SESSION 4
The Continuing Struggle to Harmonize Drug Law with Public Health Evidence and Practice

- Nicolas Terry, Indiana University McKinney School of Law
- Leo Beletsky, Northeastern University School of Law and Bouvé College of Health Sciences
- Ronda Goldfein, AIDS Law Project of Philadelphia
- Evan Anderson, University of Pennsylvania School of Nursing
- Devin Reaves, Pennsylvania Harm Reduction Coalition
- Heidi Grunwald, CPHLR (Moderator)
Opioids & Medicaid

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Hall Render Professor of Law
& Executive Director of the Hall Center for Law and Health

Indiana University Robert H. McKinney School of Law
# Social Determinants of Health

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<th>Education</th>
<th>Food</th>
<th>Community and Social Context</th>
<th>Health Care System</th>
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<td>Provider linguistic and cultural competency</td>
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<td>Medical Bills</td>
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<td>Stress</td>
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<td>Support</td>
<td>Walkability</td>
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<td>Zip code / geography</td>
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## Health Outcomes
- Mortality
- Morbidity
- Life Expectancy
- Health Care Expenditures
- Health Status
- Functional Limitations
Figure 1b. Percent Change in Predicted 12 Month-ending Count of Drug Overdose Deaths, by Jurisdiction: January 2018 to January 2019

Legend for Percent Change in Drug Overdose Deaths Between 12-Month Ending Periods

-23.8  |  0  |  23.8
Figure 2

Income of Nonelderly Adults with Opioid Use Disorder and All Nonelderly Adults, 2017

- > 200% FPL: 51% (All Nonelderly Adults with Opioid Use Disorder: 1.98 M)
- 100%-200% FPL: 26% (All Nonelderly Adults: 197.3 M)
- <100% FPL: 23% (All Nonelderly Adults with Opioid Use Disorder: 1.98 M)
- > 200% FPL: 65% (All Nonelderly Adults: 197.3 M)
- 100%-200% FPL: 19% (All Nonelderly Adults: 197.3 M)
- <100% FPL: 15% (All Nonelderly Adults: 197.3 M)

NOTE: Totals may not sum to 100% due to rounding. Nonelderly adults are 18 to 64 years. FPL is Federal Poverty Level. In 2017, the FPL for an individual was $12,060. SOURCE: KFF analysis of 2017 National Survey on Drug Use and Health (NSDUH).
Figure 3
Insurance Status of Nonelderly Adults with Opioid Use Disorder, 2017

- All Nonelderly Adults with Opioid Use Disorder (1.98 M):
  - Uninsured: 34%
  - Other: 9%
  - Private: 20%
  - Medicaid: 38%

- Low-Income Adults with Opioid Use Disorder (963,000):
  - Uninsured: 19%
  - Other: 13%
  - Private: 13%
  - Medicaid: 55%

NOTE: Totals may not sum to 100% due to rounding. Nonelderly adults are 18 to 64 years. Low income is defined as having income below 200% FPL or $24,120 in 2017. Other insurance includes Medicare, CHAMPUS, or any other type of health insurance. SOURCE: KFF analysis of 2017 National Survey on Drug Use and Health (NSDUH).
“Medicaid expansion is a key lever for expanding access to substance use treatment because many of the most vulnerable individuals with substance use disorders have incomes below 138 percent of the federal poverty level.”
(Surgeon-General’s Report, 2016)
Figure 4
Past-Year Treatment Utilization among Nonelderly Adults with Opioid Use Disorder, by Insurance Status, 2017

Total Number of Nonelderly Adults with Opioid Use Disorder: 1.98 Million

* Indicates a statistically significant difference from the Medicaid population at the p<0.05 level.
NOTE: Nonelderly adults are 18 to 64 years. Any treatment includes receiving drug and/or alcohol treatment at any of the following in the past year: inpatient hospital, residential rehabilitation, outpatient rehabilitation, mental health center, and private doctors’ office.
• In states that expanded Medicaid, the number of people hospitalized with a SUD who did not have health insurance decreased from about 20 percent in 2013... to 5 percent in 2015. And a growing number of states are using Medicaid to improve the capacity of substance use service providers to deliver comprehensive care. (CBPP)

• After Kentucky expanded Medicaid, the state experienced a 700 percent increase in the utilization of substance use services. (Foundation for a Healthy Kentucky, 2016)

• Between 2009 and 2013 — prior to Medicaid expansion — the number of Medicaid-covered naloxone prescriptions was similar in the two groups of states: those that later opted to expand program eligibility (4,025) and those that did not (3,800). After expansion, the pattern changed. In 2016, expansion states dispensed 38,000 naloxone prescriptions, compared with just 7,000 in nonexpansion states. In 2009, Medicaid sales of naloxone were less than 1 percent of sales of the drug nationwide; by 2016, that figure had grown to 25 percent. (Frank & Fry, 2019)

• Medicaid expansion in California was associated with a reduction in the number of evictions, with 24.5 fewer evictions per month in each county from a pre-expansion average of 224.7. (Heidi L. Allen, Erica Eliason, Naomi Zewde, and Tal Gross, 2019)
<table>
<thead>
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<th>Waiver Provision</th>
<th># of States with Approved Waiver</th>
<th># of States with Pending Waiver</th>
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<tbody>
<tr>
<td>IMD Payment Exclusion</td>
<td>7 approved for substance use treatment, 1 approved for mental health services</td>
<td>7 pending for substance use treatment, 2 pending for mental health services</td>
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<tr>
<td>Community-Based Benefit Expansions</td>
<td>9 approved</td>
<td>5 pending</td>
</tr>
<tr>
<td>Eligibility Expansions</td>
<td>6 approved</td>
<td>2 pending</td>
</tr>
<tr>
<td>Delivery System Reforms</td>
<td>5 approved</td>
<td>3 pending</td>
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Medicaid Morphing From Solution to Problem?

- Obama Administration—encouraged red state Medicaid Expansion with Section 1115 waivers allowing “skin-in-the-game” requirements for eligibility or increased levels of care

  - Indiana: Over half (51%) of those with income above 100% FPL determined eligible for HIP 2.0 never enrolled in coverage or lost coverage for failure to pay premiums. Without Indiana’s waiver, these people would have been enrolled in coverage after they were found eligible and would have retained coverage without having to pay a premium.

  - The top two reasons cited by people who never enrolled in or lost HIP 2.0 coverage were affordability and confusion about the payment process.

- Trump Administration—grants Section 1115 waivers allowing states to introduce “community engagement” or work requirements as conditions of eligibility

  - Fundamentally flawed—work requirement is backwards—Medicaid has little or positive effects on labor-force supply, rather having healthcare and other safety net services supports work and job-seeking.
11% of enrollees who lost coverage in 2018 due to work and reporting requirements have regained coverage in 2019.

Total enrollees who lost coverage in 2018 due to work and reporting requirements = 18,164

89% of enrollees who lost coverage in 2018 remain unenrolled in 2019.

• Reduction in Number of Insureds
  • Kentucky: Based on Arkansas’s experience, MEPS data, and [other] estimates about 108,000 people would likely lose Medicaid coverage as result of the work requirements over a 24-month period. Adding work requirements would increase the number of nondisabled adults churning off Medicaid in Kentucky from estimated 108,000 adults to 216,000 — a 100% increase. (Collins et al, 2018)

• And It’s Bad Business!
  • Kentucky: Hospital operating margins would decline 1.6%–2.9%
  • New Hampshire: Federal government pays 90%-a new study suggests’s new work requirements and so ineligibility would mean losing about 7 percent to 11 percent of the state’s entire general funds budget. (Commonwealth Fund)
SUD Carve-Outs?

• Many people with SUDs won’t be eligible for work requirement exemptions. By definition, the “medically frail” exemption includes people with “chronic” SUDs, but that suggests people must have had multiple episodes of substance use or that their illness must have persisted for a long time. Many people with SUDs will not meet this standard.

• Accommodations built around counting SUD treatment fail because of lack of treatment centers and don’t count post-treatment care

• Persons with SUD frequently churn in and out of treatment

• Accommodations require paperwork and administrative requirements that have been shown to decrease eligibility

• SUD diagnosis is based partly on whether the person’s substance use results in a failure to meet major responsibilities at work, school, or home.
Q & A
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Indiana University Robert H. McKinney School of Law
Using Legal Epidemiology to Assess Overdose Crisis Response: The Case of Drug-Induced Homicide

PHLR Symposium
September 13, 2019

Leo Beletsky, JD, MPH
Northeastern University
School of Law and
Bouvé College of Health Sciences
UC San Diego School of Medicine
No conflicts to declare
A Note about Language

1. Language begets narratives, which beget policies and practices
   - “Abuse” and “abuser” charged w/ stigma (e.g. Ashford et al, 2018)
   - Dealers, pushers, users, addicts
   - “Dependence” ≠ “addiction”
   - Treatment ≠ “substituting one drug with another,” “detox”
   - More about language: www.changingthenarrative.news

2. Linguistic norms define the goals and the means

3. Changing policy and practice requires changes in narratives, language, and imagery
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 suppliers, 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 and instead admit to a lower felony because it still is a distribution.
Operationalization: DIH Statutes

1/1/19 Does the state have a specific drug induced homicide law?

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

FOR IMMEDIATE RELEASE

United States Attorney Announces Charges Against Narcotics Trafficker Connected To Heroin Overdose Death

Preet Bharara, the United States Attorney for the Southern District of New York, William F. Sweeney Jr.,

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 overdose. Anthony Delosangeles allegedly dealt in heroin, including the heroin that killed Thomas Cippollaro, 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.”
Drug dealers would face homicide charges after overdose under new bill

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Surge of DIH Charges Over Time

DIH Charges by Year

Source: http://healthinjustice.org/drug-induced-homicide
Uneven Geographic Distribution

MOST ACTIVE STATES IN PURSUING DRUG-INDUCED HOMICIDE CHARGES

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

Number of Cases Displayed
1742
Mapping onto Drug War Disparities

Source: http://healthjustice.org/drug-induced-homicide
Mapping onto Drug War Disparities

Source: http://healthinjustice.org/drug-induced-homicide
Rising Tide of Punitive Responses
Public Health Impact: Helpseeking

“If you[‘re] the one that's with them when they go out, you're possibly going to be CHARGED WITH THEIR DEATH. So that's the main reason why a lot of people don't call [911].”

Source: Latimore and Bergstein, IJDP (2017)
Regulatory Failure

- Crowding out & opportunity costs:
  - Investigation
  - Incarceration
  - Public attention/resolve
- Public health subject to “prevention paradox”
Next Steps

- DIH statute elements as determinants of prosecution dynamics
- DIH statutes and prosecutions as overdose prevention measures
- Defining “public health approach”
- Fentanyl myths as a catalyst for DIH statutes
- Using research to shape policy
Contact

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Executive Director
Safehouse

A public health approach to overdose prevention in Philadelphia

safehousephilly.org
WHICH SHOULD BE LEGAL?

[Supervised Injection Site]

[Unsupervised Injection Site (What We Have Now)]

# Registration
NO ILLEGAL DRUGS WILL BE PROVIDED

## Assessment of physical and behavioral health
Offer of services
Data collection

### Medically supervised consumption room
- Sterile equipment
- Fentanyl test strips
- Overdose reversal and emergency care
- Safe disposal of equipment

### Medically supervised observation room
- Overdose reversal, emergency care
- Certified peer specialists
- Offer of services

### Medical services
- Wound care
- On-site initiation of MAT (Medication-Assisted Treatment) and recovery counseling
- HIV and HCV counseling, testing, and treatment
- Primary care

### Wraparound services
- Referrals to social services, legal services, and housing opportunities

## Check out
Additional data collection, offer of services, and naloxone distribution
Evan Anderson, JD, PhD
University of Pennsylvania School of Nursing
The Role of Harm Reduction in Public Health
Opioid Epidemic

Or is there more?
The Unspoken Epidemic... Communicable Disease Disease
Vulnerable Counties and Jurisdictions Experiencing or At-Risk of Outbreaks

Key

- **Green**: At Risk of Outbreak
- **Pink**: Top 220 Counties

**Luzerne**: 38th
**Cambria**: 131st
**Crawford**: 188th
Injecting of drugs is associated with skin and soft tissue infections (SSTIs) and vascular disease. These conditions include the development of cutaneous abscess and cellulitis at injection sites, and can be deadly.
Recovery: A process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential.
Engaging people who use drugs where they are at increases their chances of getting access to resources that would have otherwise been denied to them.
Many Paths To Recovery
“Medication-Assisted Recovery” is a practical, accurate, and non-stigmatizing way to describe a pathway to recovery made possible by physician-prescribed and monitored medications, along with other recovery supports, e.g., counseling and peer support. Although no medications cure dependence on drugs or alcohol, some can play a significant and lifesaving role in helping people begin and sustain recovery.
Access to Naloxone
Myths Vs Facts

• SSPs Increase & Encourage Drug Use
• SSPs Increase Crimes
• SSPs only give out needles
• Supporting SSPs isn’t an effective use of public funds
“No matter how uncomfortable syringe service programs make us, they are proven to save lives, both by preventing the spread of diseases like HIV and hepatitis C and by connecting people to treatment that can put them on a path to recovery.”

Jerome C. Adams, MD Surgeon General of the United States
“Syringe services programs aren’t necessarily the first thing that comes to mind when you think about a Republican health secretary, but we’re in a battle between sickness and health, between life and death.”
Scientists, including those at the Centers for Disease Control and Prevention (CDC), have studied SSPs for more than 30 years and found that comprehensive SSPs benefit communities.

**SSPs save lives** by lowering the likelihood of deaths from overdoses.

Providing testing, counseling, and sterile injection supplies helps prevent outbreaks of other diseases. For example, SSPs are associated with a 50% decline in the risk of HIV transmission.

Users of SSPs were **three times more likely** to stop injecting drugs.

Law enforcement benefits from reduced risk of needlesticks, no increase in crime, and the ability to save lives by preventing overdoses.

When two similar cities were compared, the one with an SSP had 86% fewer syringes in places like parks and sidewalks.
• 5/67 Counties have SSPs
• Only 15% of Pennsylvania’s population of 12.8 million can access comprehensive harm reduction services.
• Our current legal barriers leave 10 million Pennsylvanians with no viable option for harm reduction services
Counties with Cities with SSPs

• 5/67 Counties have SSPs
• Only 15% of Pennsylvania’s population of 12.8 million can access comprehensive harm reduction services.
• Our current legal barriers leave 10 million Pennsylvanians with no viable option for harm reduction services
Brown University demonstrates how fentanyl test strips work

- Research from Baltimore, MD, Boston, MA and Providence, RI
  - Test strips allow PWUD to be more informed about the drugs they are buying and using, leading to behavior change and the adoption of increased harm reduction measures, including sharing information among peers.
  - Test strips allow providers to better engage with non-injectors and non-opioid users around overdose prevention and resulted in an increase in naloxone trainings with non-opioid users.
  - PWUD demonstrate a high likelihood of implementing one or more harm reduction strategies when learning that their drugs are positive for fentanyl.
“Drug paraphernalia” means all equipment, products and materials of any kind which are used, intended for use or designed for use in planting, propagating, cultivating, growing, harvesting, manufacturing, compounding, converting, producing, processing, preparing, testing, analyzing, packaging, repackaging, storing, containing, concealing, injecting, ingesting, inhaling or otherwise introducing into the human body a controlled substance in violation of this act. It includes, but is not limited to:

1. Hypodermic syringes, needles and other objects used, intended for use, or designed for use in parenterally injected controlled substances into the human body.
# HERO THE HEROIN INITIATIVE

<table>
<thead>
<tr>
<th>Phase 1</th>
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| • Host 4 Forums  
• Train 200 People  
• Special Thanks to University of Pittsburgh School Graduate School of Public Health & Pittsburgh Foundation | • Host 20 Forums  
• Train 500 People  
• Organize “Hero Teams” with the goal of creating consistent, connected, and deliberate change agents to address the overdose epidemic in their own communities. | • Convene a Train the Trainer  
• Host 35 Forums  
• Train 750 people  
• Support 15 teams |

- Support 2 Teams
In an effort to expand effective Syringe Service Programs in Pennsylvania, PAHRC has launched the Pennsylvania Syringe Services (PASS) advocacy campaign. Currently, Pennsylvania state law defines syringes as drug paraphernalia. This legislative barrier prevents the operation of syringe service programs throughout the commonwealth.

The Pennsylvania Harm Reduction Coalition seeks to advocate for those most at risk over overdose. No population is more at risk than those leaving correctional facilities.

We believe it is the duty of treatment providers to incorporate overdose prevention training in their programs. This crucial, life-saving strategy should be the standard of care and deployed in every treatment center in Pennsylvania.
People feel more disillusioned than ever:

Despite apathy, advocacy works!

We are living in a critical and historic time, make the most of it!

People who advocate for the first time are often surprised by the impact they have.
Conference