(Almost) Everything You’ve Heard about the “Opioid Epidemic” is Wrong

Drug Law and Policy
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NUSL
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Overview

1. Opioid overdose basics
2. Problematizing the “opioid epidemic”
3. Laws as Remedies
4. Case studies

Opioid Overdose Basics

- Dosage/Bioavailability
  - Depends on pharmacokinetics of specific agent
  - Absorbed from GI tract, nasal mucosa, lungs, subcutaneous, intramuscular, IV route
  - Multiple drug toxicity
- Respiratory depression
  - Increase in blood CO₂ level
  - Typical coma onset: 1-3 hours
- Fentanyl is a game-changer

Therapeutic Index

The difference between the therapeutic threshold and the amount of the drug considered to be toxic

- Also referred to as Safe and Effective range

Opioid Overdose: Risk Factors

- Multi-drug toxicity, e.g. benzos and alcohol (Piper 2007)
- Long-acting, especially with non-medical route
- Fluctuating quality (illicit market)
- Recent abstinence, as upon re-entry from correctional or residential treatment settings (Binswanger et al. 2007)
- Other health conditions
- Increased tolerance, male, 18-49, long-term use (Sporer et al. 2006)
- Protective role of naloxone and agonist therapy

The “Opioid Epidemic”

Three phases
1. Prescription drugs
2. Heroin
3. Illicitly-manufactured fentanyl

Source: New York Times (2017), National Center for Health Statistics, Centers for Disease Control and Prevention
Not Just Opioids

- Multi-drug toxicity, e.g., benzos and alcohol (Piper 2007)
- Non-medical administration
- Long-acting, especially with non-medical routes
- Fluctuating quality (black market)
- Recent abstinence, as in newly-released inmates or those re-entering from residential treatment (Binswanger et al. 2007)
- Other health conditions
  - Increased tolerance, male, 18-49, long-term use (Sporer et al. 2006)

Addiction is not the only risk factor for overdose

Figure 9. Opioid Overdose Deaths by Number of Drugs Involved, 2014

U.S. drug overdose mortality rate
Per 100,000 people

Sources: Science; Haxwde Jhala, et al. © latimesgraphics

Supply Origin Narrative

Main Reasons for Prescription Pain Reliever Misuse for Most Recent Misuse Among Individuals Aged 12 or Older in the United States Who Misused Prescription Pain Relievers in the Past Year (2015)
Framing The Opioid “Epidemic”

“Vector” or “Agent” model
- Overprescribing
  - Lack of education, info
  - Underuse of alternatives
  - Diagnostic challenges
  - System, patient pressure
- Risk of getting “hooked” on opioid analgesics
- Dominant narrative:
  - drug pushers:
    - venal or clueless providers (doctor shopping, diversion, “pill mills,” other rogue acts)
- Signal: easy fix through vector control

Vector Control Narrative Defines Response
- Prescribing limits, guidelines (e.g. CDC)
- PDMPs authorizations and mandates
- Pill-mill laws and drug trafficking enforcement
- Prosecution of unscrupulous prescribers, dealers, opioid litigation
- Pain score/pain diagnostic mandates
- Reformulation/rescheduling of prescription analgesics
- Quarantine: Involuntary Commitment

Policy Intervention Can Do Harm
- Lack of foresight of unintended consequences: As prescription drugs came under tighter scrutiny and access became more limited (via abuse-deterrent formulations and more cautious prescribing), market forces responded by providing less expensive and more accessible illicit opioids. Increases in overdose death numbers due to prescription opioids have transitioned to overdoses largely due to heroin and, increasingly, fentanyl. Locally, this trend may have been driven, in part, by tightening controls on prescription opioids. Physicians curtailed opioid prescriptions without guidelines on tapering and without determination of whether patients had developed an opioid use disorder (OUD), and if so, how to respond.

The availability of cheaper heroin also drove prescription opioid users to illicit opioids. Black market heroin is currently much less expensive than diverted prescription opioids, and fentanyl is even much less expensive per dose than heroin. Predictable from the economics of the two drug categories, the prescription drug overdose problem has decreased, but not the overall number of opioid-related deaths.

Presidential Commission on Combating Drug Addiction and the Opioid Crisis (2017)

American Suffering
- Structural Determinants:
  - Occupational injury
  - Protracted military conflict
  - Overweight and obesity
  - Lifestyle
  - Built environment
  - Diet
  - Environmental/metabolic
  - Cultural attitudes/stigma
  - Etc.

US Exceptionalism

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Prescribing limits, guidelines
PDMPs authorizations and mandates
Pill-mill laws and trafficking enforcement
Prosecution of unscrupulous prescribers, dealers
Reformulation of prescription drugs
Withdrawal of prescription drugs?

Supply Reduction Focus
- Originally designed by, and for law enforcement
- Billions in federal, state funding
- Exist in every state
- Heterogeneity in design, legal authority, scope of registration and use mandates, and other regulatory components
- Key element in opioid crisis response

Analysis of Administrative Data (’16-18)

Trigger for Defensive Practices
Physicians currently believe that their prescribing practices are vulnerable to being monitored…I think it makes them withhold appropriate [pain] treatment and I think it destroys the physician-patient relationship between doctor or providers.

- Health Care Provider

Legal Basis: Police Access
13 States Require Warrant for Out-of-State Law Enforcement Access

Evolving Jurisprudence: OR PDMP v DEA

Even assuming that the probable cause requirement is severable, the Oregon statute stands as an obstacle to the full implementation of the CSA because it “interferes with the methods by which the federal statute was designed to reach [its] goal.” Quattlebaum, 505 U.S. at 193 (quoting Int’l Player Co. v. Quattlebaum, 479 U.S. 481, 494 (1987)). By placing the initial burden of requiring a court order to enforce the subpoena upon the DEA, § 431.865 interfaces with the scheme Congress put in place for the federal investigation of drug crimes and thereby undermines Congress’s goal of “swamping[ing]” any efforts to combat the “evil of illicit drugs.” Gonzales, 554 U.S. at 10. Consequently, we hold that the two provisions are in “positive conflict”—Id. Rev. Stat. § 431.865 is preempted by 21 U.S.C. § 876. We note, however, that this result preserves Oregon’s option to contest subpoenas for protected information and thus trigger the enforcement procedure described in § 876(c), a critical safeguard in light of the particularly important privacy interest implicated here.

REVERSED.

Opioid Crisis: Supply Origin Narrative

Figure 3. “Hooked on” prescription opioids prior to heroin use by age group: n=863

Washington State Department of Health (2017)

Other Emerging Tropes

- “Can’t arrest our way out”
- We need more “beds”
- We need more drug courts
- People behind bars are getting “treatment”
- Touching fentanyl can cause overdose

Civil Commitment for Substance Use Disorder

- Allows family members, police, others to petition a court to civilly commit an individual with substance use disorder
- Heterogeneity in procedure, legal authority, and utilization
- Rhetorical shift away from criminal justice
- Emerging emphasis in opioid crisis response

Sectioning as Opioid Crisis Response

- Popularized by parent support groups, police, politicians
- State policymakers see it as a key tool
- Proposed 72 hour holds
- Proposed expansion in scope of petitioners
- Standing order model
- Expansion of physical restraints

Because it is a white problem...

"Public Health" Approach

Punishment as an Antidote

EXCLUSIVE: U.S. Attorney Preet Bharara to slap opioid dealers linked to fatal overdoses with federal charges

U.S. Attorney Preet Bharara stated: "The epidemic of opioid abuse is devastating our communities. Charges like those announced today strike at the heart of the problem – dealers who fuel the cycle of addiction and overdoses. Anthony Delosangre allegedly dealt in heroin, including the heroin that killed Thomas Cippolone, a 25 year-old White Plains man. We thank the FBI and our local law enforcement partners for their extraordinary efforts that led to the charges today."

Punishment as an Antidote

Drug dealers would face homicide charges after overdose under Senate bill

This law would hold drug dealers accountable for the true cost of their activities, significantly diminish the open availability of these dangerous drugs on our streets and give district attorneys the necessary tools to work up the criminal chain to the ultimate supplier because facing life imprisonment for any amount of drugs that results in death is a profound disincentive to sell drugs within the state of New York.

This law seeks to punish those individuals involved in the illegal drug trade and is not intended to punish those individuals who are merely co-users... Therefore a co-user who shares the drugs with the victim still has an incentive to follow the current good Samaritan law and save the other person as he or she will be able to avoid prosecution for homicide by sale of an opiate controlled substance as instead admit to a lower felony because it still is a distribution.
Surge of DIH Charges Overtime

DIH Charges by Year (1974-2017)
Total Cases: 2534

Source: http://healthjustice.org/drug-induced-homicide

Uneven Geographic Distribution

MOST ACTIVE STATES IN PURSUING DRUG-INDUCED HOMICIDE CHARGES

Number of Cases Displaced 1754

Source: http://healthjustice.org/drug-induced-homicide

Mapping onto Drug War Disparities

Mapping onto Drug War Disparities

HEALTH IN JUSTICE

RELATIONSHIP BETWEEN ACCUSED AND VICTIM

Source: http://healthjustice.org/drug-induced-homicide

Language Matters: Changing the Narrative

RECOVERY DIALECTS

Language matters but can change depending on the setting we are in. Choosing who and what we see as various language and labels can lead to different perceptions and discrimination towards substance use and recovery.

MAT: Medication-Assisted Treatment/Therapy: 3 medications
OAT: Opioid Agonist Treatment/Therapy: 2 medications
- Buprenorphine (w/ naloxone)
- Methadone

Defining “Treatment”
1. Criminalization is stigmatization
2. Conflict between behavioral signals
   - Good Samaritan laws vs. drug-induced homicide laws and prosecutions
3. Law enforcement programs: facilitators or structural barriers to help-seeking?

1. We know what to do, but we’re not translating knowledge into law and policy
2. We need to own the metrics of policy success
3. We need to own the narratives, challenge impulse for easy fixes

1. Improve health care (defined broadly) structure, access, and quality
2. Corporate regulation imposing sensible safeguards to limit negative externalities and rent-seeking
3. Addressing structural determinants of health

We knew that [transition to black market drugs] was going to be an issue, that we were going to push addicts in a direction that was going to be more deadly... But, we also know that you have to start somewhere.

Dr. Carrie DeLone
Pennsylvania’s Former Physician General

- Harm reduction programs
- Parents’ groups
- Co-prescribing at point of care
- Pharmacies
- Correctional facilities
- Police and fire departments

### Short Training
1. Signs and symptoms
2. Call 9-1-1
3. Administer naloxone

### Opioid related overdose deaths, 100,000 population

Source: Drugabuse.org, 2018

(Walley et al., 2014)
Naloxone Access

- Robust safety profile (Speight, 1997)
- Not habit-forming, toxic, or “harmful”
- Rare side-effects (primarily withdrawal, “unmasking”)
- Laypersons able to properly diagnose and treat, without medical supervision (e.g. Green et al, 2008)
  > Evidence of major promise since 2009

Naloxone Access

Illustration of multiple health policy failures

- Cost
- Intellectual property
- Deputation (3rd party)
  > Legitimate medical purpose
  > Course of usual medical practice
- Liability, disinhibition/moral hazard
- Health insurance coverage
- Life insurance concerns

Prescription Status Bottleneck

- State laws
  > liability and standing orders
  > 20 states and more pending
- Regulations
  > Boards of medicine, pharmacy
  > Relaxing prescription requirements to allow third party prescribing, dispensing
  > Specific authorizations for police, fire
  > Often under pilot, emergency frameworks

Implementation Failures

![Naloxone Distribution Breakdown in Rhode Island, 2015 to 2018](image)

Community Organizations: 932
Pharmacies: 4,553
Hospitals: 8,616

2015: 3,392
2016: 4,553
2017: 8,616
2018: 7,589

Source: RI Dept of Health, 2019

The Treatment Gap

- Medication-Assisted Treatment/Therapy (MAT): 3 medications
  - Opioid Agonist Treatment/Therapy (OAT): 2 medications
  > Buprenorphine (w/naloxone= Suboxone)
  > Methadone

![Graph showing the treatment gap](image)

The Treatment Gap

In the 12 mo before and after index opioid overdose, Massachusetts, 2012–2014 (n = 17,568)

The Treatment Gap: Payers

Source: amFar.org (2018)

The Treatment Gap: Parity

Source: Center for Addiction (2018)


Fatal Re-entry

Figure KEY4.1: Opioid Deaths by person-years, inmates since being released from a state Correctional facility (2013-2014)

Case Study 2: The Treatment Gap

- Regulation and over-regulation: separate and unequal
  - Singular paradox of OST provision
- Insurance coverage
- Parity enforcement
- Siting and NIBY
- Health care provider stigma

Health Law vs. Public Health Law

- Population health vs. health care
- Utilitarian, Legal Realism vs. Law & Economics approach
- Emergence from being a subfield to being a field in its own right
- Many intertwining issues
Health Law Approaches to Treatment Gap

- Regulation
- Litigation
- Criminal enforcement
- Innovation

Policy Prescriptions

Take-Home Points
1. Overdose crisis is a symptom of multiple systems failures
2. Impulse to address symptoms but not root causes
3. Narrative framing begets policy responses

Policy Ethics: Do No Harm

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Thank you

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www.HealthinJustice.org
www.changingthenarrative.news