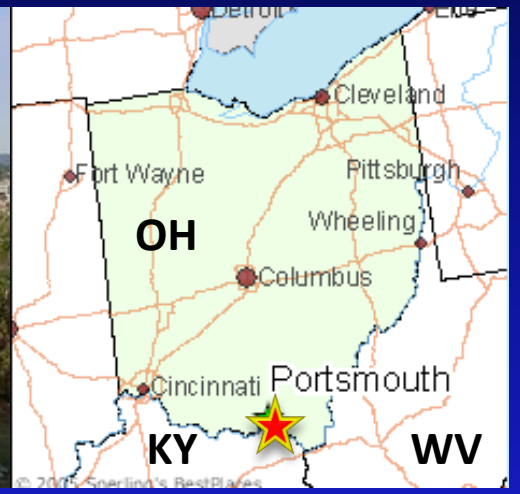
A Harm Reduction Approach to the Opioid Crisis Data and Program Evaluation



Portsmouth City Health Department

Lisa Roberts RN / Program Coordinator Drug Free Communities Support Program

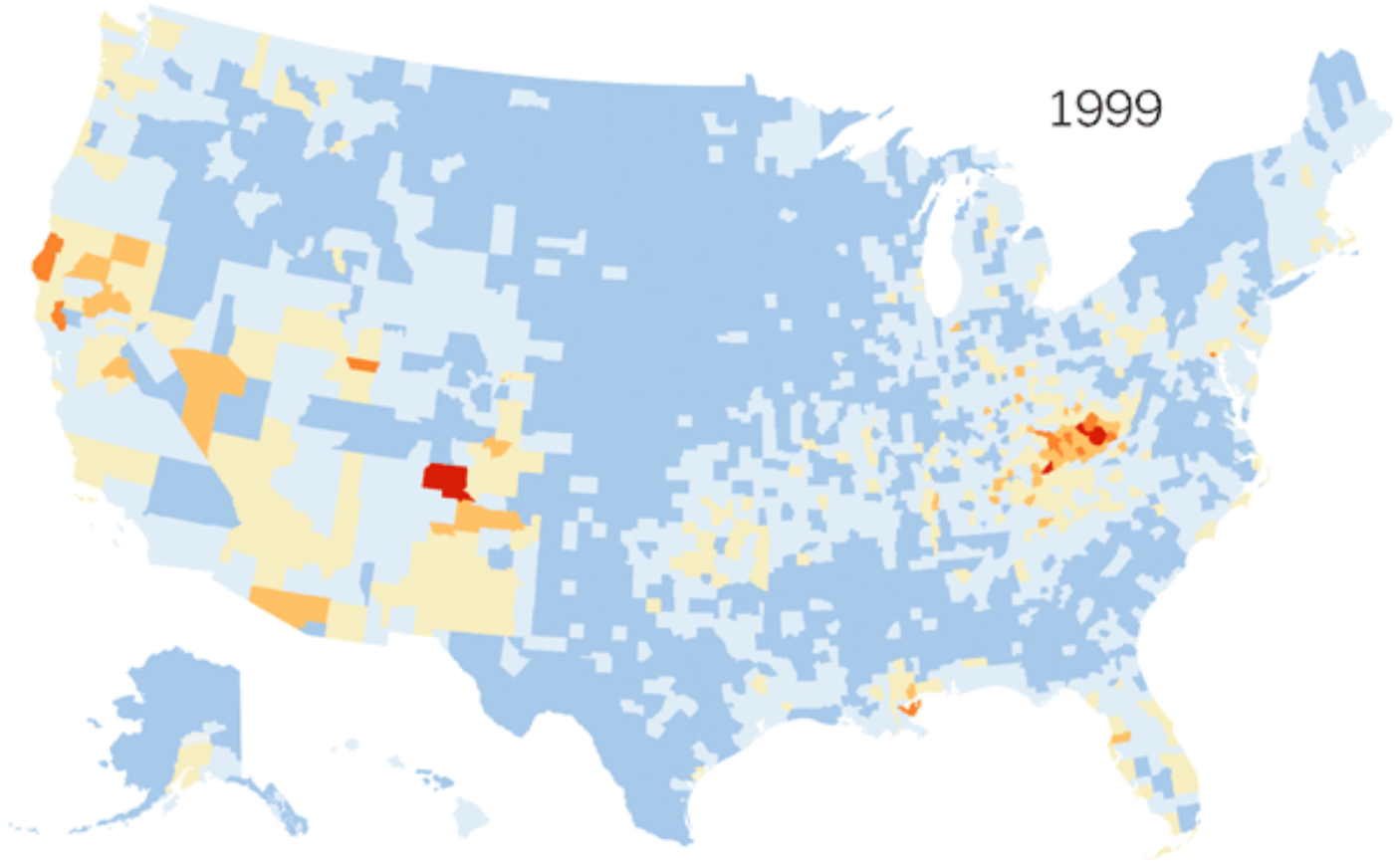
Objectives

We will:

- ❑ Describe the evolution and impact of the opioid crisis in rural America
- ❑ Understand how the opioid epidemic can be comprehensively addressed in a rural community
- ❑ Understand how to leverage data collection and analysis to improve program quality through evaluation
- ❑ Understand the link between suppressing legal drug markets and black market responses—and how rural communities can be particularly vulnerable

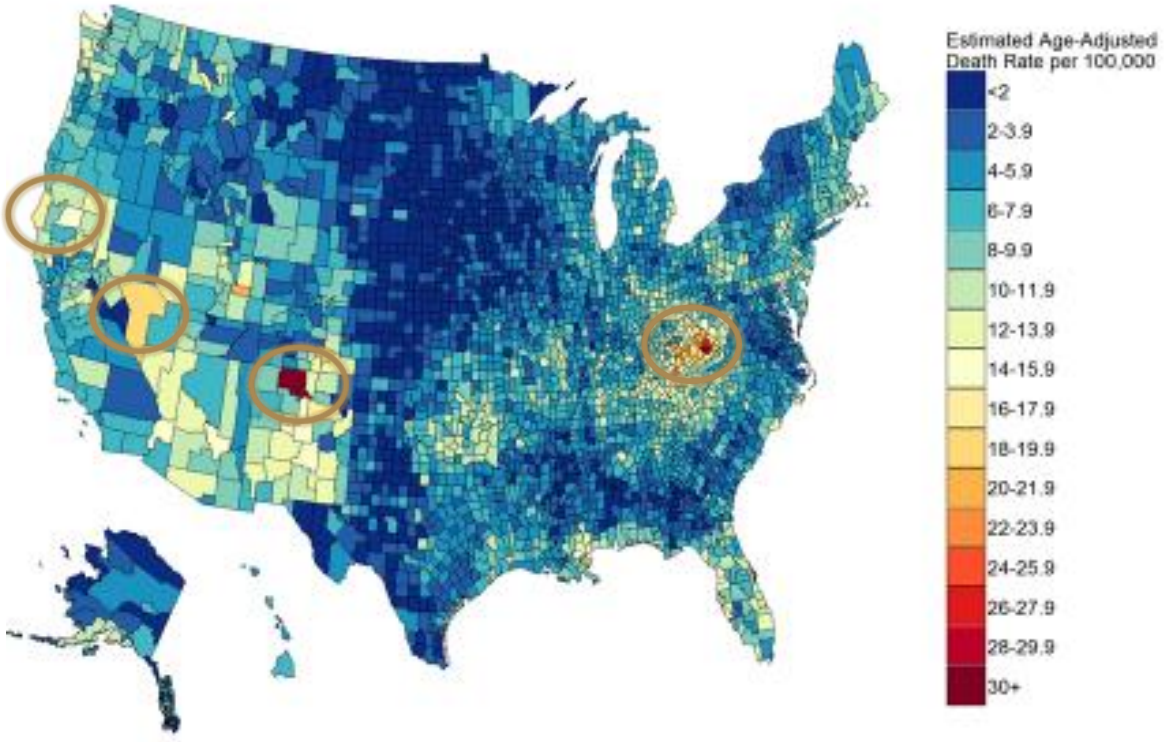
Nationally , fatal overdose has increased and spread leading to the declaration of a Public Health Emergency in 2017

Fatal Drug Overdose U.S. 1999-2015 ..... A 16 year span

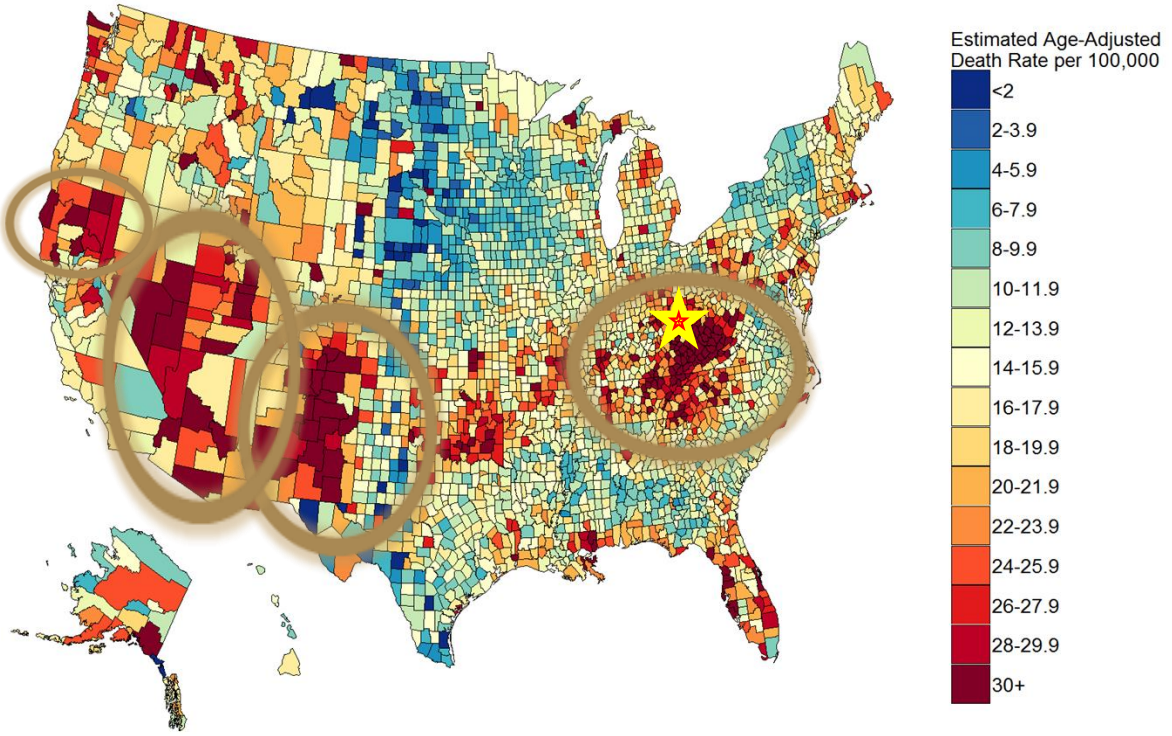


Fatal Drug Overdose Mortality U.S. 2002-2016
A 14 year span…….

2002

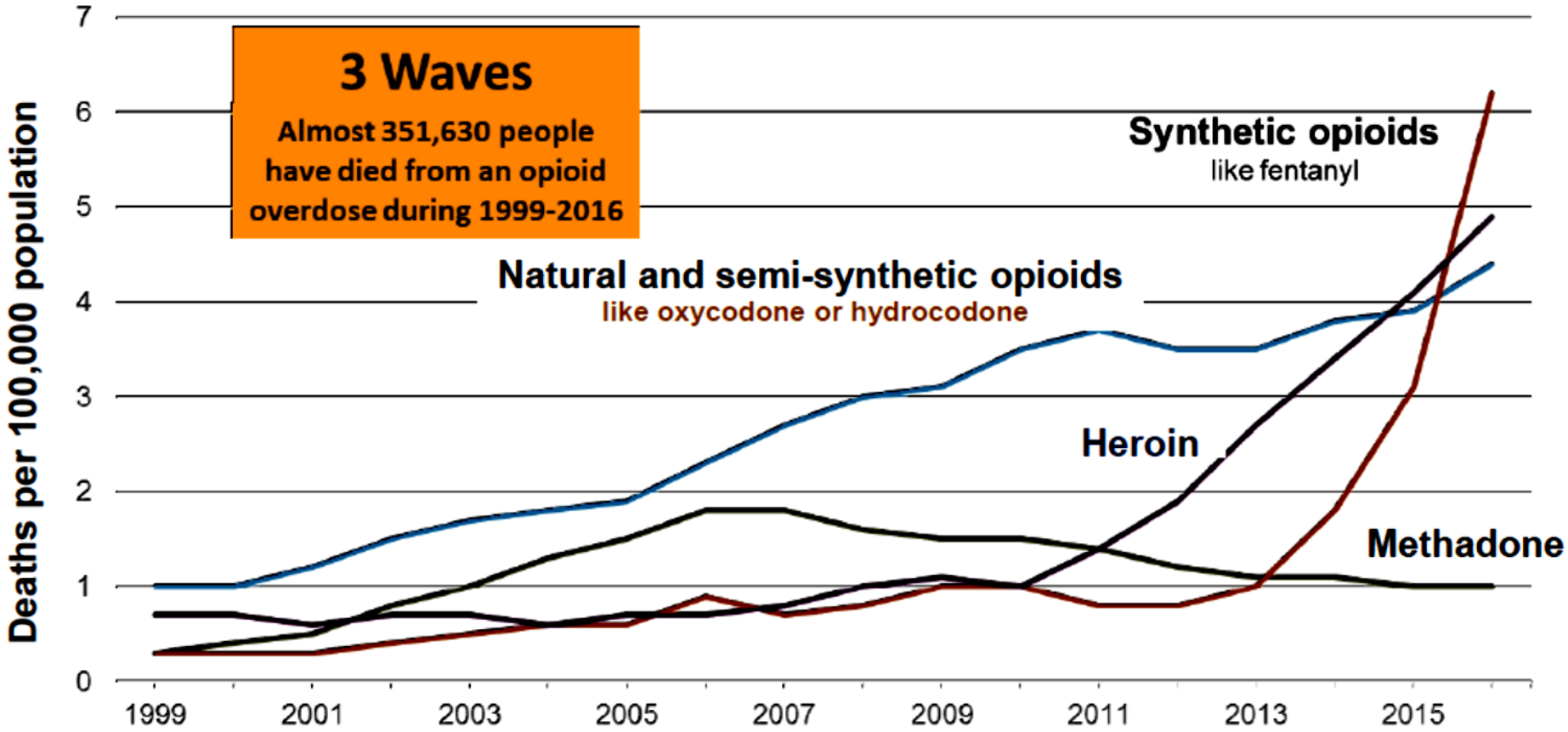


2016



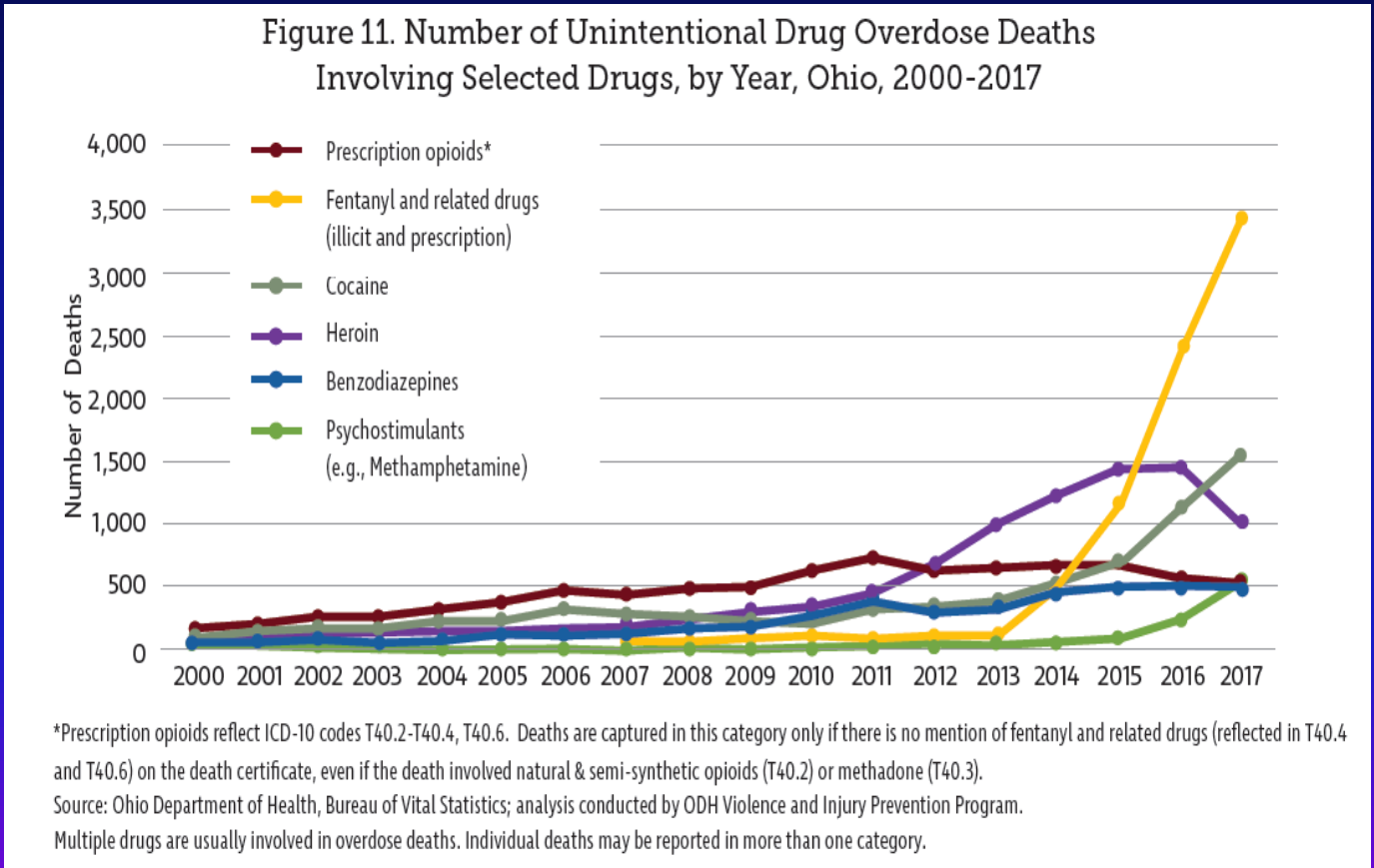
RISE IN OPIOID DEATHS

Overlapping, Entangled but Distinct Epidemics



SOURCE: National Vital Statistics System Mortality File

Unintended consequence of **Ohio's** opioid crackdown…….
* Heroin and illicit Fentanyl use and deaths increase



- Number of prescription painkillers dispensed decreased by 225 million doses, or 28%, in the past five years.

- Overall, fatal overdose has increased *significantly i*n Ohio. (4,854 in 2017) and **85.7% involved opioids**

In 2017:

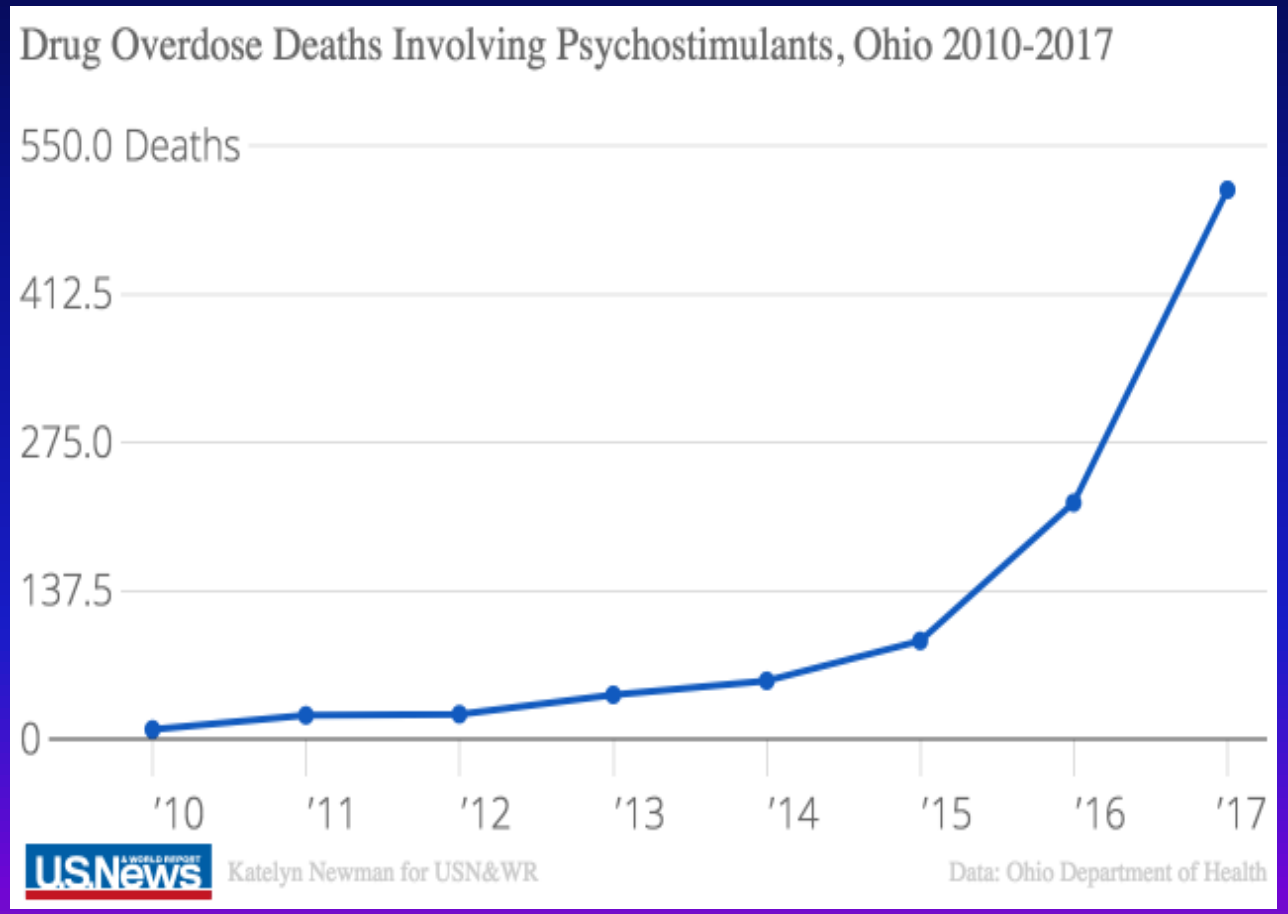
- 10.8% of fatal overdoses in Ohio involved **prescription opioids** (approx. 523 deaths)

- 20.3% involved **heroin** (approx. 987 deaths)

- 70.7% involved **fentanyl products** (approx. 3,431 deaths).

Rising incidents of deaths involving psychostimulants in Ohio

Psychostimulants like methamphetamine were involved in nine unintentional overdose deaths in Ohio in 2010. That number rose to 537 in 2017, a more than 5,000 percent increase, according to data collected by the Ohio Alliance for Innovation in Population Health.



Scioto County Data/ History and Risk Factors:

2010: First county in nation to declare public health emergency related to opioids

2017: The US declared a public health emergency

* Since 2010, numerous state policies and Legislative improvements have dramatically reduced the amounts and strengths of prescription opioids that are prescribed.

Risks:

Appalachian-Distressed County; population 75,000

Ohio's original epicenter for opioid problems

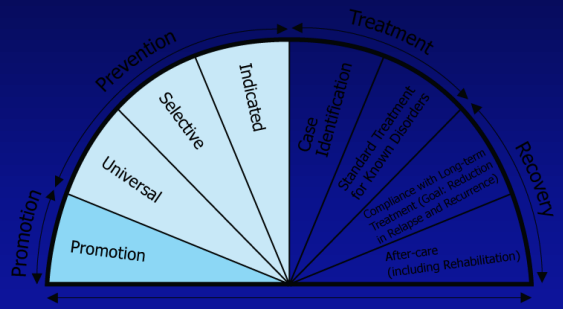
- 2000- First cluster of "pain clinics" across the river (KY)
- 2002- First pill mill established in Portsmouth (OH)
- By 2010- 12 illegitimate Pain Clinics had operated in Scioto County in a "family tree" fashion.
- Between 2002-2011 Home to a leading prescriber of oxycodone in the *nation-three different times*

- **2010**: Scioto County saw 9.7M pain pills dispensed (123 pills/person)-Highest in Ohio

Results:

- Highest fatal OD rate in state
- Highest opioid addiction rate in Ohio
- Highest rate of NAS
- Highest rate of drug incarcerations in Ohio
- Huge increase in Hepatitis C rates-highest in Ohio

Scioto County organized: Coalition formed 2010
DFC Grant began 2012



2012 -***"Drug Free Communities Support Program"*** from the White House Office of National Drug Control Policy (federal grant/ ***demand reduction***)

2012- ***HIDTA*** Designation by Congress (federal grant/ ***supply reduction***)

Used the Strategic Prevention Framework:

Strategic Planning produced 4 priorities:

1. Prevent new initiates to opioid abuse
2. Reduce harms associated with Opioid Use Disorders (death, disease, crime)
3. Reduce incidence of NAS and improve NAS outcomes
4. Treat the addicted

Scioto County Priorities and Strategies

Use data to inform strategies and Implement population-based programs designed to:

1. Prevent new initiates to opioid abuse

- Community awareness
- Promoted safe and responsible prescribing of opioids through guidelines, training, and PMP enhancements
- Promoted alternatives to opioids for pain
- Developed and implemented youth prevention initiatives

2. Reduce harms associated with Opioid Use Disorders/ Prevent further health problems

- Piloted Ohio's first Community-Based Naloxone Program
- Started a Syringe Exchange Program to reduce BBP diseases and link participants to recovery services

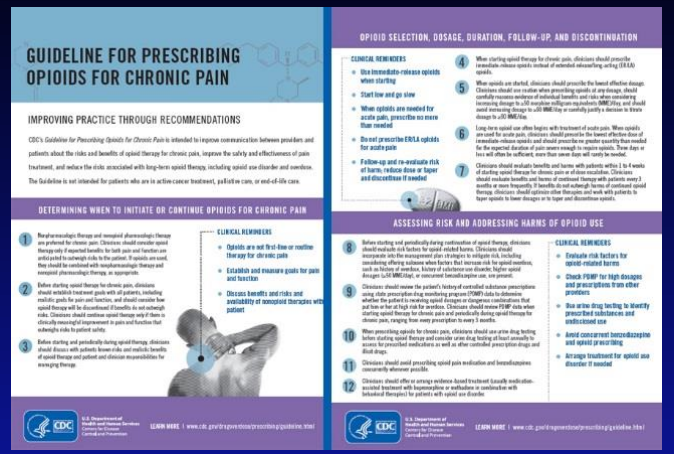
3. Reduce NAS and improve outcomes in newborns

- Established a Neonatal Task Force at the local hospital

4. Treat the addicted

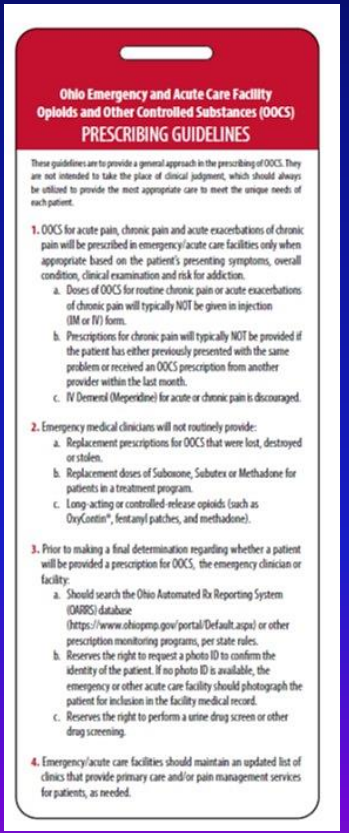
- Expanded access to addiction treatment including Medication-Assisted Treatment
- Expanded Drug Courts to provide oversight and improve addicted offender and family Outcomes
- 2017-Established a Hub and Spoke Model program at Portsmouth City Health Department

Strategy 1. Prevent new initiates to opioid abuse



- Ohio's Opioid prescribing Guidelines (2013)
- Prescription Monitoring Program mandates and enhancements
- Prescription Drug disposal (Take Back Days and permanent Rx Drop Boxes)
- Adult and adolescent prevention initiatives

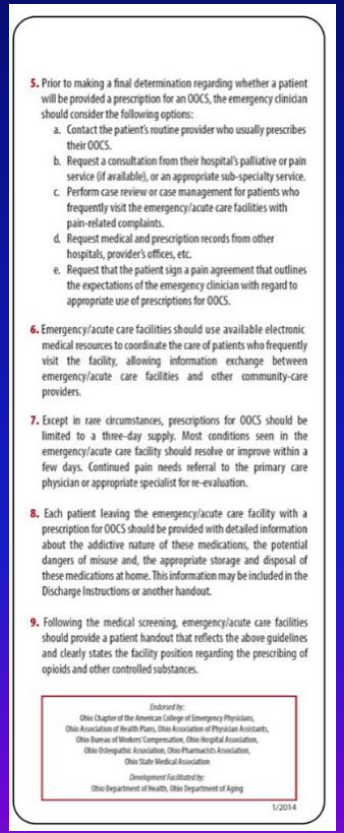
Outcomes: Scioto County- Opioid Consumption 2010-2018
(excluding treatment medications)



Ohio Emergency and Acute Care Facility Opioids and Other Controlled Substances (OOCS) PRESCRIBING GUIDELINES

These guidelines are to provide a general approach in the prescribing of OOCS. They are not intended to take the place of clinical judgment, which should always be utilized to provide the most appropriate care to meet the unique needs of each patient.

1. OOCS for acute pain, chronic pain and acute exacerbations of chronic pain will be prescribed in emergency/acute care facilities only when appropriate based on the patient's presenting symptoms, overall condition, clinical examination and risk for addiction.
   a. Doses of OOCS for routine chronic pain or acute exacerbations of chronic pain will typically NOT be given in injection (IM or IV) form.
   b. Prescriptions for chronic pain will typically NOT be provided if the patient has either previously presented with the same problem or received an OOCS prescription from another provider within the last month.
   c. IV Demerol (Meperidine) for acute or chronic pain is discouraged.
2. Emergency medical clinicians will not routinely provide:
   a. Replacement prescriptions for OOCS that were lost, destroyed or stolen.
   b. Replacement doses of Suboxone, Subutex or Methadone for patients in a treatment program.
   c. Long-acting or controlled-release opioids (such as OxyContin®, fentanyl patches, and methadone).
3. Prior to making a final determination regarding whether a patient will be provided a prescription for OOCS, the emergency clinician or facility:
   a. Should search the Ohio Automated Rx Reporting System (OARRS) database (https://www.ohiopmp.gov/portal/Default.aspx) or other prescription monitoring programs, per state rules.
   b. Reserves the right to request a photo ID to confirm the identity of the patient. If no photo ID is available, the emergency or other acute care facility should photograph the patient for inclusion in the facility medical record.
   c. Reserves the right to perform a urine drug screen or other drug screening.
4. Emergency/acute care facilities should maintain an updated list of clinics that provide primary care and/or pain management services for patients, as needed.

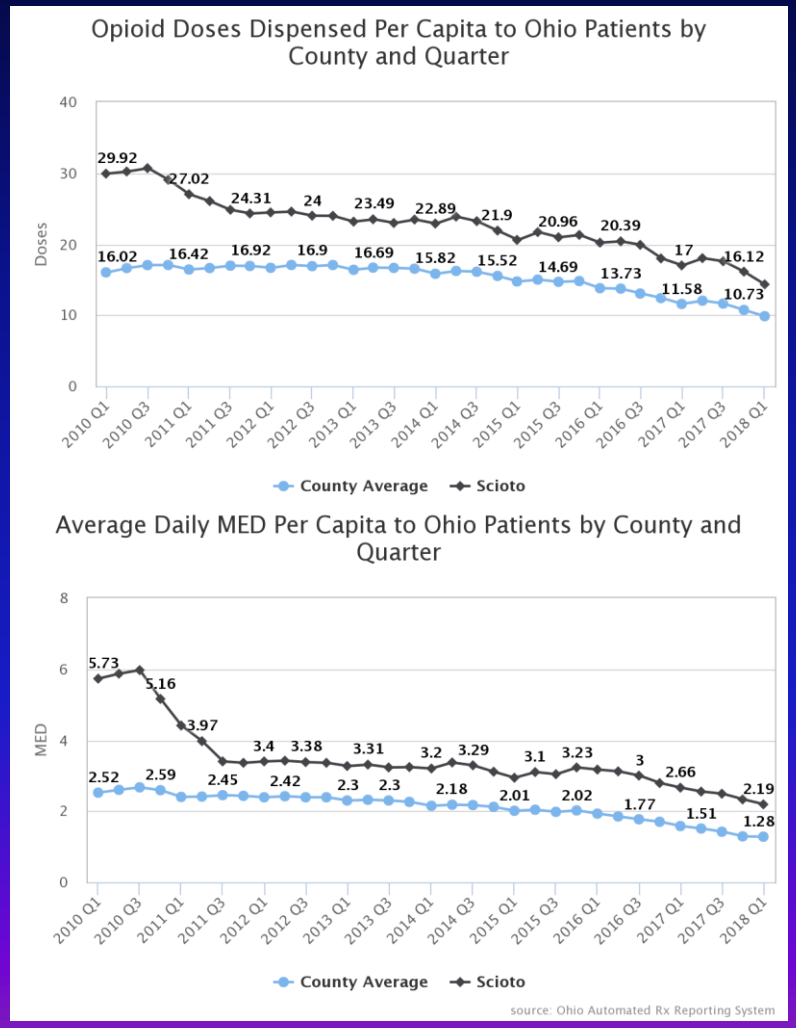


5. Prior to making a final determination regarding whether a patient will be provided a prescription for an OOCS, the emergency clinician should consider the following options:
   a. Contact the patient's routine provider who usually prescribes their OOCS.
   b. Request a consultation from their hospital's palliative or pain service (if available), or an appropriate sub-specialty service.
   c. Perform case review or case management for patients who frequently visit the emergency/acute care facilities with pain-related complaints.
   d. Request medical and prescription records from other hospitals, provider's offices, etc.
   e. Request that the patient sign a pain agreement that outlines the expectations of the emergency clinician with regard to appropriate use of prescriptions for OOCS.
6. Emergency/acute care facilities should use available electronic medical resources to coordinate the care of patients who frequently visit the facility, allowing information exchange between emergency/acute care facilities and other community-care providers.
7. Except in rare circumstances, prescriptions for OOCS should be limited to a three-day supply. Most conditions seen in the emergency/acute care facility should resolve or improve within a few days. Continued pain needs referral to the primary care physician or appropriate specialist for re-evaluation.
8. Each patient leaving the emergency/acute care facility with a prescription for OOCS should be provided with detailed information about the addictive nature of these medications, the potential dangers of misuse and, the appropriate storage and disposal of these medications at home. This information may be included in the Discharge Instructions or another handout.
9. Following the medical screening, emergency/acute care facilities should provide a patient handout that reflects the above guidelines and clearly states the facility position regarding the prescribing of opioids and other controlled substances.

Endorsed by:
Ohio Chapter of the American College of Emergency Physicians, Ohio Association of Health Plans, Ohio Association of Physician Assistants, Ohio Bureau of Workers' Compensation, Ohio Hospital Association, Ohio Osteopathic Association, Ohio Pharmacists Association, Ohio State Medical Association

Development Facilitated by:
Ohio Department of Health, Ohio Department of Aging

1/2014

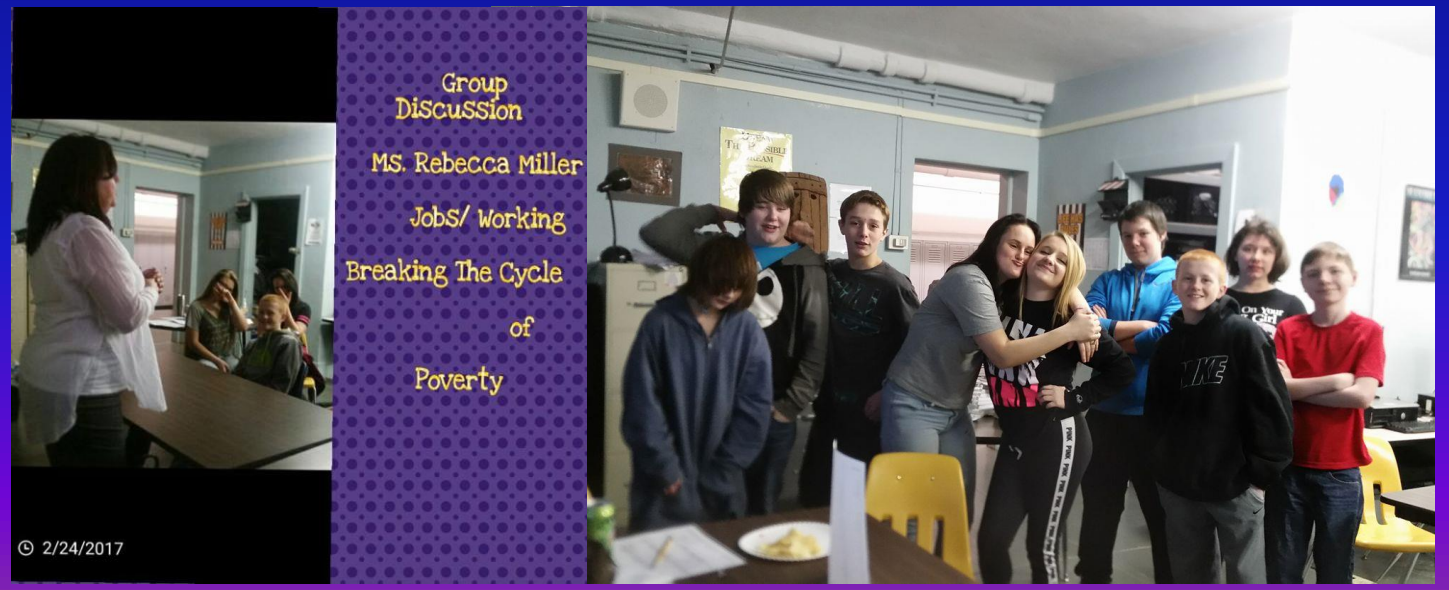


46% decrease in opioids dispensed per capita

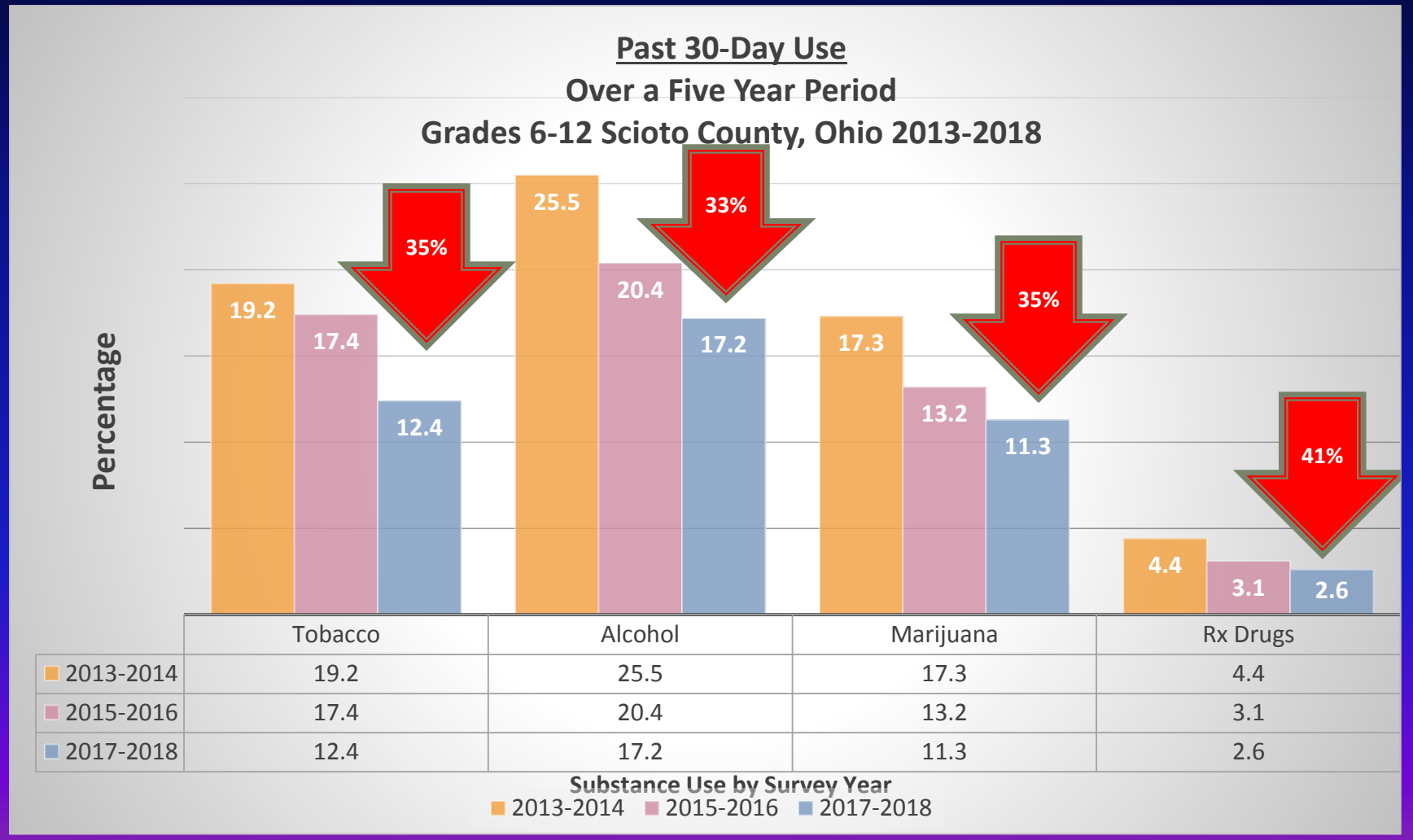
62% decrease in average Daily MED per capita

Teens Linked to Care Pilot Project

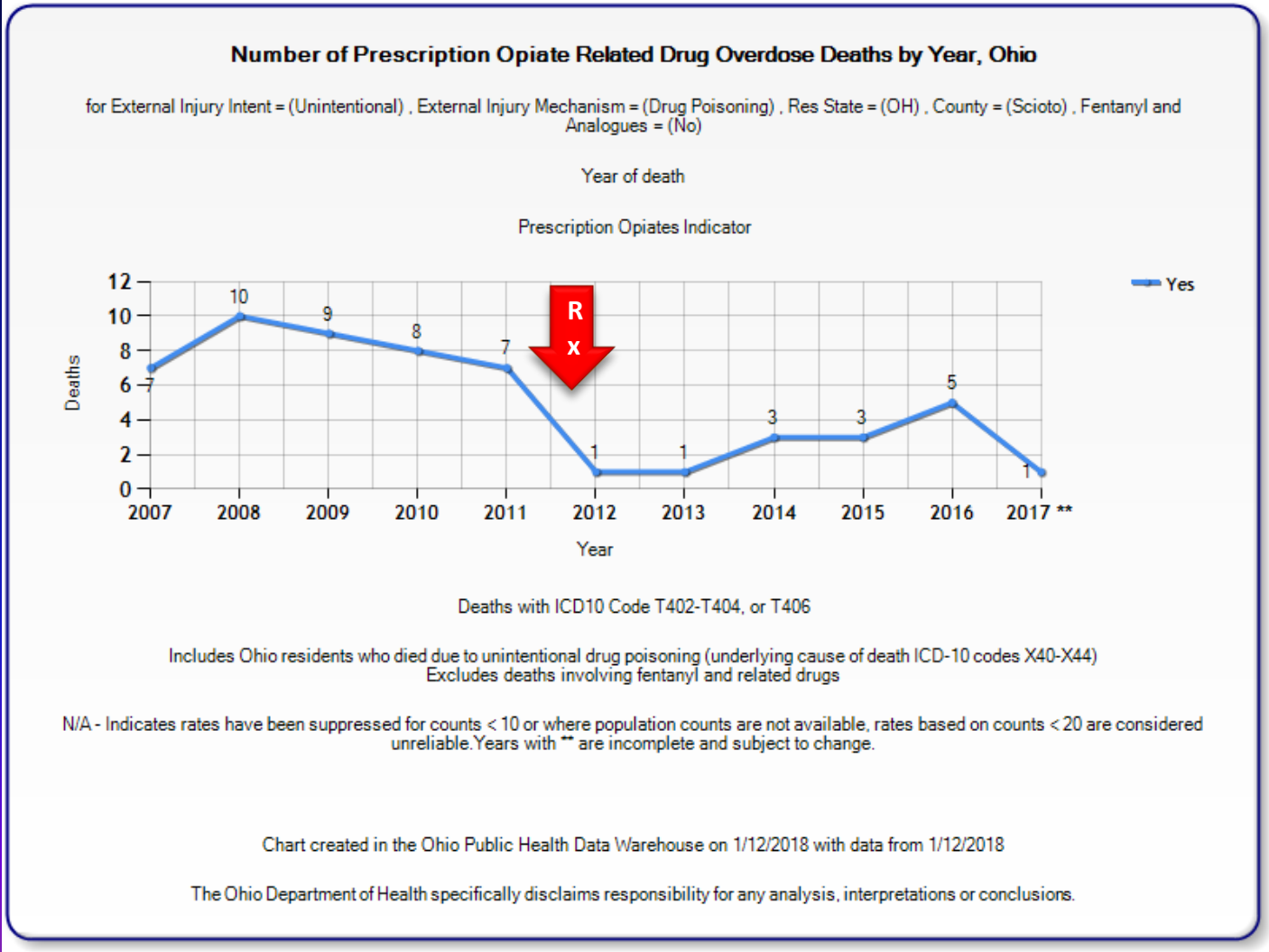
- Only 3 in the United States funded by Conrad N. Hilton Foundation through the CDC Division of Adolescent and School Health
- Provides substance use, STD, and HIV prevention education, access to health services, safe and supportive environments, and monitoring and evaluation for high-risk communities in Kentucky, Ohio and Indiana.
- Youth-Led and focuses on high-risk youth (indicated prevention) at CAPE school



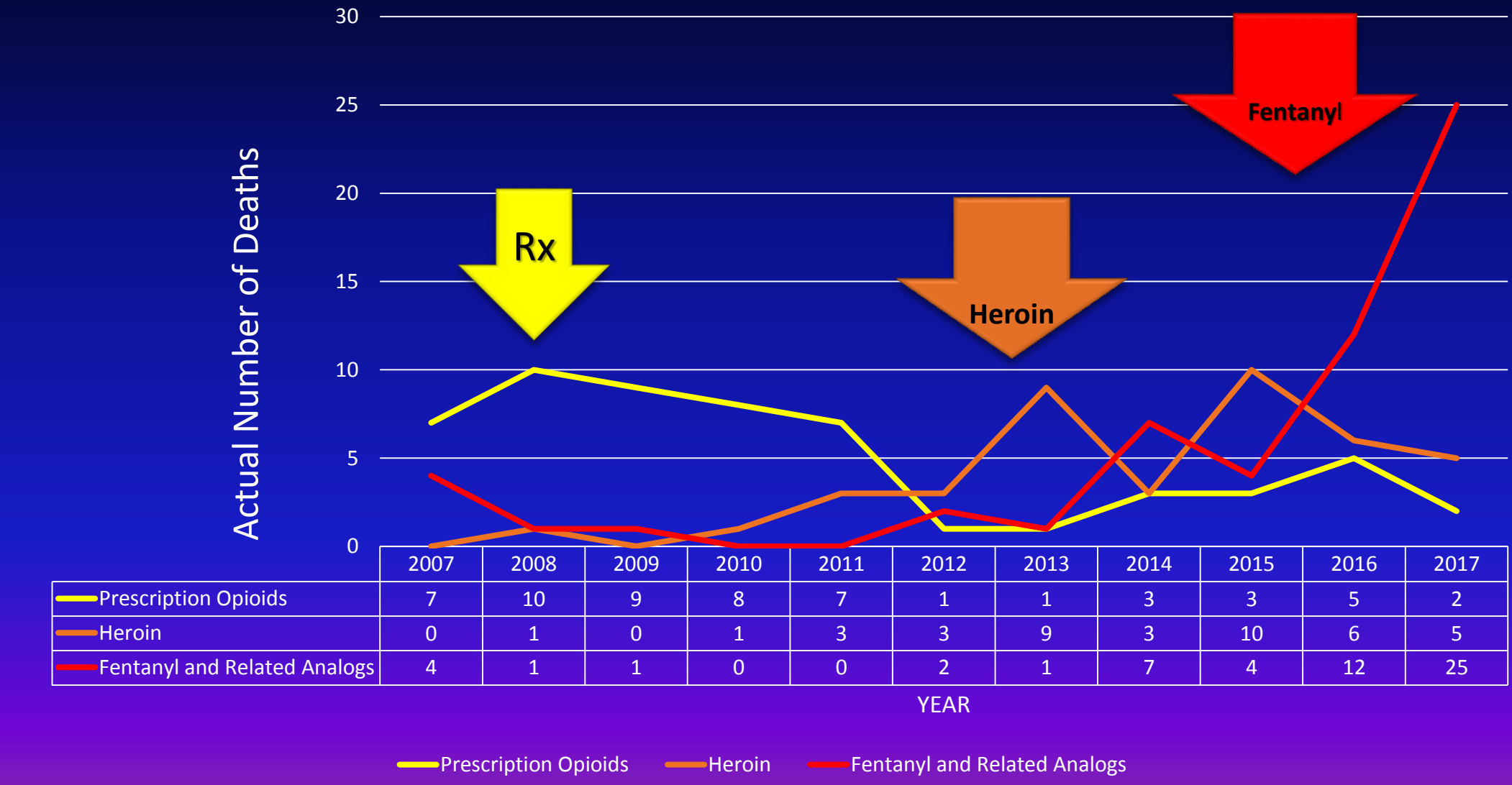
Outcomes: Scioto County High School Surveys 2013-2016
Teen substance use declined-largest reduction involved non-medical Rx use



Outcomes: Reductions in fatal OD due to *Rx Opioids* .....but an overall increase in OD's

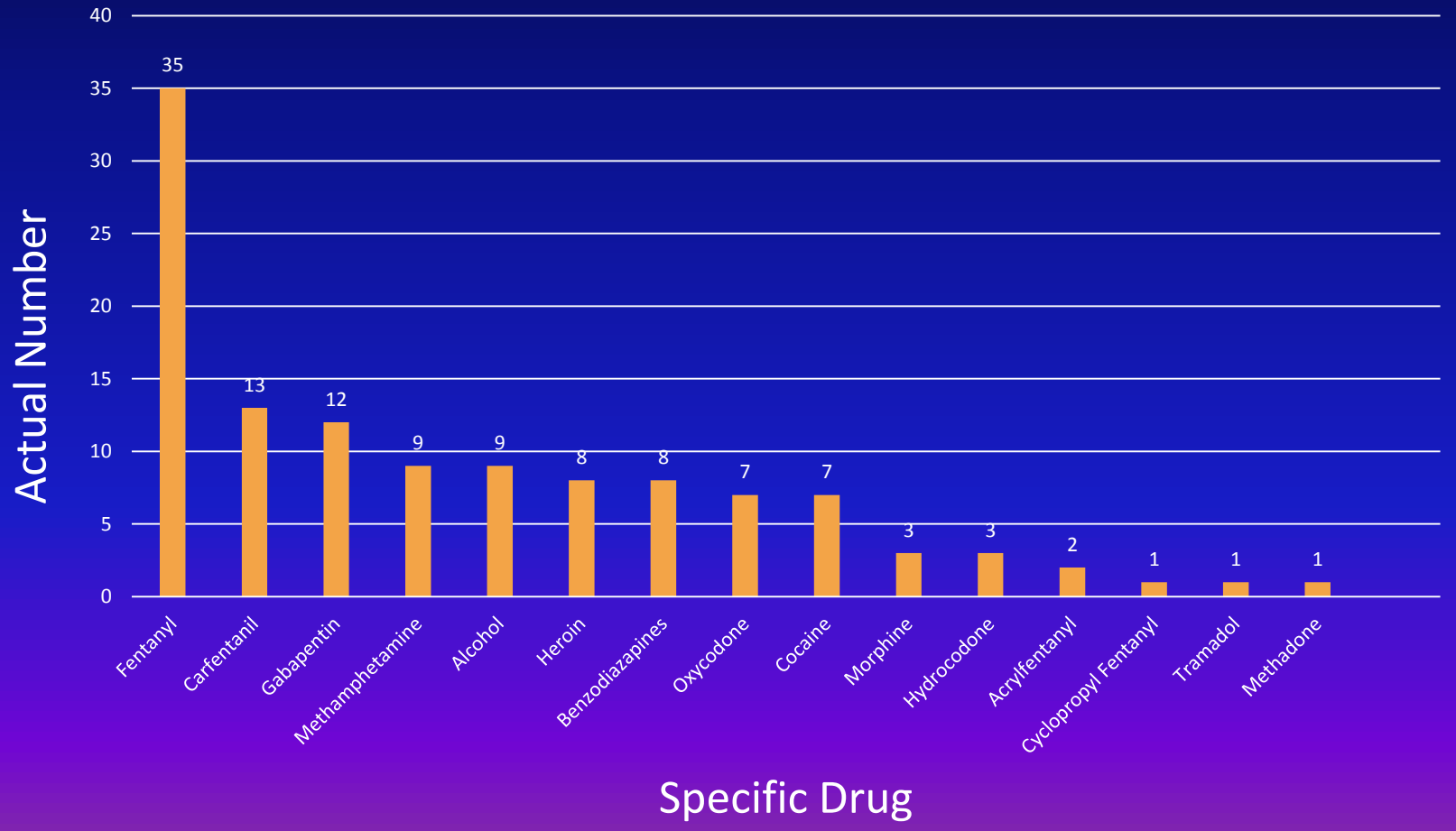


Unintentional Opioid Related Fatal Overdose Scioto County, Ohio 2007-2017, by Cause and Year

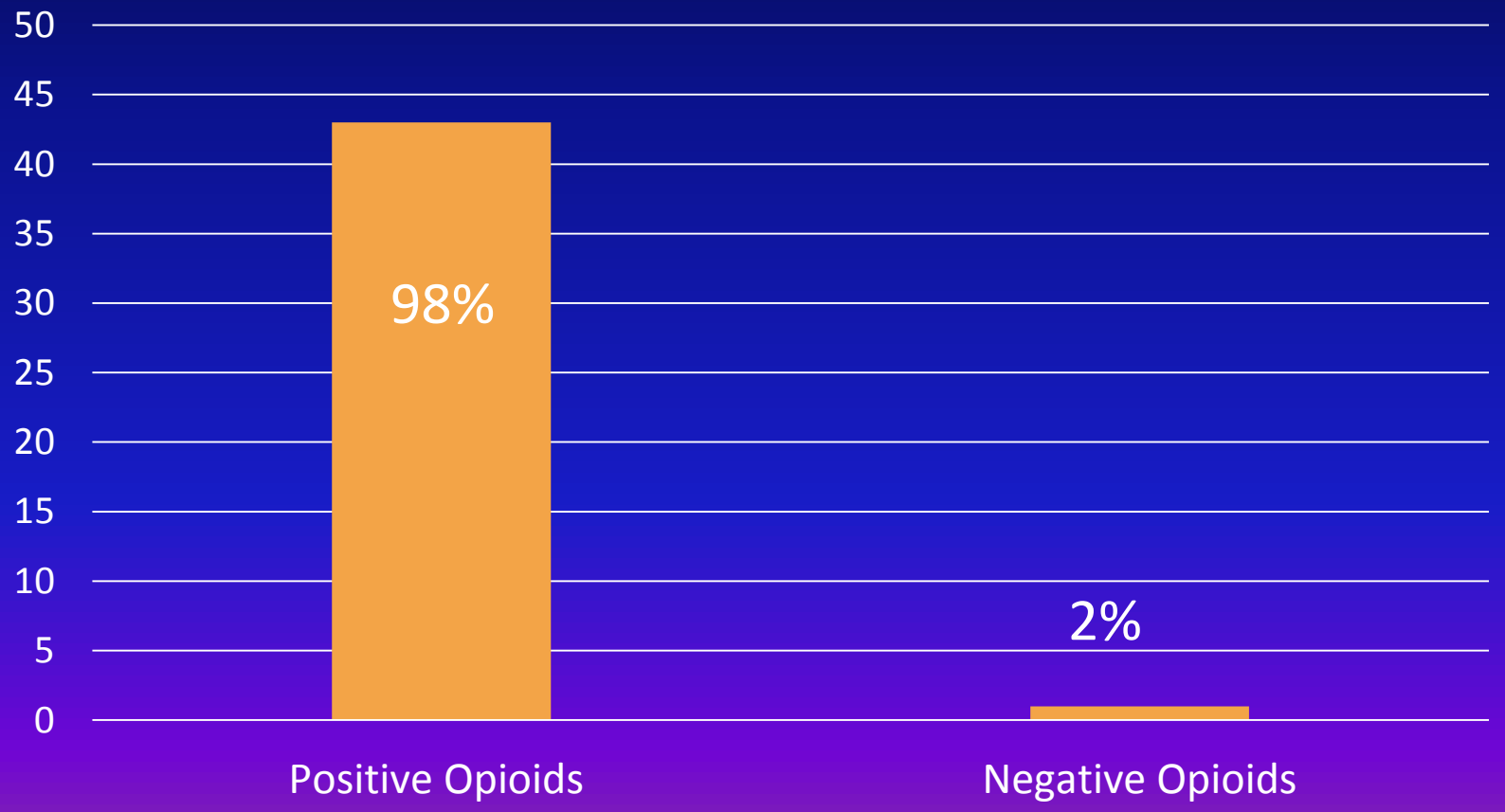


	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
Prescription Opioids	7	10	9	8	7	1	1	3	3	5	2
Heroin	0	1	0	1	3	3	9	3	10	6	5
Fentanyl and Related Analogs	4	1	1	0	0	2	1	7	4	12	25

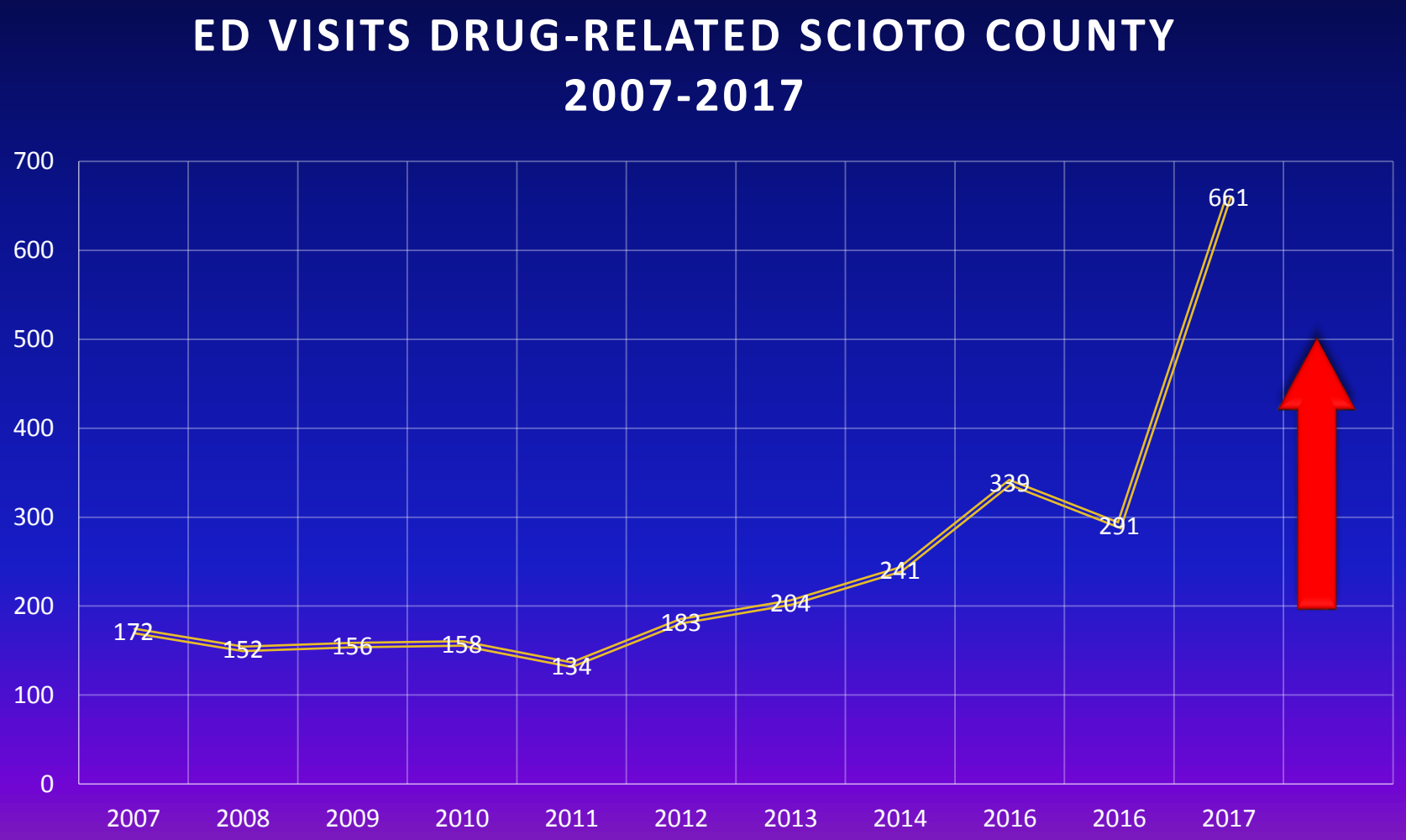
2017 Scioto County Accidental Overdose Decedents / Drugs Mentioned in Post Mortem Toxicology



2017 Scioto County Accidental Overdose Decedents/ Opioid Presence

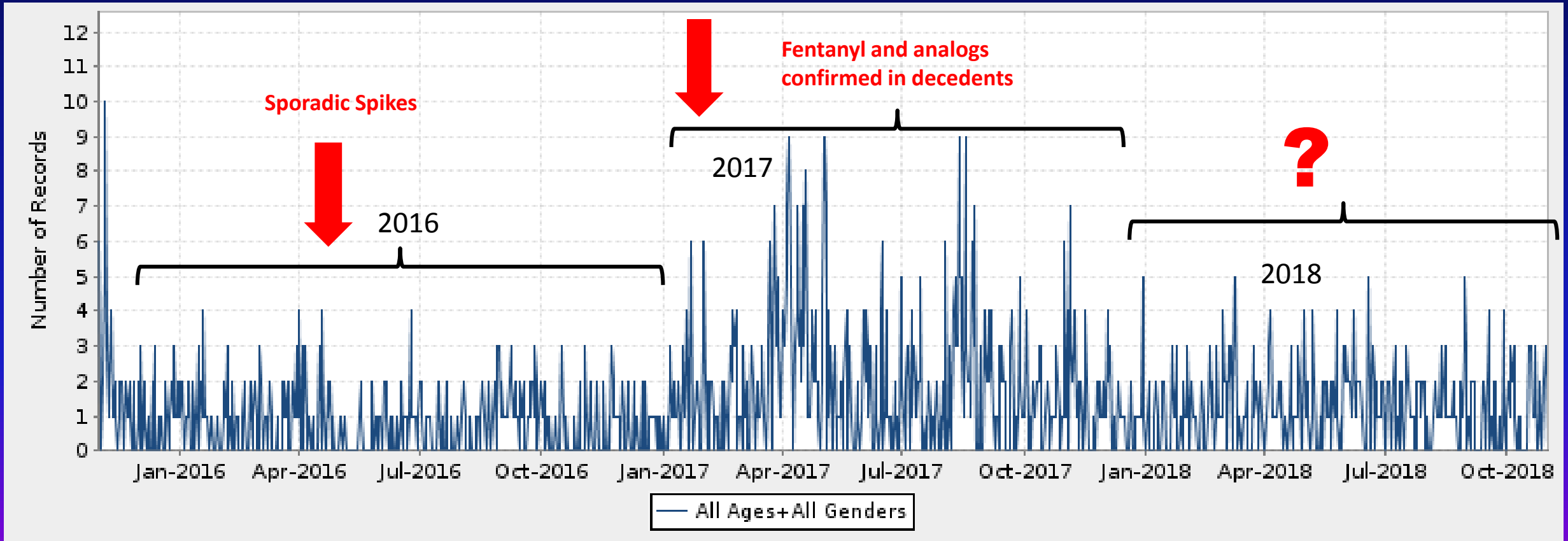


Scioto County Drug-Related ED / Urgent Care Visits 2007-2017



SCIOTO COUNTY

Live Surveillance of ED Visits over last 30 months:
Early Warning EpiCenter ALERT: Scioto County Residents Scioto County, OH – Drug-Related Visits
Jan. 1016 through Oct 2018 (Approximately 1,300 visits)



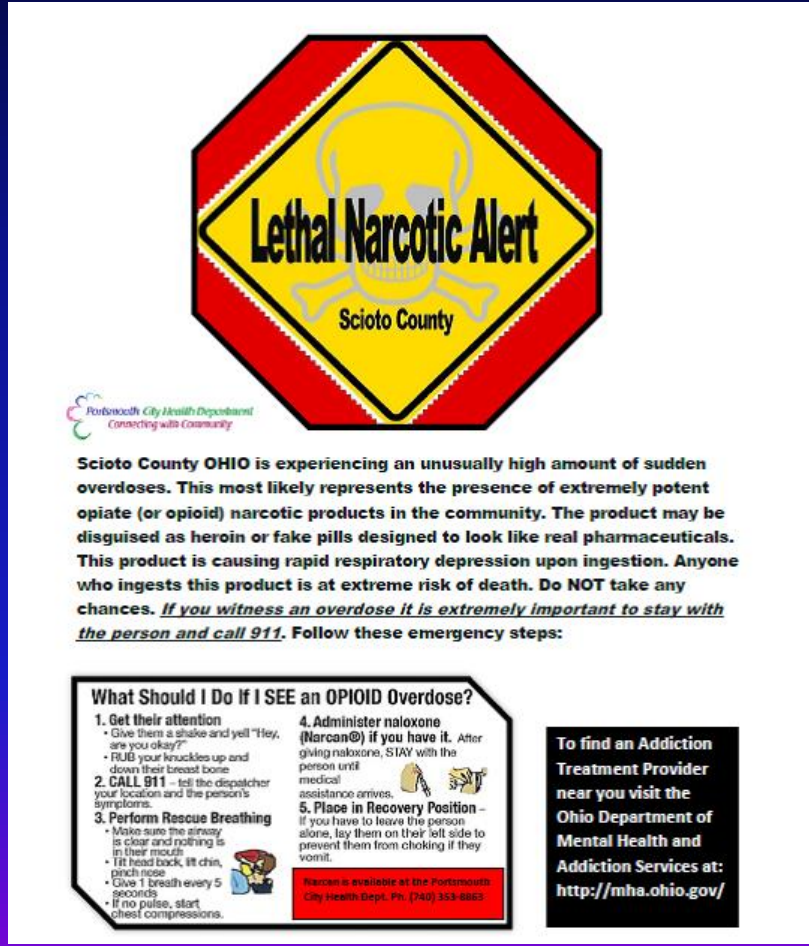
Scioto County has implemented a **Rapid Community Response Plan** to Sudden Increases in OD

- Surveillance: EpiCenter Electronic Surveillance System
- Public Health Investigation
- Analysis (OD Death Reviews by Public Health)
- Communication with Partners

(Overdose Alert Group text for immediate notification)

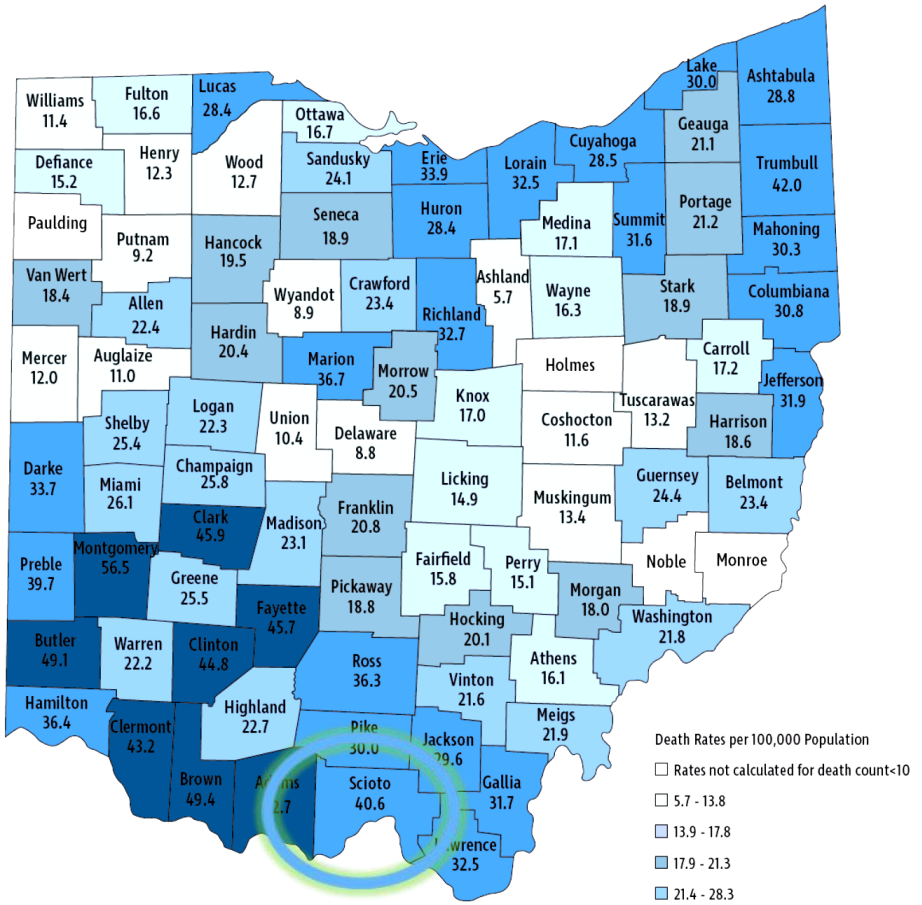
- Partner Response
- Lethal Narcotic Alerts to the Public and

First Responders through Emergency Management Agency



Scioto County **ranks #10** in Ohio for Fatal Overdose 2012-2017

Figure 13. Average Age-Adjusted Unintentional Drug Overdose Death Rate Per 100,000 Population, by County, 2012-2017 [1,2]



[1] Sources: Ohio Department of Health, Bureau of Vital Statistics; Analysis by ODH Injury Prevention Program; U.S. Census Bureau (Vintage 2016 population estimates).

Table 3. Number of Unintentional Drug Overdose Deaths and Average Crude and Age-Adjusted Annual Death Rates Per 100,000 Population, by County, 2005-2017 [1,2,3]

County	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2012-2017 Total	Crude Rate	Age Adjusted Rate
Montgomery	116	125	130	145	121	113	119	150	199	251	239	320	521	1,680	52.6	56.5
Brown	5	5	10	12	13	17	11	14	17	17	23	18	31	120	45.6	49.4
Butler	31	47	45	55	68	59	80	92	120	151	195	211	260	1,029	45.8	49.1
Clark	15	18	20	19	19	19	34	36	28	38	71	73	96	342	42	45.9
Fayette	3	5	5	2	4	3	5	5	4	12	16	7	26	70	40.7	45.7
Clinton	4	6	8	10	11	3	6	13	16	13	20	12	30	104	41.4	44.8
Clermont	22	31	36	38	32	49	49	56	65	80	105	96	91	493	40.7	43.2
Adams	6	6	5	6	10	6	6	10	6	10	12	12	14	64	38.1	42.7
Trumbull	29	30	58	41	43	43	57	34	37	54	89	111	135	460	37.6	42.0
Scioto	17	15	19	20	24	22	25	17	18	23	30	35	51	174	37.6	40.6
Preble	4	3	7	11	9	7	5	11	6	8	15	21	29	90	36.2	39.7
Marion	7	3	8	9	9	8	13	19	18	27	22	24	30	140	35.6	36.7
Hamilton	86	98	96	113	101	110	150	159	212	248	335	318	444	1,716	35.4	36.4
Ross	14	11	19	20	24	17	18	12	15	29	38	40	29	163	35.2	36.3
Erie	3	4	5	6	6	18	12	12	16	17	23	37	32	137	30.2	33.9
Darke	4	1	7	9	3	5	5	9	9	11	13	19	28	89	28.5	33.7
Richland	13	16	10	12	18	14	15	11	22	31	36	68	49	217	29.7	32.7
Lawrence	5	7	8	13	11	9	17	10	9	8	23	27	32	109	29.7	32.5
Lorain	13	18	16	18	25	21	25	70	69	71	63	146	133	552	30.2	32.5
Jefferson	12	12	9	15	23	13	25	14	17	21	16	14	28	110	27.1	31.9
Gallia	4	6	2	4	5	3	6	3	7	6	9	11	18	54	29.7	31.7
Summit	50	53	66	46	54	66	56	91	76	118	173	298	239	995	30.6	31.6
Columbiana	1	7	7	8	9	8	18	17	27	19	30	39	48	180	28.6	30.8
Mahoning	29	25	25	42	38	48	47	48	41	48	60	83	112	392	28.1	30.3
Lake	18	29	26	15	20	39	42	48	43	53	50	94	91	379	27.5	30.0
Pike	3	2	6	4	9	4	13	3	6	5	11	7	13	45	26.5	30.0
Jackson	4	14	7	8	5	7	8	9	12	8	9	7	10	55	28.1	29.6
Ashtabula	6	5	7	10	11	18	18	26	15	27	21	39	26	154	26	28.8
Cuyahoga	115	168	134	144	144	159	212	230	255	255	275	547	598	2,160	28.6	28.5
Huron	5	5	6	5	8	4	8	8	14	17	10	16	27	92	26.2	28.4
Lucas	49	44	75	73	49	54	57	88	72	115	118	157	153	703	27	28.4
Ohio total	1,020	1,261	1,351	1,473	1,423	1,544	1,772	1,914	2,110	2,531	3,050	4,050	4,854	18,509	26.6	27.9

Strategy 2. Reduce the Harms Associated with Opioid Use Disorders

PROJECT DAWN

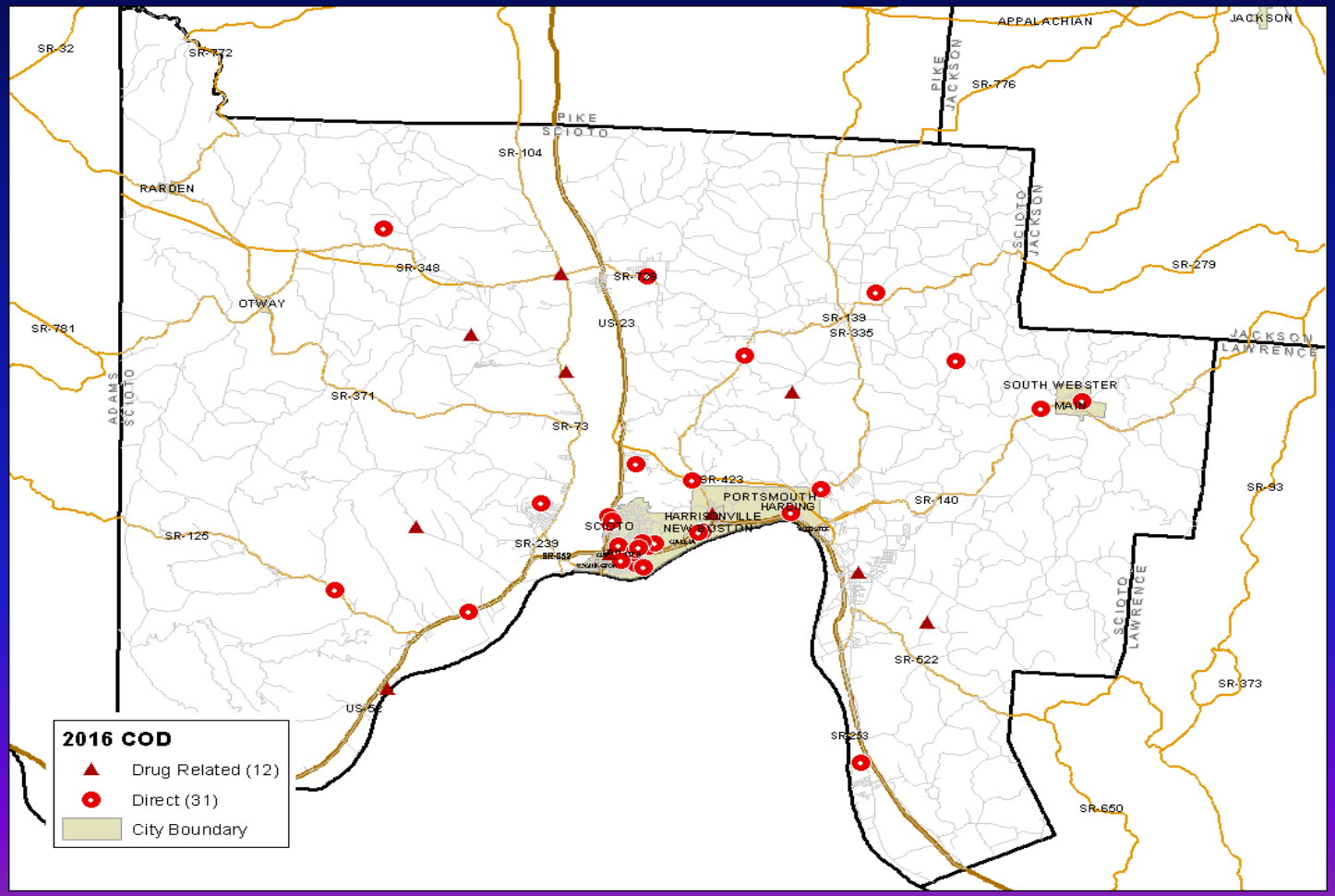
Billboards and PSA's/ State Public Awareness Campaign ODH/OhioMHAS

Naloxone use expanded to non-traditional First Responders (LE, FD, lay savers.)

- Ohio passed laws to increase and ease access
- 2016 Naloxone made available in select pharmacies through a medical protocol (*CVS and Kroger)
- Good Samaritan Law passed to encourage 911 calls
- Train and supply non-traditional first responders with naloxone

Results: Since 2012 hundreds of overdose reversals in SCIOTO COUNTY and thousands across Ohio

Geographical Drug Fatality Map
Scioto County , 2016



Annual Overdose Awareness Day and Targeted Outreach to High Burden Communities

Partner with the “community hub”

Social Media Campaign

Mass public naloxone training/provision

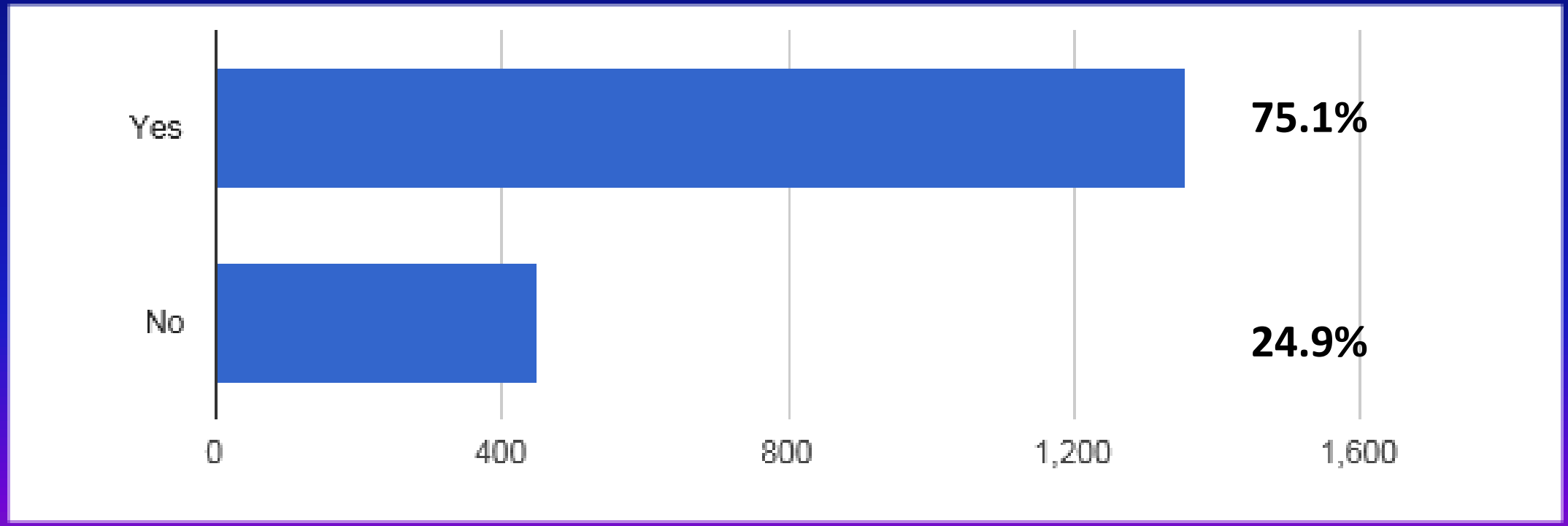
TV News “Top Story”

The Troops

Distribute “Real Life Angel” cups

Percent of SEP Participants who currently carry Narcan

***Increase of 22% in past year**

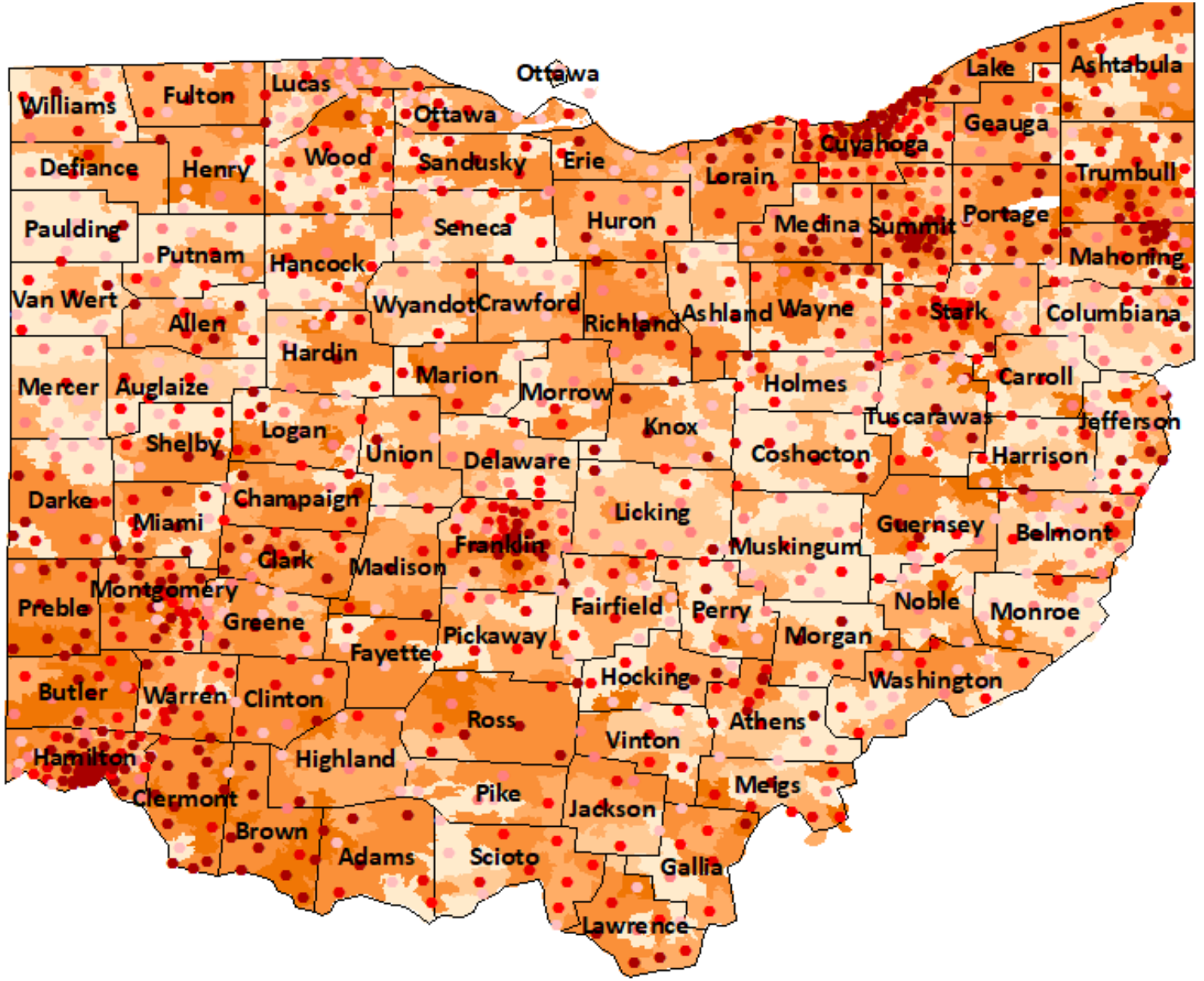


Overdose deaths per 100,000 py

- 0.000000
- 0.000001 - 10.000000
- 10.000001 - 20.000000
- 20.000001 - 50.000000
- 50.000001 - 2791.290000

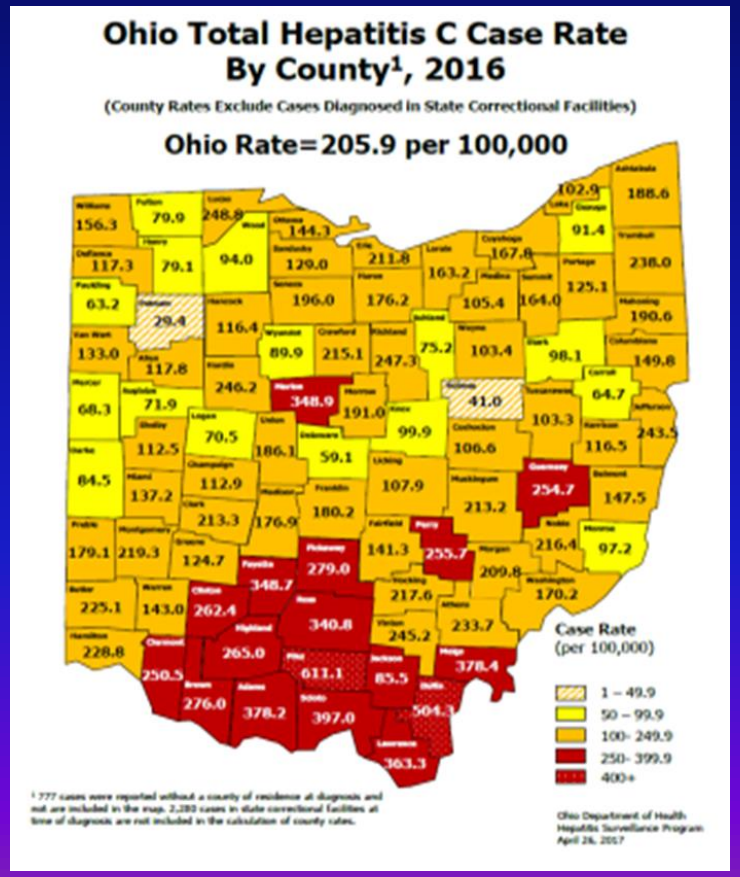
Naloxone admin. per 100,000 py

- 0.000000
- 0.000001 - 50.000000
- 50.000001 - 100.000000
- 100.000001 - 200.000000
- 200.000001 - 11844.220000



Top 220 US Counties for Hepatitis C Considered at risk for HIV Outbreaks-2015

Source: CDC



"Prevention NOT Permission" SEP at the Portsmouth City Health Department Established 2011 under old state rules. We had to declare an emergency.

Federal:

- In 2016, Congress partially lifted the ban on federal funding for SEP's.
- **Still can't purchase syringes.**

State:

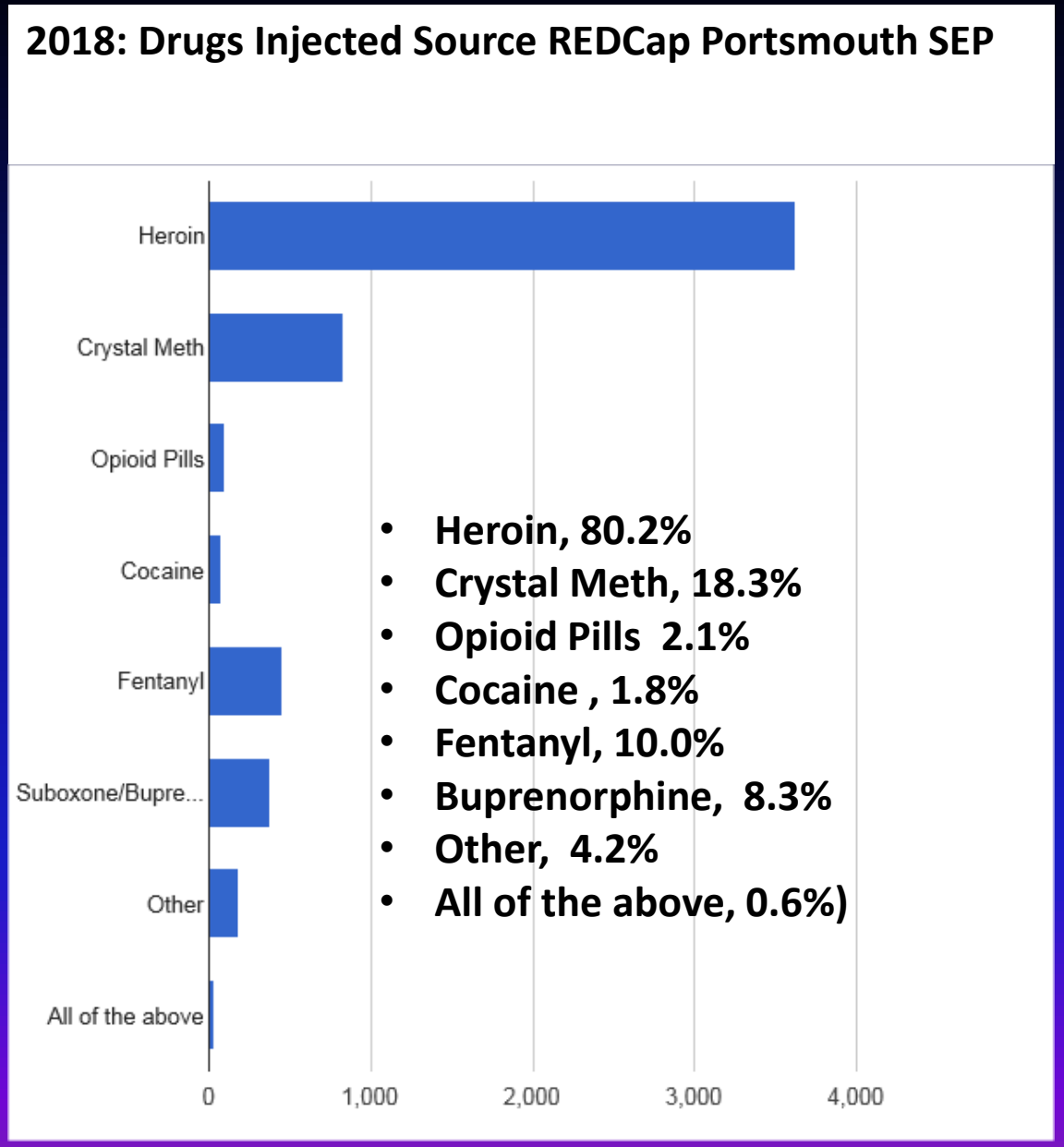
- Effective Sept. 2015, Ohio Boards of Health can establish a "Blood Born Pathogen Prevention Program" without declaring an emergency
- In July 2018, the Ohio Dept. of Health was granted a waiver from CDC to support SEP's.
- **Still can't purchase syringes**

Scioto County:

- Over 600 participants and over 250,000 syringes exchanged annually
- Staff are paid through state/federal. SYRINGES are purchased through foundation grants.
- Allows ongoing access to a high-risk population and BBP Disease Testing/ Immunizations/ Narcan
- **Recently began distributing Fentanyl Test Strips to gauge presence in illicit drug supply**
- Partner with multiple Universities on Research studies to inform science

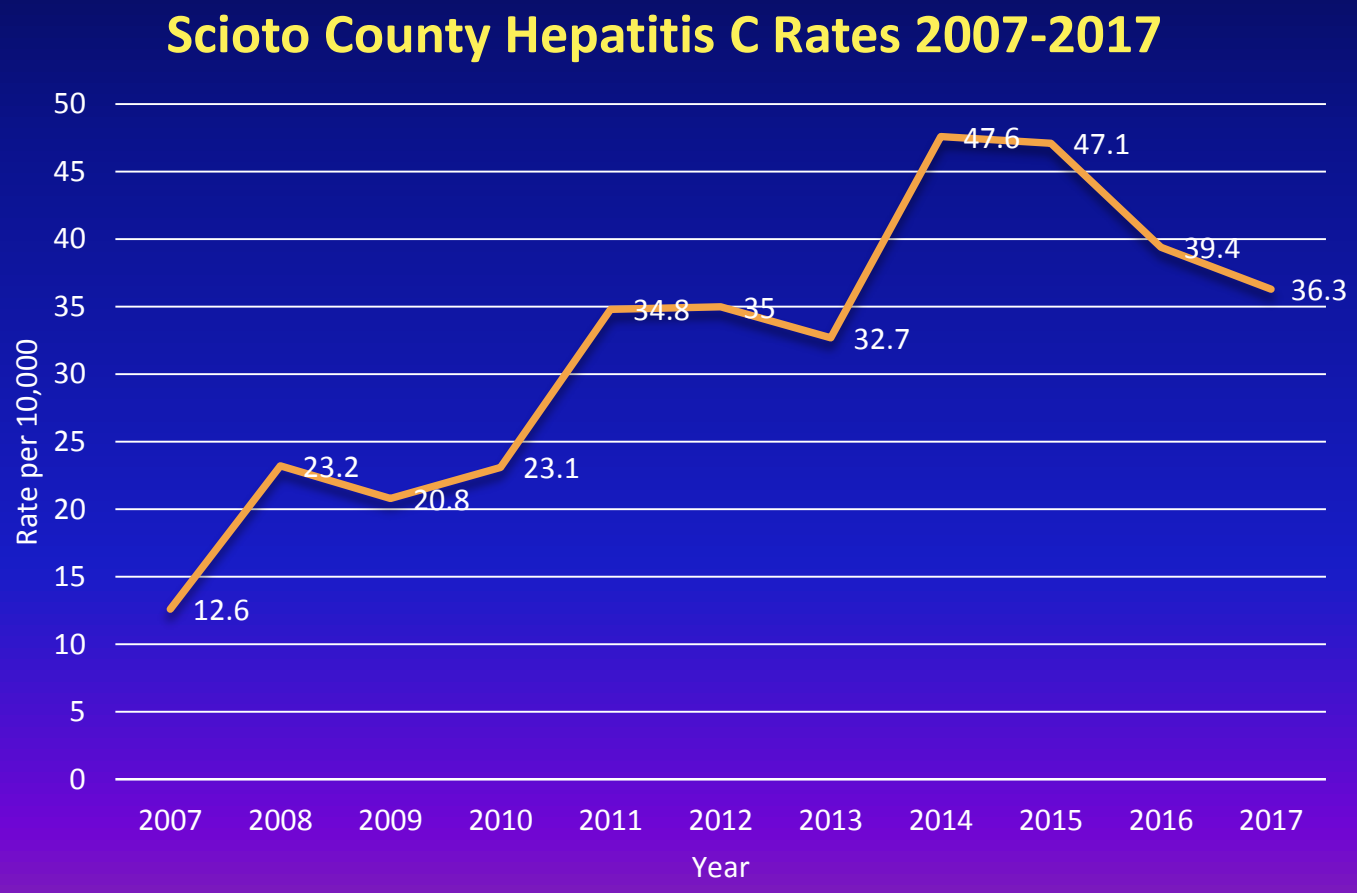
REDCap creates a record for each visit and allows for ongoing data collection and analysis. Also informing research across Ohio

- Demographic
- Exchange Visit
- Health History and Services Provided



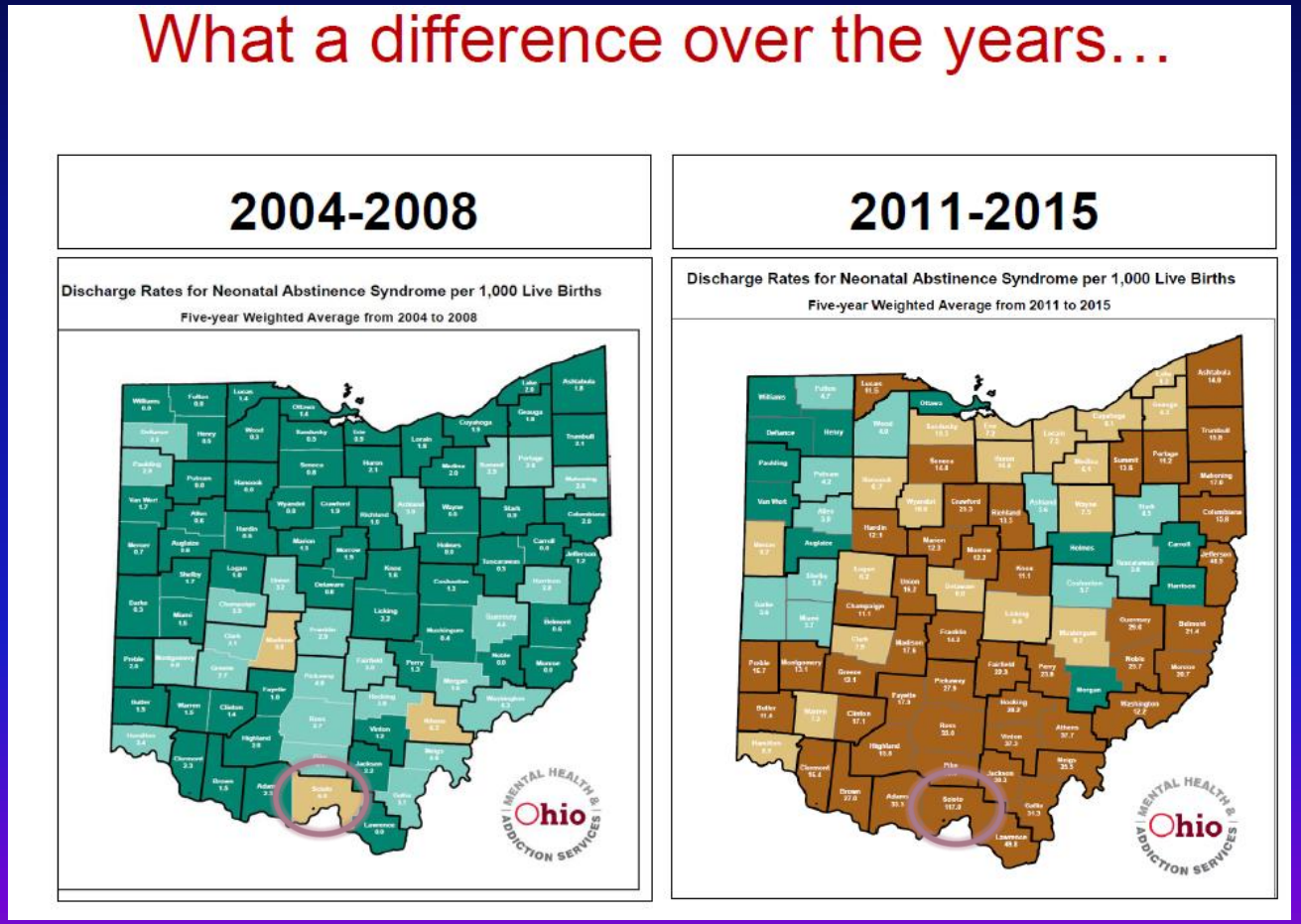
Outcomes: Too early to tell.....
but starting to see a promising decline in new HCV cases
No longer highest in the state

Beginning Jan. 2019, Ohio Medicaid will begin to cover the cost of care for individuals who have a fibrosis score, or F-score, of F0. They currently only cover care for F2-F4. A fibrosis score reflects how much damage has been done to the liver.



Strategy 3: Reduce incidence of NAS and improve outcomes

Scioto County maintains the highest rate of newborns suffering from Neonatal Abstinence Syndrome

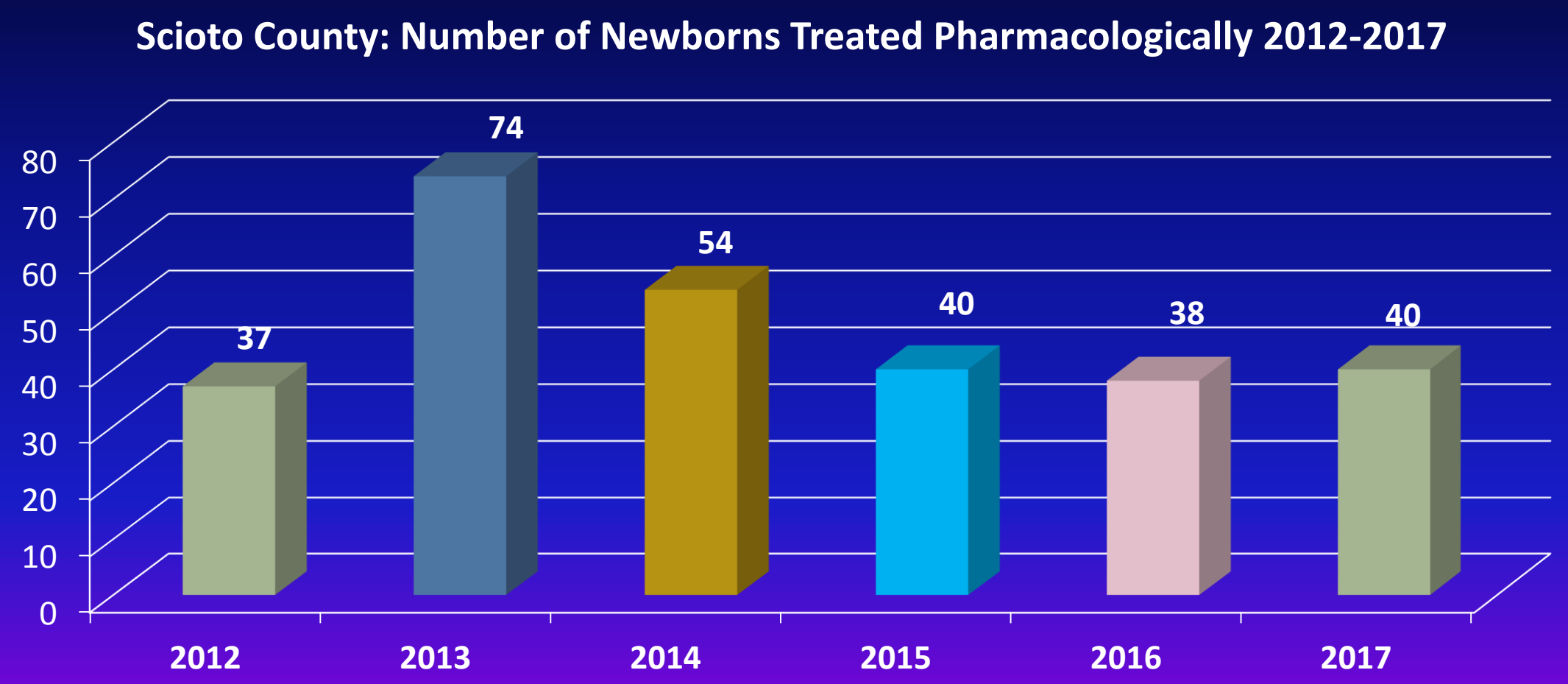


#1 Scioto	117/1,000
#2 Pike	95/1,000
#3 Lawrence	49.8/1,000
#4 Jefferson	48.5/1,000
#5 Athens	37.7/1,000
#6 Vinton	37.3/1,000
#7 Meigs	35.5/1,000
#8 Adams	33.5/1,000
#9 Ross	33/1,000
#10 Gallia	31.3/1,000

Ohio Average 12.3/1,000

Source: Ohio Perinatal Quality Collaborative

Outcomes: Althogh Scioto County NAS rates have increased *significantly*, the number of newborns treated pharmacologically has decreased



Source: SOMC Nursery

Strategy 4. Treat the Addicted

We struggled with this for many years (numerous barriers—getting better)

- In 2014 Ohio expanded Medicaid
- In 2016 the federal CARA Act passed (policy) which allowed expanded Buprenorphine prescribing
- In 2017 the federal 21st Century Cures Act passed (funding)
- We hosted DATA2000 training-in 2018 we DOUBLED our prescribers

Scioto County responses and successes to date:

- Established a Local Detox/ Crisis Unit (2014)
- Established Medical Stabilization Unit at SOMC (2014)
- Expanded licensed addiction treatment facilities
- Expanded DATA2000 waivered prescribers (Physicians, PA's, NP's)
- Conducted DATA2000-waiver training in 2018 (doubled our providers)
- Established treatment-friendly Drug Courts
- Established Overdose Response Teams in 2017 (still have HIPAA barriers)
- Gained a County Health Commissioner now Board Certified in Addiction

The Comprehensive Addiction & Recovery Act (CARA)

Authored by U.S. Senator Rob Portman

The heroin and opioid epidemic is having a devastating impact on public health and safety in communities across Ohio and the United States. According to the Centers for Disease Control and Prevention, drug overdoses now surpass automobile accidents as the leading cause of injury-related death for Americans. More than 120 people die as a result of overdose in this country every day.

Addiction is a treatable disease, but only 10 percent of those who need treatment receive it. Discoveries in the science of addiction have led to advances in drug abuse treatment that can help people stop abusing drugs, lead productive lives, and achieve their God-given potential.

Experts agree that the most effective way to address the challenges of addiction is initiate a comprehensive response that includes prevention, law enforcement strategies, addressing overdoses, expansion of evidence-based treatment, and support for those in, or seeking, recovery.

It is only through a comprehensive approach that leverages evidence-based law enforcement and health care services, including treatment, that we will stop and reverse current trends. CARA authorizes $181 million annually in federal funding to support a comprehensive response to the heroin and opioid epidemic.

1. **Funding:**
   CARA includes an authorization of $181 million in resources for a comprehensive response to the heroin and opioid epidemic.
2. **Treatment:**
   CARA brings us closer to treating addiction in America like a disease with individualized treatment and follow-up for each patient, including funding for treatment, expansion of medication assisted treatment, and specialized programs for pregnant women, mothers, veterans, and youth.
3. **Prevention:**
   CARA includes education efforts and community-based prevention, including support for community coalitions and a critical awareness campaign.
4. **Recovery:**
   CARA creates a new recovery programs to provide robust recovery services in local communities, including recovery support for high schools and higher education institutions nationwide.
5. **Overdose Reversal:**
   CARA expands the availability of naloxone to law enforcement agencies and other first responders to help reverse overdoses and save lives.
6. **Access to Treatment:**
   CARA expands access to medication assisted treatment by giving prescribing authority to nurse practitioners and physician assistants.
7. **Law Enforcement:**
   CARA expands overdose reversal drugs for law enforcement, and training resources to better divert individuals with substance use disorders, and provides assistance with expanding disposal sites for prescription medication.
8. **Criminal Justice Reform:**
   CARA expands treatment for individuals involved in the criminal justice system instead of haphazardly placing them in jails and prisons through a treatment alternative to incarceration program.

2017 New Scioto County Pilot Project

HRSA Rural Health Opioid Project funded by HRSA began 10-1-2017

- $750,000 over 3 years to pilot a comprehensive new program

Portsmouth City Health Dept. RHOP (Scioto County Collaborative Rural Health Project) will:

- Maintain a large community Consortium to respond to opioid epidemic
- *Recovery Gateway* AoD treatment and navigation program using a "Hub and Spoke" model like used in the HIV epidemic

Recovery Gateway

- The mission of “Recovery Gateway” is to provide Motivational Interviewing and Linkage to Care for people with Substance Use Disorders in order to reduce the health consequences of their behaviors and to move them towards more healthy behaviors.
- Patient Navigation: Common among cancer, diabetes, cardiovascular disease, etc. Navigation specifically for SUD.
- Niche: Case management services for individuals regardless of stage of recovery or treatment
- “Hub and Spoke” model: agencies that work with high risk individuals will be able to refer to Recovery Gateway and our clinicians will be able to offer services or place them in the services that are appropriate for their level of care.

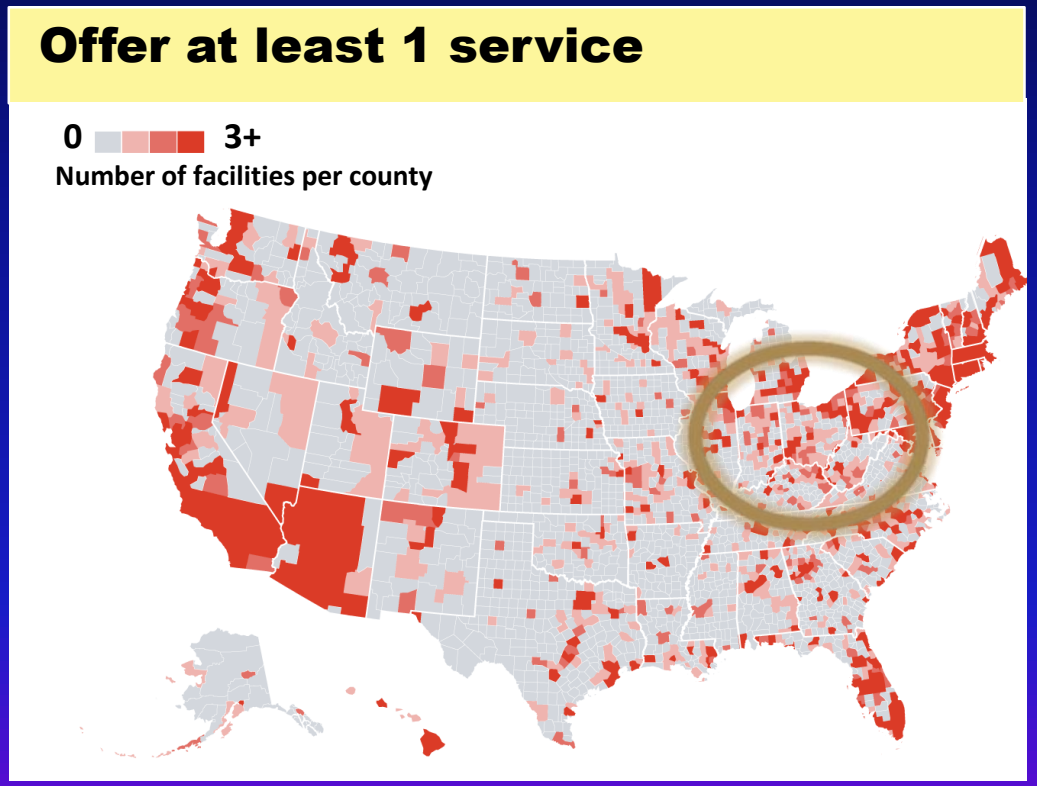
“Hub and Spoke” Model

- **“HUB”**
- A Hub is a specialty treatment center responsible for coordinating the care of individuals with complex addictions and co-occurring substance abuse and mental health conditions across the health and substance abuse treatment systems of care. A Hub is designed to do the following:
  - ♦ Provide comprehensive assessments and treatment protocols.
  - ♦ Coordinate referral to ongoing care.
  - ♦ Provide specialty addictions consultation, counseling, and support to ongoing care.
  - ♦ Provide ongoing coordination of care for clinically complex clients.

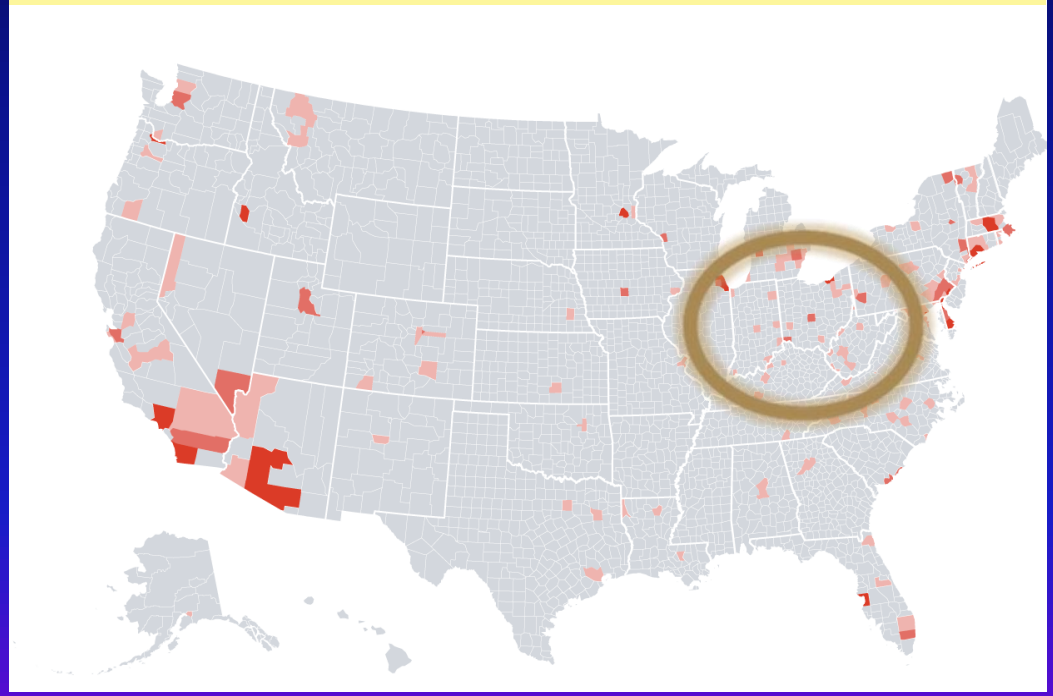
- **“SPOKE”**
- A Spoke is the ongoing care system comprised of collaborating social, health, and addictions professionals who monitor adherence to treatment, coordinate access to recovery supports, and provide the appropriate level of care or services for each patient. Spokes can be:
  - ♦ Outpatient substance abuse treatment providers
  - ♦ Primary care providers
  - ♦ Federally Qualified Health Centers
  - ♦ Independent psychiatrists/social workers

Barriers: Medication-assisted treatment facilities in each county can treat opioid addiction using buprenorphine, methadone or naltrexone.
Few counties have clinics offering all three treatments, especially in **Rural areas**.

Offer at least 1 service



Offer all 3 services



The National Survey of Substance Abuse Treatment Facilities; amfAR

NIH Rural Opioid Initiative

- **HIV, HCV and Related Comorbidities in Rural Communities Affected by Opioid Injection Drug Epidemics in the United States: Building Systems for Prevention, Treatment and Control (UG3/UH3)**
- Nine grants issued, with the goal of developing comprehensive approaches to the opioid epidemic
  - Focused on overdose, HIV, HBV, HCV, STIs, substance use treatment
  - Eight states + one award for an HCV surveillance project
  - Co-funded by:
    - The Appalachian Regional Commission (ARC)
    - The Centers for Disease Control and Prevention (CDC)
    - The Substance Abuse and Mental Health Services Administration (SAMHSA)

Project Goals

- Understand the context of opioid use and injection drug use in southern Ohio
- Understand treatment service availability
- Identify treatment gaps, barriers, and opportunities for intervention
- Develop a community intervention implementation plan for Scioto, Pike, and Jackson counties, with guidance from Community Advisory Boards

THE OHIO STATE UNIVERSITY
COLLEGE OF PUBLIC HEALTH

Lesson's Learned:

Solomon Center for Health Law and Policy at Yale University : Key Points

Focuses on the intersection of law and healthcare with emphasis on the government's role as policy-makers.

We Can't Go Cold Turkey:
Why suppressing drug markets endangers society

Nick Werle & Ernesto Zedillo

Forthcoming in the *Journal of Law, Medicine, & Ethics*, Summer 2018
Correspondence: nicholas.werle@yale.edu

Nick Werle, MSc is a student at Yale Law School, a research associate in the International Drug Policy Unit at the London School of Economics and Political Science, and a fellow at Yale's Solomon Center for Health Law and Policy. He received an MSc in economic policy from University College London and an MSc in risk and finance from the London School of Economics and Political Science with support from the U.K.'s Marshall Scholarship.

Ernesto Zedillo, Ph.D. is the director of the Yale Center for the Study of Globalization, professor in the field of international economics and politics, and a member of the Global Commission on Drug Policy. He received his M.A. and Ph.D. in economics from Yale University. He was the president of Mexico from 1994–2000.

- Compares US overdose epidemic to the Prohibition Era:
  - People kept drinking, but the illicit alcohol supply became more potent and tainted with poison resulting in thousands of deaths, blindness, and CNS damage. Organized crime flourished.

- Cutting prescription opioid supply is not a bad policy—the government's timing is just off. The genie is already out.
- The current millions of chronic opioid users are unlikely to stop when painkillers become scarce. They will switch to the dangerous black market and criminal networks will flourish.
- Absent a viable safe opioid substitute, chronic users will use potentially fatal drugs with increased frequency and the epidemic will be greatly exacerbated.
- Policies ought not push existing users to start injecting fentanyl-laced heroin by making safer alternatives (OST) inaccessible.
- Current need for OST dramatically outstrips the highly regulated and restrained supply and service-delivery in the U.S.
- Other countries have experienced an opioid overdose epidemic and overcame it by embracing proven public health approaches as opposed to enhancing the criminality of substance use.
- Low-threshold OST was the cornerstone of these successes.


Thank You!