

CountyNews

HOT topics

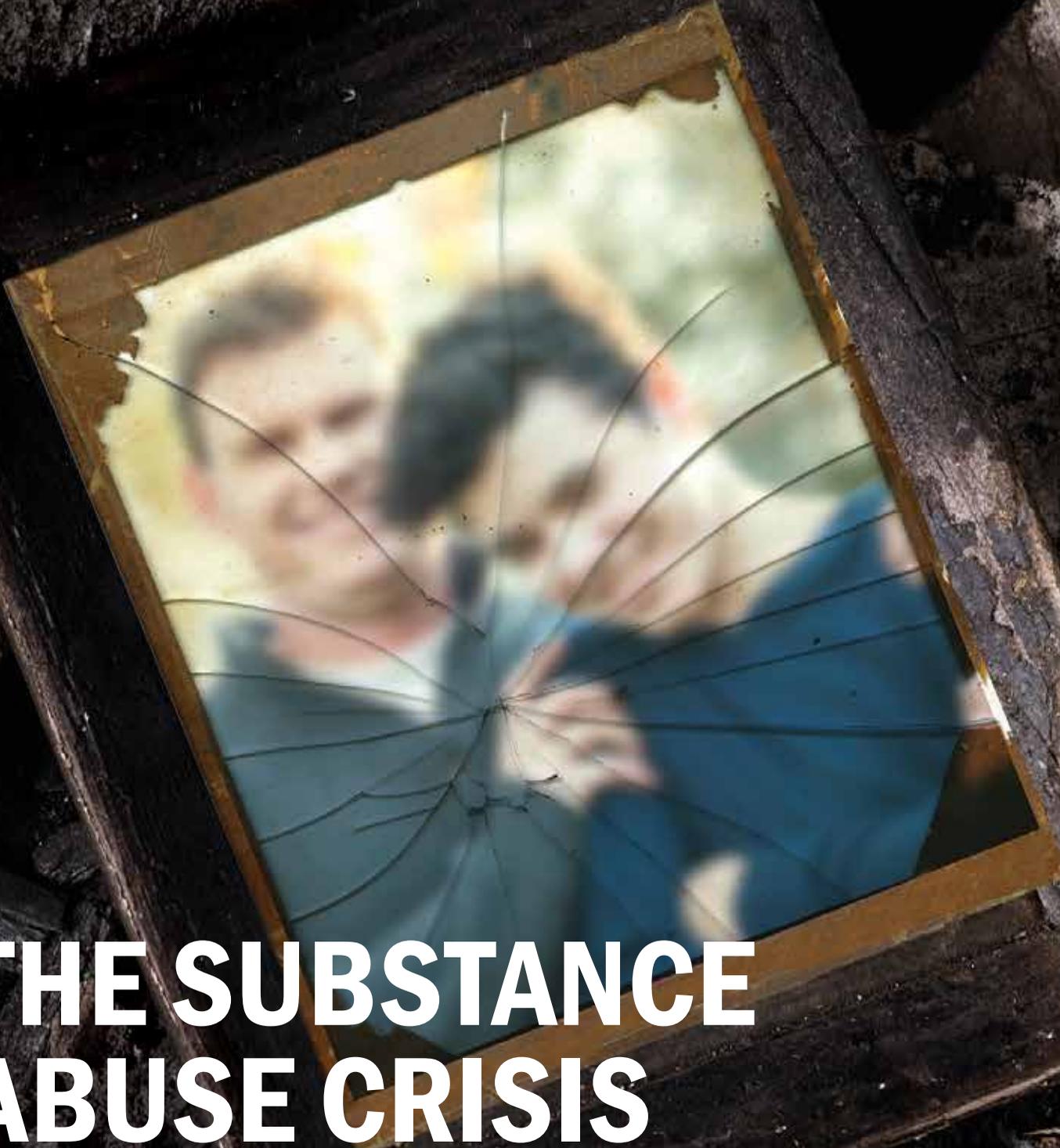
ADDICTION

Meth: Still a Problem
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Cabell County's Road to
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NATIONAL ASSOCIATION *of* COUNTIES

FEBRUARY 18, 2019



THE SUBSTANCE ABUSE CRISIS

Counties reach for solutions

COUNTIES BEAR BRUNT OF SUBSTANCE ABUSE CRISIS

Counties across the country are dealing with the fallout from a substance abuse crisis that has been on the rise for years — whether it means placing more kids in foster care when parents are absent, training librarians on how to administer Narcan or watching budgets get busted at the county coroner's office.

Drug overdose deaths topped 70,000 in 2017 and deaths involving opioids climbed to 47,000, according to the Centers for Disease Control and Prevention. Over a span of 18 years, drug overdose deaths rose from 16,849 in 1999 to 70,237 in 2017.

The highest OD death rates occurred in West Virginia, Ohio, Pennsylvania and the District of Columbia, the CDC reported.

Deaths from synthetic opioids other than meth (fentanyl, fentanyl analogs and tramadol) increased by 45 percent from 2016 to 2017. Although opioids continue to grab headlines, many counties across the country continue to have their hands full dealing with the repercussions of cocaine and meth use.

The crisis hits all walks of life. Last year, President Trump unveiled a new website, *CrisisNextDoor.gov*, where Americans share their own stories about the dangers of opioid addiction.

In this special issue of *County News*, we look at solutions and challenges and hear from county officials around the country.



by Charles Taylor

For Doug Copenhaver, a parable has come to guide his view of the opioid crisis.

“There was an addict in a six-foot hole,” the story goes, “and a person walks by and says, ‘Hey, what are doing in that hole?’ And the guy says, ‘I’m an addict, and I don’t know my way out.’ The passerby says he’ll be right back.

A second guy comes along. Same conversation; same result. “The third person jumps in the hole and says, ‘I’ve been in the hole with you and I know the way out. Follow me,’” said Copenhaver, a Berkeley County, W.Va. councilman.

“The problem we had when we were fighting our son’s addiction was where do we go? We had no place to go,” he added. That changed with the opening of a Recovery Resource Center in his West Virginia Panhandle county (pop. 115,000) in 2016. “And now we have superb people in these positions that have been in trenches where these people are trying to dig themselves out.”

But 2016 was too late for the Copenhaver family. The councilman’s 22-year-old son, Douglas, crashed an SUV into a steel light pole at high speed after a traffic stop on Aug. 5, 2011.

He’d been in jail before for substance-use-related infractions and had told his father he didn’t want to go back. In earlier conversations, Douglas had suggested a third option to “getting clean” or going to jail. Copenhaver knew what he meant — his son had attempted suicide before.

“This affected him so bad that he chose the only way to get out of it was to take his own life. That’s very powerful control from the addiction on the opioid side,” the councilman said. Deaths like Douglas’ often don’t get counted among the statistics for opioid deaths but should be, some say.

Berkeley County saw 88 overdose deaths in 2016, but that number has been dropping over the past few years — to 54 in 2017, according to the West Virginia Health Statistics Center. While data from the state for 2018 has yet to be finalized, unofficial numbers show a continued decline. Local emergency-response agencies reported 33 opioid and heroin-related deaths in 2018, the coordinator of recov-

Substance abuse hits home for county officials



Berkeley County, W.Va. Council President Doug Copenhaver and wife Jackie Copenhaver flank their son Douglas in a family photo.

ery services for the county, told the County Council recently.

As with all Americans, local elected officials are not immune to the ravages of the opioid crisis, but they have a bigger bully pulpit from which to share their stories.

More than 2,200 miles away as the crow flies from Copenhaver, in Skagit County, Wash., Commissioner Lisa Janicki also knows the pain of losing a child to opioid abuse. “I was looking at it at a policy level, a high academic level, and all of a sudden I’m submerged in the reality of a child in a rehab facility and then going through losing that son. It’s been a tough learning process.”

Since the death of her son Patrick, 30, in August 2107, the issue has become “more intensely personal” and she is “driven to talk to anybody and everybody,” Janicki said. Skagit County, population 124,000, had 298 nonfatal overdoses and 11 fatal overdoses in 2017, according

to a December 2018 report from Skagit County Public Health.

Last September, the county hosted a Solutions to Addiction Symposium that drew an audience of about 500 to open a dialogue within the community. That includes “normalizing” the conversation around addiction — “you need that community support around the family, around the addict, around the person in recovery. If we don’t start having those community conversations, it’s just not going to happen,” Janicki said.

More recently, Skagit County commissioners passed an ordinance requiring medical professionals to report non-lethal opioid overdoses to the county public health department.

When it takes effect April 1, it will provide better data on the scope of the problem and make it easier to potentially get victims into treatment sooner after an overdose.

Janicki isn’t the only one of her county’s three commissioners to have been personally affected by the opioid crisis. Commissioner Ken Dahlstedt has a son who is still struggling with addiction with the help of a medically assisted treatment program.

His son, whom Dahlstedt declined to identify by name for privacy reasons, began taking prescribed opioid drugs after a back injury “six or seven” years ago. When the prescriptions ran out, “he ended up finding a less expensive alternative, which is heroin.”

Dahlstedt blames drug companies and distributors for minimizing the potential dangers of prescription opiates.

“A lot of the data shows they knowingly have continued to advertise, market and encourage the prescribing of these drugs, knowing that there’s a high level of addiction, and now, here we are with this crisis,” he said.

In January 2018, Skagit County and its cities of Mount Vernon, Sedro-Woolley and Burlington sued Purdue Pharma, Endo, Janssen, and other companies for the reckless promotion of opioids. That lawsuit has since been combined into a nationwide class action.

Skagit County is fortunate to be home to four Native American tribes that are also playing a key role in fighting the opioid crisis.

The Swinomish tribe built its own treatment center that specializes in addiction recovery services and has made those services available to the wider, non-native community.

Dahlstedt serves on a five-county consortium of behavioral health organizations. “We’re reaching out right now to the tribes in our five-county area to try to build a facility that will have beds available for detox and treatment for tribes as well as the citizens in general,” he said.

“I really see this as a partnership, bringing communities together because this opioid crisis is no respecter of persons or ethnicity. And so, we really see this as a maybe bonding opportunity for us to come together and fight a common enemy and that’s the opioid crisis.” 

Charles Taylor is a special correspondent for County News.

METH REMAINS DOWN BUT NOT OUT

by **Charlie Ban**
senior writer

Illegal drug use in Larimer County, Colo. was once fairly predictable.

“Four years ago, if you were a coke guy, you’d stick to coke, heroin would stick to heroin, meth guys would stick to meth,” said Joe Shellhammer, a captain in the Larimer County Sheriff’s Office who is a commander in the Northern Colorado Drug Task Force. “Now people will buy \$200 of heroin, \$100 of meth and do what they can get.”

Why? Interstate 25, which runs north from the Mexican border at El Paso, Texas is a big reason, Shellhammer said. With domestic measures taken to restrict large-scale acquisition of pharmaceutical ingredients that could allow people to make the drug in their own home, the price of Mexican meth has plummeted. Shellhammer reports that a gram, which cost \$110 in 2005, can go for \$30 in 2019.

“It’s absolutely a buyer’s market, it’s so flooded,” he said. We used to have trends: Where meth would trend up, heroin would trend down, coke would trend down. Then we’d hammer meth and coke would trend up.”

In addition, Shellhammer added, some “blends” now mix meth and fentanyl.

In the shadow of the widespread opioid epidemic, meth has been somewhat forgotten. The National Institute on Drug Abuse last updated its resources on the drug in 2013, and unlike opioids, its spread was not hastened by the legitimate medical community. But even so, it remains a problem, particularly in the Midwest and interior West.

Meth labs, which were prone to exploding, have also tapered off as production has moved south, but risks still remain.

Parks and recreation workers for Larimer County, Colo., have to look out when picking up trash, because soft drink bottles could very well have been used to

make small batches of meth.

“For some reason, they like Mountain Dew bottles,” said Katie O’Donnell, public information officer for the health department. “It might be the green bottle. You can tell it’s been used for meth because there’s a pink ring.”

“Meth is still produced, but it doesn’t look like it used to,” she said. “It’s important not to open these bottles.” Meth use can also be an environmental hazard. Larimer County spent more than \$160,000 to demolish a “nuisance house” that, while the site of more than just meth use, was contaminated. The county also had to assign deputies to guard the house before it was destroyed.

“We do a lot of outreach to realtors, as far as what to look out for,” O’Connell said. “We have a lot of rentals, so often the realtor is the first person in there where people have been smoking meth. Now they know when to call someone to do testing.”

“Most people won’t come in contact

with a house like that, but realtors do,” he noted.

Shellhammer’s task force tries to disrupt the supply of drugs, but particularly with meth, it doesn’t last long.

“We can take a group of 32 [drug] runners, suppliers — and man, it gets built back up in a week,” he said. “We’re picking up 60 pounds of uncut meth in a bust and that barely makes a dent.”

Despite low unemployment, the lure of drug money can be hard to resist.

“You can make a lot of money doing something nefarious,” he said. “Why work in a lumber yard or doing something difficult if the money and the supply is out there?” He sees state’s cannabis legalization drawing in young people from surrounding states, “either to work in the industry or take up the lifestyle,” he said, which refreshes the labor force.

“The age range for the transient population is changing. It used to be the 50s, now it’s the 20s and 30s.” **HT**

OPIOID AND OTHER SUBSTANCE ABUSE TERMS TO KNOW

■ **Acute Pain:** Pain that usually starts suddenly and has a known cause, like an injury or surgery. It normally gets better as your body heals and lasts less than three months.

■ **Benzodiazepines:** Sometimes called “benzos,” these are sedatives often used to treat anxiety, insomnia, and other conditions. Combining benzodiazepines with opioids increases a person’s risk of overdose and death.

■ **Chronic pain:** Pain that lasts 3 months or more and can be caused by a disease or condition, injury, medical treatment, inflammation, or even an unknown reason.

■ **Drug misuse:** The use of prescription drugs without a prescription or in a manner other than as directed by a doctor, including use without a prescription of one’s own; use in greater amounts, more often, or longer than told to take a drug; or use in any other way not directed by a doctor.

■ **Drug abuse or addiction:** Dependence on a legal or illegal drug or medication. See Opioid use disorder.

■ **Fentanyl:** Pharmaceutical fentanyl is a synthetic opioid pain medication, approved for treating severe

pain, typically advanced cancer pain. It is 50 to 100 times more potent than morphine. However, illegally made fentanyl is sold through illegal drug markets for its heroin-like effect, and it is often mixed with heroin and/or cocaine as a combination product.

■ **Illicit drugs:** The non-medical use of a variety of drugs that are prohibited by law. These drugs can include: amphetamine-type stimulants, marijuana/cannabis, cocaine, heroin and other opioids, synthetic drugs, and MDMA (ecstasy).

■ **Medication-assisted treatment (MAT):** Treatment for opioid use disorder combining the use of medications with counseling and behavioral therapies.

■ **Morphine milligram equivalents (MME):** The amount of milligrams of morphine an opioid dose is equal to when prescribed. This is how to calculate the total amount of opioids, accounting for differences in opioid drug type and strength.

■ **Naloxone:** A prescription drug that can reverse the effects of opioid overdose and can be life-saving if administered in time. The drug is

sold under the brand name Narcan or Evzio.

■ **Nonmedical use:** Taking drugs, whether obtained by prescription or otherwise, not in the way, for the reasons, or during the time period prescribed. Or the use of prescription drugs by a person for whom the drug was not prescribed.

■ **Non-opioid therapy:** Methods of managing chronic pain that does not involve opioids. These methods can include, but are not limited to, acetaminophen (Tylenol®) or ibuprofen (Advil®), cognitive behavioral therapy, physical therapy and exercise, medications for depression or for seizures, or interventional therapies (injections).

■ **Non-pharmacologic therapy:** Treatments that do not involve medications, including physical treatments (e.g., exercise therapy, weight loss) and behavioral treatments (e.g., cognitive behavioral therapy).

■ **Opioid:** Natural or synthetic chemicals that interact with opioid receptors on nerve cells in the body and brain, and reduce the intensity of pain signals and feelings of pain. This class of drugs that include the

illegal drug heroin, synthetic opioids such as fentanyl, and pain medications available legally by prescription, such as oxycodone, hydrocodone, codeine, morphine, and many others. Opioid pain medications are generally safe when taken for a short time and as prescribed by a doctor, but because they produce euphoria in addition to pain relief, they can be misused.

■ **Opioid analgesics:** Commonly referred to as prescription opioids, medications that have been used to treat moderate to severe pain in some patients. Categories of opioids for mortality data include:

- Natural opioid analgesics, including morphine and codeine;
- Semi-synthetic opioid analgesics, including drugs such as oxycodone, hydrocodone, hydromorphone, and oxymorphone;
- Methadone, a synthetic opioid;
- Synthetic opioid analgesics other than methadone, including drugs such as tramadol and fentanyl.

■ **Opioid use disorder:** A problematic pattern of opioid use that causes significant impairment

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CONTRIBUTORS

Charlie Ban
senior writer

Mary Ann Barton
editor

Blaire Bryant
associate legislative director

Leon Lawrence III
design director

Emily Star
senior graphic designer

Charles Taylor
special correspondent

Nastassia Walsh
program manager

We must link arms to solve substance abuse crisis

by **Gary W. Moore**

The nation's opioid epidemic, stemming from the early 90s, has had several evolutions — from prescription pills to heroin to fentanyl and other synthetic opioid analogues — and continues to claim almost 200 people a day across the United States. Now on its third wave of devastation, local government must depend on the creative and cost-effective collaborations and strategic community partnerships to create sustainable pathways that allow our neighbors to enter voluntary or involuntary treatment while offering easy navigation through disease management, recovery and reentry services through an integrated system of care.



Moore

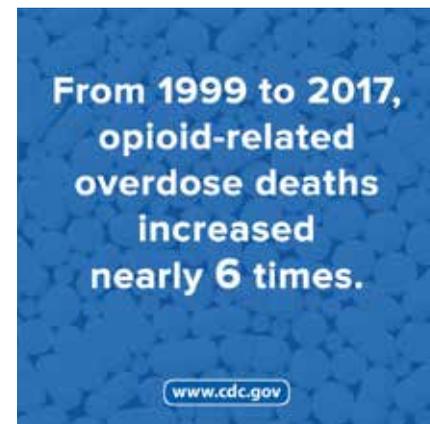
Part of the solution lies in addressing both the supply and demand of such substances and the other part of the equation has to do with the system itself. By increasing access points, coupling individuals and families with system navigators via specialized case management and institutionalizing community collaborations through private and public partnerships, resources can be maximized to create processes that are fluid and allow for easy in-take and remittance without bogging down the system with organizational bureaucracy.

According to Interact for Health's 2018 Kentucky Health Issues Poll, 50 percent of folks that entered treatment in 2018 did so when a friend or family member intervened. Therefore, a multi-generational, interdisciplinary approach to heal communities and assist the navigators at each intercept point is needed to help shoulder the burden on our criminal justice, public health, foster care, education and emergency medical systems that are feeling under-staffed and over-extended. If we create an environment where we can link arms with our community partners, we can design a better system built around shared data, common goals and better outcomes.

As public servants, we must respond with investments and commit to the long-term, sustainable strategies that chip away at the root causes of addiction, remove barriers to treatment and provide

opportunities where folks in recovery can reclaim their lives with dignity and participate in asset, coping and skill-building opportunities. And if we can offer quality accessible mental health resources to include evidence-based and individualized care plans that account for a variety of paths to remission and self-sufficiency, it will be robust for any substance and any stage of substance use.

The Surgeon General, Jerome Adams, has reminded us time and time again that "healthy communities are prosperous communities," and we can no longer have a singular conversation around opioids and instead must focus on all substance use and increasing the health outcomes for all our community members. Let us not underestimate what good govern-



ment can do to set the policy agenda to increase the impact of public health and public safety. We must lead, link arms and move forward together as a community. We cannot do it alone.

Gary W. Moore is the Boone County, Ky. judge-executive and NACo second vice president. Amanda J. Peters, director, Northern Kentucky Office of Drug Policy, contributed to this article.

or distress. A diagnosis is based on specific criteria such as unsuccessful efforts to cut down or control use, or use resulting in social problems and a failure to fulfill obligations at work, school, or home, among other criteria. Opioid use disorder has also been referred to as "opioid abuse or dependence" or "opioid addiction."

■ **Overdose:** Injury to the body (poisoning) that happens when a drug is taken in excessive amounts. An overdose can be fatal or nonfatal.

■ **Physical dependence:** Adaptation to a drug that produces symptoms of withdrawal when the drug is stopped.

■ **Prescription drug monitoring programs (PDMPs):** State-run electronic databases that track controlled substance prescriptions. PDMPs help providers identify patients at risk of opioid misuse, abuse and/or overdose due to overlapping prescriptions, high dosages, or co-prescribing of opioids with benzodiazepines.

■ **Tolerance:** Reduced response to a drug with repeated use.

Information courtesy of the CDC.



TOP 10 DRUGS TIED TO OVERDOSE DEATHS

DRUG	NUMBER OF DEATHS	% OF DEATHS
1. FENTANYL.....	18,335	28.8
2. HEROIN	15,961	25.1
3. COCAINE	11,316	17.8
4. METHAMPHETAMINE	6,762	10.6
5. ALPRAZOLAM.....	6,209	9.8
6. OXYCODONE	6,199	9.7
7. MORPHINE.....	5,014	7.9
8. METHADONE	3,493	5.5
9. HYDROCODONE.....	3,199	5.0
10. DIAZEPAM	2,022	3.2

Source: National Center for Health Statistics, 2016

A MOTHER'S CALL TO ACTION

by Lisa Janicki

Skagit County (Wash.) commissioner

Nature seems out of order when a parent stands at the grave of their child. Patrick was my little boy, the youngest of five children. I cried the first time he wrestled as a 4-year old, because he cried when he lost. I cried when he would not let me drive him to the first day of kindergarten because he wanted to ride the bus with the big kids. And I cried when he fell and broke his back while pole climbing at a logging demonstration.

For the next 10 years, Patrick fought chronic back pain. In September 2016, he told me he was addicted to prescription pain pills and that he was checking himself into treatment. Patrick spent five weeks in treatment, motivated to be back before November so he could go on a hunting trip with his dad, brothers and cousins.

He made that hunting trip and life returned to a guarded form of normal. Patrick resumed his work in logging and attended multiple support group meetings every week. On Christmas morning, he announced that he was 100 days sober. I was stunned. I didn't know what to say but his siblings congratulated him. My conversations about his recovery were limited and I now know I did not ask enough questions.

On Aug. 4, 2017, Mike went to the house to find out why Patrick wasn't at work. Patrick told his dad he had taken an oxycontin pill and had been coughing up blood. Mike called 911 and then called me. Patrick walked out to the ambulance and asked his dad to bring his shorts and shoes. Before he got to the emergency room, Patrick went into cardiac arrest. After 40 minutes of CPR, the medics and the ER doctors restarted Patrick's heart. He spent the next two weeks in a coma and gave us the opportunity to

say goodbye.

On Aug. 18 at the age of 30, Patrick lost his battle against addiction. We may never know exactly what Patrick took, but it wasn't Oxy — that didn't show up on the tox screen. And he didn't respond to Narcan, which should have reversed an opiate overdose. After a decade of addiction, Patrick lost his personal battle, but we cannot lose the bigger war.

Addiction affects all of us, yet it's a topic we rarely broach with friends. Since Patrick died, dozens of people have shared their deeply personal struggles with addiction. Some are celebrating recovery, others are still trying to find their way out. We all probably know a family member, a co-worker or a friend who uses drugs or alcohol. Patrick would say: "Do something. Help them. They cannot help themselves." Patrick got friends to go to treatment after he completed his program. We should be like Patrick.

Patrick had more opportunity than most. He was an Eagle Scout, a Rotarian and a college graduate. He worked full

time and had health insurance. He had a gigantic network of family and friends who loved and supported him. He knew he was an addict and sought treatment on his own, yet that wasn't enough.

My plea to our community is that we learn to talk about addiction and recovery. It breaks my heart when friends tell me they assume opioid use "is a

choice" that addicts make, inferring they could also "choose" to quit.

Together, let's learn about the science behind substance use. Let's learn to talk about what it takes to get clean and sober. Let's celebrate recovery — the first 100 days, the first year, the 10th year and beyond.

Addiction is not a moral failing. It is not a personal flaw. It is a medical disease. The physical changes that happen to a brain are real. And like asthma, diabetes or epilepsy, addiction is a chronic disease. There is no quick or easy fix. Addiction requires professional treatment, access to resources, and maybe most importantly, compassion and support. Judgement will

not cure addiction. Ignoring the problem will not save the addict. We can afford to be neither judgmental or complacent. We must be moved to action.

Here's what Pat would want you to do. Get educated. Do your research. Patrick knew he was an addict. He tried to help himself. He helped his friends in the same situation. Don't be afraid to talk about addiction and ask about recovery. We must normalize the conversation and break this code of silence.

After Patrick died, we found a handwritten entry in his recovery journal on his night stand. It started "Dear Mom and Dad" and went on to explain that he needed to go back to treatment and was hoping that we would attend a family treatment program with him. If only I would have asked how he was doing a little sooner, perhaps I wouldn't have had to plan his funeral.

Patrick was my little boy.  

You can reach Commissioner Janicki at: ljanicki@co.skagit.wa.us.

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Patrick Janicki; family photo courtesy of Lisa Janicki.



Lisa Janicki and son Patrick; family photo.

Cabell County's road to recovery

by **Dr. Michael Kilkenny, MD**

Here's a hard fact: Americans are now more likely to die from opioid overdoses than car crashes. That realization may be shocking to some, but this has been the reality in Cabell County, W.Va. for years.

Like many other places, we experienced a domino effect in which high opioid prescribing rates and prescription drug misuse led to increases in illicit drug use resulting in overdoses, overdose deaths, spread of hepatitis B and C, high rates of neonatal abstinence syndrome (NAS), and family fracturing. But with a county population just under 100,000 people — nearly 50,000 of whom are located in the county seat of Huntington — the impacts are magnified because everyone knows someone suffering.

Despite being hard-hit, Huntington Mayor Steve Williams said, "If we own our problems, we can solve our problems." So, with leadership from city and county government, all agencies in the community have combined their different capabilities to mount a strong and comprehensive effort to respond to the epidemic's health impacts. What's resulted is a vibrant network that prioritizes an "any avenue to recovery" philosophy.

The local health department developed a harm reduction program to provide people who use drugs (particularly injection drugs) with respectful education, testing, treatment, counseling, referral, naloxone and disease-preventing materials, such as sterile syringes. The community health center network developed a medication-assisted treatment program to augment existing mental health treatment efforts, while substance use treatment programs expanded their services and efforts. Local hospitals developed new treatment options including a quiet unit for babies experiencing NAS, which results from being exposed to drugs in the womb. These include care and clinical protocols that provide high-tech treatment for infections and other serious complications of substance misuse, as well as for substance use disorder itself.

City fire, police, and EMS workers have developed innovative strategies to address overdose, from training all responders in naloxone use to developing a Quick Response Team that follows up with overdose survivors to offer services and reduce repeat events. Law enforcement is working to arrest major drug dealers while diverting individuals actively using drugs to treatment, and Cabell County

Drug Court uses a rehabilitative approach that treats people for substance use when it is at the root of their criminal activity, resulting in a 90 percent reduction in recidivism. Public schools have developed prevention curricula and social service agencies are helping people rebuild their lives.

In addition, Marshall University, located in Cabell County, established a Division



Kilkenny

of Addiction Studies and is engaging in public health research that helps us continually monitor and define the scope of the problem, develop interventions, scale them to need, and measure results. Now, a new generation of Marshall University-trained providers will be better equipped to view

addiction through a lens of disease as opposed to criminalization or moral shortcoming.

Through our collaboration, this cross-sector, multi-pronged approach to the epidemic is finding success. New cases of hepatitis C dropped 60 percent from a peak in 2016, nonfatal overdoses fell 40 percent from 2017 to 2018, and Cabell Countians have a new sense of hope that things can get better, that recovery is real and that better times can follow one of the worst epidemics of our lives.

Dr. Michael Kilkenny, MD, is the Physician Director at the Cabell-Huntington, W.Va. Health Department

How can we save the most lives?

by **Lloyd I. Sederer, MD**

Two principal actions taken by medical and mental health professionals will have the greatest impact on saving the lives of people with Opioid Use Disorder.

Physicians played a role, however inadvertently or from misinformation, in the emergence of this epidemic. We now stand to play a vital role in its mitigation.

The actions we can take now to save lives are:

- the prescription of buprenorphine in mental health and primary care settings and
- the dispensation of naloxone at those same settings.

The former is an opioid agonist and the latter an opioid antagonist. My state, New York, has decided to make the prescription and distribution of these agents a scorable, standard of practice for licensed mental health clinics.

Buprenorphine became legal in the United States in 2000 and available a few years later. Over a decade later, however, its use remains limited, especially considering the rising death toll from the opioid epidemic and the safety of this medication.

Buprenorphine acts as a partial agonist to the opioid receptor (it is simultaneously a receptor antagonist). As an agonist, this medication binds fiercely to opioid brain

receptors thus blocking the uptake (or displacing) of other opioids, making ingestion of heroin or opioid analgesics not worth the try. It is far more difficult to get "high" or overdose on buprenorphine, unless it is mixed with other, non-narcotic substances like benzos, alcohol and sedatives.

Preparations of buprenorphine have diversified. First there was the sublingual pill, then the dissolvable film, and most recently a monthly subcutaneous injection or a set of four tiny sustained release implants under the skin that can last up to six months. While methadone works well for many people, patients need not go daily to a methadone clinic, if that becomes a deterrent to care.

Over the years, diversion of buprenorphine was limited; more recently, this drug has gained greater street value as a type of "insurance" for opioid users in the event they cannot obtain their usual supply or wanted to withdraw to reduce their tolerance. Buprenorphine can be a critical, lifesaving and life-producing medication treatment because those taking it are far more likely to not overdose and die, unlike those that are not prescribed this medication.

Naloxone is first and foremost a life-saver. EMTs, police and increasingly friends and families of people using opioids have a vial or two of naloxone nasal spray to

use if someone overdoses. Countless lives have already been saved. Naloxone preparations also include intramuscular and auto-injection syringes. It acts immediately and effectively, reversing respiratory arrest and loss of consciousness. It is like the AED (automatic defibrillator) of the world of opioid addiction.

Many pharmacies in most states have the ability to dispense naloxone without individuals needing to bring in a prescription from their health care practitioner. It can still be costly for individuals and families without insurance, and first responder departments where using insurance wouldn't be an option. Having some naloxone available at no cost is essential to continue to save lives.

I do not mean to suggest that medication alone is the right approach to treating opioid use disorder. Like any complex and persistent condition, a combination of therapy, motivational approaches, family engagement and mind-body interventions (like exercise, nutrition, yoga, meditation) are more likely to produce results since they are often additive in their effects. But medication is apt to save the most lives in the immediate future.

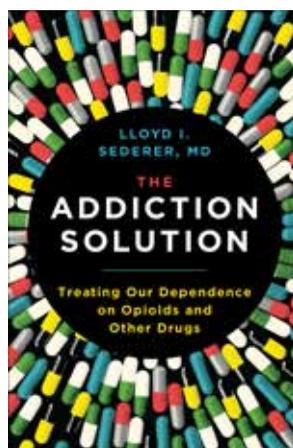
Public health has led the way to eliminating many an epidemic. Think of polio and cholera; of how we have reduced morbidity and mortality from driving deaths and tobacco; and how, with a groundswell of public support, we beat back the AIDS epidemic.

Effective solutions to the opioid epidemic exist, and they too can be achieved by a public health approach to this problem.

Sederer is a psychiatrist and public health doctor. He is the author of "The Addiction Solution: Treating Our Dependence on Opioids and Other Drugs."



Sederer



MEDICATION-ASSISTED TREATMENT FOR SUBSTANCE USE DISORDERS

A woman enters a drug rehabilitation center in Atlantic County, N.J. Photo by Bastiaan Slabbers /Alamy Stock Photo

by **Nastassia Walsh**

Nearly every community — and most residents of those communities — has been directly impacted by problem drug use, whether by individuals addicted to opioids like painkillers and heroin or those struggling with alcohol misuse or other drug abuse. In 2017, an estimated 1.7 million people in the United States suffered from substance use disorders related to prescription opioid pain relievers and 652,000 suffered from a heroin use disorder. More than 47,000 Americans died as a result of an opioid overdose that year.

The “opioid epidemic” has led to communities seeking effective and innovative solutions to addressing drug misuse and abuse and reducing drug overdoses and overdose-related deaths.

Medication-assisted treatment

One of the reasons why opioid misuse is such a challenge is that the way it interacts with the brain can contribute to physiological dependence and at times, addiction. Since drug use impacts the brain, treatment must also impact the

“Providing treatment services leading to long-term recovery for those suffering from substance use disorder, often using medication-assisted treatment (MAT) combined with therapy, moves people out of the active user population and on the path to recovery.”

– Office of National Drug Control Policy, January 2019

brain. Medication-assisted treatment (MAT) is part of “whole person treatment” that involves the use of medication along with counseling and other behavioral health therapies to treat substance use disorders — primarily opioid use disorder — and prevent overdose.

The choice and dosage of medication (see table on types of medication-assisted treatments) is tailored to each patient, following a thorough assessment by a licensed physician that accounts for a patient’s different situations such as pregnancy, mental illnesses or if he or she is currently incarcerated. Other circumstances to consider may include why the person started taking painkillers, such as

pain management for a chronic condition that still needs to be managed. Medication is most effective when paired with psychosocial treatment or therapy, which can help to identify any underlying behaviors or mental illnesses that may lead to drug misuse and encourage patients to adhere to their medications.

Some physicians compare medication-assisted treatments to methods physicians use for treating people with diabetes or other diseases. While some diabetics can manage their disease without medications, most do better with some sort of medication as part of their overall healthier lifestyle. And many individuals with diabetes or opioid use

disorders will be on their medication for years, or even the rest of their lives. In addition, like diabetics who can “relapse” and go from well-controlled sugars to uncontrolled levels, medication-assisted patients can also relapse and will need to make adjustments and check in with their treatment provider to get them back on track.

The impact

Numerous studies support the effective use of medication-assisted treatment programs for individuals with opioid use disorders. MAT is shown to decrease opioid use and opioid-related overdose deaths, as well as reduce criminal activity associated with drug-seeking behaviors. And by reducing risky behaviors such as intravenous drug use associated with heroin use disorder, for example, it also helps to decrease infectious disease transmission, like HIV and hepatitis C.

Medication-assisted treatment also increases social functioning and retention in treatment: Patients treated with MAT are more likely to remain in behavioral health treatment programs than those who receive these programs without MAT. For pregnant women who are addicted

to opioids, MAT can reduce symptoms of neonatal abstinence syndrome in the baby and length of hospital stay after childbirth.

According to the Substance Abuse and Mental Health Services Administration, “The prescribed medication operates to normalize brain chemistry, block the euphoric effects of alcohol and opioids, relieve physiological cravings, and normalize body functions without the negative effects of the abused drug.”

By helping to reduce the cravings and pain from withdrawal, people using MAT can stop constantly thinking about the drug, allowing them to focus on their recovery and returning to a healthy lifestyle.

Stigma associated with MAT

Despite research supporting its use, medication-assisted treatment continues to be underused. Nationwide, fewer than half of the privately funded substance use disorder treatment facilities offer MAT, and only a third of patients with opioid use disorders have access to those treatments. The lack of authorized buprenorphine prescribers is a prime example of barriers to accessing this treatment: Thirty million people in the United States live in counties that do not have any physicians with the waivers required that would allow them to prescribe buprenorphine.

The slow adoption of MAT could be partly due to misconceptions about substituting one drug or addiction for another or the belief that abstinence is the best method for promoting sobriety. Research supports the use of FDA-approved medications for treatment of opioid use disorders due to their effectiveness in adjusting the brain chemistry interrupted by misuse of these drugs.

Studies show that the use of medication-assisted treatment for these disorders is more effective at keeping a person in recovery than non-MAT strategies such as abstinence-only programs or detoxification. Detoxification alone can result in life-threatening or fatal overdoses when a person decides to use again due to his or her tolerance loss. In contrast, when used correctly, medications such as methadone and buprenorphine do not get individuals high, but rather help to reduce opioid cravings and withdrawal symptoms.

Naloxone (Narcan® or Evzio®), the medication that reverses overdoses, is sometimes attributed to promoting risky drug behaviors by allowing users to be “rescued” after experimenting with potentially lethal doses of opioids. Counties across the country that have started

providing naloxone to law enforcement officers, first responders and community members have seen a decrease in opioid-related overdose deaths because the medication was available.

In the first month that sheriff’s deputies in Jefferson County, Ala., started carrying naloxone, three people were revived, one of them on the first day the deputy started carrying it.

The medication is literally saving lives. Many communities are recognizing the opportunity to use an overdose reversal to connect people with longer-term care like MAT.

Finally, individuals with addictions are often still discriminated against in physicians’ offices and emergency departments, despite state and federal laws prohibiting it. Physicians may be reluctant to engage in training to establish themselves as a resource for MAT, and communities may be reluctant to house opioid treatment programs in their neighborhoods due to the stigma associated with opioid and heroin use disorders.

Rural communities: High needs, few options

A recent report by the Centers for Disease Control showed the disparate impact of opioids misuse on rural communities: From 1999 to 2015, the overdose death rate increased 325 percent in rural areas compared to 198 percent in urban areas. The report indicated that one likely cause of the increase is “persistent limited access to substance abuse treatment services in rural areas.” As is true with many behavioral health services and supports in rural communities, the need for access to treatment far exceeds its availability.

Rural counties that are providing these services often partner with local federally qualified healthcare centers and community-based treatment and service providers to create integrated care programs involving MAT. These providers may also engage peer recovery support services or specialists to help engage and maintain engagement of individuals with opioids use disorders

in treatment and services. Due to recent national attention on this important issue, federal, state, local and even private funding sources are regularly announced to address the problem in communities of all sizes.

The Substance Abuse and Mental Health Services Administration’s “State Targeted Response to the Opioid Crisis Grants” and the Department of Justice’s “Comprehensive Opioid Abuse Program” grants have each provided hundreds of millions of dollars to communities of all sizes to help address this need, including through MAT programs. The challenge of drug misuse and addiction is not new, but counties are increasingly identifying and implementing research-based approaches — like MAT — to reduce the impact of this challenge on communities, families and individuals and are saving lives in the process. 

Nastassia Walsh is a program manager in NACo’s County Solutions and Innovation department.



MEDICATION-ASSISTED TREATMENT OPTIONS FOR OPIOID USE DISORDER

Medication	Route of Administration	Common Brand Names	Frequency of Administration	Who May Prescribe or Dispense
Naltrexone	Pill	ReVia® Depade®	Daily	Any health care provider who is licensed to prescribe medicine
	Extended release injectable	Vivitrol®	Monthly	Any health care provider who is licensed to prescribe medicine
Methadone	Available in pill, liquid or wafer	Diskets Dispersible® Dolophine® Methadone HCl Intensol® Methadose®	Daily	Only SAMHSA-certified Opioid Treatment Program
Buprenorphine	Pill or film	Suboxone® Zubsolv® Belbuca® Subutex®	Daily	Physicians with board certification in addiction medicine and/or who have completed training to qualify for the federal waiver to prescribe.
	Injection	Buprenex®	Monthly	Physicians with board certification in addiction medicine and/or who have completed training to qualify for the federal waiver to prescribe.
	Implant	Probuphine®	Every Six Months	Physicians with board certification in addiction medicine and/or who have completed training to qualify for the federal waiver to prescribe.

Source: Pocket Guide to Medication-Assisted Treatment of Opioid Use Disorder, Substance Abuse and Mental Health Services Administration, U.S. Department of Health & Human Services. <https://store.samhsa.gov/system/files/sma16-4892pg.pdf>

Termination of Medicaid coverage during incarceration: Set-up for failure?

by **Blaire Bryant**

What happens to Medicaid benefits when most states suspend rather than terminate Medicaid benefits? Currently, 34 states and the District of Columbia have adopted policies that suspend — rather than terminate — an individual's eligibility for Medicaid assistance while he or she is an inmate in a public institution, according to a survey conducted in late 2018 by the Kaiser Family Foundation. This number includes states with time-limited suspension policies, in which Medicaid benefits are suspended for a specific timeframe, usually ranging from 30 days to a year.

High rates of behavioral health and substance use

Individuals entering county jails have disproportionately high rates of chronic health conditions, infectious diseases and behavioral health disorders that include substance addictions. According to data from the National Sheriffs' Association, it is estimated that of the 10 million individuals entering jails each year, at least half have substance use disorders — and at least half of those



individuals misuse opioids.

While this population is generally not eligible for Medicaid during incarceration due to what is known as the Medicaid Inmate Exclusion Policy, suspending this coverage makes it easier for a person leaving the criminal justice system to regain health coverage, and ensures

quicker access to critical mental health services, prescribed medicines and other needed care. Additionally, suspension helps provide a continuum of care for individuals leaving jails that boosts local economies, improves the health of communities and reduces the risk of mortality and recidivism for this population.

Impact of the mid-term elections and 115th Congress

The number of states that have adopted suspension policies has more than doubled in the past five years, which can be attributed in part to the expansion of Medicaid. The Affordable Care Act allowed states to have the option to expand Medicaid coverage to individuals with incomes at or below 138 percent of the federal poverty level, and has provided the opportunity to enroll more justice-involved individuals who qualify for expanded Medicaid.

Expansion was a key issue in this past November's midterm elections, in which voters in Nebraska, Idaho and Utah approved ballot initiatives on the issue. We anticipate seeing further expansion efforts in Maine and Kansas, where newly elected governors have promised to approve Medicaid expansion proposals while in office.

In the 115th Congress, NACo endorsed a number of bills that addressed the issue of healthcare for justice involved individuals, many of which were included in the comprehensive opioids bill:

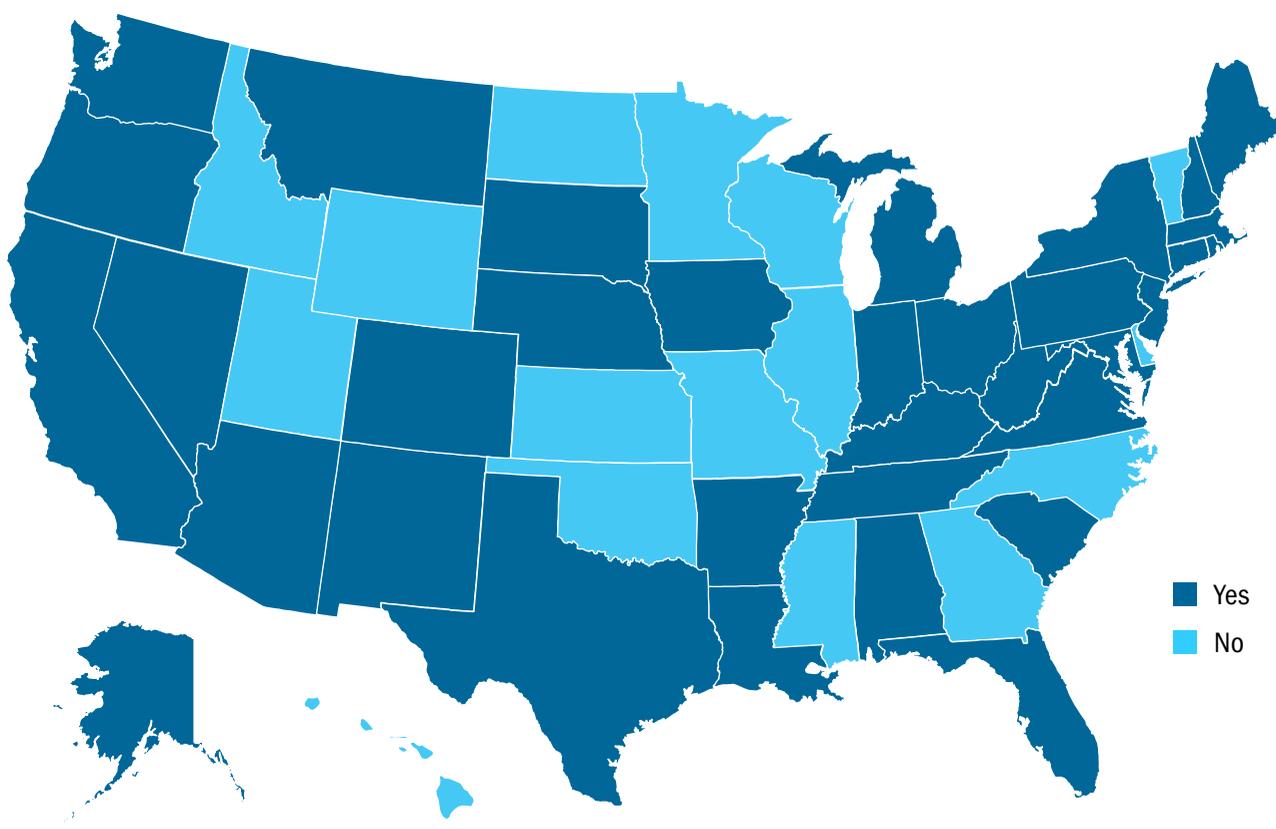
- The SUPPORT for Patients and Communities Act (Public Law No: 115-271), that was signed into law this past October.

- The At Risk Youth Medicaid Protection Act (S.874), enforces suspension over termination for juveniles and requires that health care coverage under the Medicaid program be restored upon evaluation of eligibility prior to release.

- The Medicaid Reentry Act (H.R. 4005), requires the Centers for Medicare and Medicaid Services (CMS) to convene a stakeholder workgroup in order to develop best practices for states to ensure continuity of health insurance or Medicaid coverage, implement transitional measures within 30 days of an inmate's release, and outline opportunities for states to use Medicaid demonstration waivers based on identified best practices.

As the 116th Congress begins its work, NACo will continue to advocate for legislation that would prevent states from terminating an individual's Medicaid, CHIP and SSI enrollment, and allow for the swift reinstatement of healthcare benefits upon release. **HT**

STATES REPORTING CORRECTIONS-RELATED MEDICAID ENROLLMENT POLICIES IN PLACE FOR PRISONS OR JAILS



THE BENEFITS AND CHALLENGES OF NEEDLE EXCHANGE PROGRAMS

by Charles Taylor

Orange County, Calif. is suing the state to block needle exchange programs in four of its cities. In Madison County, Ind., county commissioners have revived a syringe swap program after shutting down an earlier version in 2017.

In some communities where needle distribution has been controversial, its morality has been called into question for enabling drug users to break the law. In others, where programs have been welcomed, they've been hailed for stemming the spread of infectious diseases.

"It's not that I'm unsympathetic in terms of trying to reduce the incidence of infection in the drug use population," said Andrew Do, an Orange County supervisor.

"But we have to do it in a way that we don't expose the rest of the population, the much bigger population, to even greater risk of harm."

Do said the now-shuttered program was inadequately staffed and distributed far more needles than it collected. "Realistically, in my mind, I call it a needle giveaway program.

Because it allows each person to get up to 200 free needles a day." That is, a

person turning in one needle could get 20 more up to 10 times a day.

That imbalance, the supervisors held, led to a flood of discarded needles throughout the county. Do mentioned a clean-up effort of a homeless encampment along the Santa Ana River while the program was still operating.

"Within a stretch of less than half of a mile, we recovered 14,000 used needles." Syringes were also being found tucked inside books at a local public library.

Public concerns about discarded used needles were one factor that led to Madison County, Indiana's syringe exchange program being shut down in 2017 after two years in operation. The program, run by the county health department, had been created in response to a 30 percent rise in viral hepatitis cases in 2015.

In June, the program got a second chance when county commissioners voted unanimously to resume a modified version of the program — this time run by a nonprofit organization instead of by the county. In counties elsewhere across the United States, similar programs are running smoothly and showing positive results by at least one measure: Taking in more needles than they distribute. But

that's just one potential benefit.

According to the Centers for Disease Control and Prevention, participants in syringe exchange programs are five times more likely to enter drug treatment programs. They're 3.5 times more likely to stop injecting drugs. Research also shows that more than 90 percent of syringes distributed are returned. Generally, statistics show that the programs do not increase drug consumption.

The difference between contentment and conflict often hinges on how a state writes its laws allowing such programs to exist — and the extent to which they do more than just hand out needles.

Under California law, needle exchange programs can be set up by the county or the state, according to Supervisor Do. "On the one hand it provides for local input and control, and in the very next subparagraph, it says, by the way, the state department of public health can bypass all that and issue its own permit," he said.

A former county deputy district attorney, he chaired the Orange County Board last year and recommended suing the state. A judge issued an injunction stopping the program until the case goes to trial in October.

In Kentucky, the State Legislature passed a law in 2015 to address rising rates of heroin use and overdose death. It enabled county health departments to establish Harm Reduction and Syringe Exchange Programs to address the spread of HIV and other blood-borne diseases. A 2017 state health department ranked Kentucky as having one of the highest rates of hepatitis C in the nation, based on data from 2008 to 2015.

Henderson County is among the latest to approve a syringe exchange program. In the Blue Grass state, approval is needed from the county and city.

Clayton Horton is director of the Green River District Health Department, which encompasses Henderson. He said that while Henderson and neighboring Daviess counties aren't at crisis levels regarding the opioid epidemic, it was an easy sell to get local buy-in.

"That required us to do a lot of education and do some advocacy with local governmental bodies We weren't asking for resources; we're weren't asking them to pay for it," he said. "But we were asking them to consent and agree and to trust us and to trust the evidence-based practice to set these up and run them." ■

As opioid talks continue, pressure builds for counties

by Charlie Ban
senior writer

As the federal multidistrict litigation against pharmaceutical manufacturers and distributors moves through the legal system, the pressure is increasing for counties to file suit in hopes of recouping the costs they have shouldered to battle the opioid addiction epidemic.

More than 1,000 counties and hundreds of cities and municipalities have sued manufacturers and distributors of opioid painkiller medications, charging that they used deceptive marketing practices to underestimate the addictive nature of the drugs. The suits seek to recover losses the governments have borne in public health, justice and other functions.

Defendants in what is being called National Prescription Opiate Litigation include Purdue Pharma, Teva Pharmaceutical Industries, Johnson and Johnson,

Endo Health Solutions, Allergan, Cardinal Health and McKesson Corporation among others. If that goes to trial, it will begin Oct. 21 in Cuyahoga County, Ohio.

"There's no firm deadline or date that the court has set, but things are moving," said Mark O'Connell, executive director of the Wisconsin Counties Association. "At some point in there, there are going to be conversations (about settlements) and if something were to result from that, the manufacturers and distributors are only likely to enter into a settlement with counties that have filed. At that point there will be no more "me too" suits."

O'Connell said it was likely that when a settlement is reached, and he said Judge Daniel Polster had indicated a preference for settlement versus a trial. Polster's insistence on not allowing any public statements on ongoing talks has meant an incredibly secretive pretrial period, and O'Connell said attorneys for both sides have respected the judge's directive. That

encourages O'Connell, who feels the talks are more productive that way.

"We really don't know when white smoke will come up," signaling a settlement, he said, but "there's likely to be different pots of money, with long time litigants getting some money, recent litigants getting a different pot and counties and cities that haven't filed getting shut out.

"If you feel like your county has incurred any damages, my advice is to act quickly."

Of Wisconsin's 72 counties, all but one have filed.

"By filing you are not trying to end the pharmaceutical industry," O'Connell said. "We just want counties to be made whole for the damage these particular drugs have caused, but we want these companies to be able to go back and continue the world-changing work they do."

There's a chance pharmaceutical companies could sidestep damages. At the January meeting of National Council of County Association Executives, Steve Acquario, executive director of the New York State Association of Counties, told attend-

ees that Purdue Pharmaceutical, which was the main target of litigation, had a pre-packaged bankruptcy plan ready in case it was found liable.

"What if a jury decides against Purdue? It's pretty obviously Purdue is going to opt for their bankruptcy plan," Acquario said. "That's one reason the suits have been amended to include distributors, too, and pharmacy chains."

Some counties and cities are pursuing lawsuits in state courts. In January, a Connecticut judge dismissed a suit against Purdue brought by 37 cities and towns, saying municipalities have no right to bring this action, because they are not in fact injured, cannot stand in the shoes of someone who has died.

In addition, several states' attorneys general have sued, but O'Connell doesn't think those suits were unlikely to preclude damages for local governments. Pew's Stateline reports more the 330 opioid-related cases are pending in various state courts, with Oklahoma's case against Purdue scheduled to begin May 28. ■



Mark O'Connell

Study: Jails can play role in breaking cycle of opioid deaths

by **Mary Ann Barton**
editor

Anecdotal evidence of a link between recent incarceration and opioid deaths was recently put into cold hard numbers for Hennepin County, Minn. The county released a study that has spurred leaders there to begin a program this spring to treat those in jail who need it.

“Rather than going on our gut, we wanted to know what was happening,” said Hennepin County Board Chair Marion Greene.

The county launched a study to find out if those who were dying of opioid misuse had recently been incarcerated. Released last week, the study shows that more than a third of the opioid deaths occurred within a year of being released from custody. Almost a quarter of those occurred within two weeks of release and more than half were within 90 days.

“Now we can ask for funding with enormous credibility — there it is in the numbers,” Greene said.

Julie Bauch, the opioid response coordinator for the county and author of the study, said the “driving question was: We have all these anecdotes in our community and other communities that say we know that individuals are overdosing and dying after they leave their term of incarceration. And we know that for a few reasons including tolerance levels decrease after being incarcerated.

“We’ve heard this anecdote and do we



Hennepin County Board Chair Marion Greene

have the data to show at what rates this is happening in our community? And the answer was yes, we do have that data. Through many iterations and months of working on this we came to data that we trust and understand and know to be true for our community.”

Another author of the study, Dr. Tyler Winkelman, a physician researcher at Hennepin Healthcare, and others linked criminal justice and health care data.

After they had the data in front of them “it was really not hard to come up with some recommendations of intervention,” Bauch said.

Winkelman said acting on the recommendations was easier with stakehold-



Hennepin County Sheriff Dave Hutchinson

ers — including Bauch — at the table from the beginning. “Once we had data, there were leaders who were rapidly informed and could make decisions based on our recommendations,” he said.

The findings have spurred the county to include substance use disorder screening during jail health intake and to create a medication treatment program while the person is incarcerated for those who need it.

The collaboration between the county and the Sheriff’s Office is “hugely important,” Greene said. “I can’t overstate the importance of that partnership.”

Hennepin County Sheriff Dave Hutchinson, recently elected to the office, is build-

ing on work that former Hennepin County Sheriff Rich Stanek had started.

“Our public health team presented to us multiple times that the biggest thing we could do as a county would be to work with people we touched through the correctional system,” Greene said.

Other agencies’ work has shown that intervention for opioid use disorders is effective.

Rhode Island implemented treatment for opioid use disorders across every jail and prison in the state. A year after they implemented the program, overdose deaths following release decreased by 60 percent. Overdose deaths statewide decreased by 12 percent. **HT**

RESOURCES TO HELP WITH SUBSTANCE ABUSE

- U.S. Department of Health and Human Services: <https://www.hhs.gov/opioids/>
- Opioid Overdose Prevention Toolkit (from the Substance Abuse and Mental Health Services Administration or SAMHSA): <https://bit.ly/2AcJxE0>
- Helpline: 800-662-HELP (-4357) or visit <https://find-treatment.samhsa.gov>.
- SAMSHA “Finding Treatment for Substance Use Disorders”: <http://bit.ly/2EIJb9I>
- CDC: Evidence-Based Strategies for Preventing Opioid Overdose: What’s Working in the United States: <https://bit.ly/2OSVIMI>
- Federal Resources for Rural Communities to Help Address Substance Use Disorder and Opioid Misuse (Office of National Drug Control Policy, U.S. Department of Agriculture): <https://bit.ly/2Jprzix>
- The Opioid Crisis: Supporting County Medical Examiners’ and Coroners’ Offices: <https://bit.ly/2By4UxU>
- Smarter Counties Summit panel discussion on substance use disorder. Watch it here: <https://bit.ly/2Bzwzyk>
- National Institute on Drug Abuse funding opportunities: <https://bit.ly/2N1AaK6>
- A Prescription for Action: Local Leadership in Ending the Opioid Crisis: www.opioidaction.org