ISSUE BRIEF

U.S. OPIOID CRISIS:

CAUSES, EFFECTS, AND STEPS BEING TAKEN

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JUSTICE PROGRAMS OFFICE
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The National Drug Court Resource Center (NDCRC) is housed at the Justice Programs Office, a center in American University's School of Public Affairs, and is funded by the Bureau of Justice Assistance. Issue briefs such as this are created to educate and inform the treatment court field about topics of importance. For more information please visit the National Drug Court Resource Center at www.ndcrc.org.

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The Justice Programs Office, a center in American University's School of Public Affairs, supports the National Drug Court Resource Center, part of a BJA-funded drug court initiative. This issue brief was created to respond to significant issues identified during the provision of technical assistance to the field. For more information about accessing technical assistance services or to learn more about the AU Justice Programs Office, go to www.american.edu/justice.

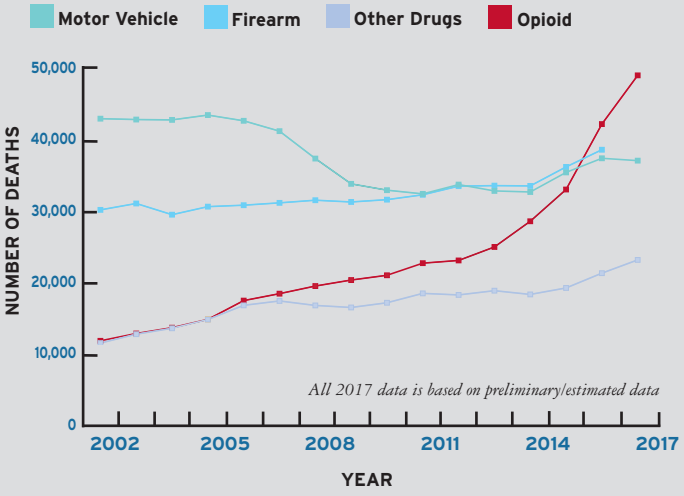
The United States' opioid crisis is a national public health emergency of staggering proportions.

The Office of National Drug Control Policy, various components of the Department of Health and Human Services and Department of Justice, as well as state and local governments are all focused on combating this serious issue due to the significant loss of life involved.

Between 1999 and 2016, more than 350,000 people died of an opioid-related drug overdose in the United States.[1] Over 42,000 of those overdoses were in 2016 alone, a five-fold increase since 1999.[2] The opioid-related overdose death rate has continued to intensify in the last decade and a half and now surpasses the death rate of all other drug overdoses, firearm injury related deaths, and motor vehicle crash fatalities.

One Centers for Disease Control and Prevention (CDC) article predicts that the total economic burden of just prescription opioid overdose, abuse, and dependence in the United States to be $78.5 billion per year. This number reflects increased costs of healthcare and substance use treatment; costs associated with criminal justice involvement; and lost productivity.[3]

SELECT CAUSES OF DEATH IN THE UNITED STATES



HOW DID WE GET HERE?

America and opioids have been linked since the birth of the nation. Opium was used during the American Revolution to treat soldiers on both sides of the conflict.[4] Recreational opium use became increasingly popular during the mid-1800s due, in part, to a significant rise in the number of opium dens operated by Chinese immigrants throughout the West.[5]

During and immediately after the American Civil War, physicians commonly used morphine – an opium derivative which is ten times as potent as opium itself – as a pain reliever.[6] Concerns about the addictiveness of morphine led the pharmaceutical company Bayer to develop and market a new pain reliever (and cough suppressant), called heroin, in the late 1800s.[7]

Starting in the early 1900s and up through the 1970s, the American medical community recognized the danger of addiction posed by opioid medications. Unfortunately, this attitude began to change in early 1980s due, in part, to a one-paragraph letter published in the New England Journal of Medicine. In their letter, Jane Porter and Dr. Hershel Jick described their analysis of nearly 12,000 patients who had been given at least one dose of a narcotic painkiller. According to Porter and Jick, their analysis only uncovered "four cases of reasonably well documented addiction in patients who had no history of addiction," leading them to conclude that addiction was rare in patients with no history of addiction.[8] While it was generally considered inconsequential at the time, Porter and Jick's letter – coupled with other small studies in the 1980s – paved the way for physicians to rely on drugs such as Percocet® (oxycodone) Vicodin® (hydrocodone) for pain management more and more, as they came to market.

With the release of OxyContin® (oxycodone) in 1996, consumption of opioids in the United States continued to increase.[9] Americans consumed record quantities of legal prescription opioids, encouraged by companies such as Perdue Pharma (maker of OxyContin®) through extensive promotional and advertisement campaigns. Sales of OxyContin® grew from $48 million in 1996 to just under $1.1 billion in 2000, making OxyContin® one of the leading drugs of abuse in the United States.[10] Perdue Pharma's financial success did not last however. Just over a decade after it came to market, Perdue Pharma and three of its executives pled guilty to misbranding OxyContin® and downplaying its addictive qualities. Ultimately, the company settled with the United States government for $634 million.[11]

Wide availability of prescription opioids in the late 1990s and the 2000s was accompanied by an increase in prescription opioid overdose deaths, starting in 1999. The CDC refers to this as the first wave of opioid overdose deaths (followed by a rise in heroin overdose deaths in 2010 and synthetic overdose deaths in 2013).[12] As of 2017, more than 191 million opioid prescriptions were distributed to Americans.[13] With a United States population of just over 325 million, it is not surprising that many of those prescriptions are never fully consumed. Instead, many partial prescriptions are left forgotten in medicine cabinets across the country, easily accessible for a family member or friend to find and misuse. Indeed, as of 2016, over 11.5 million Americans reported misusing prescription opioids within the past year.[14]

Once addicted to prescription opioids, it is exceedingly common for people to transition to illicit opioids due to their reduced cost and increased availability. Nearly 80% of heroin users report misusing prescription opioids prior to using heroin.[15] Equally as tragic as the number of people whose opioid addiction starts with a prescription, is the number of people whose opioid addiction ends in an overdose involving heroin or, increasingly, powerful synthetic opioids such as fentanyl. With a potency ten times that of heroin and 100 times that of morphine,[16] fentanyl poses a clear and present danger. Fentanyl has been found combined with heroin, cocaine, and other drugs, which only highlights the danger this illicitly manufactured drug poses.

TREATING THE OPIOID CRISIS

OPIOID INTERVENTION COURTS

The first drug treatment court in the United States was implemented in Miami, Florida in 1989 as a radically new approach to addressing the cyclical nature of drug use and crime. Individuals with substance-use disorders were being incarcerated and released without addressing the root cause of their criminal activity – their substance-use disorder. By combining judicial monitoring with intensive drug treatment and wrap-around services (such as housing assistance, transportation assistance, education and training, medical care, child care, etc.) the treatment court team was able to reduce recidivism and increase sobriety rates for those with a substance-use disorder. Nearly 30 years and over 3,100 drug treatment courts later, more is needed to address the evolving face of drug addiction in our criminal justice system, particularly for those with an opioid addiction.

One potential solution is a new intervention court model being piloted in Buffalo, New York. Recognizing the unique challenges associated with treating individuals with an opioid use disorder, the Buffalo Opioid Intervention Court emphases immediately (within 24 hours of arraignment) linking participants with fully integrated behavioral and medical treatment – including medication-assisted treatment (MAT).[17] At its core, the opioid intervention court (OIC) was created to keep individuals alive while they progress through the criminal justice system.[18] Whereas standard treatment courts can take two weeks or more to connect new participants with treatment services, the OIC model acknowledges that two weeks can be the difference between life and death for someone with an opioid use disorder.

To successfully achieve its goal of reducing opioid overdose rates, the Buffalo Intervention Court utilizes a 10-prong approach[19]:

1) Participants are diverted at arraignment.
2) Participants are placed into MAT, if medically appropriate, within 24 hours.
3) Criminal charges are held in abeyance while focusing on and treating a participant's needs.
4) Honesty is more important than relapse.
5) Participant is linked to ancillary services such as housing and transportation.
6) All participants are required to abide by an 8pm curfew, unless they are participating in sober living activities.
7) Participants are subject to regular and random drug testing.
8) Participants are subject to random wellness checks.
9) Participants engage in daily face-to-face contact with the Judge.
10) The program uses "control dates" to ensure a participant's criminal case is progressing in their absence. The objective is to have cases ready to be transferred to a traditional treatment court when a participant has completed their 30- or 60-day period in the OIC.

By utilizing this 10-prong approach, in conjunction with the Adult Drug Court Best Practice Standards[20], programs such as Opioid Intervention Courts are a valuable tool in any jurisdiction's battle to stem the tide of opioid addiction and overdose.

OPIOID VS. OPIATE

Simply put, an opioid is a class of drugs that acts on the opioid receptors in the brain. Opioids include illicit drugs such as heroin, fentanyl, and carfentanil, as well as drugs legally obtainable with a prescription such as oxycodone, hydrocodone, codeine, and morphine.

Opiates on the other hand, are a subset of opioids. They are drugs that are naturally derived from the opium poppy plant such as morphine, codeine, and heroin. Synthetically manufactured drugs such as fentanyl and carfentanil are not considered opiates.

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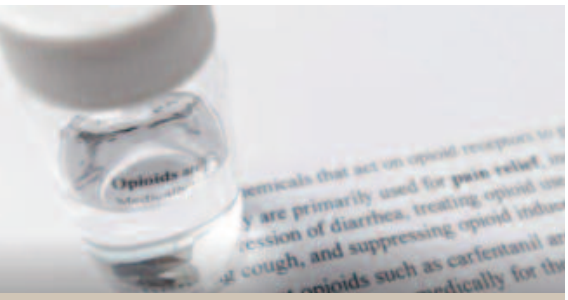

THE FDA HAS APPROVED THREE MEDICATIONS FOR MAT

Buprenorphine – can be prescribed and administered by qualified physicians in a variety of settings. As a partial opioid agonist, buprenorphine can produce effects such as euphoria and respiratory depression but to a lesser extent than a full opioid agonist such as methadone. Buprenorphine blocks other narcotics while also reducing the effects of opioid withdraw and cravings.

Methadone – can only be dispensed in regulated clinics under the supervision of a physician. As an opioid agonist, methadone blocks the euphoric effect of other opioids while also reducing symptoms of opioid withdrawal. Methadone can be addictive.

Naltrexone – can be prescribed by any health care provider that is licensed to do so. As an opioid antagonist, naltrexone blocks the effects of and cravings for other narcotics but does not reduce opioid withdrawal symptoms. There is no abuse potential with naltrexone but patients on naltrexone may have a reduced tolerance to opioids, increasing the chance of overdose if relapse occurs.

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MEDICATION-ASSISTED TREATMENT (MAT)

By combining the use of specific, Food and Drug Administration (FDA) approved medications with counseling and behavioral therapies, MAT is a particularly effective, evidence-based treatment protocol for treating opioid use disorders.[21] The medications used in MAT help to normalize brain chemistry of individuals with opioid use disorders, allowing them to focus on and sustain their recovery and prevent opioid overdoses.

A common misconception regarding MAT is that it is merely substituting one drug for another. However, chronic use of opioids can change the brain chemistry of individuals, significantly reducing the effectiveness of regular, non-MAT treatment programs. It can be helpful to think of an opioid use disorder like type-1 diabetes. Regular injections of insulin are necessary for a type-1 diabetic since their pancreas cannot produce insulin in sufficient quantities. Likewise, MAT medications help to "restore balance to the brain circuits affected by addiction, allowing the patient's brain to heal while working toward recovery."[22] MAT has been shown to increase retention in treatment and decrease opioid use, opioid overdose deaths, criminal activity, and even infectious disease transmission.[23]

The Bureau of Justice Assistance (BJA) supports the use of MAT by treatment court programs in several ways. All applicants for BJA funds to implement a new treatment court program or enhance an existing program are prohibited from denying eligible individuals' access to the treatment court due to their use of FDA-approved MAT medications. In addition, all BJA funded treatment court programs are expected to provide MAT to participants with an opioid use disorder when clinically indicated.[24] Between 2015 and 2016, treatment courts funded by BJA that provided MAT to at least one program participant increased by 40%.[25] Other federal agencies such as the Substance Abuse and Mental Health Services Administration (SAMHSA) produce a wide range of informational products to assist MAT providers, policymakers, and other stakeholders. Resources such as SAMHSA's MAT Implementation Checklist[26] and Pocket Guide for MAT of Opioid Use Disorder[27] are particularly useful.

NALOXONE

Naloxone is an opioid antagonist medication that can quickly reverse the effects of an opioid overdose (such as slowed or stopped breathing) if administered soon enough after an overdose has occurred. As an opioid antagonist, naloxone binds to opioid receptors in the brain, thereby blocking the effects of other opioids. Naloxone is a safe antidote to an opioid overdose that can save lives.[28]

Forty-eight states now allow individuals to acquire doses of naloxone without a prescription.[29] Commonly available as an autoinjectable (EVZIO ©) or as a nasal spray (NARCAN ©), naloxone is available at most major pharmacies such as CVS and Walgreens.

As barriers to access have been removed and availability has increased it is becoming easier and more common for friends and family members of people suffering from opioid addiction to keep a few doses of naloxone on hand in case of emergencies.[30] Depending on state and local regulations, friends, family members, and others may administer the autoinjectable and nasal spray forms of naloxone to someone who is experiencing an opioid overdose.

State legislatures have also enacted Good Samaritan laws to prevent overdoes fatalities.[31] While these laws can vary widely from one state to the next, they generally create legal protections for individuals who call for help in the event of an opioid-related overdose. By eliminating the fear of being arrested for drug-related crimes, Good Samaritan laws are designed to encourage bystanders (or the individual in distress) to call for medical assistance. Some states provide broad protections or immunity for those that call for help, while other states' Good Samaritan laws consider calling for help an affirmative defense or a mitigating factor during sentencing.[32]

The National Institute on Drug Abuse's Prescription Drug Abuse Policy System website[33] provides excellent, up-to-date information on Good Samaritan laws and state laws related to naloxone access.

Recommendations to expand naloxone availability and administration are also prominent in the President's Commission on Combating Drug Addiction and the Opioid Crisis final report. These recommendations include ensuring all law enforcement officers in the United States are equipped with naloxone, encouraging the National Highway Traffic Safety Administration review its National Emergency Medical Services Scope of Practice Model to allow Emergency Medical Technicians to administer naloxone, and that model legislation be provided to states to allow naloxone dispensing via standing orders.[34]

NATIONAL PRESCRIPTION DRUG TAKE BACK DAY

A national survey of US adults with recent opioid medication use from 2015 found that over 60% of respondents indicated that they kept unused opioid medication for future use.[35] This, coupled with the fact that there were over 191 million opioid prescriptions in the United States last year and the vast majority of heroin users report misusing prescription opioids prior to switching over to heroin, makes it clear that the issue of excess prescription opioid medication in the nation's medicine cabinets must be addressed to stem opioid addiction and overdose.

One effort to counteract excess, unused opioid medication has been the Drug Enforcement Administration's (DEA) National Drug Take Back Initiative. Since it began in 2010, the twice-annual National Prescription Drug Take Back Day has recovered and safely disposed of over 9.9 million pounds of prescription drugs. The most recent take back, in April 2018, collected over 949,000 pounds of unused or expired medication from over 5,800 collection sites.[36]

Sometimes twice annual collection just isn't enough, which is why some states are expanding on the DEA's concept. New Jersey's Project Medicine Drop is an initiative to install locked metal boxes indoors at participating New Jersey Police Departments. This allows for a convenient, year-round option for the public to safely dispose of unused medication.[37]

CONCLUSION

THE UNITES STATES IS IN THE MIDST OF ONE OF THE WORSE DRUG CRISES IN OUR HISTORY. THE CHALLENGES FACING THE COUNTRY ARE DAUNTING.

The crisis of opioid use over the past few years has accelerated with misuse of prescription opioids as well as overprescribing of opioids by physicians. Policymakers are looking to justice stakeholders to aid in implementing policies that are grounded in treatment. Drug treatment courts are well situated to take advantage of their unique location at the nexus of the criminal justice and the public health arenas. By implementing the various responses outlined in this document, local jurisdictions can help to stem the tide of this devastating national crisis.

ENDNOTES

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