: 69, https://www.whitehouse.gov/sites/whitehouse.gov/files/images/Final_Report_Draft_11-1-2017.pdf.

[35] Frank S. Abderholden, "Text-A-Tip Initiative Designed to Assist Teens in Crisis," *Lake County News-Sun*, May 12, 2016, http://www.chicagotribune.com/suburbs/lake-county-news-sun/news/ct-lns-text-mental-health-help-lake-county-st-0513-20160512-story.html.

Role of Law Enforcement

Law enforcement has developed several strategies in response to the opioid epidemic to decrease the amount of opioids available. For example, the federal government's "DEA 360" strategy developed directly out of the opioid crisis and "takes an innovative three-pronged approach to combating heroin/opioid use."[36] In addition, law enforcement is targeting nefarious high volume prescribers – commonly referred to as "pill mills."

The DEA 360 strategy is an approach developed by the federal government in conjunction with state and local partners in pilot cities.[37] The strategy has three prongs: (1) "coordinated law enforcement actions against drug cartels and heroin traffickers in specific communities; (2) diversion control enforcement actions against DEA registrants operating outside the law and long-term engagement with pharmaceutical drug manufacturers, wholesalers, pharmacies, and practitioners; an (3) community outreach through local partnerships that empower communities to take back affected neighborhoods after enforcement actions and prevent the same problems from cropping up again."[38]

Concurrently, federal law enforcement is targeting prescribers whose conduct is so egregious as to amount to criminal charges. Specifically, prescribers who, knowing the addictiveness of opioids, "run clinics in which they give patients opioid prescriptions, typically for cash, with few questions asked."[39] Such prescribers "allowed patients who were clearly buying the drugs either for misuse or to resell them to easily obtain opioids."[40] In July, the U.S. Department of Justice announced that it has charged 120 individuals with opioid-related crimes, including prescribers "who were allegedly running pill mills in which they unscrupulously prescribed opioids to patients."[41]

Prescription Practices and Pain Management Alternatives

While the opioid epidemic in Chicago is mostly a heroin issue, developing SUD from use of an opioid prescription can occur as well. In addition, prescription misuse – use of any drug in a way

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[36] "DEA 360 Strategy," *Drug Enforcement Administration*, accessed on December 8, 2017, https://www.dea.gov/prevention/360-strategy/360-strategy.shtml.
[37] *Ibid*.
[38] *Ibid*.
[39] German Lopez, "Some doctors were handing out opioids like candy. The Justice Department just shut them down." *Vox.com* (July 14, 2017), https://www.vox.com/policy-and-politics/2017/7/14/15968304/justice-department-opioid-epidemic; "National Health Care Fraud Takedown Results in Charges Against Over 412 Individuals Responsible for $1.3 Billion in Fraud Losses," *U.S. Department of Justice* (July 13, 2017), https://www.justice.gov/opa/pr/national-health-care-fraud-takedown-results-charges-against-over-412-individuals-responsible.
[40] German Lopez, "Some doctors were handing out opioids like candy. The Justice Department just shut them down." *Vox.com* (July 14, 2017), https://www.vox.com/policy-and-politics/2017/7/14/15968304/justice-department-opioid-epidemic; "National Health Care Fraud Takedown Results in Charges Against Over 412 Individuals Responsible for $1.3 Billion in Fraud Losses," *U.S. Department of Justice* (July 13, 2017), https://www.justice.gov/opa/pr/national-health-care-fraud-takedown-results-charges-against-over-412-individuals-responsible.
[41] German Lopez, "Some doctors were handing out opioids like candy. The Justice Department just shut them down." *Vox.com* (July 14, 2017), https://www.vox.com/policy-and-politics/2017/7/14/15968304/justice-department-opioid-epidemic; "National Health Care Fraud Takedown Results in Charges Against Over 412 Individuals Responsible for $1.3 Billion in Fraud Losses," *U.S. Department of Justice* (July 13, 2017), https://www.justice.gov/opa/pr/national-health-care-fraud-takedown-results-charges-against-over-412-individuals-responsible.

other than indicated, intended or prescribed – presents another concern as it occurs more often than developing a SUD from use of a prescription.[42] Thus, another important avenue to curbing the opioid supply is through changing opioid prescription practices[43] and increasing use of pain management alternatives. These objectives can be achieved through prescription guidelines and policies as well as (re)education programs tailored to all individuals with the ability to prescribe opioids.

In order to appropriately lower prescription opioid availability, it is necessary to re-examine prescribing practices. However, the roundtable identified three important considerations for policies aimed at lowering prescription opioids: (1) such policies must be cautious to avoid denying opioids to patients who actually need them (e.g., severe chronic nonmalignant pain including such conditions as sickle cell, postlaminectomy pain syndrome, neurological and rheumatological diseases), (2) any prescribing policy must not create such an overreaction in prescribers that they immediately end all current opioid prescriptions to their patients, thus forcing them into withdrawal and leaving them in their original state of pain, and (3) any prescribing policy must address all prescribers in Illinois, including nurses, oral surgeons, and more.

One example of a potentially effective policy for lowering the prescribing of opioids is the new guideline published by the Center for Disease Control and Prevention ("CDC"). The guideline offers prescribers recommendations on prescribing opioids for chronic pain.[44] Importantly, the CDC guideline applies to "primary care clinicians who are prescribing opioids for chronic pain outside of active cancer treatment, palliative care, and end-of-life care."[45] The CDC guideline provides three major takeaways: (1) "[n]onopioid therapy is preferred for chronic pain outside of active cancer, palliative, and end-of-life care," (2) "[w]hen opioids are used, the lowest possible effective dosage should be prescribed to reduce risks of opioid use disorder and overdose," and (3) "[c]linicians should always exercise caution when prescribing opioids and monitor all patients closely."[46]

Alongside the effort to decrease unnecessary opioid prescriptions is the effort to increase alternatives to opioids for pain management where appropriate. Alternatives to opioid use for pain management include physical therapy, cognitive behavioral therapy, acupuncture, chiropractic therapy, massage therapy, mind-body methods, yoga, and non-opioid medications as indicated.[47] However, these alternatives, while supported by research and providers of care, face

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[42] Jamison et al., "Substance misuse treatment for high-risk chronic pain patients on opioid therapy: a randomized trial," *Pain* 150, no. 3 (September 2010): 390-400.
[43] In addition to decreasing opioid prescriptions, roundtable participants flagged as important decreasing prescriptions for drug combinations that play a major role in overdose deaths, like benzodiazepines, and educating prescribers on the dangers of co-prescribing.
[44] "CDC Guideline for Prescribing Opioids for Chronic Pain – United States, 2016," *Morbidity and Mortality Weekly Report* 65, no. 1 (March 18, 2016): 1-49, https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm.
[45] *Ibid*.
[46] Centers for Disease Control and Prevention, *Factsheet: CDC Guideline for Prescribing Opioids for Chronic Pain* (2016), https://www.cdc.gov/drugoverdose/pdf/guidelines_at-a-glance-a.pdf.
[47] Wayne Jonas, "An Integrative Approach to Managing Chronic Pain can Help Solve the Opioid Crisis," *STAT News*, October 31, 2017, https://www.statnews.com/2017/10/31/chronic-pain-opioid-crisis/.

two hurdles: (1) they cost more in the short term and are much less likely to be covered by insurance plans and Medicaid and (2) they are time consuming for patients and providers alike.[48]

One potential solution to the barriers facing alternative pain management is to encourage payment systems, like Medicaid and associated managed care organization ("MCO") contracts, to adopt a long-term perspective of patient treatment. Focusing on a contract for the current year, as these systems do now, may not encourage MCO reimbursement for alternatives to opioids. One system that takes a successful long-term approach to patient treatment, and thus provides alternative pain management more freely, is the Veterans Affairs system, which includes the use of innovate new procedures to treat chronic co-occurring mental health issues like PTSD.[49]

While barriers exist to decreasing unnecessary opioid prescriptions and increasing pain management alternatives, increasing prescribers' capacity and knowledge of the importance of such methods is a first step. Increased knowledge can be achieved by integrating education on pain management, alternatives to opioids, and appropriate opioid prescription practices in the context of the opioid epidemic into professional school curricula (e.g., medical, dental, nursing). Concurrently, continuing professional education (e.g., continuing medical education, or "CME") must integrate information on the opioid epidemic, pain management, and prescribing practices. Continuing education generally is a requirement to maintain professional licenses and some states, like Wisconsin, require opioid-focused CMEs.[50] However, while Illinois prescribers can choose to take a continuing education program with a focus on opioids, [51] Illinois prescribers are not required to take continuing professional programs on this particular subject. Yet, given that neither Illinois[52] nor Cook County[53] are a high-prescribing areas comparatively, participants suggested a response more focused on prescribers in the top percentiles might be more appropriate in the local context.

Opioid Litigation

Prescription opioid use increased exponentially beginning in the 1990s when big pharmaceutical companies aggressively marketed opioids for treating chronic pain and minimized the risk of

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[48] National Academy for State Health Policy, *Chronic Pain Management Therapies in Medicaid: Policy Considerations for Non-Parmacological Alternatives to Opioids* (August 2016): 3-4, https://nashp.org/wp-content/uploads/2016/09/Pain-Brief.pdf.

[49] "Transforming VA Pain Care," *U.S. Department of Veterans Affairs*, accessed on December 8, 2017, https://www.va.gov/painmanagement/; "VA to Provide Hyperbaric Oxygen Therapy to Some Veterans with Chronic PTSD," *U.S. Department of Veterans Affairs* (November 29, 2017), https://www.va.gov/opa/pressrel/pressrelease.cfm?id=3978.

[50] "New Continuing Medical Education Requirement in Effect in the Current Biennium," *Wisconsin Department of Safety and Professional Services*, November 10, 2016, https://dsps.wi.gov/Documents/BoardCouncils/MED/20161116MEDAdditional1.pdf.

[51] "Opioid Prescribing Course for Health Care Providers," *Substance Abuse and Mental Health Services Administration*, last updated February 9, 2017, https://www.samhsa.gov/medication-assisted-treatment/training-resources/opioid-courses.

[52] "U.S. State Prescribing Rates 2016," *Centers for Disease Control and Prevention*, last updated on July 31, 2017, https://www.cdc.gov/drugoverdose/maps/rxstate2016.html.

[53] "U.S. County Prescribing Rates 2016," *Centers for Disease Control and Prevention*, last updated on July 31, 2017,https://www.cdc.gov/drugoverdose/maps/rxcounty2016.html.

addiction.[54] Before then, prescription opioids were used almost exclusively for cancer patients, palliative care and short-term care for post-surgery and trauma patients.[55] According to many government plaintiffs in litigation across the country, the opioid lobby and the misleading literature it produced – especially in disseminating false information that addiction to opioids was rare – was so effective that it helped to create a paradigm shift wherein physicians considered pain the "fifth vital sign"[56] and the medical community believed that "compassionate treatment of pain required opioids."[57]

Government plaintiff litigation against these big pharmaceutical companies for their alleged role in creating the opioid epidemic could help stem the flow of opioids through: (1) the injunctive relief it seeks to enjoin opioid manufacturers from continuing these deceptive and aggressive marketing practices and to warn about the addictive qualities of opioids, (2) raising awareness about the widespread deceptive strategies surrounding opioids, and (3) an award of damages to the government which can go to funding SUD prevention, harm reduction, and recovery policies.

Presently, government entities across the nation have filed more than 70 lawsuits in 11 federal districts against opioid manufacturers and distributors. Claims for which suit has been brought include false advertising, consumer fraud, false claims, gross negligence, and unfair and deceptive practices. In 2014, the City of Chicago was the first city[58] to take such action, suing five major opioid manufacturers, including Purdue Pharma, the maker of OxyContin. In fact, the City of Chicago is the first government plaintiff to make it to the discovery phase of litigation.[59]

HARM REDUCTION

In the context of the opioid epidemic, harm reduction is a public health strategy that aims to diminish the negative effects of opioid use, without actually decreasing opioid use.[60] A harm reduction strategy often means a focus on allaying the immediate dangers of the opioid epidemic like opioid-related overdose death.

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[54] Andrew Kolodny et al., "The Prescription opioid and heroin crisis: A public health approach to an epidemic of addiction," *Annual Review of Public Health* 36 (2015): 559-574, https://www.ncbi.nlm.nih.gov/pubmed/25581144. Of course, the pharmaceutical companies were aided by the "low quality evidence" and now infamous "Porter and Jick" letter to the editor, which detailed a study that declared opioid addiction risk low.

[55] *Ibid*.

[56] Brian F. Mandell, "The fifth vital sign: A complex story of politics and patient care," *Cleveland Clinic Journal of Medicine* 83, no. 6 (June 2016): 400-401, http://www.mdedge.com/ccjm/article/109138/drug-therapy/fifth-vital-sign-complex-story-politics-and-patient-care; Andrew Kolodny et al., "The Prescription opioid and heroin crisis: A public health approach to an epidemic of addiction," *Annual Review of Public Health* 36 (2015): 559-574, https://www.ncbi.nlm.nih.gov/pubmed/25581144.

[57] Third Amended Complaint and Demand for Jury Trial at 6, City of Chicago v. Purdue Pharma LP et al., No. 14-cv-04361 (N.D. Ill, 2016).

[58] "Mayor Emanuel, President Preckwinkle, Chairman Cronin urge Medical Associations to Take Action to Limit Over-Prescribing of Opioids," *Officer of the Mayor City of Chicago*, November 1, 2017, https://www.cityofchicago.org/content/dam/city/depts/mayor/Press%20Room/Press%20Releases/2017/October/110117_OpioidsLetter.pdf.

[59] *Ibid*.

[60] Yuet W. Cheung, "Substance abuse and developments in harm reduction," *Canadian Medical Association Journal* 162, no. 12 (June 2000): 1699, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1232508/pdf/cmaj_162_12_1697.pdf.

Harm reduction is key to the response on an individual level because of the human life that is lost and deeply affected by the adverse effects of opioid use. The emotional toll this epidemic has enacted on families, friends, and society is inconceivable. Society cannot ignore what is happening or allow individuals affected to continue to die.

On a societal level, the costs of opioid overdose – such as acute care, lost earnings and employment, and incarceration – are momentous.[61] For instance, a single trip to the ICU for overdose cost, on average, $92,408 in 2015, an increase of 58% since 2009.[62] The epidemic as a whole is said to have cost $25.6 billion in lost earnings and employment so far.[63] Harm reduction aims to bring those costs down.

Four important issues relevant to opioid use harm reduction in Chicago are: (1) stigma, (2) the use of naloxone, (3) safe consumption sites, and (4) the regulation of illicit opioids.[64]

Destigmatization

Destigmatizing substance use disorder ("SUD"), drug use, and mental health issues is an important part of harm reduction policies.[65] Stigma associated with SUD stems from the common misunderstanding that those with SUD are "morally weak" or making a "willful choice" rather than suffering from a legitimate medical condition, a misunderstanding exacerbated by the criminality of drug use.[66] While stigma attaches to almost all aspects of substance use and mental health, it is especially prevalent in relation to medication-assisted treatment ("MAT").[67] For instance, physicians at the roundtable reported law enforcement officers misunderstanding MAT for recovery patients. Officers have gone so far as seizing recovery patients' prescribed Suboxone, leaving patients to return to using heroin to prevent withdrawal.

Importantly, "stigma is impeding progress in reducing the toll of overdose" directly through its effects on individuals with substance abuse disorder and mental health issues as well as indirectly through its effects on public policy.[68] Stigma has a strong effect on many people suffering from SUD. Research shows stigma prevents individuals from utilizing needle

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[61] It should be noted that chronic pain, too, has negative financial consequences. See, for example, *Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education, and Research* (Washington, DC: The National Academies Press, 2011), 91-95.
[62] Jennifer P. Stevens et al., "The Critical Care Crisis of Opioid Overdoses in the United States," *Annals of the American Thoracic Society* 14, no. 12 (December 2017) http://www.atsjournals.org/doi/10.1513/AnnalsATS.201701-022OC.
[63] Sheelah Kolhatkar, "The Cost of the Opioid Crisis," *New Yorker*, September 18, 2017, https://www.newyorker.com/magazine/2017/09/18/the-cost-of-the-opioid-crisis.
[64] Other solutions that were mentioned at the roundtable but not discussed at length include Good Samaritan laws.
[65] Lesley Simmonds and Ross Coomber, "Injecting Drug Users: A Stigmatised and Stigmatising Population," *International Journal of Drug Policy* 20 (2009): 128.
[66] Yngvild Olsen and Joshua M. Sharfstein, "Confronting the Stigma of Opioid Use Disorder—and Its Treatment," *JAMA*, April 9, 2014, https://jamanetwork.com/journals/jama/fullarticle/1838170.
[67] *Ibid*.
[68] *Ibid*.

exchanges,[69] seeking treatment,[70] and completing treatment.[71] Stigma is especially harmful to groups who already suffer from other forms of stigma due to their race, gender, or socioeconomic status,[72] for instance. In addition, stigma effects public policy decisions regarding allocation of resources, availability of care, and what type of care is made available.[73]

While there are a plethora of avenues to destigmatize SUD, they generally aim to educate so as to debunk misunderstandings and increase compassion. Direct destigmatization efforts through public education campaigns and specific educational programs for health professionals can help decrease stigma.[74] Stigma can also be addressed indirectly by changing the language used to describe individuals with SUD, decriminalizing opioid use, and increasing insurance coverage of treatments.[75]

Role of Naloxone

Naloxone is often a major part of harm reduction strategies aimed at the opioid epidemic, including in the Illinois Opioid Action Plan.[76] Naloxone – or Narcan – is a drug used to prevent opioid overdose by "block[ing] opioid receptor sites, reversing the toxic effects of the overdose."[77]

Naloxone is relatively cheap, easy to administer and has limited negative side effects.[78] As such, it has been used across different sectors as an immediate step to address opioids-related overdose deaths. Police and other first responders have used it when responding to overdose calls.[79] Doctors have issued naloxone co-prescriptions when prescribing opioids to patients.[80] Prisons and jails have distributed naloxone kits to at-risk incarcerated persons upon release.[81] And non-

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[69] Lesley Simmonds and Ross Coomber, "Injecting Drug Users: A Stigmatised and Stigmatising Population," *International Journal of Drug Policy* 20 (2009): 128.
[70] Gov. Bruce Rauner, *State of Illinois Opioid Action Plan*, September 2017: 15, http://dph.illinois.gov/sites/default/files/publications/Illinois-Opioid-Action-Plan-Sept-6-2017-FINAL.pdf.
[71] Charlie Lloyd, "The Stigmatization of Problem Drug Users: A Narrative Literature Review," *Drugs: Education, Prevention and Policy* 20, no. 2 (April 2013).
[72] See, for example, Kristi L. Stringer, "Stigma as a Barrier to Formal Treatment for Substance Use: A Gendered Analysis" (master's thesis, University of Alabama at Birmingham, 2012).
[73] Yngvild Olsen and Joshua M. Sharfstein, "Confronting the Stigma of Opioid Use Disorder—and Its Treatment," *JAMA*, April 9, 2014, https://jamanetwork.com/journals/jama/fullarticle/1838170.
[74]Gov. Bruce Rauner, *State of Illinois Opioid Action Plan*, September 2017: 15, http://dph.illinois.gov/sites/default/files/publications/Illinois-Opioid-Action-Plan-Sept-6-2017-FINAL.pdf.
[75] Yngvild Olsen and Joshua M. Sharfstein, "Confronting the Stigma of Opioid Use Disorder—and Its Treatment," *JAMA*, April 9, 2014, https://jamanetwork.com/journals/jama/fullarticle/1838170.
[76] See, for example, Gov. Bruce Rauner, *State of Illinois Opioid Action Plan*, September 2017: 28, http://dph.illinois.gov/sites/default/files/publications/Illinois-Opioid-Action-Plan-Sept-6-2017-FINAL.pdf.
[77] "Naloxone," *Substance Abuse and Mental Health Services Administration*, last updated March 3, 2016, https://www.samhsa.gov/medication-assisted-treatment/treatment/naloxone.
[78] Phillip O. Coffin and Sean D. Sullivan, "Cost-Effectiveness of Distributing Naloxone to Heroin Users for Lay Overdose Reversal, *Annals of Internal Medicine* 158, no. 1 (January 2013): 1-9, http://annals.org/aim/article-abstract/1487798/cost-effectiveness-distributing-naloxone-heroin-users-lay-overdose-reversal.
[79] Gov. Bruce Rauner, *State of Illinois Opioid Action Plan*, September 2017: 27, http://dph.illinois.gov/sites/default/files/publications/Illinois-Opioid-Action-Plan-Sept-6-2017-FINAL.pdf.
[80] *Ibid*., 14.
[81] Don Babwin, "Chicago giving departing inmates overdose-reversing drug," *Chicago Tribune*, July 29, 2017, http://www.chicagotribune.com/news/local/breaking/ct-chicago-inmates-naloxone-20170729-story.html.

profit programs have trained lay people on naloxone use including children/teens, drug users, and family and friends of drug users.[82]

In Emergency Response

Recently, there has been a push to provide police officers with naloxone to carry with them when responding to emergency calls.[83] At the federal level, the Office of National Drug Control Policy issued a statement that naloxone "should be in the patrol cars of every law enforcement professional across the nation."[84] At the state level, the 2014 Illinois Heroin Crisis Act instructs law enforcement and other first responders to carry naloxone.[85] However, the state government has yet to determine by what date police departments must be in compliance.[86]

Some counties – like Lake County – in the Chicago area have already implemented the policy in their police departments.[87] In addition, beginning in January 2018, all graduates of the Police Academy in Illinois will be trained in administering naloxone. [88] As for Cook County, in October 2017, Chicago city officials agreed that every patrol car should carry two doses of the naloxone nasal spray. However, the city has yet to find a way to pay for the program, which is reported to cost about $75 per patrol car.[89]

While having police departments administer naloxone can function as a successful step in harm reduction, there are two important factors to consider when implementing such a plan. First, police officers are not medical professionals. While naloxone is extremely easy to administer – especially in its nasal spray form – officers still need training on how to use it and how to deal with the aftermath of an opioid-related overdose. Second, in order to ensure limited resources are put to best use, consider who in the particular area is the first to respond to an emergency call involving an opioid-related overdose. In more rural areas, those first on the scene tend to be police officers. However, in certain urban settings, first on the scene may be firefighters or emergency medical technicians. In those cases, a naloxone program may be better targeted to those agencies.[90]

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[82] Gov. Bruce Rauner, *State of Illinois Opioid Action Plan*, September 2017: 28, http://dph.illinois.gov/sites/default/files/publications/Illinois-Opioid-Action-Plan-Sept-6-2017-FINAL.pdf.
[83] *Ibid*., 27.
[84] Micheal Botticelli, "Announcing the Opioid Overdose Toolkit," *Office of the National Drug Control Policy*, August 28, 2013, https://obamawhitehouse.archives.gov/blog/2013/08/28/announcing-opioid-overdose-toolkit.
[85] Heroin Crisis Act, PA 099-0480 (2015), http://www.ilga.gov/legislation/publicacts/99/PDF/099-0480.pdf.
[86] Gov. Bruce Rauner, *State of Illinois Opioid Action Plan*, September 2017: 50, http://dph.illinois.gov/sites/default/files/publications/Illinois-Opioid-Action-Plan-Sept-6-2017-FINAL.pdf.
[87] Lauren Zumbach, "Law clears way for drug overdose antidote in schools," *Chicago Tribune*, September 21, 2015, http://www.chicagotribune.com/news/local/breaking/ct-lns-naloxone-schools-st-0922-20150921-story.html.
[88] Gov. Bruce Rauner, *State of Illinois Opioid Action Plan*, September 2017: 27, http://dph.illinois.gov/sites/default/files/publications/Illinois-Opioid-Action-Plan-Sept-6-2017-FINAL.pdf.
[89] Heather Cherone, "18 Overdoses Per Day in Chicago Draw Support for Officer-Equipped Remedy, DNAInfo.com, October 6, 2017, https://www.dnainfo.com/chicago/20171006/bronzeville/all-cops-should-have-overdose-remedy-on-hand-officials-agree.
[90] In Cook County, firefighters already carry naloxone. *See* Gov. Bruce Rauner, *State of Illinois Opioid Action Plan*, September 2017: 27, http://dph.illinois.gov/sites/default/files/publications/Illinois-Opioid-Action-Plan-Sept-6-2017-FINAL.pdf.

No matter which emergency responder is carrying and administering naloxone, some have expressed a concern regarding potential liability of the administering individual. While liability is always a possibility, in practice "the legal risk to any person who acts in good faith to rescue another is very low."[91] The risk is "reduced further when the individual involved is a [law enforcement officer] acting in the course of his or her professional duties" as law enforcement enjoy several levels of immunity.[92] Moreover, Illinois state law explicitly protects law enforcement officers from civil and criminal liability for administering naloxone.[93] In addition, studies show that filing suit for the administration of naloxone by a police officer or other emergency responder is infrequent.[94]

In Primary Care Practice

Naloxone is also commonly employed in the primary care context in the form of co-prescribing. Co-prescribing is when doctors who prescribe opioids to a patient also prescribe the patient naloxone in the case of overdose.[95] The prescribing doctor counsels the patient on the potential for overdose and demonstrates how to administer the naloxone.[96]

In August 2017, the American Medical Association issued new guidance encouraging primary care providers to "co-prescribe naloxone to patients at risk of overdose."[97] The guideline specifies that co-prescriptions should only be given "when clinically appropriate" and includes a list of factors to consider when determining whether to issue a co-prescription.

In response to a dearth of research on the effectiveness of co-prescribing, the National Institute on Drug Abuse funded research that "found that patients taking opioids for long-term chronic pain, who were given prescriptions for naloxone in a primary care setting, had 63 percent fewer opioid-related emergency department visits after one year compared to those who did not receive prescriptions for naloxone."[98]

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[91] Corey S. Davis et al., "Engaging Law Enforcement in Overdose Reversal Initiatives: Authorization and Liability for Naloxone Administration," *American Journal of Public Health* 105, No. 8 (August 2015), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4504282/#bib32.
[92] *Ibid*.
[93] Heroin Crisis Act, PA 099-0480 (2015), http://www.ilga.gov/legislation/publicacts/99/PDF/099-0480.pdf.
[94] Corey S. Davis et al., "Engaging Law Enforcement in Overdose Reversal Initiatives: Authorization and Liability for Naloxone Administration," *American Journal of Public Health* 105, No. 8 (August 2015), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4504282/#bib32.
[95] Sarah Wakeman, "Saving lives by prescribing naloxone with opioid painkillers," *Harvard Health Blog*, August 26, 2016, https://www.health.harvard.edu/blog/saving-lives-prescription-prescribing-naloxone-opioid-painkillers-2016082610075.
[96] *Ibid*.
[97] "Help save lives: Co-prescribe naloxone to patients at risk of overdose," *American Medical Association*, August 2017, https://www.end-opioid-epidemic.org/wp-content/uploads/2017/08/AMA-Opioid-Task-Force-naloxone-one-pager-updated-August-2017-FINAL.pdf.
[98] "Co-prescribing naloxone in primary care settings may reduce ER visits," *National Institute on Drug Abuse*, June 28, 2016, https://www.drugabuse.gov/news-events/news-releases/2016/06/co-prescribing-naloxone-in-primary-care-settings-may-reduce-er-visits.

However, as previously stated, in Chicago, the primary threat in the opioid epidemic is heroin, not prescription opioid misuse. Therefore, making co-prescription a primary policy concern in this context may not be an efficient use of resources.

In Other Settings

Another frequently noted use of naloxone is to provide it directly to opioid users themselves outside of the primary care context. The Illinois Department of Public Health implemented the Drug Overdose Prevention Program ("DOPP") to facilitate naloxone distribution to opioid users.[99] DOPP allows prescribers and community based organizations, among others, to provide naloxone kits to users.[100] DOPP requires programs to register with the state and complete training[101] while also providing assistance with accessing naloxone.[102]

Concurrently, Cook County Health & Hospital Systems distributes naloxone training and kits to individuals in the criminal justice system as well as through the hospital. [103] The program at Cook County Jail trains and provides at-risk incarcerated individuals with naloxone upon release.[104] Distribution of naloxone in the hospital seeing, however, has proved more difficult. While dispensing naloxone kits in hospitals has the potential to be highly impactful, internal rules and federal regulations hamper hospitals from handing out naloxone kits with the same ease as non-profits or other entities. Bureaucratic rules on the dispensation of medications such as obtaining lot numbers, attaching medication to a record, and tracking who gets the medication prevent naloxone from being distributed freely. Moreover, legal restrictions prevent handing out medication in a clinical area. While these rules and regulations are important for other medications, given that naloxone is virtually harmless and can directly save lives, an exception should be made for naloxone.

Naloxone is a key to harm reduction as it is relatively cheap, effective at saving lives, and has changed the conversation about opioid use toward one of compassion.[105]

Safe Consumption Facilities

The third harm reduction policy discussed here is safe consumption facilities. Safe consumption facilities are "professional supervised healthcare facilities providing safer and more hygienic

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[99] Illinois Department of Human Services, *Drug Overdose Prevention Program (DOPP) Guidelines for Implementation* (2016), http://www.dhs.state.il.us/OneNetLibrary/27896/documents/By_Division/OASA/Overdose_Prevention_Program/DOPP_GuidelinesforImplementation.pdf.
[100] *Ibid*.
[101] *Ibid*.
[102] Illinois Department of Human Services, *Illinois Naloxone Purchase, Training, and Distribution Services*, (September 7, 2017), http://www.dhs.state.il.us/OneNetLibrary/27896/documents/9.7.17.Final.DOPPProgram Summary.pdf.
[103] Chicago-Cook County Task Force on Heroin, *Final Report* (October 6, 2016): 9-10, https://www.cityof chicago.org/content/dam/city/depts/cdph/tobacco_alchohol_abuse/HeroinTaskForceReport_Final_10.6.16.pdf.
[104] *Ibid*., 10.
[105] However it is important to keep in mind that naloxone is a product of "big pharma," which not only has fixed financial incentives and a very powerful lobby, but also is the industry that significantly contributed the opioid epidemic in the first place.

conditions for drug users to take drugs."[106] Typically, safe consumption sites reduce harm by "providing clean injecting equipment…good light, clean surfaces and sharps disposal; facilitating individually tailored health education, and promoting access to healthcare and drug treatment."[107] Safe consumption sites train staff "to provide assistance and emergency care in cases of overdose or other adverse events but do not assist clients to inject."[108]

Safe consumption facilities are part of a harm reduction model, but also contribute to recovery, since relapse is a part of recovery and because the facilities increase treatment uptake. Safe consumption facilities exist for the health and dignity of drug users themselves. They also better the public health overall by addressing issues "linked to open drug scenes and drug markets," like open consumption, unsafely discarded syringes, and other associated nuisance.[109] In fact, research has shown that safe consumption facilities have the potential to reduce violence in the surrounding community, especially against women,[110] decrease overdose deaths,[111] and increase MAT uptake.[112] Contrary to some fears, research has shown safe consumption facilities do not contribute to initiation.[113]

Safe consumption facilities exist all over the world, sometimes with the cooperation of governmental authorities and other times not.[114] Here in the United States, no legal safe consumption facility has been established although legal facilities in Seattle and San Francisco may open soon.[115] While a matter of great debate in the United States, many have argued safe consumption facilities are an effective part of a harm reduction model, including the American

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[106] Dagmar Hedrich, Thomas Kerr and Francoise Dubois-Arber, *Drug consumption facilities in Europe and beyond*, (January 2010): 306, https://www.researchgate.net/publication/281335915_Drug_consumption_facilities_in_Europe_and_beyond.
[107] *Ibid*.
[108] *Ibid*., 306-7.
[109] "Drug Consumption Rooms: An Overview of Provision and Evidence," *European Monitoring Centre for Drugs and Drug Addiction* 2, no. 5 (June 6, 2017), http://www.emcdda.europa.eu/system/files/publications/2734/POD_Drug%20consumption%20rooms.pdf.
[110] Massachusetts Medical Society, *Establishment of a Pilot Medically Supervised Injection Facility in Massachusetts: Report of the Task Force on Opioid Therapy and Physician Communication* (April 2017): 14-15, http://www.massmed.org/advocacy/state-advocacy/sif-report-2017/.
[111] *Ibid*., 4.
[112] Amos Irwin et al., "A Cost-Benefit Analysis of a Potential Supervised Injection Facility in San Francisco, California, USA," *Journal of Drug Issues* 47, no. 2 (December 13, 2016): 164-184, http://journals.sagepub.com/doi/abs/10.1177/0022042616679829.
[113] Massachusetts Medical Society, *Establishment of a Pilot Medically Supervised Injection Facility in Massachusetts: Report of the Task Force on Opioid Therapy and Physician Communication* (April 2017): 14, http://www.massmed.org/advocacy/state-advocacy/sif-report-2017/.
[114] *Ibid*., 19.
[115] Amanda Holpuch, "Secret supervised drug injection facility has been operating at US site for years, *The Guardian*, August 8, 2017, https://www.theguardian.com/society/2017/aug/08/secret-supervised-drug-injection-facility-us-opioids-overdoses. While no legal safe consumption facilities have been maintained, some sites similar to safe consumption facilities do exist (see Dr. Sanjay Gupta, "Opioid addiction and the most controversial bathroom in New York," *CNN*, October 26, 2017, http://www.cnn.com/2017/10/25/health/opioid-addiction-bathroom-safe-injection-site/index.html). Moreover, at least one secret, illegal safe consumption site has been operated in the use (see Amanda Holpuch, "Secret supervised drug injection facility has been operating at US site for years, *The Guardian*, August 8, 2017, https://www.theguardian.com/society/2017/aug/08/secret-supervised-drug-injection-facility-us-opioids-overdoses.).

Medical Association.[116] Moreover, the new Surgeon General, Jerome Adams, indicated that safe consumption facilities should be considered in the opioid epidemic response.[117]

Decriminalization of Illicit Opioids

Another aspect of harm reduction is to change the existing criminal law surrounding opioids. Numerous cities, regional governments, and entire countries have loosened drug laws including decriminalizing and legalizing opioids.[118] In the drug context, decriminalization is different that legalization. Decriminalization "typically reduces penalties, mainly incarceration, for conduct that remains illegal."[119] By contrast, legalization "represents a roll-back of the state's regulatory authority, the elimination of state power to punish certain individual choices, and the concomitant expansion of liberty and privacy zones."[120]

Decriminalization can and does take many forms on the global stage and in the United States. Decriminalization can be sorted into two broad categories: partial and full decriminalization. Partial decriminalization often sees "offenses retain their criminal character and attendant burdens" however "defendants cannot be incarcerated for the underlying offense."[121] Partial decriminalization "can take other forms as well, from shortened or deferred sentences to supervision and treatment."[122] In contrast, full decriminalization "removes an offense from the criminal system entirely" and "[a]lthough the conduct remains punishable, full decriminalization can spare offenders many of the collateral consequences of the criminal process such as arrest or a criminal record."[123]

While controversial in the United States, there are documented benefits to decriminalization of opioids. First, while research is limited as to direct causation, decriminalizing opioids may lead to a decrease in opioid-related overdose deaths, as it did in Portugal. In particular, should illicit drugs be decriminalized such that they be provided by prescription, allowing access to a regulated "clean" supply for users, accidental drug overdoses due to fentanyl may decrease. Given the alarming increase in fentanyl-related overdose deaths recently, decriminalization could directly impact mortality rates. Second, many opine that decriminalization would decrease stigma surrounding opioid addiction and use, which may "encourage people to seek treatment," as discussed above.[124]

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[116] "AMA Wants New Approaches to Combat Synthetic and Injectable Drugs," *American Medical Association*, June 12, 2017, https://www.ama-assn.org/ama-wants-new-approaches-combat-synthetic-and-injectable-drugs .
[117] U.S. Senate Committee on Health, Education, Labor & Pensions, *Full Committee Hearing: Nomination Hearing*, August 1, 2017, video, 02:15:30, https://www.help.senate.gov/hearings/nomination-hearing5; Amanda Holpuch, "Secret Supervised Drug Injection Facility has been Operating at US Site for Years," *The Guardian*, August 8, 2017, https://www.theguardian.com/society/2017/aug/08/secret-supervised-drug-injection-facility-us-opioids-overdoses.
[118] Open Society Foundation, *A Quiet Revolution: Drug Decriminalisation Policies in Practice Across the Globe* (2012), https://www.opensocietyfoundations.org/sites/default/files/release-quiet-revolution-drug-decriminalisation-policies-20120709.pdf.
[119] Alexandra Natapoff, "Misdemeanor Decriminalization," *Vanderbilt Law Review* 68 (May 2015): 1057.
[120] *Ibid*., 1066.
[121] *Ibid*., 1057-8.
[122] *Ibid*., 1057.
[123] *Ibid*.,
[124] Paul Gaita, "Can Decriminalizing Drugs Solve Canada's Opioid Crisis?," *The Fix*, February 23, 2017, https://www.thefix.com/can-decriminalizing-drugs-solve-canadas-opioid-crisis.

Third, the state could potentially save – and earn – billions of dollars, which could be redirected to the opioid response. Research shows the potential for "immense savings [for the state] in the costs of prosecution, incarceration, and defense counsel"[125] as well as in the cost of police resources. In addition, decriminalization could function as a way to "divert[] infraction revenues away from law enforcement coffers" and instead into public health budgets, as was exemplified by Maryland, which "directs all revenues from decriminalized marijuana offense to the Department of Health and Mental Hygiene" to fund "'drug treatment and education programs.'"[126]

Fourth, a cited harm reduction benefit to decriminalization of opioids is a decrease in violence surrounding the drug trade.[127] Decriminalization allows the drug market to come above ground and reduces the need to self-enforce or resort to violence and other antisocial behavior.[128] Moreover, legalization would help curb the illegal trafficking markets currently in place, which would similarly reduce violence.[129]

While decriminalization opponents often worry about initiation of new drug users should opioids become decriminalized, comparative practice in Portugal and elsewhere saw "no significant increase in drug use" and in fact, in some places "a drop in use among adolescents."[130]

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Harm reduction in the context of the opioid epidemic aims to decrease the immediate adverse consequences of opioid use without decreasing actual use. Often, harm reduction focuses on bringing down mortality rates but can include other focuses as well, including general health of users, increased uptake of treatment, and decreased drug-related violence, litter, and nuisance.

The roundtable discussion yielded four major strategies for harm reduction in the local context, including decreasing stigma surrounding SUD, use of naloxone throughout different sectors, piloting safe consumption sites, and decriminalizing illicit opioids.

While harm reduction is an essential part of any response to the opioid epidemic, it is not the final solution. Providing all opioid-using individuals – regardless of class, race or gender – who want treatment with a path to recovery is also necessary.[131]

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[125] *Ibid*., 1072.
[126] *Ibid*., 1115.
[127] Evelina Gavrilova, Takuma Kamada and Floris Zoutman, "Is Legal Pot Crippling Mexican Drug Trafficking Organisations? The Effect of Medical Marijuana Laws on US Crime*," The Economic Journal* (2017), http://onlinelibrary.wiley.com/doi/10.1111/ecoj.12521/epdf.
[128] *Ibid*.
[129] *Ibid*.
[130] Paul Gaita, "Can Decriminalizing Drugs Solve Canada's Opioid Crisis?," *The Fix*, February 23, 2017, https://www.thefix.com/can-decriminalizing-drugs-solve-canadas-opioid-crisis.
[131] It is important to note that there is a critique that individuals of low socio-economic status receive only harm reduction while those with high socio-economic status receive recovery and treatment. In a Chicago-area opioid response, it is necessary to ensure services are offered equally to all individuals in the area.

RECOVERY

Recovery is the goal of treatment and key to overcoming the opioid epidemic. Recovery is "a process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential."[132] The Substance Abuse and Mental Health Service Administration ("SAMHSA") provides four dimensions of recovery: health, home, purpose, and community.[133]

There are numerous types and approaches to treatment and recovery in Chicago. This section begins by examining the approaches available to connect individuals with substance use disorder ("SUD") to treatment – also known as the "warm handoff." Such approaches include screening by medical professionals, pre-arrest diversion programs, and post-arrest diversion programs, specifically drug courts. Next, treatment programs themselves are investigated, including the role of detox, medication-assisted treatment ("MAT"), mental and behavioral health care, and wrap-around services.

Getting to Treatment: Warm Handoffs

Those suffering from SUD "face a range of obstacles preventing them from entering or gaining access to treatment, including lack of knowledge regarding access to services, shame and stigma, denial of [SUD] or substance misuse, costs and lack of insurance/Medicaid, transportation, treatment waiting lists, and prior negative treatment experiences."[134] Therefore, it is essential to implement procedures and programs that overcome these barriers and work effectively to connect those suffering from SUD to treatment services. Three important methods of connecting individuals with SUD to treatment are discussed here: (1) screening, (2) pre-arrest diversion, and (3) post-arrest interventions.

It is important to note that while the programs explored below are meant to connect those with SUD to treatment, the decision to enter treatment must be completely and totally voluntary. A person who has been forced or coerced into treatment will not only be unsuccessful but will also "poison the well" for the others in that treatment program. Therefore, the baseline of any program connecting people with treatment services must be the voluntary decision of the person entering treatment.

Screening

Screening refers to a process whereby health care professionals "identify whether an individual has a SUD that needs intervention."[135] Equally important is screening for co-occurring mental

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[132] "Recovery and Recovery Support," *Substance Abuse and Mental Health Services Administration*, last updated September 20, 2017, https://www.samhsa.gov/recovery.
[133] *Ibid*.
[134] Jessica Reichert and Lily Gleicher, *Rethinking Law Enforcement's Role on Drugs: Community Drug Intervention and Diversion Efforts* (Illinois Criminal Justice Information Authority, January 2017): 4, http://www.icjia.state.il.us/articles/rethinking-law-enforcement-s-role-on-drugs-community-drug-intervention-and-diversion-efforts.
[135] "Opioid Use Disorder," *Athena Health, Inc*., accessed on November 15, 2017, https://online.epocrates.com/diseases/20037/Opioid-use-disorder/Screening.

health issues.[136] Screening can involve questionnaires/interviews[137] and/or laboratory tests, such as urine toxicology testing.[138] While typically screening is accomplished with the use of standardized assessment tools, such as the Drug Abuse Screening Test ("DAST"),[139] informal practices such as pill counting and questioning are also methods implemented by health care professionals.[140]

In addition to traditional screening methods, the Illinois Prescription Monitoring Program ("PMP"), an electronic database that collects information on controlled substance prescriptions, may be used to track a patient's history and detect behavior related to SUD.[141] However, due to federal confidentiality law,[142] Opioid Treatment Programs ("OTPs") and Drug Addiction Treatment Act of 2000 ("DATA")-waived physicians are not permitted to disclose patient-identifying information regarding methadone prescriptions to state PMPs.[143] Therefore, prescriptions of methadone used in MAT often do not show up in PMPs.

Because screening is frequently an essential first step to connecting those with SUD to treatment, it is important to increase effective and appropriate screening efforts on all fronts. Primary care providers are well positioned to take up the task of increasing screening efforts because they have extensive access to patients and because many patients do not come into contact with someone who could provide screening other than a primary care provider. In addition to increased primary care screening, ambulatory screening clinics may be an important part of the solution.

Whether the setting is a primary care office, the emergency room, or a pain clinic, it is essential that screening procedures are developed to be effective and appropriate. Determining which patients are screened, how screening will occur, and what process is in place if a health professional determines a patient has a SUD are key components to any screening procedure. Moreover, ensuring that the entire screening procedure remains compassionate and non-judgmental through special training for health professionals administering screenings is fundamental.

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[136] "Co-occurring Disorders," *Substance Abuse and Mental Health Services Association*, last updated March, 8, 2016, https://www.samhsa.gov/disorders/co-occurring.
[137] "The CAGE and CAGE-AID Questionnaire," *The Society of Teachers of Family Medicine,* http://www.mqic.org/pdf/CAGE_CAGE_AID_QUESTIONNAIRES.pdf.
[138] "Urine Drug Testing for Chronic Pain Management," *National Institute on Drug Abuse*, https://www.drugabuse.gov/sites/default/files/files/UrineDrugTesting.pdf.
[139] "The Drug Abuse Screening Test (DAST)," *Addiction Research Foundation*, https://integrationacademy.ahrq.gov/sites/default/files/DAST_0.pdf.
[140] "Opioid Use Disorder," *Athena Health, Inc*., accessed on November 15, 2017, https://online.epocrates.com/diseases/20037/Opioid-use-disorder/Screening.
[141] "Illinois Prescription Monitoring Program," *Illinois Prescription Monitoring Program*, accessed on November 16, 2017, https://www.ilpmp.org/.
[142] 42 C.F.R. Part 2, https://www.law.cornell.edu/cfr/text/42/part-2.
[143] "Letter on the illicit use of prescription drugs and State Prescription Drug Monitoring Programs," *Substance Abuse and Mental Health Services Association*, September 27, 2011, https://www.samhsa.gov/sites/default/files/programs_campaigns/medication_assisted/dear_colleague_letters/2011-colleague-letter-state-prescription-drug-monitoring-programs.pdf.

When determining who should be screened, the Substance Abuse and Mental Health Services Administration "recommends universal screening for substance use…as part of routine health care."[144] Universal screening means screening every patient.[145] Because Medicaid and most health insurance plans cover screening at full cost, universal screening is possible in most - if not all - settings.

Screening is vital in identifying SUD. However, connecting patients to treatment is the ultimate goal of screening. As a result, SAMHSA recommends an approach called "Screening, Brief Intervention, and Referral to Treatment" or "SBIRT."[146] The approach follows three steps: (1) "[s]creening quickly assess the severity of substance use and identifies the appropriate level of treatment," (2) "[b]rief intervention focuses on increasing insignt and awareness regarding substance use and motivation toward behavioral change," and (3) "[r]eferral to treatment provides those identified as needing more extensive treatment with access to specialty care."[147]

Pre-Arrest Diversion Programs

Pre-arrest diversion – also called deflection – "refers to the broad category of justice models that divert people away from further prosecution, jail, or sentencing, and into services in the community."[148] In the context of the opioid epidemic, pre-arrest diversion programs such as A Way Out,[149] LEAD,[150] and the Safe Passage Program[151] "entail substance users either voluntarily contacting the police or being contacted via outreach efforts."[152] Substance users are then "offered SUD treatment without fear of arrest, and police provide referral and transportation to treatment facilities."[153]

Police departments are particularly well suited for running diversion programs for several reasons. First, police are available 24 hours a day, 7 days a week. Given that swift action is required once a person with SUD decides he or she would like treatment, 24/7 availability is a strength of police-run diversion programs. Second, police regularly interact with those suffering

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[144] "Substance Use Screening, Brief Intervention, and Referral to Treatment," American Academy of Pediatrics, June 2015, http://pediatrics.aappublications.org/content/early/2016/06/16/peds.2016-1210#ref-2; "Screening, Brief Intervention, and Referral to Treatment (SBIRT)," *Substance Abuse and Mental Health Services Administration*, last updated September 15, 2017, https://www.samhsa.gov/sbirt.

[145] "Opioid Use Disorder," *Athena Health, Inc.*, accessed on November 15, 2017, https://online.epocrates.com/diseases/20037/Opioid-use-disorder/Screening.

[146] "Screening, Brief Intervention, and Referral to Treatment (SBIRT)," *Substance Abuse and Mental Health Services Association,* last updated on September 15, 2017, https://www.samhsa.gov/sbirt.

[147] "About Screening, Brief Intervention, and Referral to Treatment (SBIRT)," *Substance Abuse and Mental Health Services Association,* last updated on September 20, 2017https://www.samhsa.gov/sbirt/about.

[148] "Pre-Arrest Diversion," *Center for Health and Justice at TASC*, accessed on November 15, 2017, http://www2.centerforhealthandjustice.org/content/project/police-deflection.

[149] "Program Overview," *A Way Out Lake County*, accessed on November 15, 2017, http://awayoutlc.org/.

[150] "Home," *LEAD: Law Enforcement Assisted Diversion*, accessed on November 15, 2017, http://leadkingcounty.org/.

[151] "Safe Passage – Opiate Addiction Program," *City of Dixon, Illinois*, accessed on November 15, 2017, https://www.discoverdixon.org/departments/police-department/inside-the-dixon-police-dept/safe-passage.html.

[152] Jessica Reichert and Lily Gleicher, *Rethinking Law Enforcement's Role on Drugs: Community Drug Intervention and Diversion Efforts* (Illinois Criminal Justice Information Authority, January 2017): 4, http://www.icjia.state.il.us/articles/rethinking-law-enforcement-s-role-on-drugs-community-drug-intervention-and-diversion-efforts.

[153] *Ibid*.

from SUD given the criminality of drug use, the negative nuisance-type behavior associated with SUD, and the cyclical nature of both.

While pre-arrest diversion programs can operate at virtually no monetary costs,[154] such programs require a high degree of cross-sector cooperation.[155] Police departments must coordinate with, for instance, (1) local SUD treatment facilities to take in patients, (2) local hospitals and emergency rooms to provide immediate treatment, (3) prosecutors to work around existing criminal charges or warrants, and (4) the public to foster community buy-in.

The benefits of pre-arrest diversion programs are enormous. Pre-arrest diversion programs function to connect individuals who need and want treatment to appropriate services while at the same time saving the state the immense expense of arresting, investigating, prosecuting, and incarcerating an individual.[156] Especially given that substance users are often cyclically involved in low-level, nuisance-type crimes, the fiscal benefit of a pre-arrest diversion program on the criminal justice system alone is huge.[157] Combined with the public health benefits of treating those with SUD, and the low operating cost, pre-arrest diversion programs are extremely effective.[158]

In addition, by treating SUD as a medical illness rather than as a criminal offense, pre-arrest diversion programs work to destigmatize those suffering from SUD in the eyes of the public as well as in the eyes of police and others working in the criminal justice system.[159] Relatedly, pre-arrest diversion programs can improve police-community relations by providing the space for police officers and community members to interact positively and collaboratively.[160]

In Chicagoland, there are a number of recently implemented pre-arrest diversion programs. DuPage County has one police department operating a pre-arrest diversion program called "Connect for Life."[161] Lake and McHenry Counties host the well-known A Way Out program with 31 participating police departments.[162] Will County recently received a grant to expand their

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[154] Jessica Reichert, *Fighting the Opioid Crisis through Substance Use Disorder Treatment: A Study of a Police Program Model in Illinois* (Illinois Criminal Justice Information Authority, September 2017), http://www.icjia.state.il.us/articles/fighting-the-opioid-crisis-through-substance-use-disorder-treatment-a-study-of-a-police-program-model-in-illinois. Many programs operate with no budget whatsoever while others find creative funding sources, such as drug forfeiture funds, to cover costs.

[155] *Ibid*.

[156] Chicago-Cook County Task Force on Heroin, *Final Report* (October 6, 2016): 25, https://www.cityofchicago.org/content/dam/city/depts/cdph/tobacco_alchohol_abuse/HeroinTaskForceReport_Final_10.6.16.pdf.

[157] *Ibid*.

[158] *Ibid*.

[159] *Ibid*.

[160] *Ibid*.

[161] "Connect for Life*," City of Naperville*, *Illinois*, accessed on November 15, 2017, https://www.naperville.il.us/services/naperville-police-department/programs-and-services/connect-for-life/.

[162] "Participating PD's," *A Way Out Lake County*, accessed on November 15, 2017, http://awayoutlc.org/police departments/; "Participating Police Departments," *A Way Out McHenry County*, accessed on November 15, 2017, https://www.co.mchenry.il.us/county-government/departments-j-z/state-s-attorney-s-office/programs-and-initiatives/a-way-out/participating-police-departments.

Safe Passage program.[163] However, Chicago Police Department has only recently begun a small pilot pre-arrest diversion program.[164]

Post-Arrest Diversion: Drug Courts

Drug courts are an increasingly implemented strategy in addressing the opioid crisis. Indeed, the President's Commission on Combating Drug Addiction and the Opioid Crisis ("The President's Opioid Commission") recommended in its final report that "a drug court be established in every one of the 93 federal district courts in America."[165] These "special court dockets" employ "a multidisciplinary team of professionals" to implement a treatment program for criminal defendants suffering from SUD.[166] Often, "[i]n exchange for successful completion of the treatment program, the court may dismiss the original charge, reduce or set aside a sentence, offer some lesser penalty, or offer a combination of these."[167] Drug courts operate at the state,[168] and federal level[169] in Chicagoland.

Drug court programs are administered by a judge who consults with an interdisciplinary team typically including "a program coordinator, prosecuting attorney, defense attorney, probation or community supervision officer, treatment representatives, and law enforcement."[170] However, the judge "is legally and ethically required to make the final decision on the consequences to be imposed."[171]

Typically, judges are not medical professionals, nor do they have a background in SUD treatment. Moreover, their background in dealing with criminal defendants can result in strong opinions about how treatment programs should be administered, including misconceptions about SUD and associated behaviors. Because judges ultimately determine the success of a participant,

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[163] Mike Mallory, "Will County gets grant for Safe Passage drug abuse program," *Herald News*, September 23, 2017, http://www.theherald-news.com/2017/09/22/will-county-gets-grant-for-safe-passage-drug-abuse-program/aflskgj/.

[164] Chicago-Cook County Task Force on Heroin, *Final Report* (October 6, 2016): 10, https://www.cityofchicago.org/content/dam/city/depts/cdph/tobacco_alchohol_abuse/HeroinTaskForceReport_Final_10.6.16.pdf.

[165] United States White House, *The President's Commission on Combating Drug Addiction and the Opioid Crisis: Final Report*, November 2017: 10, https://www.whitehouse.gov/sites/whitehouse.gov/files/images/Final_Report_Draft_11-1-2017.pdf.

[166] Douglas B. Marlowe, Carolyn D. Hardin, and Carson L. Fox, *Painting the Current Picture: A National Report on Drug Courts and Other Problem-Solving Courts in the United States* (National Drug Court Institute, June 2016): 11, https://www.ndci.org/wp-content/uploads/2016/05/Painting-the-Current-Picture-2016.pdf.

[167] *Defining Drug Courts: The Key Components* (U.S. Department of Justice, January 1997): 7, https://www.ndci.org/wp-content/uploads/2016/05/Defining-Drug-Courts-The-Key-Components.pdf.

[168] *See* "Cook County Drug Court Treatment Program," *State of Illinois Circuit Court of Cook County*, accessed on November 15, 2017, http://www.cookcountycourt.org/ABOUTTHECOURT/CountyDepartment/CriminalDivision/SpecialtyTreatmentCourts/DrugCourtTreatmentProgram.aspx; "Adult Drug Court," *Will County State's Attorney*, accessed on November 15, 2017, http://www.willcountysao.com/courts-adult_drug_court.htm.

[169] Hon. Joan Gottschall and Molly Armour, "Second Chance: Establishing a Reentry Program in the Northern District of Illinois," *DePaul Journal for Social Justice* 5, no. 1 (Fall 2011), http://via.library.depaul.edu/cgi/viewcontent.cgi?article=1028&context=jsj.

[170] Douglas B. Marlowe, Carolyn D. Hardin, and Carson L. Fox, *Painting the Current Picture: A National Report on Drug Courts and Other Problem-Solving Courts in the United States* (National Drug Court Institute, June 2016): 11, https://www.ndci.org/wp-content/uploads/2016/05/Painting-the-Current-Picture-2016.pdf.

[171] *Ibid*.

it is essential that judges working in drug court understand that SUD is a physiological medical illness that affects behavior. Moreover, judges must understand how evidence-based treatment works. Formal training of drug court judges in this regard is therefore necessary.

Components of Treatment Programs

Treatment of SUD is at the heart of addressing the opioid epidemic. As noted above, stigma and misunderstandings surrounding substance use is rampant. Misunderstandings about the nature of SUD being a moral or behavioral issue over which people have control, rather than a physiological medical illness, have resulted in treatment programs that are not appropriately tailored to SUD. Even when treatment programs do respond directly to SUD, they can fail to address common co-occurring mental and behavioral health issues.

Like any illness, SUD is unique to the individual and thus responds differently to different treatment programs. While one person may find success with one method, others may not. Therefore, it is important for treatment providers to understand the difference between treatments and to understand that if a patient is unsuccessful in one program, he or she may need a different type of treatment.

This section examines four components of treatment programs, which can be offered separately or in combination with each other: (1) detox, (2) medication-assisted treatment ("MAT"), (3) mental and behavioral health care, and (4) wrap-around services.

Detox

Detoxification, or detox, is the process of eliminating opioids from a person's system. Depending on the level of opioids in a person's system, the process could take days or even weeks.[172] For those suffering from SUD, detox can be difficult because it forces the person into withdrawal. Thus, medically managed detox – whether in hospitals, detox facilities, or treatment centers – developed as a way to aid patients in completing a detox period.[173]

Detox can be accomplished by simply discontinuing opioid use for a certain period of time. However, certain drugs like methadone or Suboxone – a combination of buprenorphine and naloxone – can be administered or prescribed to a patient as a transition drug and to help relieve the severe and painful symptoms of opioid withdrawal.[174] The buprenorphine in Suboxone functions as a partial opioid agonist by "[a]ttach[ing] to the opioid receptors, but only activat[ing] enough to suppress withdrawal and cravings" resulting in feeling "'normal'" as opposed to euphoric or "'high.'"[175] The naloxone in the Suboxone functions as an opioid

[172]Jessica Reichert, Lily Gleicher, and Elizabeth Salisbury-Afshar, *An Overview of Medication-Assisted Treatment for Opioid Use Disorders for Criminal Justice-Involved Individuals* (Illinois Criminal Justice Information Authority, July 18, 2017) http://www.icjia.state.il.us/articles/an-overview-of-medication-assisted-treatment-for-opioid-use-disorders-for-criminal-justice-involved-individuals.
[173] *Ibid*.
[174] *Ibid*.
[175] *Ibid*.

antagonist, blocking any effects of opioids taken with it.[176] Similarly, "[m]ethadone is a long-lasting synthetic opioid agonist that activates the opioid receptors in the brain to reduce cravings, block euphoric effects [that occur with short acting opioids,] and decrease withdrawal symptoms."[177]

Detox can be an important first step in the treatment of SUD. However, the vast majority of the time, detox alone is not enough to "cure" SUD, nor is it typically safe to administer without any other form of treatment. Research has shown that detox alone does not typically produce successful recovery for SUD patients. [178] Even post-detox, "physical changes in the brain persist," not to mention non-physical factors such as trauma, stress, social networks, and habit that can cause a person to relapse.[179]

In addition, detox significantly increases the risk of opioid-related overdose death because it takes the patient from an opioid tolerant state to an intolerant state.[180] Therefore, overdose risk is high "because psychological and physical cravings exist but physical tolerance for opioids is low."[181] Because SUD is a chronic illness with frequent relapse, if a person with SUD uses opioids after a detox, she may take a dose that, while previously safe for her, is now potentially fatally dangerous.[182]

Therefore, detox should only be administered as part of a larger treatment program that provides MAT, mental and behavioral health care, and wrap-around services. This could translate to detox provided within a treatment facility that provides other services, or detox units in hospitals and other acute care settings that directly and automatically translates into next level care after the detox is complete. Importantly, a simple referral is not sufficient.

There are several barriers to implementing detox programs. First, as mentioned previously, detox alone is not generally successful as a treatment for SUD, especially given the wide variety in philosophies of treatment protocols in detox programs.[183] More involved treatment programs with MAT incorporation are typically necessary[184] but often are not sufficiently provided for post-detox. Second, and relatedly, intensive outpatient treatment provided by mental health

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[176] Jeffrey Stuckert, "How is Suboxone Treatment Different than Drug Abuse?," *Psych Central* (2016), https://psychcentral.com/lib/how-is-suboxone-treatment-different-than-drug-abuse/.
[177] Jessica Reichert, Lily Gleicher, and Elizabeth Salisbury-Afshar, *An Overview of Medication-Assisted Treatment for Opioid Use Disorders for Criminal Justice-Involved Individuals* (Illinois Criminal Justice Information Authority, July 18, 2017) http://www.icjia.state.il.us/articles/an-overview-of-medication-assisted-treatment-for-opioid-use-disorders-for-criminal-justice-involved-individuals.
[178] Barbara Andraka-Christou, "America Needs the TREAT Act: Expanding Access to Effective Medication for Treating Addiction," *Health Matrix* 26 (2016): 313.
[179] *Ibid*.
[180] *Ibid*.
[181] *Ibid*.
[182] John Strang et al., "Loss of Tolerance and Overdose Mortality After Inpatient opiate Detoxification: Follow Up Study," *BMJ* (May 2003): 959-960, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC153851/.
[183] *See* Jessica Reichert, Lily Gleicher, and Elizabeth Salisbury-Afshar, *An Overview of Medication-Assisted Treatment for Opioid Use Disorders for Criminal Justice-Involved Individuals* (Illinois Criminal Justice Information Authority, July 18, 2017) http://www.icjia.state.il.us/articles/an-overview-of-medication-assisted-treatment-for-opioid-use-disorders-for-criminal-justice-involved-individuals.
[184] *Ibid*.

agencies is hard to find and often have with long waiting lists. Such treatment is also difficult to reimburse through Medicaid as medical care payments and mental health care payments exist in separate silos, making payments for integrated care a challenge. Third, while Suboxone can be administered or prescribed for detox by a physician in an office setting,[185] under federal law methadone administration and prescriptions for detox requires may only be dispensed by authorized clinics.[186] A physician in a hospital, however, can administer methadone for detox for up to 72 hours without a license.[187] Fourth, stigma and misunderstanding around SUD can make hospitals resistant to implementing detox units.

Detox can be an important part of a treatment regimen but the bridge to next level care, like MAT, must also be established. Typically, a referral at the time of discharge from a detox program is not enough. Rather, patients need a definite appointment the day of or the day after discharge as well as enough medication to last until the next clinical follow up appointment.

Medication-Assisted Treatment (MAT)

Medication-assisted treatment ("MAT") "is medication combined with counseling" to treat SUD.[188] MAT often uses one of three drugs – Suboxone, methadone, and/or Vivitrol – to relieve symptoms of withdrawal and cravings for opioids in conjunction with behavioral therapy.[189] Importantly, detox is not a prerequisite to undergoing MAT.[190] MAT can be offered through inpatient or outpatient federally licensed "opioid treatment programs" ("OTPs") as well as out of a primary care physician's office.[191] In addition, "[i]n Illinois, MAT is available for Medicaid-eligible individuals with OUD [opioid use disorder] without prior authorization mandates or lifetime limits."[192] However, some Medicaid managed care organizations ("MCOs") have created barriers around this law that functionally require a prior authorization for Suboxone, impeding access to care. In addition, most Medicare MCOs also require prior authorization for Suboxone.

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[185] So long as the physician has obtained a SAMHSA waiver, *see* "Buprenorphine Waiver Management," *Substance Abuse and Mental Health Services Administration*, last updated February 2, 2017, https://www.samhsa.gov/medication-assisted-treatment/buprenorphine-waiver-management.

[186] The Drug Addiction Treatment Act of 2000 35 U.S.C. § 3502 (2000), https://www.gpo.gov/fdsys/pkg/BILLS-106hr4365enr/pdf/BILLS-106hr4365enr.pdf. However, no special license is needed to administer methadone for pain management.

[187] 21 C.F.R. 1306.07(b). See also, "Emergency Narcotic Addiction Treatment," *Drug Enforcement Administration*, https://www.deadiversion.usdoj.gov/pubs/advisories/emerg_treat.htm.

[188] Barbara Andraka-Christou, "America Needs the TREAT Act: Expanding Access to Effective Medication for Treating Addiction," *Health Matrix* 26 (2016): 313.

[189] *Ibid*., 314.

[190] Jessica Reichert, Lily Gleicher, and Elizabeth Salisbury-Afshar, *An Overview of Medication-Assisted Treatment for Opioid Use Disorders for Criminal Justice-Involved Individuals* (Illinois Criminal Justice Information Authority, July 18, 2017) http://www.icjia.state.il.us/articles/an-overview-of-medication-assisted-treatment-for-opioid-use-disorders-for-criminal-justice-involved-individuals.

[191] "Medication and Counseling," *Substance Abuse and Mental Health Services Administration*, accessed on November 16, 2017, https://www.samhsa.gov/medication-assisted-treatment/treatment.

[192] Gov. Bruce Rauner, *State of Illinois Opioid Action Plan*, September 2017: 23, http://dph.illinois.gov/sites/default/files/publications/Illinois-Opioid-Action-Plan-Sept-6-2017-FINAL.pdf.

MAT has consistently been acknowledged, including by the U.S. Department of Health and Human Services, as "the most effective form of treatment for opioid use disorders."[193] Despite the overwhelming evidence of the effectiveness of MAT, it remains underutilized.[194] In order to increase MAT availability, the roundtable identified targeting primary care physicians to prescribe MAT, drug courts and prisons to implement MAT, and destigmatizing MAT in the public eye. In addition, the roundtable expressed concerns surrounding the use of Vivitrol in MAT.

As discussed throughout this white paper, primary care providers have an essential role to play in addressing the opioid epidemic because they "are the 'gateway' to medical treatment," their approval is often needed to see a specialist by health insurance, their fees are typically lower than specialists' fees, and they are the only physician available to many individuals.[195] Because of these unique qualities, combined with the epidemic-level of the opioid crisis, primary care providers should increase prescribing of MAT.

While primary care providers cannot prescribe methadone for SUD treatment[196] from their office, they can prescribe Suboxone as long as they receive a federal DATA – or SAMHSA – waiver, which is a relatively simple process.[197] Once a waiver is obtained, physicians may treat 30 patients with Suboxone "in the first year."[198] After the first year, the prescriber can apply for an increase in 100 patients.[199] Physicians who have prescribed buprenorphine to 100 patients for at least one year can now apply to increase their patient limits to 275 under new federal regulations.[200] Currently, there are only 213 physicians in Illinois with waivers allowing for 30 patients and 33 with waivers allowing for 100 patients.[201] Moreover, research indicates that the majority of physicians who obtained the federal waiver are not prescribing to the allowed capacity.[202] In a 2016 survey on why prescribing is low, physician respondents indicated: (1) "no time for more patients" and (2) "insufficient reimbursement."[203]

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[193] *Executive Summary: Opioid Abuse in the U.S. and HHS Actions to Address Opioid-Drug Related Overdoses and Deaths* (U.S. Department of Health and Human Services, 2015): 3, https://aspe.hhs.gov/system/files/pdf/122101/es_OpioidInitiative_0.pdf.

[194] Barbara Andraka-Christou, "America Needs the TREAT Act: Expanding Access to Effective Medication for Treating Addiction," *Health Matrix* 26 (2016): 314.

[195] *Ibid*., 342-3.

[196] Although those same prescribers can prescribe methadone for pain management from their offices and without waivers.

[197] "Buprenorphine Waiver Management," *Substance Abuse and Mental Health Services Administration*, lasted updated on February 9, 2017, https://www.samhsa.gov/medication-assisted-treatment/buprenorphine-waiver-management.

[198] Jim Sliwa, "Why Are Doctors Underusing a Drug to Treat Opioid Addiction?," *American Psychological Association*, August 3, 2017, http://www.apa.org/news/press/releases/2017/08/opioid-addiction.aspx.

[199] "Buprenorphine Waiver Management," *Substance Abuse and Mental Health Services Administration*, lasted updated on February 9, 2017, https://www.samhsa.gov/medication-assisted-treatment/buprenorphine-waiver-management.

[200] *Ibid*.

[201] "Number of DATA-Certified Physicians," *Substance Abuse and Mental Health Services Administration*, accessed on November 16, 2017, https://www.samhsa.gov/medication-assisted-treatment/physician-program-data/certified-physicians?field_bup_us_state_code_value=IL.

[202] Jim Sliwa, "Why Are Doctors Underusing a Drug to Treat Opioid Addiction?," *American Psychological Association*, August 3, 2017, http://www.apa.org/news/press/releases/2017/08/opioid-addiction.aspx.

[203] *Ibid*.

When surveyed on what "the resources most likely to increase [prescribers] willingness either to obtain waivers or prescribe to capacity were receiving information about local counseling resources, being paired with an experienced provider and receiving more continuing medical education courses on opioid disorder."[204] Often, primary care providers are hesitant to prescribe Suboxone because they feel they lack the behavioral health support necessary for an effective MAT program. Providing primary care physicians with these tools is the first step in increasing MAT provision in the primary care setting.

Research indicates that MAT can be very effective for individuals involved in the criminal justice system.[205] As such, both drug courts and prisons should implement MAT programs for individuals with SUD. In drug courts, MAT often is not only underused but also specifically disallowed such that "many drug court programs will not admit individuals who are already using methadone."[206] In Illinois, state law "prevents judges from barring drug court participants from using mediations such as methadone when prescribed by a doctor to treat" SUD.[207] However, allowing MAT patients to take their medication is not enough, as the final report from the President's Opioid Commission stresses, "drug courts need to embrace the use of medication-assisted treatment for their populations, as it clearly improves outcomes."[208] That is, drug courts should implement MAT into their program curriculum. It is unclear whether Cook County or any of the surrounding counties' drug courts including MAT as part of their programs.

In correctional facilities, implementing a MAT program is essential to address the fact that individuals recently released from incarceration are at a high risk for opioid-related overdose death. [209] As such, any MAT program in a correctional facility must provide a link to post-release programs. Despite the plethora of evidence showing high success of MAT programs in correctional facilities – individuals receiving MAT are 85% less likely to die of drug poisoning in the first month after release – very few programs have been implemented.[210] However, in July 2017, the City of Chicago announced the initiation of a MAT program in Cook County Jail.[211]

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[204] *Ibid*.
[205] Jessica Reichert, Lily Gleicher, and Elizabeth Salisbury-Afshar, *An Overview of Medication-Assisted Treatment for Opioid Use Disorders for Criminal Justice-Involved Individuals* (Illinois Criminal Justice Information Authority, July 18, 2017), http://www.icjia.state.il.us/articles/an-overview-of-medication-assisted-treatment-for-opioid-use-disorders-for-criminal-justice-involved-individuals.
[206] "Adult Drug Courts and Medication-Assisted Treatment for Opioid Dependence," *Substance Abuse and Mental Health Services Administration: In Brief* 8, no.1 (Summer 2014): 2-3, https://store.samhsa.gov/shin/content/ /SMA14-4852/SMA14-4852.pdf.
[207] Dan Petrella, "Bill allows medication-based treatment for drug court participants," *Northwest Indiana Times*, July 19, 2016, http://www.nwitimes.com/news/statehouse/illinois/bill-allows-medication-based-treatment-for-drug-court-participants/article_312ed5b7-3972-5e95-aaa2-30073cbca4f5.html.
[208] United States White House, *The President's Commission on Combating Drug Addiction and the Opioid Crisis: Final Report*, November 2017: 10, https://www.whitehouse.gov/sites/whitehouse.gov/files/images/Final_Report_Draft_11-1-2017.pdf.
[209] *Ibid*., 31.
[210] *Ibid*., 72.
[211] "Mayor Emanuel Announces City's Opioid Addiction Treatment Expansion," *Office of the Mayor City of Chicago*, July 20, 2017, https://www.cityofchicago.org/city/en/depts/mayor/press_room/press_releases/2017/july/OpioidAddictionTreatment.html.

Specifically, "Cermak Health will work with residents in Cook County Jail and bond court to provide medication-assisted treatment within the jail system."[212]

One of the few programs in place presently is New York City's Rikers Island Correctional Facility's Key Extended Entry Program ("KEEP"), which has proved effective not only in curbing death rates but in post-release recovery with "[b]etween 78 and 80 percent of inmates report[ing] to the aftercare program each year for four years."[213] Again, one of the recommendations forwarded by the President's Opioid Commission's final report is to increase MAT programs in prison.[214]

Despite that MAT is considered "the gold standard" of SUD treatment, strong stigma surrounds MAT, typically arising from misunderstandings about MAT and the misinformed view "that use of medication is simply replacing one drug for another."[215] The effect of such stigma is twofold: First, "[s]tigma attached to individuals who choose recovery with the assistance of medication – embarrassment shame, failure – increases individuals' reluctance to use medications as part of their treatment." [216] Second, stigma associated with MAT can make it more difficult for institutions and others wishing to implement the program to do so. Public backlash and lack of institutional buy-in can be a deep barrier to the provision of what extensive research has shown to be the best treatment available.

While stigma must be battled, it is important to remain cautious about the newest medication addition to MAT: Vivitrol. Many have expressed concerns regarding the Vivitrol lobby, which has targeted drug courts, prisons, and physicians in pushing the medication.[217] Importantly, physicians have expressed concern that there is not enough evidence available to properly evaluate whether Vivitrol is effective.[218] Moreover, the evidence that is available tends to be negative. For instance, a recent study sponsored by NIDA found that while Vivitrol could be as

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[212] "Mayor Emanuel Announces City's Opioid Addiction Treatment Expansion*," Office of the Mayor City of Chicago*, July 20, 2017, https://www.cityofchicago.org/city/en/depts/mayor/press_room/press_releases/2017/july/OpioidAddictionTreatment.html.

[213] Jessica Reichert, Lily Gleicher, and Elizabeth Salisbury-Afshar, *An Overview of Medication-Assisted Treatment for Opioid Use Disorders for Criminal Justice-Involved Individuals* (Illinois Criminal Justice Information Authority, July 18, 2017) http://www.icjia.state.il.us/articles/an-overview-of-medication-assisted-treatment-for-opioid-use-disorders-for-criminal-justice-involved-individuals.

[214] United States White House, *The President's Commission on Combating Drug Addiction and the Opioid Crisis: Final Report*, November 2017: 72, https://www.whitehouse.gov/sites/whitehouse.gov/files/images/Final_Report_Draft_11-1-2017.pdf.

[215] Jessica Reichert, Lily Gleicher, and Elizabeth Salisbury-Afshar, *An Overview of Medication-Assisted Treatment for Opioid Use Disorders for Criminal Justice-Involved Individuals* (Illinois Criminal Justice Information Authority, July 18, 2017) http://www.icjia.state.il.us/articles/an-overview-of-medication-assisted-treatment-for-opioid-use-disorders-for-criminal-justice-involved-individuals.

[216] *Ibid*.

[217] Abby Goodnough and Kate Zernike, "Seizing on Opioid Crisis, a Drug Maker Lobbies Hard for Its Product," New York Times, June 11, 2017, https://www.nytimes.com/2017/06/11/health/vivitrol-drug-opioid-addiction.html.

[218] "A Drugmaker Tries to Cash in on the Opioid Epidemic, One State Law at a Time," *NPR*, June 12, 2017, https://www.npr.org/sections/health-shots/2017/06/12/523774660/a-drugmaker-tries-to-cash-in-on-the-opioid-epidemic-one-state-law-at-a-time.

effective as Suboxone once initiated, a major barrier to initiation exists, namely that a patient must be fully detoxed in order to begin Vivitrol.[219]

Integrated Mental and Behavioral Health Care

Mental illness is correlated with SUDs. "People with a mental disorder are more likely to experience a SUD and people with a SUD are more likely to have a mental disorder when compared with the general population."[220] This "coexistence of both a mental health and a SUD is referred to as a co-occurring disorder."[221] Treatment for a SUD will be unsuccessful if person is not receiving treatment for underlying mental health issues.[222] While counseling is an integral part of MAT, specific counseling and other treatment for co-occurring mental illness needs more attention. Two recommendations emerged from the roundtable: first, integrating mental health care into treatment programs, and second, addressing the silos of medical, mental, and addiction care providers.

First, integrated treatment is "treatment that addresses mental and substance use conditions at the same time."[223] SAMHSA recommends that integrated treatment programs utilize one practitioner – or a case manager[224] – who is "trained in psychopathology, assessment, and treatment strategies for both mental illness and SUD."[225] Use of motivational interventions, cognitive-behavioral therapy, varying formats of treatment such as group therapy and peer-to-peer counseling, and coordination between medication provision are also recommended.[226] Such treatment is extremely successful and is "associated with lower costs and better outcomes" including "reduced substance use, improved psychiatric symptoms and functioning, decreased hospitalization, increased housing stability, fewer arrests, and improved quality of life."[227]

A major barrier to integrated treatment, as well as mental health treatment generally, is reimbursement and coverage by Medicaid and health insurance plans. As a general matter, reimbursement and coverage by health insurers and Medicaid for mental health services provided by psychologists and social workers needs to increase. The Mental Health Parity and Addiction Equity Act "prevents group health plans and health insurance issuers that provide mental health or SUD benefits from imposing less favorable benefit limitations on those benefits than on

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[219] German Lopez, "A new study found a big problem with a popular opioid addiction medication," *Vox*, November 15, 2017, https://www.vox.com/science-and-health/2017/11/15/16653718/study-buprenorphine-naltrexone-suboxone-vivitrol.
[220] "Treatment for Co-occurring Mental and Substance Use Disorders," *Substance Abuse and Mental Health Services Administration*, last updated on September 20, 2017, https://www.samhsa.gov/treatment#co-occurring.
[221] "Co-occurring Disorders," *Substance Abuse and Mental Health Services Administration*, last updated on March, 8, 2016, https://www.samhsa.gov/disorders/co-occurring.
[222] "Treatment for Co-occurring Mental and Substance Use Disorders," *Substance Abuse and Mental Health Services Administration*, last updated on September 20, 2017, https://www.samhsa.gov/treatment#co-occurring.
[223] *Ibid*.
[224] Substance Abuse and Mental Health Services Administration, *Comprehensive Case Management for Substance Abuse Treatment* (2000): 13, https://store.samhsa.gov/shin/content/SMA15-4215/SMA15-4215.pdf.
[225] *Building Your Program: Integrated Treatment for Co-Occurring Disorders* (SAMHSA, 2009): 2-4, https://store.samhsa.gov/shin/content/SMA08-4367/BuildingYourProgram-ITC.pdf.
[226] *Ibid.*
[227] "Treatment for Co-occurring Mental and Substance Use Disorders," *Substance Abuse and Mental Health Services Administration*, last updated on September 20, 2017, https://www.samhsa.gov/treatment#co-occurring.

medical/surgical benefits."[228] However, more policies need to be implemented to remove loopholes in this bill as well as increase coverage of mental health services in other areas.

Another major barrier is the federal Institutes for Mental Diseases exclusion in the Medicaid program. This exclusion "prohibits federal Medicaid funds from reimbursing services provided in an inpatient facility treating 'mental diseases' (including SUDs) that have more than 16 beds."[229] Federal legislation should be passed to repeal the exclusion altogether and until then, the Department of Health and Human Services Secretary should, as recommended by the President's Opioid Commission "immediately grant waivers to each state that requests one."[230]

Second, as described above, "integrated treatment requires collaboration across disciplines."[231] An important and necessary part of appropriately and successfully treating co-occurring conditions is addressing the silos of medical, mental, and addiction care providers. Primary care providers and other SUD treatment providers must understand and recognize mental health issues and integrate mental health into their practice and treatment programs. Similarly, mental health professionals must be able to recognize SUDs. In addition, hospitals and other acute care settings must work in conjunction with mental health care professionals and others to better treat patients with chronic conditions like SUD and co-occurring conditions, connecting them to long-term care.

As discussed above in reference to SUD, it is particularly important for primary care providers to be able to understand, recognize, and ensure a bridge to next level care for mental health issues. Because mental illness, like SUD, is highly stigmatized, many patients will not come into contact with mental health professionals. Therefore, the responsibility falls to primary care providers to initiate mental health interventions.

Wrap-Around Services

Wrap-around services are defined as "psychosocial services that treatment programs may provide to facilitate access, improve retention and address clients' co-occurring problems."[232] Without such services, many patients, especially marginalized and indigent patients, will not be successful in treatment programs. As such, "[f]ederal law requires patients who receive treatment in an OTP [opioid treatment program] to receive…counseling, vocational, educational, and other assessment and treatment services" in addition to any medication.[233] Three major categories of wrap-around services identified at the roundtable as crucial are: housing, employment, and child care.

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[228] Center for Consumer Information & Insurance Oversight, *Factsheet: Mental Health Parity and Addiction Equity Act*, https://www.cms.gov/cciio/programs-and-initiatives/other-insurance-protections/mhpaea_factsheet.html.
[229] United States White House, *The President's Commission on Combating Drug Addiction and the Opioid Crisis: Interim Report*, https://www.whitehouse.gov/sites/whitehouse.gov/files/ondcp/commission-interim-report.pdf.
[230] *Ibid*.
[231] "Treatment for Co-occurring Mental and Substance Use Disorders," *Substance Abuse and Mental Health Services Administration*, last updated on September 20, 2017, https://www.samhsa.gov/treatment#co-occurring.
[232] Etheridge and Hubbard, "Conceptualizing and assessing treatment structure and process in community-based drug dependency treatment programs," *Substance Misuse* 35 (October 2000).
[233] "Medication and Counseling Treatment," *Substance Abuse and Mental Health Services Administration*, last updated on September 28, 2015, https://www.samhsa.gov/medication-assisted-treatment/treatment.

Housing: Access to safe and healthy living environments is a necessary element of recovery.[234] Because housing is integral to recovery, a housing plan should be included in treatment programs. Moreover, Medicaid and other health insurance plans should reimburse and provide coverage for patients who use treatment housing – whether inpatient treatment or transitional housing. A key issue is access to recovery housing for MAT patients, who are often excluded from sober living environments based on the misunderstanding that a person taking medication prescribed through MAT is not sober.

Two major housing models in treatment are: (1) treatment first programs, and (2) housing first programs. Treatment first housing programs typically "require detoxification and sobriety before giving access to services such as independent housing."[235] Treatment first housing is "characterized by alcohol-and-drug-free living settings" and "peer support and other addiction recovery aids."[236] Treatment first housing typically falls into one of four broad categories: (1) peer-run housing, (2) monitored sober living, (3) supervised housing, and (4) residential treatment housing.[237]

A significant problem identified by the roundtable discussion is that treatment first housing's abstinence rule very often disallows patients who are undergoing MAT.[238] As discussed throughout the white paper, a common misunderstanding about MAT is that the medication component of MAT programs is "that it substitutes one drug for another" and thus means patients taking such medication are not "sober."[239] However, MAT medication is simply a medication to treat an illness just like any other illness like insulin for diabetic patients, for instance. Therefore, treatment first housing programs should not exclude MAT patients from their facilities.

The second housing model, housing first, "rank[s] stable housing as the first and highest priority vis-à-vis abstinence from substance use."[240] Other characteristics of a housing first model include low barrier admission policies, rapid and streamlined access to housing, and voluntary supportive services.[241] Typically, unlike most recovery housing, the housing first model ensures

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[234] "Affording Housing Models and Recovery," *Substance Abuse and Mental Health Services Administration*, last updated on April 19, 2016, https://www.samhsa.gov/homelessness-programs-resources/hpr-resources/affording-housing-models-recovery.
[235] Deborah K. Padgett, Leyla Gulcur, Sam Tsemberis, "Housing First Services for People who are Homeless with Co-occurring Serious Mental Illness and Substance Abuse," *Research on Social Work Practice* 16, no. 1 (2006), http://journals.sagepub.com/doi/pdf/10.1177/1049731505282593.
[236] "Affording Housing Models and Recovery," *Substance Abuse and Mental Health Services Administration*, last updated on April 19, 2016, https://www.samhsa.gov/homelessness-programs-resources/hpr-resources/affording-housing-models-recovery.
[237] *Ibid*.
[238] U.S. Department of Health and Human Services, *Rights of Individuals on Medication-Assisted Treatment* (2009): 10, http://atforum.com/documents/Know_Your_Rights_Brochure_0110.pdf.
[239] "Misconceptions around Medication Assisted Treatment: a Pharmacist's View," *Axial Healthcare*, May 24, 2017, https://axialhealthcare.com/resources/blog/misconceptions-around-medication-assisted-treatment-pharmacists-view/.
[240] Deborah K. Padgett, Leyla Gulcur, Sam Tsemberis, "Housing First Services for People who are Homeless with Co-occurring Serious Mental Illness and Substance Abuse," *Research on Social Work Practice* 16, no. 1 (2006), http://journals.sagepub.com/doi/pdf/10.1177/1049731505282593.
[241] Department of Housing and Urban Development, *Housing First in Permanent Supportive Housing*, https://www.hudexchange.info/resources/documents/Housing-First-Permanent-Supportive-Housing-Brief.pdf.

tenants have full rights, responsibilities, and legal protections.[242] It does not appear that MAT patients experience discrimination in this setting.

Access to safe and healthy housing is an important element to recovery and treatment programs should include access to housing to individuals who need it. Importantly, MAT patients who need access to housing should not be discriminated against because of their medications. While housing may be accessible to MAT patients through programs taking a housing first approach, for those who wish to stay in a sober living environment, it is essential they have access to one.

Employment: Employment is "associated with improved recovery rates."[243] In fact, research shows that "employment before or during substance abuse treatment predicts both longer retention in treatment and the likelihood of a successful outcome."[244] Moreover, studies indicate employment helps to prevent relapse.[245] Indeed, "'work can serve as a rehabilitative tool and be an integral part of the process of stabilizing [any] mental illness and attaining sobriety.'"[246]

Given the evidentiary support of employment's positive effect on recovery, SAMHSA recommends treatment programs include services to help patients gain employment such as vocational training.[247] Moreover, federal law entitles "those with substance abuse disorders to receive VR [vocational rehabilitation] services funded by Federal and State governments."[248]

Child Care: Individuals with SUD "are more likely to enter and remain in substance abuse treatment" if they have access to child care.[249] Research shows that some parents with SUD "avoid seeking substance abuse treatment because they fear losing custody of their child in the absence of child care."[250] Child care provides (1) an immediate benefit of the recovery of the parent but also (2) a later benefit of the child(ren) who will gain access to early childhood supportive setting and steer them away from potential SUD development in the future.

However, access to child care for individuals with SUD, especially single and low-income parents, is often difficult.[251] Given the barriers to accessing child care and the benefits to people with SUD and children of individuals with SUD, treatment programs should offer child care services where appropriate.

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[242] Department of Housing and Urban Development, *Housing First in Permanent Supportive Housing*, https://www.hudexchange.info/resources/documents/Housing-First-Permanent-Supportive-Housing-Brief.pdf.
[243] United States White House, *The President's Commission on Combating Drug Addiction and the Opioid Crisis: Final Report*, November 2017: 29, https://www.whitehouse.gov/sites/whitehouse.gov/files/images/Final_Report_Draft_11-1-2017.pdf.
[244] Substance Abuse and Mental Health Services Administration, *Integrating Substance Abuse Treatment and Vocational Services* (2014): 2, https://store.samhsa.gov/shin/content/SMA12-4216/SMA12-4216.pdf.
[245] *Ibid*.
[246] *Ibid*.
[247] *Ibid*.
[248] *Ibid*., 19.
[249] Jonathan David Brown, Sonya Vartivarian, and Cathie E. Alderks, "Child Care in Outpatient Substance Abuse Treatment Facilities for Women: Findings from the 2008 National Survey of Substance Abuse Treatment Services, *Journal of Behavioral Health Services & Research* 38, no. 4 (October 2011): 478, https://link.springer.com/content/pdf/10.1007%2Fs11414-011-9235-1.pdf.
[250] *Ibid*., 479.
[251] *Ibid*.

CONCLUSION: NEXT STEPS

Interdisciplinary engagement at every level of the opioid response is vital to successfully address the opioid epidemic in Chicago. Interdisciplinary engagement means formally and informally working across sectors on every policy and solution moving forward. The roundtable from which this white paper is derived convened experts from across diverse disciplines in the Chicago area to distill key steps forward:

- Integrate treatment for SUD, as well as co-occurring mental health issues, into **primary care**.
- Increase **coordination within the health sector** between mental, medical, and SUD treatment providers to improve treatment success.
    - Encourage coordinated Medicaid payments to managed care organizations (MCOs) and providers with the goal of integrated medical and behavioral health care, with special attention paid to easily accessed trauma-informed mental health care.
- Improve **data** collection, analysis, and information sharing across sectors to allow all key stakeholders to make evidence-based, data-informed decisions regarding the epidemic.
    - Encourage and publicize social science and public health research into workable interventions to address the income and opportunity gaps prevalent in communities of color so greatly affected by the opioid crisis.
- Decrease **stigma** surrounding SUD, substance use, and mental and behavioral health issues.
- Improve the PMP at the state level as well as encourage a national PMP program allowing prescribers to see their patients prescription history beyond one state.
- Appropriately and safely adjust **prescribing practices** and increase access and availability of non-opioid interventions and alternatives for pain management, including better reimbursement for non-opioid pain treatment.
    - With professional provider input, create a plan for education and intervention for those providers who are heavy prescribers of opioids, and publicize those efforts to all providers.
- Decrease the influx of illicit opioids in Chicago.
- Expand access and use of **naloxone** in emergency response, primary care, and hospitals.
- Adapt the role of the **criminal justice system** away from ineffective practices of cyclic arrest and toward compassionate and comprehensive treatment of those with SUD through pre-arrest diversion and drug courts.
    - Integrate information on SUD, overdoses, and treatment in the training of all law enforcement officials, including how to help a person with a SUD and prioritizing areas most affected by overdose deaths.
    - Identify pilots and interventions for those who need continuing SUD treatment on release from jail or prison.
- Reevaluate effectiveness and content of detox programs and ensure all programs include follow-up after discharge from hospital.

- Incorporate support and **"wrap-around" services** into SUD treatment programs especially for housing, employment, and child care.
- Increase the use and funding of **medication-assisted treatment ("MAT")** in all aspects of SUD treatment including and especially in drug courts, prisons, primary care, and recovery housing.

While the opioid crisis has been operating at epidemic levels for some time, the most recent data shows that opioid-related overdose deaths are still on the rise. Stakeholders have struggled to appropriately respond to the epidemic despite long knowing of its existence and repeated attempts at solutions. Society's approach to date is, simply put, not working. Cresting the arc of the opioid epidemic ultimately comes down to the development of a coordinated, interdisciplinary response, which is what this white paper and the preceding roundtable aims to initiate in the Chicago area.

STEP ONE – ADMITTING WE HAVE A PROBLEM

LEADERSHIP RESPONSES TO THE OPIOIDS EPIDEMIC AT FEDERAL, STATE, AND LOCAL LEVELS

Keynote Address by Ed Siskel
Corporation Counsel, City of Chicago
Northwestern University Access to Health Roundtable
October 27, 2017

Some Hard Statistics on the Opioids Crisis:

- Overdoses killed more people in 2016 than guns or car accidents.
- Overdose deaths are occurring at a pace faster than the HIV epidemic at its peak in the early 1990s.
- In 2015, over 97 million people took prescription painkillers; of these, 12 million (1 in 8) took painkillers that were not prescribed by a doctor.
- In Chicago alone, there were over 700 deaths due to opioid overdose in 2016, a 74% increase from the year before. The increase was driven by a nearly 600% increase in deaths due to illicit fentanyl.
- A recent CDC report found that “In 2015, the amount of opioids prescribed was enough for every American to be medicated around the clock for 3 weeks.” Opioids are being prescribed at a higher rate than anywhere else in the world, over 33% higher than next nearest comparator nations (Canada and Germany).

Recent highlights of federal response:

- March 2016 – U.S. Center for Disease Control and Prevention released its Guideline for Prescribing Opioids for Chronic Pain, together with educational resources on opioid prescribing intended for primary care doctors treating chronic pain.

- July 2016 – President Obama signed into law the Comprehensive Addiction and Recovery Act, which legislated action on prevention and education, treatment, law enforcement efforts, and substance abuse recovery. Obama made clear that the bill needed significantly more funding to turn the tide on the opioid epidemic.

- August 2017 – President Trump's Commission on Drug Addiction and The Opioid Crisis issues its interim report recommending that the President declare the opioid crisis a national emergency. The Commission's report found that 142 Americans die from opioid overdoses every day. Commission recommendations included: passage of legislation that shields people who report overdoses from criminal prosecution, an expansion of Medicaid-funded drug treatment, and a requirement that law enforcement officers carry naloxone to counteract the effects of opiate overdose.

Recent highlights of federal response:

- Yesterday, President Trump directed HHS to declare the opioid crisis a "public health emergency" under the Public Health Service Act.

- Key features of the announcement include:
  - Use of telemedicine to prescribe "medicine commonly used for substance abuse or mental health treatment"
  - Temporary appointment of specialists by HHS or at governors' request
  - DOL "dislocated worker grants" – subject to available funds
  - Shifts resources within HIV/AIDS programs.
  - Section 1135 waivers – allowing Medicaid reimbursement for inpatient facilities with more than 16 beds that treat addiction?

- What's not included:
  - Allowing HHS to negotiate lower prices on naloxone.
  - A substantial commitment of resources.

Recent highlights of federal response:

- Ensuring Patient Access and Effective Drug Enforcement Act – Two Key Provisions:
  - Corrective Action Plan
  - Imminent Danger to Public Health and Safety for Immediate Suspension Orders

- Potential impact on enforcement -- Judge John Mulrooney, DEA Chief ALJ :
  - On the CAP provision – It is "akin to a state legislature mandating that law enforcement authorities allow shoplifting suspects caught in the act to outline how they intend to replace purloined items on store shelves; allow intoxicated drivers to pull to the side of the road and park their previously swerving vehicles; or perhaps allow bank robbers to round up and return ink-stained money and agree not to rob any more banks – all before any of those wrongdoers actually admit fault and without any consequences that might deter such behavior in the future."
  - On the definition of imminent danger – "If it had been the intent of Congress to completely eliminate the DEA's ability to ever impose an immediate suspension on distributors or manufacturers, it would be difficult to conceive of a more effective vehicle for achieving that goal."

Significant state/local response efforts:

- In 2015, Illinois's state legislature passed the Heroin Crisis Act, sweeping legislation that addressed reversing of overdoses, reimbursing patients for more substance abuse treatment, educating stakeholders, and improving data collection.

- 2015-2016 – Chicago/Cook County Task Force on Heroin. After the Task Force's members conducted months of public hearings, research, and deliberation, the Task Force made recommendations regarding: (1) education of community members; (2) education of health care professionals; (3) robust sharing and collection of data across law enforcement and public health departments and organizations; and (4) comprehensive improvements to enable expanded access to treatment, to create drop-off centers for unused medications, for expanded assistance to primary care centers, and to enhance medication-assisted treatment programs.

- State legislation/rules limiting the initial amount of opioids practitioners can prescribe (Connecticut, Delaware, Indiana, Kentucky, Maine, Massachusetts, New Jersey, New York, Ohio, Pennsylvania, Rhode Island, and Vermont)

Chicago sues the opioid manufacturers :

- June 2014 – Chicago initiated its lawsuit against five major opioid pharmaceutical manufacturers on consumer fraud, false claims, and other theories.
- June 2015 – Chicago settles with Pfizer (not sued as a defendant); portion of settlement proceeds earmarked for naloxone purchases for local Chicago agency first responders.
- September 2016 – Chicago files its Third Amended Complaint, and the case proceeds to discovery against all manufacturers.
- September 2017 – 46 cities/counties out of 66 similar pending federal lawsuits nationwide) moved for transfer of all cases for coordinated or consolidated pretrial proceedings before the Judicial Panel on Multidistrict Litigation (MDL).

Chicago's other affirmative steps :

- City Council passed legislation requiring all pharmaceutical representatives who market and promote opioids in the City to become licensed. City is using fees from pharmaceutical representative licensing to increase the City's funding of drug treatment by 50 percent.

- City Council passed legislation requiring pharmaceutical representatives to undergo ethics training and share data, including what drugs they are pitching to doctors, what free samples they provide, and to disclose if they are paying doctors for their time.

- Chicago is making increased investments in education, treatment, and prevention of opioids abuse. Chicago made a new $250,000 investment in naloxone, an overdose antidote that saved over 1,500 lives in the City in 2016.

- Chicago Fire Department units are armed with naloxone to reverse suspected overdoses. 75 ambulances, 72 fire companies, and all paramedic field chiefs on duty 24/7 carry naloxone for opioid overdose reversal.

Chicago's other affirmative steps :

- In 2015, Chicago's Department of Public Health educated healthcare providers by disseminating newsletters on appropriate opioid prescribing practices to over 11,000 physicians in the City.

- Chicago has urged its insurance and workers compensation carriers, and the pharmacy benefit managers who work with Chicago's health insurance plans, to implement changes in how opioids are prescribed and covered, and to distribute CDC's March 2016 Guideline for Prescribing Opioids for Chronic Pain to all doctors and health care providers in Chicago and neighboring suburbs.

- Chicago Police Department now has drop boxes at all police stations, where residents can dispose of expired prescriptions and other drugs.

Metrics for success?

- Reform of marketing practices
- Penalties commensurate with the damage caused
- Funding to support prevention and treatment
- Ensuring implementation of the CDC Guidelines