New York State Joint Senate Task Force on Opioids, Addiction and Overdose Prevention

Statement to Hearing
November 15, 2019
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To the Task Force and Chairs Rivera, Harckham and Carlucci, thank you for allowing me to share a few thoughts about the importance of employing a community-engaged, data-informed approach supporting evidence-base practices to address the opioid overdose epidemic NYS is facing. My name is Dr. Timothy Hunt and I am a research scientist and Associate Director of the Social Intervention Group (SIG) at the Columbia University School of Social Work. SIG for 30 years has developed and implemented evidence-based sustainable solutions to emerging health and social issues affecting diverse populations domestically and globally and is committed to training the next generation of scientists from underrepresented affected communities to address these issues.

Additionally, I am a Co-Investigator with the NIDA and SAMHSA-funded HEALing Communities Study led by Dr. Nabila El-Bassel from Columbia University being conducted in 16 NYS counties highly effected by opioid overdose. I am speaking from the viewpoint of a substance abuse treatment provider for 29 years and research scientist with a current focus on implementation science, as well as, someone who has lost a family member to opioid overdose. I plan to submit my full testimony for the hearing record, but would like to focus my remarks today on three key points with the introduction of the historic HEALing Communities Study being implemented in our state.

1. **The opioid crisis and a national call to action**
   The opioid epidemic has been declared a national emergency in the US, and OD deaths from prescription opioids, synthetic opioids, and heroin continue to increase, with almost 400,000 deaths from 1999 to 2017. Despite efforts to stem the tide of this public health crisis, opioid- related fatalities continue to climb contributing to a reduction in life expectancy. Incontrovertible evidence supports the use of FDA-approved medications for the treatment of opioid use disorder (MOUD), such as methadone and buprenorphine (BUP), to reduce illicit drug use and protect against fatal OD. However, estimates suggest that <16% of those needing treatment can obtain MOUD because access and utilization are limited by many factors, including insufficient providers, cost barriers, and stigma. Distribution of naloxone—an opioid antagonist effective at reversing OD—and overdose education and naloxone distribution (OEND) are becoming more widely implemented, particularly for OD bystanders. Training on opioid OD recognition and response along with naloxone distribution has saved countless lives, but utilization of this evidence-based practice (EBP) has also been limited by cost, stigma and, in some cases, policy.

   The opioid crisis is growing across rural, semi-rural suburban, semi-urban, and urban New York State (NYS) communities. From 2015 to 2016, opioid overdose deaths increased in NYS by 32%, NYS ranks second in the nation for absolute numbers of opioid overdose deaths – 3,198 in 2017.

   Like many counties across the US, NYS state counties face the following major barriers to addressing the opioid epidemic: a) lack of evidence-based interventions for opioid use disorder (OUD), need of primary care (PC) providers trained in OUD treatments, addiction services, emergency departments (EDs) prepared to initiate treatment for OUD with a handoff to maintenance treatments, criminal justice (CJ) settings prepared to address the co-occurring disorders contributing to incarceration; b) a lack of comprehensive programs considering the entire opioid care continuum (prevention, treatment, harm reduction, and recovery) in all settings; c) insufficient number of providers trained to prescribe MOUD in PC, EDs, CJ and other settings; and d) efforts have not effectively considered the social determinants of health such as stigma that inhibit engagement of those at highest risk.

2. **People with or at risk of OUD lack access to key opioid prevention and treatment services.**
   Preventive interventions and effective treatments, including medications for opioid use disorder (MOUD also known as Medication assisted treatment (MAT)—methadone, buprenorphine, and injection naltrexone--exist, but access to them remains limited. Comprehensive, community-based public health

responses are urgently needed to make these effective interventions available to stem the tide of the epidemic. In NYS, there are significant differences and gaps in opioid prevention and in the treatment cascade services in our counties that are critical to reversing the epidemic. Increasing the number of buprenorphine providers in primary care programs and initiating buprenorphine treatment in EDs and jails is urgently needed. Although efforts to scale up overdose education and naloxone distribution (OEND) in NYS counties have made significant progress, lay naloxone administration remains very limited – only 8% of naloxone reversals in our 16 counties we identified for the HCS study were conducted by a layperson. Getting naloxone to the social network of individuals at risk of overdose is critical given the short window for reversing synthetic opioid overdoses. For communities to be successful in addressing their opioid crises, implementation strategies currently being applied or will be need to take into account unique local needs and resources and be systematically evaluated.

MOUD is best practice in criminal justice settings and can help rebuild and save the lives of those with substance use disorders:

- By facilitating continued access to MOUD for individuals who are on prescribed FDA-approved medications, correctional settings can minimize the risk of post-release overdose and death. For individuals with OUDs who were not receiving MOUD prior to arrest, correctional facilities can initiate prior to release, taking into account individual preferences and clinician judgment and link to follow-up maintenance care. Importantly, best practice is the recommendation for facilities to offer all three MAT options. Progress is being made in many NYS counties though collaboration within integrated systems of care.
- When MOUD is not feasible (e.g., the individual is facing transfer to a facility that does not offer MOUD), FDA-approved medications (e.g., methadone or buprenorphine) should be used to provide medically managed opioid withdrawal.
- Considering that the criminal justice system is the largest source of organizational referrals to addiction treatment, justice leadership has a unique and valuable opportunity to facilitate the path to recovery and in partnership with state and local providers can find cost effective solutions.
- With bail reform, there is an urgent need to hasten implementation of discharge services, linkages, navigation and OEND programming to those discharged from incarceration and to implement engagement programming for those who will be diverted.

Best practice for correctional medical care would include:

- Thorough standardized screening and assessment for OUD, and polysubstance use upon enrollment in a jail or prison; forced detox should be minimized when possible based on treatment history. Forced detox and withdrawal from treatments using agonist, partial agonist and psychotropic medications can lead to poor outcomes upon release and to behavioral issues during incarceration. Unsupervised detox or “cold turkey” protocols are dangerous and experienced as inhumane. Empathic monitoring is needed.
- The full range of medication for opioid use disorder and dosages decided based on best practice and in collaboration with the detainee, co-decision making based on readiness for recovery, length and severity of addiction and length of incarceration. Resources can be sought through collaboration with outpatient providers in the community, and state federal initiatives
- Medication alone may not be enough for some, but should not deter offering the range of MOUD if counseling is not available. Behavioral health, motivational interviewing and substance use counseling may accompany the MOUD during incarceration.
- Safe guards and monitoring to reduce potential for diversion have been implemented with success; some jails are incorporating recovery dorms/units as a reward for expressed motivation for change as related to a detainee’s addiction.
- Utilization of educational resources such as counseling and individualized tablets with programming on addictions, and overdose risk and response using Naloxone are effective and cost effective. Counseling on overdose should be standard of care prior to release with distribution of Naloxone at release
- Staff need training on stigma related to addictions and on the best practice models and protocols of MAT and addiction treatment. Incorporating peer recovery coaches is an effective model.

- Build partnerships with treatment and social service providers to assist at release to make a warm handoff with peer support and navigation. Transportation and housing is critical to successful and stable transition.
- Primary care can engage those formerly incarcerated by demonstrating that self-care with a holistic approach builds self-esteem and sense of value that motivates.

Partnerships with local legislators and law enforcement, DOH, OMH, OASAS/SAMHSA SOR programs can make this happen.
(Jail-Based medication assisted treatment promising practices, guidelines and resources for the field, National Sheriff's Association, October 2018)

3. **The need for evaluation and research on best practice models and integrated systems of care: The HEALing Communities Study (HCS)**
Through the Helping to End Addiction Long-term Initiative, or NIH HEAL Initiative, NIH awarded four grants to academic institutions to conduct research as part of the HEALing Communities Study (HCS) over a four-year period. The HCS is testing the impact of a comprehensive, data-driven community response plan to deploy evidence-based practices (EBPs) across multiple sectors to reduce opioid-related OD deaths. The primary goal is to reduce opioid-related OD deaths by 40 percent in communities receiving the HCS intervention. A total of 67 communities in 4 states [Kentucky (KY), Massachusetts (MA), New York (NY), and Ohio (OH)] are enrolled in the study to measure the impact of the intervention.

Contracting with county commissioners of health or mental health, we included 16 rural and non-rural counties in NYS with the highest overdose rates in the state outside of New York City with an average of 27.8 death per 100,000. Seven of the 16 counties (47%) meet Federal Office of Rural Health criteria of rural; 27.0% of overdose deaths in the selected counties occurred in these rural counties.

The need for data driven approaches through community engagement
So often county officials, task force and coalitions, public health, law enforcement and other stakeholders are working without data access and making decisions not informed to the full capacity.

The HCS investigators hypothesize that the fastest and most sustainable way to achieve a relative 40% reduction in opioid-related overdose deaths is to support local community coalitions and their stakeholders in building and enhancing a comprehensive, data-driven community response to the opioid crisis in their community.

The Communities That HEAL (CTH) Intervention
Based on the Communities That Care model, the CTH seeks to promote a common vision, shared goals, and tailored strategies to mobilize HCS communities to implement communication campaigns and adopt EBPs using a stepwise community change process. Drawing on community-based participatory research (CBPR) principles, the CTH intervention is implemented with local implementation teams led by county health or mental health leadership in partnership with the research team using a multi-sector coalition (taskforce or steering committee) to develop a community-driven change process to be more effective in preventing opioid related deaths. The sectors represented in coalitions along with people with lived experience are public health, law enforcement, criminal justice including sheriffs, jails administrators and correctional health, parole and probation offices and drug and opioid courts, behavioral health, social services, harm reduction including DOH-funded Hubs, drug treatment including OASAS-funded Centers of Treatment Innovation and Prevention Resource Centers, faith-based organizations, community health and hospitals.

Embedded within this work is the belief that the primary responsibility for practice change lies within the community. Further, it is recognized that communities are complex, and that distinct priorities exist across and within them. Thus, community members, particularly those who are most impacted, have a nuanced understanding of the best ways to implement and promote EBPs locally. This dynamic interplay of theories of change, EBPs, and the realities in each community will establish a data-driven learning system to facilitate a greater understanding of principles needed for community change.

- **The core components of the CTH intervention.**
  The CTH includes co-creation, or participatory, approaches that lead to coalition-driven community change and action planning, enhanced decision making with a portal and data dashboard, and the design and implementation of communication campaigns that focus on increasing demand for EBPs and reducing stigma.
  The selection and adoption of EBPs in each community is guided by a menu of options that prioritizes EBPs, populations, and venues most likely to reduce opioid overdose fatalities. The approach is supported by data from implementation science and will be a focus of cost-effectiveness research.

  The menu of evidence-based practices include three primary objectives:
  - Opioid overdose prevention education and naloxone distribution (OEND) in high-risk populations
  - Effective delivery of medication for opioid use disorder (MOUD) maintenance treatment, including agonist/ partial agonist medication, and including outreach and delivery to high-risk populations
  - Safer opioid prescribing and dispensing

  The Community-based communication campaign objectives support intervention implementation and outcomes and include the following:
  - Increase the demand for and availability of overdose education, naloxone, and medication for OUD.
  - Increase entry and retention in treatment.
  - Reduce stigma associated with OUD.

- **Capacity building (technical assistance and training) and sustainability**
  Localized HCS implementation teams will conduct ongoing assessment of community partners' TA and training needs. To build on existing and emerging resources for sustainability, HCS implementation teams assist with linkage to local, state and federal resources and academic expertise. These providers include the Opioid Response Network (ORN), Providers Clinical Support System (PCSS), Addiction Technology Transfer Center (ATTC) Network, OASAS and DOH available technical assistance and academic detailing, Prevention Resource Centers, The Academy of Peer Services and others. We need these resources to remain sufficiently funded to fully address this addiction crisis.

Closing comment

On behalf of Columbia University, Dr. El-Bassel and the Social Intervention Group, our diverse investigative team and stakeholders in the HEALing Communities initiative, I am grateful to the Task Force for hosting this critical hearing and for shining a spotlight on this issue. Thank you for your time and for your consideration of my testimony, and we look forward to working with you, your partners in government at the state and county levels on this initiative. If you have any questions or would like to discuss these issues further, I hope that you will be in touch.

Sincerely,

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