NIC
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COLLABORATIVE

The Opioid Use Disorder Prevention Playbook

FEBRUARY 2019 • THE PLAYS

Acknowledgements

The National Interoperability Collaborative (NIC) Opioid Use Disorder Prevention Playbook was researched and written by Paul Wormeli, a member of the Stewards of Change Institute (SOCI) Board of Directors. It was edited by Adam Pertman, an SOCI senior consultant and NIC's Coordination and Communications Director. NIC is an initiative of SOCI.

This NIC playbook addresses the most-significant public health emergency in modern U.S. history by focusing on an aspect of the epidemic that we believe has received far too little attention: prevention. This collection of ideas, approaches and strategies – or plays – is derived from the growing number of efforts by practitioners, researchers and policy-makers around the country to "get upstream" of this national crisis, in addition to providing treatment and saving lives.

The feedback from reviewers of earlier drafts of this document has been invaluable in shaping this collection of plays, which we hope will not only focus greater national attention on prevention, but also will provide guidance on specific actions that communities, jurisdictions, governments and organizations can take toward prioritizing that end. We acknowledge and appreciate the constructive contributions to this playbook from the following:

Melinda Baldwin, PhD, Child Welfare Department Specialist at the Administration for Children and Families, U.S. Department of Health and Human Services

Mannone A. Butler, Esq, Executive Director of the Criminal Justice Coordinating Council

Kate Garvey, Director of the Department of Community and Human Services of Alexandria, VA

Fran Gerbig, MPH, OCPC, Assistant Executive Director of Prevention Action Alliance

Sean Gunderson, Co-Founder of iTether Technologies Inc.

William Hazel, MD, Senior Advisor for Strategic Initiatives and Policy at George Mason University; former Secretary of Health and Human Resources for the Commonwealth of Virginia; and member of the Board of Directors of the Stewards of Change Institute

Linda Hill, Director of the Archer Group and former Executive Director of Stafford Junction

Bryant Thomas Karras, MD, Chief Public Health Informatics Officer, Washington State Department of Health; founding member of the International Society for Disease Surveillance

Anna Lembke, MD, Associate Professor and Medical Director of Addiction Medicine, Stanford University School of Medicine; Program Director of the Stanford Addiction Medicine Fellowship; and Chief of the Stanford Addiction Medicine Dual Diagnosis Clinic

Robert May, Assistant Director of Program Services at the IJIS Institute

Tanya L. Stauffer, Practice Director at Analysts International Corporation and Board Member at the IJIS Institute

Chris Traver, Senior Advisor for Information Sharing at the Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services

We also sincerely thank the Kresge Foundation for providing the funding and vision that enabled the Stewards of Change Institute and its leadership partner, AcademyHealth, to create NIC. In addition, we are very grateful to IBM, Microsoft and the Annie E. Casey Foundation for their support in launching NIC. Finally, we extend our deep appreciation to all of the passionate people throughout the United States who are working every day to combat the devastating opioid epidemic.

Sincerely,

Daniel Stein, Co-Principal Investigator of NIC
President, Stewards of Change Institute

The Plays

The word "play" in this document refers to a specific idea, initiative or strategy that a community, jurisdiction, government and/or organization might select to bolster collaborative efforts to prevent opioid use disorders. The play descriptions attempt to define purposes, goals and objectives, theories of change, ways to implement the strategy, evidence of the previous success or lack thereof, and resources for further study/examination. These plays are intentionally short synopses of current knowledge, designed to be a starting point for group discussion and further exploration of how each might benefit the population served.

This list is not exhaustive. Many strategies have been proposed and many trials have been conducted as the entire nation seeks answers to the question of how to cope with this historic epidemic. We selected the plays below because they appear to have traction by virtue of their perceived or actual positive value/impact. Research to provide concrete evidence of the success of various strategies (plays) has been emerging over the past decade, but there are still many that have not been exposed to evidentiary evaluations.[28] Inclusion of the plays on this list was based either on demonstrable evidence of their value or actual impact.

1. Remove the stigma

Addiction is a disease. Educating the public, health care professionals, health care systems and plans, community organizations and law enforcement about that reality – and, as a result, about the need for prevention, detection and treatment with a comprehensive team approach – may be the most important component of any program to stem the tide of opioid use disorders.

There is considerable research about the extent to which the stigma of drug use or misuse impedes the prevention or treatment of the problem. In a paper on this topic, SAMHSA explores the extent to which words matter in the effort to address misuse.[29] In addition, the negative effects of the stigma associated with substance use disorder have been documented, as has discrimination in employment and social relationships.[30]

Substance use disorders are often treated as a moral and criminal issue, rather than as a health concern. This is especially true of illegal substances, which are perceived more negatively than legal ones. The use of particular substances (e.g. heroin) has not only been deemed deserving of social disapproval and moral condemnation, but has

also been designated as a crime. This criminalization exacerbates stigma and produces exclusionary processes that deepen the marginalization of people who use illegal substances. Therefore, the social processes and institutions created to control substance use may actuality contribute to its continuation.[31]

An article proposing to frame the opioid epidemic as a public health issue states that:

> *The national dialogue around opioids has been dominated by several approaches that on their own are inadequate or harmful. "War on drugs" approaches that would increase arrests and incarceration to deter drug use and distribution have had long-term scarring effects on many communities, primarily those of color, without measurably reducing access to street drugs. Likewise, defining drug use as an individual's moral failing that can be remedied through willpower alone is inconsistent with biological triggers that create susceptibility to addiction. The moral failing approach also fails to recognize the role of trauma and adverse childhood experiences in addiction. Most importantly, the willpower approach lacks evidence for efficacy. Likewise, a single-minded focus on abstinence led to opposition from several self-help advocates against highly effective treatments such as methadone, buprenorphine, and harm reduction. Moving beyond moralized and punitive approaches to addiction could help reduce stigma and increase acceptance of treatment, not only for people who use opioids but also for the safety and wellbeing of society at large*.[32]

Considerable research has found that there are positive effects on recovery from efforts to remove the stigma associated with substance use disorder, both from professional interactions with the patient and self-inflicted stigma.[33]

Programs aligned with this play will seek to change the culture of interaction with those who have substance use disorders. The specific components include educational programs, small group discussions, seminars and training in specific approaches, and language that professionals – ranging from police to health care providers – should avoid. Rachel Wurzman gives this Ted talk on how social isolation fuels opioid addiction.

Changing the cultural view of substance use disorders will require the development of a shared vision between public safety and public health, as well as other stakeholders. Committees or task forces dedicated to just this initiative could be helpful in developing such a vision.

Goals and Objectives

The goal of this play is to reduce the effect of stigma in interactions between individuals with substance use disorders and the professionals with whom they come into contact, as well as the effect of behaviors related to self-stigma. Creating non-judgmental interaction patterns can increase the probability of recovery and reduce the likelihood of continued disorders.

Theory of Change

If the environment of interaction by professionals (police, health care providers, etc.) can be become more non-discriminatory and non-judgmental, there is a higher probability that the road to recovery will be shorter and more likely to result in a positive outcome.

Example

The Toronto Drug Strategy Implementation Panel has published a report on its initiative to deal with the stigma problem. It includes recommendations for program content.

Resources

SAMSHA has developed a brochure on how to create a stigma-reduction initiative.

Ohio created a brochure to describe better language about substance use disorders.

The Central East Addiction Technology Transfer Center has published an anti-stigma toolkit that provides a comprehensive set of guidelines for reducing stigma related to substance use disorder. It is available at https://attcnetwork.org/centers/new-england-attc/coming-light-breaking-stigma-substance-use-disorders

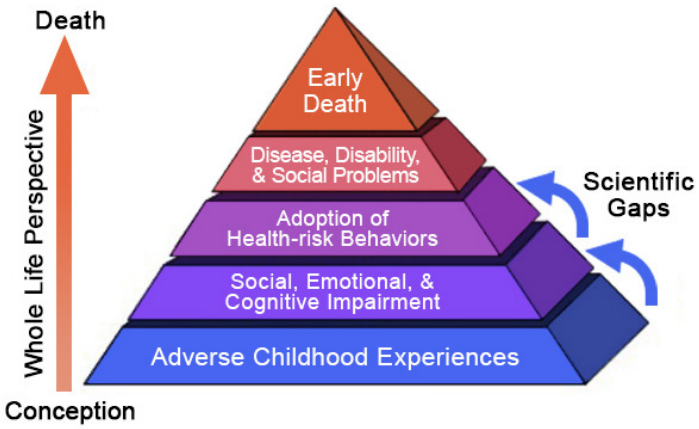
Shatterproof has a useful guide on language that should be avoided in dealing with people suffering from substance use disorder.

2. Reduce the risk of developing an opioid use disorder [34]

According to the Center for the Application of Prevention Technologies (CAPT) in SAMHSA, adverse childhood experiences (ACEs) – including stressful or traumatic events such as abuse and neglect – are "strongly related to the development and prevalence of a wide range of health problems throughout a person's lifespan, including those associating with substance misuse." This image from CAPT illustrates the impact of ACEs throughout a lifetime.

In a policy brief, the Campaign for Trauma-Informed Policy and Practice reports a recent study that finds "over 80% of the patients seeking treatment for opioid addiction had at least one form of childhood trauma, with almost two-thirds reporting having witnessed violence in childhood."[35] A 2017 study showed that, even in people over 50, mental health issues and substance use disorders are significantly associated with ACEs, leading to the conclusion that prevention strategies should take this correlation into account.[36]

The research on this topic began with a foundational study of ACEs in 1998. In this significant work, persons who had experienced four or more categories of childhood exposure, compared to those who had experienced none, had 4- to 12-fold increased health risks for alcoholism, drug abuse, depression and suicide attempts, among other negative outcomes.[37]



Source: Center for the Application of Prevention Technologie

SAMHSA has developed a Strategic Prevention Framework (SPF) as a planning process for preventing substance misuse. SPF's five steps and two guiding principles offer prevention professionals a comprehensive process for addressing substance misuse and related behavioral health problems. SPF's effectiveness begins with a clear understanding of community needs and involves community members in all stages of the planning proces

The steps of SPF include:

Step 1: Assess Needs: What is the problem, and how can I learn more?

Step 2: Build Capacity: What do I have to work with?

Step 3: Plan: What should I do and how should I do it?

Step 4: Implement: How can I put my plan into action?

Step 5: Evaluate: Is my plan succeeding?

SPF also includes two guiding principles:

1.Cultural competence: The ability to interact effectively with members of diverse populations

2.Sustainability: The process of achieving and maintaining long-term results[38]

Ohio has developed its own version of the SPF to create the Ohio Strategic Planning Framework as it is applied to the opioid crisis.

Goals and Objectives

The development of one or more plays that address the impact of ACEs on the development of substance use disorders is a very important component of a community strategy for prevention. The goal is to halt or reduce the extent to which ACEs leads to substance use disorder or that influences the development of such disorders. It could be argued that policies and programs directly aimed at reducing the prevalence of ACEs is in itself an aspect of prevention strategies in as much as we have seen the high correlation with substance use disorder.

Objectives for each such initiative under the play could be structured to reduce the propensity for substance use disorder by a specified percentage within a specified time period for a particular set (cohort) of people having a common ACEs scoring.

Theory of Change

A significant number of studies have strongly concluded that reducing exposure to adverse childhood experiences will reduce the likelihood of a person developing a substance use disorder. Well-documented programs that can have this effect include: home visiting, parenting assistance, parent/child interaction therapy and others that focus on the reduction of ACEs. [39] The theory of change is that by offering evidentiary-based programs that reduce the number of ACEs, the likelihood of fostering the development of a substance use disorder is lessened.

Another relevant theory applies to the design of treatment programs for current addicts. By improving the resilience of those having an experience leading to a substance use disorder, the perpetuation of this condition can be reduced or eliminated.

Examples

Seeking Safety,[40] an approach developed by Dr. Lisa Najavits, addresses trauma-related problems and substance use at the same time. It is the most evidence-based model for people with both trauma and addiction. Seeking Safety can be delivered by peers, as well as by counselors or other professionals. Seeking Safety is also the lowest-cost evidence-based model available for trauma and addiction, and has shown especially strong results for heavy drug users.

Dr. Stephanie Covington has developed several evidence-based, gender-responsive programs: ***Helping Women Recover, Beyond Trauma and Beyond Violence.*** The two newest interventions are Healing Trauma: ***A Brief Intervention for Women and Exploring Trauma: A Brief Intervention for Men.*** All the programs incorporate knowledge about gender differences in risks of and responses to trauma. Treatment strategies include approaches for treating trauma

and substance use disorders: cognitive-behavioral, mindfulness, body-oriented (i.e., yoga) and expressive arts.[41]

The City of Martinsburg, WVA, has developed an innovative collaboration between law enforcement and the schools, also including other stakeholders, to directly approach ACEs as a preventive measure against opioid use disorder. This program provides evidence of progress in reducing the level of the problem in this jurisdiction.[42]

The RxSafe program in Marin County, CA, has invested in a community prevention action team to explore the upstream factors that facilitate the development of opioid use disorders, as part of a comprehensive community-based approach to the opioid crisis.[43]

The Ohio Department of Mental Health and Addiction Services (OhioMHAS), Bureau of Prevention, has adopted a strategic planning process that combines the Prevention Institute's Adverse Community Experiences and Resilience Framework with SAMHSA's Strategic Prevention Framework to develop multi-sector collaboration addressing opioid use disorders. The Ohio approach takes a community trauma approach that galvanizes efforts to explore community and environmental factors of health that can be addressed by a coalition of participants.[44]

The Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act (H.R.6), which focuses on changing provisions to state Medicaid programs and Medicare requirements to address substance use disorders (SUDs), incorporates language related to trauma-informed care in the health, early childhood and education sectors, including:

- Authorization of the Centers for Disease Control and Prevention to support states in collecting and reporting data on ACEs for children and adults;
- Creation of an interagency task force to recommend best practices related to the identification, prevention and mitigation of trauma across the lifespan, and to better coordinate the federal government's response;
- Authorization of increased funding for the National Child Traumatic Stress Initiative to provide technical assistance, direct service, evaluation, and dissemination of best practices related to trauma-informed care for children and families;
- Creation of grants to connect education and mental health agencies to increase students' access to evidence-based trauma treatments and services with learnings disseminated by the Secretary of Education; and
- Recognition of the relationship between early adversity and SUDs by requiring the Secretary of Health and Human Services to disseminate information and resources to early childhood programs and educators on how to recognize and respond to early childhood trauma.

Resources

SAMSHA has produced a guidebook on "Building Resilient and Trauma-Informed Communities."

The Prevention Institute has created a framework for "Addressing and Preventing Community Trauma."

ACEs Resources offers substantial resources, including tools, briefings, grant resources and supporting documents.

3. Reduce the use of opioids for pain mitigation

The literature abounds with research and stories of how individual patients became addicted to opioids for pain management and how such addiction was sustained long beyond that need. A clear consensus has emerged that one very important way to reduce the use and misuse of prescription drugs, as well as illicit drugs, is to control and limit the use of opioids for pain management. This strategy requires a substantial educational effort aimed at physicians and patients about the risks and cautions in the use of opioids for this purpose. In a real sense, the effort under this play seeks to change the culture of pain management to provide more of a focus on protocols for weaning patients from the use of opioids.

The Chronic Pain Initiative (CPI), a project of Project Lazarus and Community Care of North Carolina, lists some activities that have been successfully implemented:

- Promoting adoption of the CPI toolkit for primary care providers, emergency departments and care managers.
- One-on-one provider education or "academic detailing" on pain management.
- Continuing medical education sessions on pain management, appropriate prescribing and diversion control.
- Continuing education for pharmacists on diversion, forgery and the use of the Prescription Drug Monitoring Program (PDMP).
- Promoting provider and dispenser use of the PDMP.
- Information concerning the Good Samaritan Law and prescribing naloxone.[45]

Another example of how to build a collaborative effort is reflected in the work of the Northern Shenandoah Valley Substance Abuse Coalition in the Commonwealth of Virginia. NSVSAC[46] is a coalition of law enforcement, health care, substance abuse treatment, and youth advocacy organizations and families impacted by substance abuse and addiction in the state's Winchester region. The group formed in May 2014 following a community heroin summit in Winchester convened by the Northwest Virginia Regional Drug Task Force.

Goals and Objectives

The basic goal of this strategy is simply to reduce the quantity of opioids prescribed for long-term pain management, following guidelines to limit the use of opioids for this purpose.

Measurable objectives can be constructed along the lines of making a percentage decrease in the number of opioid prescriptions filled that are for longer than a specified time period.

Theory of Change

Reducing the number of long-term prescriptions will result in fewer people becoming addicted to opioids beyond pain management, thereby reducing the addiction rate and, in particular, overdoses resulting in death.

Examples

California has created a Statewide Opioid Safety (SOS) Workgroup under the auspices of the State Health Officer, focusing on promoting safe prescribing guidelines as a singular pillar of the prevention program. California issued guidelines for prescribing controlled substances for pain in 2014, and then adopted the 2016 prescribing guidelines issued by the Centers for Disease Control and Prevention (CDC). The California Department of Public Health has issued educational materials to promote and disseminate these guidelines throughout the state.

The CDPH Director/State Health Officer, in partnership with the SOS Workgroup, developed and disseminated a health care provider resource letter in March 2017 offering encouragement and resources on best prescribing practices and assistance for patients who may need special medical guidance due to opioid addiction and substance use disorder treatment.

Massachusetts enacted legislation that calls for these constraints on prescribing opioids:

- Imposes a seven-day limit on prescribing opioids to a patient for the first time.
- Mandates that prescribers check the Prescription Monitoring Program (PMP) every time a Schedule II or III narcotic is prescribed.
- Allows patients to request a partially filled opioid prescription.
- Instructs all prescribers to complete appropriate training in pain management and addiction, to be determined by boards of registration.
- Prior to issuing an extended-release long-acting opioid in a non-abuse deterrent form for outpatient use for the first time, says a practitioner must evaluate the patient's current condition, risk factors, history of substance use disorder, if any, and current medications; and must inform the patient and note in the patient's medical record that the prescribed medication, in the prescriber's medical opinion, is an appropriate course of treatment based on the patient's medical need.
- Directs the prescriber and patient to enter into a written pain management treatment agreement for prescriptions for extended-release, long-acting opioids.
- Requires the Department of Public Health to establish a voluntary non-opioid directive form, indicating to all practitioners that an individual shall not be administered or offered a prescription or medication order for an opioid.
- Establishes a benchmarking mechanism for prescribers. The Department of Public Health determines mean and median quantity and volume of prescriptions for opioids within categories of similar specialty or practice types. Prescribers who go beyond the mean or median will be sent a notice that they have exceeded the limit.[47]

Resources

The CDC produced prescription drug guidelines related to opioids in 2016.

The American Academy of Pain Medicine and its board of directors have researched and approved certain evidence-based clinical practice guidelines for treating pain patients.

The *Permanente Journal* published the "Physician Guide to Appropriate Opioid Prescribing for Noncancer Pain" by Timothy Munzing, MD.

4. Reduce the supply of opioids from illegitimate sources

The President's opioid initiative contains a provision for federal efforts to focus on interdicting the flow of international and domestic illicit drug supply chains, including by requiring definitive package markings on all shipments into the U.S. as a way of tracking suspicious ones. Carrying this effort forward at the state and local levels includes the potential for such activities as:

- detecting and disrupting distribution channels for illicit drugs through local or online means
- working with the DOJ Opioid Fraud and Abuse Detection Unit to prosecute corrupt or criminally negligent doctors, pharmacies and distributors
- strengthening criminal penalties for dealers of fentanyl and other synthetic opioids

One of the most effective activities for supporting this strategy is the deployment of drug task forces designed to disrupt the flow of illegitimate drugs such as heroin and fentanyl. For jurisdictions not yet working with such a multi-agency, multi-jurisdictional task force, a useful play might be to create one and link it to the Drug Enforcement Administration (DEA) and other federal resources, including DOJ funding sources to sustain this effort on a local/regional level. Local task forces have been successful in disrupting and even eliminating distribution networks.

Since most heroin and fentanyl originate outside the U.S., much of the counter-narcotics programming is at the federal level. The 2018 SUPPORT for Patients and Communities Act calls for the Postal Service to step up inspections of all packages coming into the country in order to detect the presence of heroin and synthetic opioids such as fentanyl. However, the current delivery systems in the U.S. are geared to local distribution, and for many years there have been effective multiagency drug task forces in place that concentrate on detecting and destructing distribution channels at the local level, frequently in conjunction with state and federal agencies. As noted in the Washington State strategic plan, funding for such entities has been cut just as the extent of the opioid crisis has grown.[48]

The Drug Enforcement Administration currently maintains and supports 271 drug task forces throughout the country.[49]

For jurisdictions that match the criteria, many are involved in the formation of High Intensity Drug Trafficking Area (HIDTA) task forces. The HIDTA program, created by Congress through the Anti-Drug Abuse Act of 1988, provides assistance to federal, state, local and tribal law-enforcement agencies operating in areas determined to be critical drug-trafficking regions of the United States. This grant program is administered by the Office of National Drug Control Policy (ONDCP). There are currently 28 HIDTAs, encompassing approximately 18 percent of all counties in the United States and 66 percent of the U.S. population.[50]

The Congressional Research Service has published a history and discussion of HIDTA.

Theory of Change

By reducing the availability of illicit drugs, the task force will prevent the incidence of some substance use disorders and thereby decrease the number of people affected. It is far easier to articulate this theory than it is to measure the complex relationship between involved organizations and environmental values. A study published in Ireland in February 2017 proposes a performance measurement approach based on this theory of change.[51]

Goals and Objectives

Drug task forces seek to identify and destroy distribution networks and their operations in specific jurisdictions. The objectives are to disrupt drug sales in all sectors, arrest and prosecute the sales and delivery forces, and otherwise upset the distribution process.

Examples

Most states have developed statewide programs to create multijurisdictional task forces that focus on drug-related criminal activity.

Ohio has funded numerous task forces the have been found to be highly effective in addressing and interdicting drug crimes. Information is available in the state's most-recent annual report.

An evaluation of Illinois' multijurisdictional task forces showed that these units had a significantly higher arrest rate than local police agencies, and that the units supported the guidelines for implementation.

A state publication provides details of the evaluation.

Applied Research Services provided a thorough evaluation of Georgia's implementation of multijurisdictional task forces.

Resources

The Center for Task Force Training of the Bureau for Justice Assistance (BJA) offers training and technical support, including specifically relating to substance abuse.

5. Improve and implement better prescription monitoring programs

Laws in 49 of the 50 states support the creation of prescription drug monitoring programs (PDMPs), which require pharmacies to report to a state repository the sale of controlled substances in fulfillment of prescriptions. Most physicians who intend to prescribe an opioid for pain management therefore have the ability to determine if the patient has already gone to other physicians for the same or similar drugs, a practice sometimes referred to as doctor shopping.

In addition, the system records all prior disbursement of controlled substances to the patient, so the prescribing physician has a more complete picture of prior medications that may be in conflict. It took a number of years for state legislatures to enable these monitoring programs, and there was a reluctance to share information across state lines, but this capability has now been implemented in several regions around the country.

The PDMP concept is explained in detail in SAMHSA's Guide for Healthcare Providers. Much of the funding for the creation of the PDMP network has come from the Bureau of Justice Assistance in the Office of Justice Programs at the U.S. Department of Justice under the Harold Rogers Prescription Drug Monitoring grant program.[52] BJA has continued to fund improvements under this grant program and gives priority to funding state programs that introduce evidence-based practices to improve PDMP effectiveness.

The need for a play to address these systems is founded in the extent to which physicians and pharmacies actually have access to and use the PDMPs. Some doctors are either unaware of the system, unsure of how to use it or have concerns about its accuracy. So the essence of this play is to undertake efforts to ensure that doctors know about and use their state system; that they check across states to ensure that a patient is not "doctor shopping;" and that the prescription history for prior medication does not indicate that a new prescription should not be written.

The research on the impact of PDMPs is mixed. Because the policies requiring physicians to use a PDMP vary significantly across the states, it is difficult to conclude that the program directly prevents substance use disorder. However, in states where it is designed to motivate physicians and pharmacists to check with a PDMP before releasing controlled substances to the patient, the research shows a positive impact on reducing opioid use, which to some degree prevents the start of a substance use disorder.[53]

A common theme in numerous national and local initiatives addressing substance use orders includes the strengthening of these programs. States continue to upgrade and improve their PDMPs, including by:

- creating algorithms in the PDMP system to automatically validate the prescription vs. prior prescriptions to detect over-subscribing or mistakes in dosages
- mandating that pharmacies require patients to show identification prior to obtaining the medication
- mandating the use of the PDMP system by prescribers and pharmacists

The Prescription Drug Monitoring Program Training and Technical Assistance Center at Brandeis University has created a "Best Practices Checklist," which outlines many of the improvements that have been identified to make PDMP usage more effective.

Goals and Objectives

The goal of a project to improve PDMP programs is to (1) ensure that the system does as much as possible to collect and make available data on past prescriptions and other indicators helpful to making decisions on prescriptions and (2) ensure that the system is used by physicians and pharmacists in dispensing controlled substances. While PDMPs are operated at the state level, local coalitions of interest can promote the inclusion and accessibility of the system to assure its maximum effectiveness. Greater use can be mandated legislatively, but also by efforts to educate and persuade physicians and pharmacists to take advantage of this effective tool. The PDMP instituted by the Bureau of Justice Assistance has published a presentation from SAMSHA that helps define goals for this work.

Theory of Change

Having an effective and accessible PDMP, and ensuring its use in the process of dispensing medications, will reduce the number of people who begin the development of a substance use disorder because they have been prescribed excessive amounts of opioid medication.

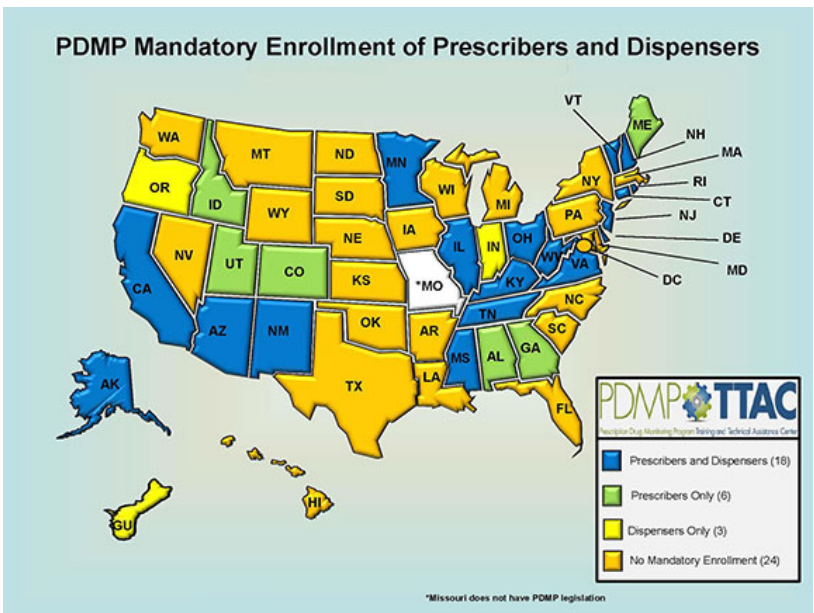
Examples

Florida was one of the later entrants into PDMPs, but it has moved swiftly to create a program that has reduced opioid prescriptions written for pain management. The Florida PDMP, called E-FORCSE (Electronic-Florida Online Reporting of Controlled Substance Evaluation Program), has introduced a number of effective collaborative programs in its strategy. Through its 2013 Harold Rogers Data-Driven Multi-Disciplinary Approach to Reducing Prescription Drug Abuse Grant, a long-term collaboration has been established between the PDMP, law enforcement, and the public health and research community in Florida to:

- collect and analyze data by centralizing existing data sources
- complete practitioner surveys and establish a focus group
- increase the engagement of Florida's public health community in PDMP use via early participation in technical design and development of practitioner metrics
- work with interested parties and stakeholders to develop educational opportunities and brochures to educate health care practitioners regarding legitimate and appropriate use of controlled substances
- develop valid data-driven analytic strategies."[54]

Kentucky has become one of the leading showcases for PDMP programs. According to Peter Kreiner, principal investigator for the PDMP Center of Excellence at Brandeis University, the Kentucky All Schedule Prescription Electronic Reporting Schedule (KASPER) is regarded by many as a "gold standard" for state PDMPs. KASPER has published its reporting guide. Kreiner attributes its success to three primary factors: legislation that mandates physician and pharmacy compliance; ongoing innovation, such as improvements in timeliness of data reporting; and high levels of ongoing cooperation among key stakeholders.[55]

The Washington state Department of Health developed an innovative approach to creating its Prescription Monitoring Program (PMP) by focusing on integrating its registry with electronic medical records, so that separate inquiries to a PDMP system were not required.[56] The result was a dramatic increase in the use of the PDMP records. The state made this possible by using its health information exchange (HIE) as a transport mechanism to accomplish the integration with major health information systems. Washington also successfully positioned the process as qualifying under meaningful use regulations for federal funding support. The Association of State and Territorial Health Organizations has posted a story about this effort.



The BJA Comprehensive Opioid Abuse Program highlights additional examples of PDMPs.

Resources

The CDC has a prevention program in which it funds states to enhance their PDMPs to improve their usefulness and support community efforts to maximize their value.

Additional information and resources are available from the National Alliance for Model State Drug Laws, the National Association of State Controlled Substances Authorities and the Prescription Drug Monitoring Program Training and Technical Assistance Center (the PDMP TTAC and the PDMP Center of Excellence have merged into a single program).

6. Reduce the involvement of opioid users in the criminal justice system

In a major study, individuals who reported any level of opioid use were more likely than those who reported no opioid use to have physical and mental health conditions and co-occurring substance use. Involvement in the criminal justice system increased with the intensity of opioid use, and any level of opioid use was significantly associated with involvement in the criminal justice system in the previous year. The study concluded that policies are needed that reduce criminal justice involvement among individuals with substance use disorders.[57]

The value of diverting people from involvement with the criminal justice system has been clear since the 1970's. Following recommendations from the President's Crime Commission report in 1967, the Law Enforcement Assistance Administration funded the creation of a program for Treatment Alternatives to Street Crime (TASC) expressly to test ideas for the diversion of low-level defendants into treatment programs instead of supervision resulting from criminal

convictions. Over the years, the focus of diversion programs has been on individuals charged with drug-related offenses, particularly those exclusively about drugs.

Central to diversion programs is "the understanding that a criminal conviction – misdemeanor or felony – triggers a cascade of collateral consequences that often severely hamper an individual's ability to become a productive member of the community. While policies and practices minimizing the use of incarceration certainly may be sound options, the conviction itself precludes or restricts an individual's pursuit of education, housing, and employment, and creates a platform for enhanced sanctions and consequences upon further justice system involvement."[58]

Many scenarios describe how individuals escalate engagement with the criminal justice system if there is no intervention, showing that such a path can result in the deepening of a substance use disorder. Since recidivism is often tied to further substance use and related activities, reducing its probability through diversion programs has the effect of preventing continued substance use disorder. Finding alternatives to arrest, prosecution and correctional supervision is therefore a reasonable part of any strategy to reduce opioid use disorder.

There are various points in the administration of justice where individuals can be diverted from further engagement with the criminal justice system. The major ones are (1) pre-arrest, (2) pre-trial and (3) post-adjudication. These intervention points are connected in what is termed the Sequential Intercept Model for providing a framework to link and coordinate a diversion strategy.

"The Sequential Intercept Model provides a conceptual framework for communities to use when considering the interface between the criminal justice and mental health systems as they address concerns about criminalization of people with mental illness. The model envisions a series of points of interception at which an intervention can be made to prevent individuals from entering or penetrating deeper into the criminal justice system. Ideally, most people will be intercepted at early points, with decreasing numbers at each subsequent point. The interception points are law enforcement and emergency services; initial detention and initial hearings; jail, courts, forensic evaluations, and forensic commitments; reentry from jails, state prisons, and forensic hospitalization; and community corrections and community support. The model provides an organizing tool for a discussion of diversion and linkage alternatives and for systematically addressing criminalization. Using the model, a community can develop targeted strategies that evolve over time to increase diversion of people with mental illness from the criminal justice system and to link them with community treatment."[59]

Police are increasingly "recognizing that increasing arrests of those with OUD will not improve individual and community outcomes, police have become a point of contact for those seeking help by facilitating immediate access to treatment.[60] These deflection and diversion initiatives can help with barriers (e.g., lack of knowledge of available services, shame and stigma, cost and lack of insurance/Medicaid, lack of transportation, long treatment waiting lists) that prevent individuals from receiving treatment." There are a variety of diversion programs, including models in which individuals referred to police – once it is discovered they have a substance use disorder – can instead be transported to a treatment facility.

Substantial interest in and implementation of pre-trial diversion programs has developed over the past decade. After the police bring a case to the prosecutor, the prosecutor can elect to not file charges with the court and instead make a referral to a treatment program or, even after filing charges, the prosecutor can work to have the individual referred to treatment – in which case all charges are normally dropped.

The National Institute of Justice, a coalition of the Center for Court Innovation, the RAND Corporation and the Association of Prosecuting Attorneys, in a multisite study, found that diversion programs in these jurisdictions appeared highly successful in reducing exposure to a conviction, in freeing up resources for criminal justice agencies and in reducing recidivism.[61]

A major focus of diversion programs that has been highly successful across the country is the creation of drug courts. A significant and thorough evaluation of these programs by the National Institute of Justice came to the following conclusions: "The impact evaluation found that adult drug courts significantly reduce participants' drug use and criminal offending during and after program participation. Drug court participants reported less drug use (56 percent versus 76 percent) and were less likely to test positive for drug use (29 percent versus 46 percent) than the comparison probationers. Participants also reported less criminal activity (40 percent versus 53 percent) and had fewer rearrests (52 percent versus 62 percent, but not statistically significant difference) than the comparison probationers. Differences in employment, schooling, community service and other outcomes were not statistically significant."[62]

Goals and Objectives

The basic goal of this strategy is simply to divert first-time offenders from proceeding through the criminal justice system by engaging them in treatment alternatives that will benefit their long-term control of substance use disorders. Local programs have varying criteria for eligibility, but they generally focus their efforts on non-violent, first-time offenders. It can be difficult to quantify the impact of diversion programs, but indirect measures – for example, the percentage of people remaining in treatment over time and the recidivism rates related to re-arrest for drug-related charges – can be indicators of programmatic success.

Theory of Change

The likelihood of extended opioid use will be reduced by diverting individuals from the criminal justice system. Offenders can be reintegrated into the community and sustain productive lives if they receive treatment rather than being criminally prosecuted and convicted.

Examples

Numerous successful law-enforcement programs have been created around the country.

In King County, WA, police officers can refer individuals facing possible drug charges to case workers who conduct in-house assessments and then connect the individuals to treatment services. An evaluation concluded that participants in the program were less likely to be arrested and incarcerated than those in a comparison group.[63]

The City of Alexandria, VA, has introduced a novel program, called the Burner Phone Initiative, that aims to guide overdose patients onto a path that leads to treatment rather than the criminal justice system. Individuals in Alexandria who are revived from an overdose by a city official are taken to recover in a hospital, where a detective will meet them and exchange their personal cell phone with a burner phone. The burner phones are pre-programmed with the numbers of a detective and the city's substance use treatment program. When calling the latter number, patients speak with a social worker about their substance use and treatment options. Even if they do not pursue treatment, they are counseled about harm-reduction approaches, where to get free Narcan, etc. They can call a detective to discuss issues such as whether the drug they took was tainted. The phones are also used by treatment staff to try and engage overdose survivors.

In 2016, the Office of Community Oriented Policing Services hosted a forum with the White House Office of National Drug Control Policy and the Police Executive Research Forum to study the experiences of police agencies in collaborating with public health agencies to prevent or reduce opioid substance use through diversion programs. The report contains numerous examples of successful programs, including Montgomery County, MD, Dayton, OH, and Gloucester, MA.[64]

There are over 3,100 drug courts in the nation, and a substantial number of program descriptions are available from the resource centers cited below.

Resources

The Police Assisted Addiction & Recovery Initiative (PAARI) provides support and resources to help law enforcement agencies nationwide create non-arrest pathways to treatment and recovery. Any law enforcement or public safety agency that creates such pathways can join PAARI free of cost to access resources such as technical assistance, coaching, program templates and tools, seed grants, convening, connections to treatment providers, a network of like-minded law enforcement agencies, and capacity-building and recovery coaches through AmeriCorps.

The Bureau of Justice Assistance in the Office of Justice Programs (OJP) within the U.S. Department of Justice has a Comprehensive Opioid Abuse Program, through which grant funds are available for diversion projects.

The Association of Prosecuting Attorneys has created a toolkit to support prosecutor-led diversion programs.

The National Drug Court Resource Center lists a wide variety of evidence-based practices that are useful in implementing drug courts at the local level. In addition, the National Center for State Courts publishes a directory of resources for implementing drug/DWI court programs. The OJP lists resources (including grant programs) available to support drug court programs, and has also published a listing of all of its programs that have to do with substance use disorder.

7. Provide medication-assisted treatment to inmates

On a national basis, 65 percent of all incarcerated offenders meet the criteria for suffering from a substance use disorder.[65] Research has shown that medication-assisted treatment (MAT), including with buprenorphine, methadone and extended-release naltrexone, can decrease opioid use, opioid-related overdose deaths, criminal activity and infectious disease transmission – while increasing social functioning and retention in treatment.[66] Numerous studies have shown that the provision of MAT has long-term impacts on preventing both continued substance use disorder and criminal behaviors, thereby both preventing such disorders and reducing crime.[67] In one recent study, a MAT program resulted in a 60 percent reduction in opioid overdose deaths among individuals who were recently incarcerated.[68]

Goals and Objectives

The overriding goal of a MAT program in jails is to prevent the relapse to opioid use upon the offender's release from incarceration. Specific objectives for such a program could include: (1) a specific percentage reduction in overdose deaths for inmates after release, as compared to those not involved with MAT; and a percentage reduction in recidivism, as compared to a cohort not involved in MAT.

Theory of Change

Incarceration for offenders with opioid use disorders comes most often with the hard detoxification experience and the effects of withdrawal. The consequences of this "immediate end to addiction" while incarcerated can be very damaging to offenders after release. At that point, they can be more-seriously impacted by returning to drug use, and may be more likely to experience overdoses that lead to death. The operational theory of change in instituting a MAT program is that if this discontinuity is erased, the offender is less likely to return to drug addiction behaviors or criminal activity. An expected outcome of the introduction of a MAT program is a reduction in the number of overdose deaths.

Examples

The Rhode Island Department of Corrections recorded a 61 percent reduction in overdose deaths in less than a year after implementing a MAT. A new model of screening was instituted in July 2016 in the Department, which is a unified prison/jail, to implement MAT upon intake and to follow up after release into the community. Individuals arriving while receiving MAT were maintained on their respective medications regimens without tapering or discontinuing their use. A system of 12 community-located centers of excellence in MAT were established to promote transitions and referrals of released inmates.[69]

The Medication Assisted Treatment and Directed Opioid Recovery (MATADOR) program, introduced by the Middlesex County Sheriff's Office in Massachusetts, has had striking results. It combines the MAT concept with pre- and post-release counseling and other services, resulting in a non-recidivism rate of 82 percent.[70] In 2018, MATADOR program was recognized by the National Sheriffs' Association and the National Commission on Correctional Health Care as one of five national "best practices."[71]

According to the Vera Institute, "The New York City jail system has run an opioid treatment program with MAT since 1987 and, more recently, some jails have piloted programs with injectable naltrexone, a non-habit forming, long-lasting medication which blocks the effects of opioids. The MATADOR program in Middlesex County, Massachusetts, for example, combines the use of naltrexone with substance use disorder counseling and continuity of care for participants upon return to the community. And, encouragingly, there are signs that other criminal justice stakeholders are beginning to embrace their role in combatting the opioid crisis."[72]

In Texas, the state Commission on Jail Standards and Department of State Health Services (DHS) partnered to implement comprehensive care coordination and education for women who are pregnant and involved in the justice system, 400 of whom are detained in county jails each month. To address opioid addiction in this population, county jails provide referrals to DHS services and DHS conducts outreach to the women while they're incarcerated, providing Methadone, counseling and education services, as needed.

Washington County, MD, also developed a collaborative approach between the Health Department, the local correctional facility, Conmed Health Care Management, Inc., and the Alcohol and Drug Abuse Administration. The county's MAT program builds on existing treatment services and includes risk and needs assessments, trauma-informed parenting guidance and care coordination. Through this partnership, behavioral health clinicians utilize telemedicine and site visits in detention centers to issue Vivitrol MAT, as appropriate.

Virtually all studies on the effectiveness of MAT emphasize that behavioral therapy and counseling are essential and integral parts of the program.[73]

Resources

The Bureau of Justice Assistance has issued a Promising Practices Guidelines for Residential Substance Abuse Treatment publication. BJA has also supported the development of a Prison/Jail Medication Assisted Treatment Program Manual. In addition, grant funding and technical assistance from BJA may be available.

The National Sheriff's Association approved a resolution supporting the development of MAT programs in jails.

The American Society of Addictive Medicine has developed guidelines for the placement, continued stay and transfer/discharge of patients with addiction and co-occurring conditions.

8. Expand treatment programs after incarceration

Research has shown a high rate of overdose deaths from drug abuse following inmates' release from prison or jail. A key finding in a major study by the Massachusetts Department of Correction was that the likelihood of an inmate released from prison dying from an opioid overdose was 56 times higher than for someone not previously incarcerated.[74] The study also showed that "receiving evidence-based opioid agonist treatment following a nonfatal overdose was associated with a reduced risk of a subsequent fatal opioid overdose. This suggests that overdose survivors have a short window of opportunity after a nonfatal overdose to reduce their risk of death by undergoing an evidence-based medication-assisted treatment (MAT)."

A focus on offender reentry programs has long been a hallmark of U.S. Department of Justice programs, if only for the attempt to improve the high rates of recidivism nationwide. DOJ grant programs and technical assistance have spurred considerable interest at the state and local levels, where recidivism problems are well known. However, the systematic inclusion of prevention programs for abating the relapse into the misuse of prescription drugs, or the use of illicit drugs, is not as widespread as could be the case given the logical correlation between the use of drugs and criminal activity.

An integrated substance use disorder treatment program designed expressly for offenders released from prison or jail will need to encompass a breadth of treatments, which may include both behavior modification and medication-assisted treatment. In a study on the effectiveness of treatment programs in the criminal justice system, the following principles of treatment for offenders were proposed:

- tailoring services to fit the needs of the individual
- targeting criminogenic factors associated with criminal behavior
- incorporating treatment planning into criminal justice supervision and being sure treatment providers are aware of correctional supervision requirements
- providing continuity of care for released drug abusers re-entering the community
- providing a balance of rewards and sanctions to encourage pro-social behavior and treatment participation
- using an integrated treatment approach for offenders with co-occurring drug abuse and mental health disorders.[75]

Evaluations of post-release substance use disorder treatment have generally shown positive results for reducing both relapse rates and recidivism.

The American Psychiatric Association issued a policy statement in 2016 that said: "It is essential for continuity of care that offenders who received some form of substance use treatment while incarcerated have community treatment resources available after release. Aftercare planning should include attention to the medical, mental health and substance use disorder needs of inmates and detainees as well as regular, random testing for substance use, coupled with low-level sanctions for relapses. When indicated, inmates and detainees should be referred to programs specializing in the treatment of individuals with co- occurring psychiatric and addictive disorders. The menu of options for aftercare should include the entire spectrum of addiction programs, including treatment with medications for alcohol and opioid use disorders (e.g. methadone, buprenorphine, extended-release injectable naltrexone), outpatient psychosocial interventions, and residential rehabilitation facilities."[76]

It is clear from abundant research, which shows greater success when a MAT program is fully integrated with behavioral health treatment programs, that a collaborative effort between health care providers and behavioral health departments can have a positive effect on preventing the reoccurrence of substance use disorders.

Theory of Change

The provision of substance use disorder treatment for a sufficient period of time, and including a robust set of methods, will have the effect of diminishing the prospects of relapse, preventing the further use of opioids and other substances, and reducing the probability of recidivism.

Examples

Studies show that treatment has a positive impact on recidivism and relapse when combined with continuing community care, but caution is needed in drawing conclusions owing to methodological problems with some of the research, as well as the relatively low proportion of inmates who access care following release. More research,

using stronger designs and controlling for selection bias, is needed on the types and length of post-release care that are most effective for reducing relapse and recidivism.[77] There has been relatively little research on the impact of other types of prison treatment. Recent pilot studies suggest that MAT (included extended-release naltrexone) may have promise for improving outcomes for offenders with opioid dependence. There has been very little research on effective treatment models or modalities for offenders on probation or parole, although most are under such supervision.

A full set of practices and components for programs seeking to improve post-release treatment programs is provided in the Treatment Improvement Protocol (TIP) developed by SAMSHA for this express purpose. While somewhat dated, TIP describes best practices for designing and implementing a program based on evidence of success.

The Virginia Department of Corrections has instituted a substance use disorder treatment program for inmates and, by extension, for post-release treatment. "Upon release, the participants are required to transition into an outpatient substance use disorder treatment program provided by a local Community Service Board (CSB) that employs a multi-faceted approach to treatment including the use of medication, counseling and wrap-around services."[78]

California has a Substance Abuse Treatment and Recovery (STAR) Program. "The STAR program provides relapse prevention education to parolees with substance use disorder treatment needs. STAR is designed to help parolees understand addiction and recovery as an ongoing process, not a singular event. STAR teachers work closely with students to help them identify their needs and develop a plan of action that will support post-release recovery activities."[79]

Resources

The Justice Center under the Council of State Governments offers a resource page.

The National Institute of Drug Abuse provides a rich set of publications related to treatment and prevention modalities and provides funding for research on drug abuse issues.

The GAINS Center at SAMSHA provides resources and links to further information related to criminal justice and behavioral health.

The National Reentry Resource Center lists a grant program under the Second Chance Act Reentry Program for Adults with Co-Occurring Substance Use and Mental Disorders.

9. Reduce the risk of opioid-based treatment

It has become clear that the extensive, long-term use of opioids that are legitimately prescribed for pain management increases the risk of a patient becoming addicted and thereby developing a substance use disorder. A fundamental and widespread approach to the mitigation of this risk is to ensure that: (1) both the prescriber and the patient fully understand the consequences of taking the drug and (2) the physician and the patient have a clear and unequivocal understanding of the conditions under which the prescription will be continued.

This strategy only relates to a situation where the physician and the patient have agreed that the use of opioids is the solution of choice, as opposed to finding an alternative approach to pain management. It is also assumed that the provisions for controlling the amount and duration of the prescription are consistent with the guidelines referenced in Play 2 above.

In utilizing this strategy, the first step in reducing risk is to provide physicians and patients with the information they need. Literature, briefings to community groups and handouts in medical offices are all parts of an educational effort to ensure that every party is aware of the guidelines and constraints for using an opioid as a long-term medication.

The California Department of Public Health (CDPH) has developed "The Risks Are Real," a statewide campaign designed to encourage patients to talk to their doctors about options for safe pain management and addiction treatment. A preview of the campaign outlining how coalitions can utilize its materials to amplify their community-based opioid overdose prevention programs is available through a recording, slides and campaign FAQs.

Having achieved greater awareness of the risks and constraints, a number of organizations have promoted the concept of a written doctor-patient agreement that documents their mutual understanding of the issues involved in any long-term treatment program. There are numerous examples of policies that over the years have been expressed as such "contracts,"[80] and models have been proposed by many professional organizations. They typically define circumstances in which the contract will be voided, such as failing a urine test.[81]

However, the concept of a doctor-patient "contract" has been seen by many as too legalistic an approach for something as personal and important as pain management. There have been cases of severe damage done to patients by the strict enforcement of contract terms.[82] In general, the mere act of laying out this understanding between the physician and the patient is seen as a way of imposing a stigma on the patient that presumes a violation of the agreement.[83]

An updated means of documenting a doctor-patient understanding is proposed in an article in the Cleveland Clinic Journal of Medicine, which argues that the term "controlled substance agreement" is better and less obnoxious than "narcotic contract." The authors further suggest that the agreement must:

- engage the patient, emphasizing the shared, reciprocal obligations of physician and patient
- address goals of treatment that are personalized and mutually agreed-upon and that incorporate the patient's values and preferences
- explain treatment options in a way that is understandable and informative for the patient[84]

Goals and Objectives

The goal of this strategy is to ensure that physicians and patients fully understand the risks and obligations each has in undertaking opioid-based treatment, and to make clear the conditions for its continuation. The objective is to document this understanding, so it is clear to the patient.

Theory of Change

Patients are less likely to develop opioid use disorders if they receive sufficient education and agree to a clear, written understanding as the basis for and conditions of treatment using opioids.

Examples

Massachusetts law (Chapter 52) requires the physician and the patient to create a contract covering the use of opioids: "In the event that a practitioner recommends that an extended-release long-acting opioid be utilized during the course of long-term pain management, the practitioner shall enter into a written pain management treatment agreement with the patient that appropriately addresses the benefits as well as the risk factors for misuse of the prescribed substance under guidelines published by the department. Such an agreement shall be filed in the patient's medical record or included in the patient's electronic health record."

The New Hampshire Board of Medicine has published strict rules that require the development of a written agreement that contains at least the following:

- The requirement of safe medication use and storage
- The requirement of obtaining opioids from only one prescriber or practice
- The consent to periodic and random drug testing
- The prescriber's responsibility to be available or to have clinical coverage available[85]

Resources

The New Hampshire Medical Society provides sample agreements.

The American Academy of Pain Management publishes a template.

10. Make provisions for safe disposal of unused opioids

Two-thirds of teenagers who have misused prescription drugs get them from their family and friends, according to a report from SAMHSA.[86] The conclusion reached by many practitioners is that it is important to clear out medicine cabinets at home that contain unused drugs, particularly opioids. Doing so is not as simple as might be expected, however, as regulations require that law enforcement take custody of discarded controlled substances (rather than, for example, making it easy to just return the drugs to a pharmacy). Many communities have organized annual drives during which people can give their unused controlled substances to the police, who then dispose of them in approved ways.

Studies evaluating such take-back programs generally show a positive outcome for removing drugs from broad availability. Recent research shows a more-positive impact for programs that allow drugs to be turned in at any time, rather than just once or twice a year.[87]

Task-based programs need a methodology for collection and disposal, as well as a marketing/awareness effort to persuade citizens to participate.

Goals and Objectives

The goal of drug take-back programs is simply to reduce the amount of controlled substances that are contained in readily openable places, such as home medicine cabinets. Objectives in many programs are stated in the specific amounts of drugs that are turned in.

Theory of Change

By reducing the amount of controlled substances that are easily obtained from friends and family, this program will prevent the development of substance use disorders by those who have ready access to these medicines without a prescription.

Examples

The sweeping Massachusetts law (Chapter 52) that addresses the opioid crisis calls for the establishment of a drug stewardship program, to be paid for by pharmaceutical companies, that makes it easier for patients to safety dispose of unwanted and unused medications. The law became effective Jan. 1, 2017 (Section 31).

In June 2007, the La Crosse County, WI, Solid Waste Department became the first permanent collection site in the state. The county developed a unique strategy for disposing of unwanted pharmaceuticals, specifically controlled substances. Employees from the department are conditionally deputized by the county sheriff to receive controlled substances. County residents are allowed to drop off any unused medications at the hazardous waste facility. Under supervision by the deputized staff, residents drop off their drugs through a funnel into a gallon drum of solvent that dissolves them. The program is funded through a tax levy, grants and fees charged to non-area residents and businesses.[88]

The San Diego Police Department has set up boxes at two of its locations where citizens can just drop off expired or unused prescriptions.[89]

Resources

The U.S. Drug Enforcement Administration works with state and local agencies to create national drug take-back programs, which have been successful in removing significant amounts of controlled substances from the streets. At its most-recent take-back event, the DEA set a record, collecting about 447 tons at almost 5,400 sites in all 50 states (US DEA Public Affairs, 2016).

What Works for Health includes references and resources for Wisconsin's program.

11. Encourage the use of non-opioid formulations for pain management

As it has become clear that long-term pain management using opioids increases the likelihood of patients developing a substance use disorder, research has intensified on finding effective alternatives. Meanwhile, there are already significant, evidence-based alternatives that physicians are finding useful. Based on an evaluative compilation of the alternative treatments, physicians can consider the following substitutes:

- Ketamine has been endorsed by the American Academy of Emergency Medicine, with some limitations for patients who have complications related to psychiatric disorders.
- Nitrous oxide has long been prescribed in pediatric situations for pain reduction, and its use seems to be growing as more doctors seek alternatives to opioid-based medications.
- Intravenous lidocaine has been shown to be effective for a variety of specific situations.[90]

Other non-pharmacological treatments have been developed and tested and well. St. Joseph's Healthcare System in Paterson, NJ, has developed the Alternatives to Opioids (ALTO) program, which utilizes protocols that primarily target five common conditions: renal colic, sciatica, headaches, musculoskeletal pain and extremity fractures. Administrators say they have successfully treated more than 300 patients under the new program, and they see ALTO as a model that other hospitals can duplicate. Among the alternative therapies called for in the ALTO program are trigger point injections, nitrous oxide and ultrasound-guided nerve blocks. [91]

The CDC Chronic Pain Guidelines and National Safety Council recommendations highlight and underscore the need to utilize alternative, non-opioid pharmacologic therapies to treat chronic pain. Physical therapy, occupational therapy, water therapy, acupuncture, yoga, Tai chi and massage have all been recognized as effective interventions to treat chronic pain.[92]

A strategy on this topic involves educating both physicians and patients on the options available and their consequences (strength, side effects, etc.). Health care providers can develop and set guidelines that call for the use of non-opioid alternatives. This strategy would include efforts required to stay current with the emerging research and development of new alternatives for pain management, including from the various aggressive research programs undertaken by the National Institutes of Health and the CDC.

Goals and Objectives

The goal for this play is to develop and institutionalize practices across the health care continuum that minimize the use of opioid-based treatments where possible and appropriate. The objective is to put in place protocols for the active consideration of alternative therapies.

Theory of Change

Substituting alternative treatments for opioid-based pain management will result in fewer patients who develop substance use disorders resulting from long-term reliance on opioids.

Examples

The Colorado Chapter of the American College of Emergency Physicians (COACEP) has published guidelines for responding to the opioid crisis, along with practice recommendations that call for non-opioid treatment alternatives as the first course of action in pain management.[93]

The University of Tennessee Medical Center has developed a protocol of alternative pathways to treatment based on giving priority to non-opioid treatments. The program is described in a video.

Resources

The American Hospital Association has published materials in support of educational efforts, as well as examples of practices dealing with non-opioid treatments.[94]

The National Safety Council has published a 2018 report in which it assesses state practices that support the use of non-non-opioid treatments.

The CDC has published its 2018 Guideline for Prescribing Opioids for Chronic Pain.[95]

The research plan of the National Institutes of Health describes NIH's program aimed at finding alternatives to addictive substances.[96]