The show will be filmed in a panel format, with free discussion between the show host and other panelists. This discussion guide is not to be considered a script. The information and resources provided in this discussion guide are provided to assist panelists in show preparation. The questions identified in each panel section will be asked by the show host. Panelists will respond to questions asked by the host, and they will also comment and add to information presented by other panelists in a discussion format. Panelists will bring their own keen anecdotal experiences to the show as well as references from scientific studies from the field.

Show Description. When used as directed, prescription opioids are safe and effective and provide much needed relief to those in pain. However, prescription opioid nonmedical use or misuse (i.e., not following a prescription or using pain relievers prescribed to someone else)—which can progress to opioid use disorder—remains a significant problem in the United States. In 2014, 4.3 million people aged 12 or older were nonmedical users of pain relievers during the past month. Approximately 1.9 million people aged 12 or older experienced prescription pain reliever use disorder during the past year in 2013. The United States also witnessed a near quadrupling of overdoses from prescription opioids from 1999 to 2011. A significant public health concern is the transition from prescription opioid misuse to heroin use.

increase in heroin use\(^6,7\) and a near fourfold increase in heroin overdose deaths from 2000 to 2013, with most occurring after 2010.\(^8\) The devastating impact of the opioid overdose epidemic on individuals, families, and communities has prompted a comprehensive federal response—including promoting the wider use of naloxone to reverse opioid overdose and efforts to increase the number of people receiving treatment, particularly medication assisted treatment (MAT)\(^9,10\).

This show will highlight recent trends in the following: prescription opioid misuse and heroin use; opioid use disorders; and emergency department visits, overdose, and treatment episodes related to prescription opioids and heroin. The discussion will highlight the White House initiative on High Intensity Drug Trafficking Areas, which applies a broad range of efforts to reduce the distribution and use of heroin\(^11\). This episode will also cover the Centers for Disease Control and Prevention’s (CDC) Guideline for Prescribing Opioids for Chronic Pain (released on March 15, 2016). Panelists will focus on prevention efforts and resources—particularly greater use of naloxone to reverse opioid overdose; the SAMHSA Opioid Overdose Prevention Toolkit; and the training/certification of law enforcement and other community-based professionals in the use of naloxone, which has been shown to reduce deaths.\(^12\) The show will highlight a federal initiative that helps health care professionals make the most informed opioid-prescribing decisions, increases the use of naloxone (including training first responders in its use), and expands the use of MAT.\(^13\) The panel discussion will cover prevention efforts and resources to counter the increased risk of HIV and hepatitis related to injection drug use. The show will also address treatment options, including MAT, and SAMHSA resources that can help people with opioid use disorder find their own path to recovery. The importance of family, friends, and support networks in recovery from opioid use disorder will be addressed.

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Panel 1: Opioid Misuse: The Challenge Before Us

Key Questions

1. The media has recently stepped up their coverage of the heroin challenges in this country—what is the extent of the problem? And, what is the major cause of the epidemic?
2. Why is it important to understand the potential risks of prescription opioids? What are some of those risks?
3. What is nonmedical use or misuse of prescription opioids? How many people engage in nonmedical use of prescription pain relievers in the United States? What are the potential negative effects of prescription opioid misuse?
4. What is opioid use disorder? How are people who experience mental or substance use disorders at risk for opioid use disorder? Who else is at risk for opioid use disorder? Where are the trigger points where patients and others might get access to opioid-based medications?
5. How many people overdose from prescription opioids in the United States? How have rates of prescription opioids overdose changed?
6. What are the negative health consequences of opioid use disorder? What is the impact of opioid use disorder on society? What is the impact on families?

Extent of the Heroin Challenges Facing the United States

[The issue of heroin overdose is addressed in Panel 3.]


- About 435,000 people aged 12 or older were current heroin users in 2014, which rounds to 0.4 million people.
- For past-year use, 0.3 percent of people aged 12 or older in 2014 had used heroin, which represents about 914,000 people.
- Despite the dangers associated with heroin use, its use has increased in the population. The estimate of current heroin use in 2014 among people aged 12 or older was higher than the estimates for most years between 2002 and 2013. However, this difference represents a change from 0.1 percent in 2002 to 2013 to 0.2 percent in 2014. Data from future survey years would be useful for monitoring whether this increase in 2014 signals the start of a change in the trend, or if the percentage goes back down.
- The estimate of past-year heroin use in 2014 (0.3 percent) also was greater than the estimates from 2002 to 2013 (ranging from 0.1 to 0.3 percent). This rise in heroin use among people aged 12 or older may reflect increases in heroin use by adults aged 26 or older and, to a lesser extent, increases in heroin use among young adults aged 18 to 25.
- In 2014, 0.1 percent of adolescents aged 12 to 17 were current heroin users, and 0.1 percent were past-year users. These percentages represent 28,000 adolescents who used heroin in the past year, including 16,000 who currently used heroin.
Among young adults aged 18 to 25 in 2014, 0.2 percent were current heroin users, and 0.8 percent were past-year users. These percentages represent 268,000 young adults who used heroin in the past year, including 82,000 who currently used heroin.

In 2014, 0.2 percent of adults aged 26 or older were current heroin users, and 0.3 percent were past-year users. These percentages represent 618,000 adults aged 26 or older who used heroin in the past year, including 337,000 who currently used heroin.

Heroin use has increased across the United States among men and women, most age groups, and all income levels. Some of the greatest increases occurred in demographic groups with historically low rates of heroin use: women, the privately insured, and people with higher incomes.

Not only are people using heroin, they are also abusing multiple other substances, especially cocaine and prescription opioid pain [relievers].

Heroin use more than doubled among young adults ages 18–25 in the past decade.

More than 9 in 10 people who used heroin also used at least one other drug.

45 percent of people who used heroin were also addicted to prescription opioid pain [relievers].

Major Cause of the Epidemic


Key findings include:

Nearly all (96 percent) people who reported heroin use also reported using at least one other drug in the past year with more than half (61 percent) using at least three other drugs.

The people most at-risk of heroin abuse or dependence include non-Hispanic whites, men, 18-to-25 year-olds, people with an annual household income less than $20,000, Medicaid recipients, and the uninsured.

Significant increases in heroin use were found in groups with historically low rates of heroin use, including women and people with private insurance and higher incomes. The gaps between men and women, low and higher incomes, and people with Medicaid and private insurance have narrowed in the past decade.
• People who abuse or are dependent on:
  o prescription opioid painkillers are 40 times more likely to abuse or be dependent on heroin.
  o cocaine are 15 times more likely to abuse or be dependent on heroin.
  o marijuana are 3 times more likely to abuse or be dependent on heroin.
  o alcohol are 2 times more likely to abuse or be dependent on heroin.
• As heroin abuse or dependence has increased so has heroin-related overdose deaths. From 2002 through 2013, the rate of heroin-related overdose deaths nearly quadrupled.
• “Approximately 120 people die each day in the United States of a drug overdose,” said DEA Acting Administrator Chuck Rosenberg. “The CDC’s Vital Signs illustrates two significant factors partly fueling that alarming number – the misuse of prescription drugs and a related increase in heroin use. We will continue to target the criminal gangs that supply heroin, and we will work to educate folks about the dangers and to reduce demand. In this way, we hope to complement the crucial efforts of the CDC and our nation’s public health agencies.”
• These key findings highlight the need for a comprehensive response that addresses the growing number of demographic groups using heroin along with multiple other drugs and should be considered in the development and implementation of prevention policies.
• "We are working with federal, state and local partners to increase access to effective treatment, while reducing overdoses and other consequences of the opioid epidemic, including the spread of Hepatitis C and HIV," said Michael Botticelli, director of National Drug Control Policy. "It is not enough to simply reverse overdoses. We must also connect overdose victims and people struggling with prescription drug and heroin use disorders to treatment facilities and doctors that offer medication-assisted treatment."

Importance of Understanding the Potential Risks/Benefits of Opioids


• In 2013, 207 million prescriptions were written for prescription opioid pain medications.


• Opioids are a mainstay in the treatment of pain both chronically and acutely.
• In the past 20 years, the prescribing of opioids has increased exponentially. As the population for whom opioids are indicated has grown, with the number of opioid prescriptions written increased, so have indicators of opioid misuse, [opioid use disorder], morbidity, and mortality.

Potential Risks of Prescription Opioids
Taken as prescribed, opioids can be used to manage pain safely and effectively. However, when [misused], even a single large dose can cause severe respiratory depression and death.

Properly managed, short-term medical use of opioid analgesics rarely causes addiction—characterized by compulsive drug seeking and use despite serious adverse consequences.

Regular (e.g., several times a day, for several weeks or more) or longer term use or [misuse] of opioids can lead to physical dependence and, in some cases, addiction.

Physical dependence is a normal adaptation to chronic exposure to a drug and is not the same as addiction [see description of dependence versus addiction below].

In either case, withdrawal symptoms may occur if drug use is suddenly reduced or stopped. These symptoms can include restlessness, muscle and bone pain, insomnia, diarrhea, vomiting, cold flashes with goose bumps (“cold turkey”), and involuntary leg movements.


- Physical dependence occurs because of normal adaptations to chronic exposure to a drug and is not the same as addiction. Addiction, which can include physical dependence, is distinguished by compulsive drug seeking and use despite sometimes devastating consequences. Someone who is physically dependent on a medication will experience withdrawal symptoms when use of the drug is abruptly reduced or stopped. These symptoms can be mild or severe (depending on the drug) and can usually be managed medically or avoided by using a slow drug taper.

- Dependence is often accompanied by tolerance, or the need to take higher doses of a medication to get the same effect. When tolerance occurs, it can be difficult for a physician to evaluate whether patients are developing a drug problem, or have a real medical need for higher doses to control their symptoms. For this reason, physicians need to be vigilant and attentive to their patients’ symptoms and level of functioning to treat them appropriately.


- Physicians considering initiation or continuation of opioid therapy for a patient with chronic nonterminal pain should first use a structured approach that includes a biopsychosocial evaluation and a treatment plan that encourages patients to set and reach functional goals. There should be a comprehensive evaluation for the cause of pain, assessment for risk of opioid complications (including misuse and addiction), and a detailed treatment history, including a review of medical records and data from the state prescription [drug] monitoring program.
• Opioids should be prescribed on a trial basis, to be continued only if progress toward functional goals is demonstrated. [If necessary, patients can be provided with alternative pain treatment.]

• Ongoing monitoring for safety and effectiveness is essential, including regular review of functional progress or maintenance, urine drug testing, and surveillance of data from the state prescription [drug] monitoring program. Ineffective, unsafe, or diverted opioid therapy should be promptly tapered or stopped.


• Every day, 44 people in the [United States] die from overdose of prescription pain [relievers].

Definition of Nonmedical Use/Misuse


• Prescription drug misuse and abuse is the intentional or unintentional use of medication without a prescription, in a way other than prescribed, or for the experience or feeling it causes.


• Misuse: The use of prescription drugs in a manner other than as directed.
• Abuse: Continued use of illicit or prescription drugs despite problems from drug use with relationships, work, school, health, or safety. People with substance abuse often experience loss of control and take drugs in larger amounts or for longer than they intended.

Data on Nonmedical Use of Prescription Pain Relievers


• The estimated 4.3 million people aged 12 or older in 2014 who were current nonmedical users of pain relievers represent 1.6 percent of the population aged 12 or older.
• In 2014, an estimated 467,000 adolescents aged 12 to 17 were current nonmedical users of pain relievers, which corresponds to 1.9 percent of adolescents.
• An estimated 978,000 young adults aged 18 to 25 were current nonmedical users of pain relievers in 2014, which represents 2.8 percent of young adults.
• In 2014, an estimated 2.9 million adults aged 26 or older were current nonmedical users of pain relievers, which corresponds to 1.4 percent of adults aged 26 or older.

Risks and Negative Outcomes of Non-medical Use of Prescription Opioids


• Of the estimated 1,244,872 emergency department (ED) visits involving non-medical use of pharmaceuticals in 2011, 366,181 (29 percent) involved narcotic pain relievers.
• Narcotic pain reliever-related ED visits involving non-medical use of pharmaceuticals increased 117 percent from 2005 to 2011, but leveled off from 2008 to 2011.
• From 2005 to 2011, all age groups experienced increases in the rate of narcotic pain reliever-related ED visits involving non-medical use, except for adolescents aged 12 to 17.


During the 7 years from 2005 to 2011, almost a million (an estimated 943,032) emergency department (ED) visits involved benzodiazepines alone or in combination with opioid pain relievers or alcohol and no other substances.

• Combinations of benzodiazepines with opioid pain relievers or alcohol were associated with a 24 to 55 percent increase in the predicted risk of a more serious outcome compared with benzodiazepines alone.
• Increasing age was associated with increasing predicted risk of a more serious outcome for visits involving benzodiazepines alone or in combination with opioid pain relievers or alcohol and no other substances.
• with a 24 to 55 percent increase in the predicted risk of a more serious outcome compared with benzodiazepines alone.
• Increasing age was associated with increasing predicted risk of a more serious outcome for visits involving benzodiazepines alone or in combination with opioid pain relievers or alcohol and no other substances.

Definition of Opioid Use Disorder


• The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), no longer uses the terms substance abuse and substance dependence, rather it refers to substance use disorders, which are defined as mild, moderate, or severe to indicate the level of severity, which is determined by the number of diagnostic criteria met by an individual. Substance use disorders occur when the recurrent use of alcohol and/or drugs causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home. According
to the DSM-5, a diagnosis of substance use disorder is based on evidence of impaired control, social impairment, risky use, and pharmacological criteria.

- **Opioid Use Disorder**—Illegal opioid drugs, such as heroin and legally available pain relievers such as oxycodone and hydrocodone can cause serious health effects in those who misuse them. Some people experience a euphoric response to opioid medications, and it is common that people misusing opioids try to intensify their experience by snorting or injecting them. These methods increase their risk for serious medical complications, including overdose. Other users have switched from prescription opioids to heroin as a result of availability and lower price. Because of variable purity and other chemicals and drugs mixed with heroin and other illicit opioids on the black market, this also increases risk of overdose.

- **Symptoms of opioid use disorders** include strong desire for opioids, inability to control or reduce use, continued use despite interference with major obligations or social functioning, use of larger amounts over time, development of tolerance, spending a great deal of time to obtain and use opioids, and withdrawal symptoms that occur after stopping or reducing use, such as negative mood, nausea or vomiting, muscle aches, diarrhea, fever, and insomnia.

**How People Who Experience Mental or Substance Use Disorders Are at Risk for Opioid Use Disorder**


- A systematic review and meta-analysis found that the pooled prevalence of ‘any’ mental health issues (both diagnosis and symptoms) among substance [use] treatment patients reporting nonmedical prescription opioid use was 43 percent.
- Among these patients, the pooled prevalence of depression diagnosis was 27 percent, and 29 percent had an anxiety diagnosis.


- Data come from Waves 1 and 2 of the National Epidemiologic Survey on Alcohol and Related Conditions (N=34,653; ≥20 years old). Mental disorders were assessed using the Alcohol Use Disorder and Associated Disabilities Interview Schedule-DSM-IV edition. Physical conditions were based on self-reports of physician-diaoses. Multiple logistic regression models examined the associations between mental and physical health predictors at Wave 1 and their association to incident [non-medical use of prescription opioids and opioid use disorders] at Wave 2.
- After adjusting for sociodemographics, Axis I and II mental disorders and physical conditions, the presence of mental disorders (i.e., mood, personality disorders and
substance use disorders), physical conditions (i.e., increasing number of physical conditions, any physical condition, arteriosclerosis or hypertension, cardiovascular disease and arthritis) and sociodemographic factors (i.e., sex and marital status) at Wave 1 positively predicted incident opioid use disorders at Wave 2. Comorbid disorders increased the risk of non-medical use of prescription opioids and opioid use disorders.

Risk Factors for Opioid Use Disorder


- Research shows that some risk factors make people particularly vulnerable to prescription pain reliever misuse and overdose, including:
  - Obtaining overlapping prescriptions from multiple providers and pharmacies.
  - Taking high daily dosages of prescription pain relievers.
  - Having mental illness or a history of alcohol or other substance misuse.
  - Living in rural areas and having low income.

Medicaid Patients

- Inappropriate provider prescribing practices and patient use are substantially higher among Medicaid patients than among privately insured patients.
- In one study based on 2010 data, 40 percent of Medicaid enrollees with pain reliever prescriptions had at least one indicator of potentially inappropriate use or prescribing: overlapping pain reliever prescriptions; overlapping pain reliever and benzodiazepine prescriptions; and long-acting or extended release prescription pain relievers for acute pain and high daily doses.

Points Where Patients and Others Get Access to Opioid-Based Medicines


- Most people who abuse prescription opioids get them for free from a friend or relative.
- However, those who are at highest risk of overdose (using prescription opioids nonmedically 200 or more days a year) get them in ways that are different from those who use them less frequently. These people get opioids using their own prescriptions (27 percent), from friends or relatives for free (26 percent), buying from friends or relatives (23 percent), or buying from a drug dealer (15 percent).
- Those at highest risk of overdose are about four times more likely than the average user to buy the drugs from a dealer or other stranger.

• The use of prescription opioid medications has increased greatly in the United States during the past two decades; in 2010, there were 16,651 opioid-related deaths. In response, hundreds of federal, state, and local interventions have been implemented. We describe trends in the diversion and abuse of prescription opioid analgesics using data through 2013.

• We used five programs from the Researched Abuse, Diversion, and Addiction-Related Surveillance (RADARS) System to describe trends between 2002 and 2013 in the diversion and abuse of all products and formulations of six prescription opioid analgesics: oxycodone, hydrocodone, hydromorphone, fentanyl, morphine, and tramadol. The programs gather data from drug-diversion investigators, poison centers, substance-abuse treatment centers, and college students.

• Prescriptions for opioid analgesics increased substantially from 2002 through 2010 in the United States but then decreased slightly from 2011 through 2013. In general, RADARS System programs reported large increases in the rates of opioid diversion and abuse from 2002 to 2010, but then the rates flattened or decreased from 2011 through 2013. The rate of opioid-related deaths rose and fell in a similar pattern. Reported nonmedical use did not change significantly among college students.

• Postmarketing surveillance indicates that the diversion and abuse of prescription opioid medications increased between 2002 and 2010 and plateaued or decreased between 2011 and 2013. These findings suggest that the United States may be making progress in controlling the abuse of opioid analgesics.

Data on Prescription Opioid Overdoses


• During 2013, 43,982 drug overdose deaths (unintentional, intentional [suicide or homicide], or undetermined intent) were reported. Among these, 16,235 (37 percent) were associated with prescription opioid analgesics (e.g., oxycodone and hydrocodone).

Changes in Rates of Prescription Opioid Overdoses


• Deaths from prescription pain [relievers] have also quadrupled since 1999, killing more than 16,000 people in the U.S. in 2013.

• While the public health burden of this epidemic remains enormous, 2012 saw the first national drop in prescription overdose deaths since the 1990s, and essentially leveled off. This drop in deaths mirrors a similar drop in pain [reliever] prescribing rates across the country and gives promise to making even more progress in reversing this epidemic.

Data on Opioid Use Disorder
Pain Reliever Use Disorder

- The estimated 1.9 million people aged 12 or older in 2014 who had a pain reliever use disorder represent 0.7 percent of the people aged 12 or older.
- An estimated 0.7 percent of adolescents aged 12 to 17 in 2014 had a pain reliever use disorder in the past year, which represents about 168,000 adolescents.
- Approximately 430,000 young adults aged 18 to 25 in 2014 had a pain reliever use disorder in the past year, or 1.2 percent of young adults.
- In 2014, approximately 1.3 million adults aged 26 or older had a pain reliever use disorder in the past year, or 0.6 percent of the population aged 26 or older.

Heroin Use Disorder

- About 586,000 people aged 12 or older in 2014 had a heroin use disorder, which represents 0.2 percent of the people aged 12 or older. Although the percentage of people aged 12 or older in 2014 who were current heroin users was higher than the percentages in most years between 2002 and 2013, the percentage of people aged 12 or older with a heroin use disorder remained steady from 2011 to 2014. However, the percentage in 2014 was higher than the percentages in 2002 to 2010 (0.1 percent in each year).
- An estimated 0.1 percent of adolescents aged 12 to 17 in 2014 had a heroin use disorder in the past year, which corresponds to about 18,000 adolescents.
- Approximately 168,000 young adults aged 18 to 25 in 2014 had a heroin use disorder in the past year, which represents 0.5 percent of young adults.
- In 2014, approximately 400,000 adults aged 26 or older had a heroin use disorder in the past year, which represents 0.2 percent of adults aged 26 or older.

Negative Health Consequences of Opioid Use Disorder


Prescription Pain Relievers

- In 2011, there were 5.1 million drug-related emergency department (ED) visits; about one-half (49 percent) were attributed to drug misuse or abuse with a nearly equal percentage (45 percent) attributed to adverse drug reactions.
- ED visits involving misuse or abuse of pharmaceuticals increased from 2004 (626,470 visits) through 2011 (1,428,145 visits); the most commonly involved drugs were anti-
anxiety and insomnia medications and narcotic pain relievers (160.9 and 134.8 visits per 100,000 population, respectively).

- Oxycodone products were the narcotic pain relievers most commonly involved in ED visits (175,229 visits, or 56.2 visits per 100,000 population). Involvement of hydrocodone, methadone [(for pain)], and morphine products followed oxycodone with 31.2, 24.3, and 12.3 visits per 100,000 population, respectively. Narcotic pain relievers and anti-anxiety and insomnia medications are often not specifically identified by drug or brand name in the ED records, so the actual involvement of specific drugs is likely higher than reported here.

- [DAWN provides] the rates of ED visits per 100,000 population for the major pharmaceutical drugs among patients aged 12 to 17, aged 18 to 20, and aged 21 to 24 in 2011. Rates of visits for narcotic pain relievers and anti-anxiety and insomnia medications rose for each successively older age group: [38.4 visits per 100,000 population for persons ages 12 to 17; 157.2 visits per 100,000 population for persons ages 18 to 20; and 306.2 visits per 100,000 population for persons ages 21 to 24].

- A central finding of the 2011 DAWN is that the involvement of certain commonly abused pharmaceuticals in ED visits associated with drug misuse or abuse did not change from 2009 to 2011. There were no significant increases in the rates of visits involving narcotic pain relievers from 2009 to 2011.

**Heroin**

- In 2011, there were 402.0 ED visits per 100,000 population involving illicit drugs [for heroin, there were 258,482 ED visits in 2011] (83.0 visits per 100,000 population).

- [In 2011, among patients aged 12 to 17, aged 18 to 20, and aged 21 to 24 there were 8.5, 134.6, and 266.1 visits per 100,000 population, respectively.]


- Opioids can produce drowsiness, cause constipation, and—depending upon the amount taken—depress breathing. The latter effect makes opioids particularly dangerous, especially when they are snorted or injected or combined with other drugs or alcohol.

- More people die from overdoses of prescription opioids than from all other drugs combined.


- Heroin is an illegal, highly addictive opioid drug.

- A heroin overdose can cause slow and shallow breathing, coma, and death.

- People often use heroin along with other drugs or alcohol. This practice is especially dangerous because it increases the risk of overdose.

- Heroin is typically injected but is also smoked or snorted. When people inject heroin, they are at risk of serious, long-term viral infections such as HIV, Hepatitis C, and Hepatitis B, as well as bacterial infections of the skin, bloodstream, and heart.
Impact of Opioid Use Disorder on Society


- The objective of this study was to estimate the societal costs of prescription opioid [use disorder] and misuse in the United States.
- Costs were grouped into three categories: health care, workplace, and criminal justice. Costs were estimated by (1) quantity method, which multiplies the number of opioid abuse patients by cost per opioid abuse patient; and (2) apportionment method, which begins with overall costs of drug abuse per component and apportions the share associated with prescription opioid abuse based on relative prevalence of prescription opioid to overall drug abuse. Excess health care costs per patient were based on claims data analysis of privately insured and Medicaid beneficiaries. Other data/information were derived from publicly available survey and other secondary sources.
- Total U.S. societal costs of prescription opioid [misuse and use disorder] were estimated at $55.7 billion in 2007 (USD in 2009). Workplace costs accounted for $25.6 billion (46 percent), health care costs accounted for $25.0 billion (45 percent), and criminal justice costs accounted for $5.1 billion (9 percent). Workplace costs were driven by lost earnings from premature death ($11.2 billion) and reduced compensation/lost employment ($7.9 billion). Health care costs consisted primarily of excess medical and prescription costs ($23.7 billion). Criminal justice costs were largely composed of correctional facility ($2.3 billion) and police costs ($1.5 billion).


- Rates of opioid poisoning and related mortality have increased substantially over the past decade. Although previous studies have measured the costs of misuse, costs related specifically to opioid poisoning have not been quantified. This study quantifies the economic burden of opioid poisoning in the United States to help evaluate the economic case for efforts to reverse or prevent opioid poisoning and its associated morbidity and mortality.
- Mean costs and prevalence estimates were estimated using publically available datasets. A societal perspective was assumed and accordingly estimated direct medical and productivity costs. Direct medical costs included treatment for opioid poisoning in the emergency department (ED) and inpatient settings, along with emergency transport and drug costs. Productivity costs were estimated using the human capital method and included lost wages due to mortality and absenteeism costs from ED visits and hospitalizations. All costs were inflated to 2011 U.S. dollars.
- In 2009, total costs were estimated at approximately $20.4 billion with indirect costs constituting 89 percent of the total. Direct medical costs were approximately $2.2 billion. ED costs and inpatient costs were estimated to be $800 million and $1.3 billion, respectively. Absenteeism costs were $335 million and lost future earnings due to mortality were $18.2 billion.
• Opioid-related poisoning causes a substantial burden to the United States each year. Costs related to mortality account for the majority of costs. Interventions designed to prevent or reverse opioid-related poisoning can have significant impacts on cost, especially where death is prevented.

Impact of Opioid Use Disorder on Families


• [Having a loved one with a substance use disorder] puts a lot of stress on parents, brothers and sisters, grandparents—anyone who is part of the home.
• When family members take drugs:
  o You can't count on them to do what they say they will do.
  o They may forget or get distracted because their focus is on getting and taking drugs.
  o They might lie or steal money to buy drugs.
  o They might get fired from their jobs.
  o They might not come home at night.
  o They may do bad things they would never do if they weren't [using] drugs.
• Family members might fight a lot because of the problems the drug [use] is causing. The drug user might do and say things that upset neighbors and friends, and make the family ashamed.


• When parents or other family members [use] drugs, the children get hurt.
• People with [substance use disorders] can forget to take care of the kids. There might not be anyone making meals or helping the kids get washed and dressed. There might not be anyone to buy clothes or do the laundry. There might not be anyone to take the kids to the doctor or help with homework.
• Drug [use] can use up the family's money and make parents unable to work and earn money. The kids might go without heat, food, electricity, or even a place to live.
• When family members with [substance use disorders] are at home, it may not be safe for the kids. They might not be alert enough to protect kids from accidents or from other adults who would harm them. There might be a lot of fighting. They might abuse or neglect the children.
• If someone at home is dealing drugs or doing other crimes, it's also dangerous for the kids, and the adults could end up in prison.

Federal Efforts to Address Prescription Opioid Misuse and Heroin Use

The SPF Rx grant program provides an opportunity for states, U.S. territories, pacific jurisdictions (herein referred to as “states”), and tribal entities that have completed a Strategic Prevention Framework State Incentive Grant (SPF SIG) to target the priority issue of prescription drug misuse. The program is designed to raise awareness about the dangers of sharing medications and work with pharmaceutical and medical communities on the risks of overprescribing to young adults. SPF Rx will also raise community awareness and bring prescription drug abuse prevention activities and education to schools, communities, parents, prescribers, and their patients. In addition, SAMHSA will track reductions in opioid overdoses and the incorporation of Prescription Drug Monitoring Program (PDMP) data into needs assessments and strategic plans as indicators of the program’s success.

PDMPs are state-run databases used to track the prescribing and dispensing of controlled prescription drugs to patients. They are designed to monitor this information for suspected abuse or diversion (i.e., channeling drugs into illegal use), and can give a prescriber or pharmacist critical information regarding a patient’s controlled substance prescription history. State applicants must have a fully operational PDMP in order to apply for the SPF Rx program. Tribes must coordinate with the state run PDMPs to identify opportunities for collaboration that will limit overprescribing in tribal communities.


The purpose of this grant program is to address two of the nation’s top substance misuse prevention priorities: 1) underage drinking among persons aged 12 to 20; and 2) prescription drug misuse among persons aged 12 to 25. At their discretion, states/tribes may also use grant funds to target an additional, data-driven substance [misuse] prevention priority (marijuana, heroin, etc.) in their state/tribe. The SPF-PFS grant program is intended to prevent the onset and reduce the progression of substance misuse and its related problems while strengthening prevention capacity and infrastructure at the state, tribal, and community levels.


The purpose of this program is to reduce the number of prescription drug/opioid overdose-related deaths and adverse events among individuals 18 years of age and older by training first responders and other key community sectors on the prevention of prescription drug/opioid overdose-related deaths and implementing secondary prevention strategies, including the purchase and distribution of naloxone to first responders.
Today the President joins individuals in recovery, family members, medical professionals, law enforcement officials and other leaders at the National Rx Drug Abuse and Heroin Summit in Atlanta, Georgia. The annual summit is organized by Operation UNITE, which was launched by Congressman Hal Rogers (R-KY). As part of today’s event, the President is announcing additional public and private sector actions to escalate the fight against the prescription opioid abuse and heroin epidemic, which is claiming the lives of tens of thousands of Americans each year.

The President has made clear that addressing this epidemic is a priority for his Administration, and today’s actions represent further steps to expand access to treatment, prevent overdose deaths and increase community prevention strategies. These actions build on the President’s proposal for $1.1 billion in new funding to help every American with an opioid use disorder who wants treatment get the help they need.

As part of today’s event, the President will announce the following Administration actions:

**Expanding Access to Treatment:**

- The Department of Health and Human Services (HHS) is issuing a proposed rule to increase the current patient limit for qualified physicians who prescribe buprenorphine to treat opioid use disorders from 100 to 200 patients with the goal of expanding access to this evidence-based treatment while preventing diversion. The proposed rule aims to increase access to medication-assisted treatment and behavioral health supports for tens of thousands of people with opioid use disorders.
- HHS released $94 million in new funding to 271 Community Health Centers across the country earlier this month to increase substance use disorder treatment services, with a specific focus on expanding medication-assisted treatment of opioid use disorders in underserved communities. This funding is expected to help health centers treat nearly 124,000 new patients with substance use disorders.
- The Substance Abuse and Mental Health Services Administration (SAMHSA) is releasing a new $11 million funding opportunity for up to 11 States to expand their medication-assisted treatment services. SAMHSA also is distributing 10,000 pocket guides for clinicians that include a checklist for prescribing medication for opioid use disorder treatment and integrating non-pharmacologic therapies into treatment. SAMHSA also will coordinate trainings to increase the number of doctors qualified to prescribe buprenorphine, which will be held in targeted States in greatest need.

**Establishing a Mental Health and Substance Use Disorder Parity Task Force:** The President is signing a Memorandum today directing the creation of an interagency Task Force, to be chaired by the Domestic Policy Council, to advance access to mental health and substance use disorder treatment; promote compliance with best practices for mental health and substance use disorder parity implementation; and develop additional agency guidance as needed. Federal parity protections are intended to ensure that health plans’ coverage of mental health and substance use disorder benefits is comparable to their coverage of medical and surgical benefits. The Task
Force will work quickly, with an October 31 deadline, across Federal Departments and with diverse stakeholders to ensure implementation of these important parity protections.

- **Implementing Mental Health and Substance Use Disorder Parity in Medicaid**: HHS is finalizing a rule to strengthen access to mental health and substance use services for people enrolled in Medicaid and Children’s Health Insurance Program (CHIP) plans by requiring that these benefits be offered at parity, meaning that they be comparable to medical and surgical benefits. These protections are expected to benefit more than 23 million people in Medicaid and CHIP.

- **Preventing Opioid Overdose Deaths**: SAMHSA is releasing a new $11 million funding opportunity to States to purchase and distribute the opioid overdose reversal drug, naloxone, and to train first responders and others on its use along with other overdose prevention strategies.

- **Expanding Public Health-Public Safety Partnerships to Combat the Spread of Heroin**: The Office of National Drug Control Policy is expanding its heroin initiative among regional High Intensity Drug Trafficking Areas (HIDTAs) by adding Ohio and Michigan to the effort. These States will join the Appalachia, New England, Philadelphia/Camden, New York/New Jersey, and Washington/Baltimore HIDTAs in accelerating local partnerships between law enforcement and their counterparts in public health to combat heroin use and overdose.

- **Investing in Community Policing to Address Heroin**: The Department of Justice’s COPS program is announcing a $7 million funding opportunity called the COPS Anti-Heroin Task Force Program to advance public safety and to investigate the distribution of heroin, unlawful distribution of prescription opioids and unlawful heroin and prescription opioid traffickers. These grants will provide funds directly to law enforcement agencies in States with high rates of primary treatment admissions for heroin and other opioids.

- **Tackling Substance Use Disorders in Rural Communities**: On Monday, the Department of Agriculture announced that its $1.4 million Rural Health and Safety Education Grant Program to enhance the quality of life in rural areas through health and safety education projects has been expanded to include a focus on addressing the critical challenges related to substance use disorders in rural communities across the country.

- **Implementing Syringe Services Programs**: HHS is issuing guidance for HHS-funded programs regarding the use of Federal funds to implement or expand syringe services programs for people who inject drugs. Syringe services programs are an effective component of a comprehensive approach to preventing HIV and viral hepatitis among people who inject drugs. The bipartisan budget agreement signed by the President last year revised a longstanding ban on these programs and allows communities with a demonstrated need to use Federal funds for the operational components of syringe services programs.

**New Private Sector Commitments to Address the Epidemic**

- In connection with today’s Federal announcements, more than 60 medical schools are announcing that, beginning in fall 2016, they will require their students to take some form of prescriber education, in line with the newly released Centers for Disease
Control and Prevention Guideline for Prescribing Opioids for Chronic Pain, in order to graduate.

- **Rite Aid** has trained over 8,400 pharmacists on naloxone and is dispensing naloxone to patients without needing an individual prescription in 10 States with plans to expand to additional States. **Kroger** currently dispenses naloxone without an individual prescription at its pharmacies in 7 States with plans to expand to at least 12 more by the end of the year. **AmerisourceBergen/ Good Neighbor Pharmacy** will provide educational materials to encourage their 4,000 independently owned and operated retail pharmacy locations to provide naloxone without an individual prescription.

**Updates on Federal Actions and Private Sector Commitments**

- In October 2015, as part of his visit to West Virginia to discuss the prescription opioid abuse and heroin epidemic, the President announced a number of new public and private sector actions, including a Presidential Memorandum requiring Federal Departments to provide training on appropriate opioid prescribing to Federal health care professionals and requiring Departments to develop plans to address barriers to opioid use disorder treatment in Federal programs. Departments are ahead of schedule in fulfilling the President’s directive that Federal agencies ensure that all employees who prescribe these drugs are trained in appropriate opioid prescribing practices by 2017. Approximately 75 percent of federal prescribers have been trained to date. In addition, since the President’s Memorandum was released, Departments have taken numerous steps to expand access to opioid use disorder treatment, including medication-assisted treatment, such as:
  - **TRICARE:** The Department of Defense issued a proposed rule to implement parity protections in TRICARE, including expanding mental health and substance use disorder treatment to include coverage of intensive outpatient programs and treatment of opioid use disorders with medication-assisted treatment. TRICARE currently has an estimated 15,000 to 20,000 beneficiaries with opioid use disorder who, under the current benefit, cannot access medication-assisted treatment.
  - **FEHBP:** The Office of Personnel Management released a 2017 Call Letter to health plans participating in the Federal Employees Health Benefits Program (FEHBP) making opioid use disorder treatment a priority and calling on health plans to review and improve access to medication-assisted treatment.
  - **Medicare:** The Centers for Medicare and Medicaid Services (CMS) released a 2017 Call Letter to plans participating in the Medicare Prescription Drug Program reiterating that reducing the unsafe use of opioids is a priority and making clear that Part D formulary and plan benefit designs that hinder access to medication-assisted treatment for opioid use disorder will not be approved.
  - **Medicaid:** CMS released a guidance document to States identifying “Best Practices for Addressing Prescription Opioid Overdoses, Misuse and Addiction” including effective Medicaid pharmacy benefit management strategies, steps to increase the use of naloxone to reverse opioid overdose, and options for expanding Medicaid coverage of and access to opioid use disorder treatment. This builds on Medicaid’s work with States over the past year to increase access to Medicaid substance use disorder treatment services.
• **Health Insurance Marketplace**: In the last month, CMS finalized a 2017 Marketplace payment notice that clarified that both essential health benefits requirements and Federal mental health and substance use disorder parity requirements apply to qualified health plan coverage of medications to treat opioid use disorder, and additional guidance is forthcoming.

• Earlier this month, the **Centers for Disease Control and Prevention** issued its Guideline for Prescribing Opioids for Chronic Pain – the Agency’s first-ever recommendations for primary care clinicians on prescribing opioids. The Guideline provides recommendations for clinicians on appropriate prescribing, including determining if and when to start prescription opioids for chronic pain treatment; guidance on medication selection, dose, and duration, including when to discontinue medication, if needed; and guidance to help assess the benefits and risks and address the harms of prescription opioid use.

• The **Food and Drug Administration** recently announced safety labeling changes for all immediate-release opioid pain medications, including requiring a new boxed warning about the serious risks of misuse, abuse, addiction, overdose and death associated with these drugs. The Agency also issued a draft guidance intended to support the development of generic versions of abuse-deterrent opioids. Abuse-deterrent drug formulations are designed to make the drug more difficult to abuse, including making it harder to crush a tablet in order to snort the contents or more difficult to dissolve the product in order to inject it.

• The **Drug Enforcement Administration** (DEA) recently announced it will hold its 11th **National Prescription Drug Take-Back Day** on Saturday, April 30, providing a safe, convenient, and responsible way of disposing of unneeded prescription drugs. More than 5.5 million pounds of medication have been collected over the last ten Take Back Days. Local communities are also establishing ongoing drug take-back programs.

• Examples of private sector actions taken to date include the following:
  o In conjunction with the October event, more than 40 **health care provider groups** announced a commitment to ensure that more than 540,000 health care providers will complete training on appropriate opioid prescribing in the next two years. In the first five months of this initiative, the provider coalition reports that more than 75,000 providers have completed prescriber training. In addition, more than 2,200 additional physicians have committed to completing training to prescribe buprenorphine as part of the coalition’s effort to double the number of buprenorphine prescribers in the next three years.
  o As part of their commitment announced at the October 2015 event, the **National Association of Counties, National Governors Association, National League of Cities and United States Conference of Mayors**, with the **U.S. Communities Purchasing Alliance** and **Premier, Inc.**, announced in January they had secured discounts on naloxone and medication-assisted treatment drugs through their purchasing program for State and local agencies.
  o In February, **Walgreens** announced it will install safe medication disposal kiosks in more than 500 drugstores across the country, primarily at locations...
open 24 hours. The program will make the disposal of medications — including opioids and other controlled substances — easier and more convenient while helping to reduce the misuse of medications. Walgreens also will make naloxone available without needing an individual prescription at its pharmacies in 35 States and Washington, D.C. throughout this year.

CVS Health has worked to increase access to naloxone by establishing standing orders or collaborative practice agreements. By the end of March 2016, CVS Pharmacy locations in 23 States will be able to dispense naloxone to patients without needing an individual prescription, increasing to 35 States by the end of 2016 as part of its program expansion announced at the October 2015 event. CVS Health has also launched a drug abuse prevention program called Pharmacists Teach, which brings CVS Pharmacists into schools across the country to educate students about the dangers of drug abuse. To date, more than 30,000 students have participated in the program.


- The Secretary of the Department of Health and Human Services (the Secretary) (HHS) proposes a rule to increase the highest patient limit for qualified physicians to treat opioid use disorder under section 303(g)(2) of the Controlled Substances Act (CSA) from 100 to 200. The purpose of the proposed rule is to increase access to treatment for opioid use disorder while reducing the opportunity for diversion of the medication to unlawful use.


- Today, the President issued a Memorandum to Federal Departments and Agencies directing two important steps to combat the prescription drug [misuse] and heroin epidemic:
  - **Prescriber Training**: First, to help ensure that health care professionals who prescribe opioids are properly trained in opioid prescribing and to establish the Federal Government as a model, the Presidential Memorandum requires Federal Departments and Agencies to provide training on the prescribing of these medications to Federal health care professionals who prescribe controlled substances as part of their Federal responsibilities.
  - **Improving Access to Treatment**: Second, to improve access to treatment for prescription drug [misuse] and heroin use, the Presidential Memorandum directs Federal Departments and Agencies that directly provide, contract to provide, reimburse for, or otherwise facilitate access to health benefits, to
conduct a review to identify barriers to medication-assisted treatment for opioid use disorders and develop action plans to address these barriers.

- In 2010, the President released his first National Drug Control Strategy, which emphasized the need for action to address opioid use disorders and overdose, while ensuring that individuals with pain receive safe, effective treatment. Since then, the Administration has supported and expanded community-based efforts to prevent drug use, pursue ‘smart on crime’ approaches to drug enforcement, improve prescribing practices for pain medication, increase access to treatment, work to reduce overdose deaths, and support the millions of Americans in recovery.

- Additional Federal actions announced today include:
  - The Drug Enforcement Administration announced that it will continue its National Prescription Drug Take-Back Day program events in the spring and fall of 2016. As the President highlighted in a recent Weekly Address, Take-Back Day aims to provide a safe, convenient, and responsible means of disposing of unused prescription drugs, while educating the public about the dangers of misusing medications.
  - The U.S. Department of Health and Human Services (HHS) will undertake a review of how pain management is evaluated by patient satisfaction surveys used by hospitals and other health care providers, including review of how the questions these surveys use to assess pain management may relate to pain management practices and opioid prescribing.
  - The Centers for Disease Control and Prevention (CDC) will invest $8.5 million on the development of tools and resources to help inform prescribers about appropriate opioid prescribing; track data on prescribing trends; research, develop, and evaluate clinical quality improvement measures and programs on opioid prescribing; and improve public understanding of the risks and benefits of opioid use.
  - HHS also launched HHS.gov/opioids as a one-stop federal resource with tools and information for families, health care providers, law enforcement, and other stakeholders on prescription drug [misuse] and heroin use prevention, treatment, and response.
  - U.S. Surgeon General Vivek Murthy is developing an education campaign for doctors, dentists and other health care professionals who prescribe opioid pain medications. Earlier this month, Dr. Murthy also announced that work has begun on the first-ever Surgeon General’s Report on substance use, addiction and health scheduled for publication in 2016.
  - Centers for Medicare and Medicaid Services (CMS) will release an Information Bulletin to States by the end of the year on steps States can take through their Medicaid preferred drug lists (PDLs) and other utilization management mechanisms to reduce the risk of overdose. This includes a recommendation that they consider removing methadone from their PDLs for pain management. The Centers for Disease Control and Prevention has found that the use of methadone in pain treatment is associated with a disproportionately high number of overdose deaths compared to other opioid pain relievers.
  - This fall, CMS is testing three new Medicare prescription drug plan measures designed to identify potential opioid overutilization, with the goal of proposing publicly reportable measures for Part D drug plans next year. These measures are based on the work of the Pharmacy Quality Alliance.
The Department of Veterans Affairs will lead a research initiative to evaluate non-opioid alternative approaches to pain management. The Department of Defense (DoD) and VA are developing a standardized pain management curriculum for widespread use in education and training programs.

The Bureau of Indian Affairs (BIA) and the Indian Health Service will provide BIA police officers and investigators the opioid overdose reversal drug naloxone and training on its use. In 2016, the BIA, through the United States Indian Police Academy, will provide training to all BIA and tribal police officer cadets in recognizing opioid use disorders and overdose symptoms.

The White House will host a Champions of Change event this spring to highlight individuals in communities across the country who are leading the fight to respond to prescription drug misuse and heroin use.

Examples of additional actions by the Administration to address the opioid epidemic include:

**Community Prevention and Overdose Response**

- In 2015, the CDC launched the Prescription Drug Overdose: Prevention for States Program, which provided $20 million to states to support strategies to improve prescribing practices and prevent opioid overdose deaths.

- Through the National Take Back Days to remove unused prescription drugs from the community, the Drug Enforcement Administration (DEA) has collected more than 5.5 million pounds of medication and introduced several new ways to dispose of unused prescription drugs—including pre-paid return-mail packages. DEA also finalized a new rule making it easier for communities to establish ongoing drug take-back programs.

- In 2012, the Department of Veterans Affairs established an Opioid Safety Initiative to enhance safe and effective pain care for veterans. VA medical centers have filled more than 6,500 naloxone kit prescriptions, and VA’s efforts to make opioid overdose kits available has resulted in at least 100 lives saved.

- With support from the Department of Justice (DOJ) and other funders, 49 states have established Prescription Drug Monitoring Programs to help prescribers identify potential opioid misuse issues.

- In 2015, HHS announced a targeted initiative to combat opioid related overdose, death, and dependence focused on increasing prescriber training, increasing the use of the overdose reversal drug naloxone, and expanding the use of medication-assisted treatment.

- The federal government is expanding access to prescription drug monitoring program data throughout federal agencies. DoD’s Pharmacy Data Transaction Service automatically screens all new medication orders against a patient’s computerized medication history and permits DoD to monitor for concerning drug usage patterns. DoD’s Polypharmacy Medication Analysis Reporting is being used to identify high risk active duty service members based on their medication use and emergency department encounters. The Indian Health Service has successfully piloted integrating this data into their electronic systems, and a pilot to integrate data into the workflow of physicians in the DoD health system is slated to launch in 2016.

- The DOJ Bureau of Justice Assistance released a Law Enforcement Naloxone Toolkit to support law enforcement agencies in establishing naloxone programs. The toolkit has been downloaded more than 2,200 times in the last year.
• DoD is ensuring that opioid overdose reversal kits and training are available to every first responder on military bases or other areas under its control.
• The Office of National Drug Control Policy supports local Drug-Free Communities coalitions to reduce youth substance use through evidence-based prevention. In recent years, hundreds of these coalitions have specifically focused on prescription drug misuse issues in their areas.
• **Treatment**
  - Thanks to the Affordable Care Act, substance use disorder and mental health services are essential health benefits that are required to be covered by health plans in the Health Insurance Marketplace.
  - New rules finalized by this Administration ensure that covered mental health and substance use disorder benefits are comparable to medical and surgical benefits.
  - HHS is investing up to $100 million in Affordable Care Act funding to expand substance use disorder treatment, with a focus on medication-assisted treatment for opioid use disorders, in community health centers across the country.
  - HHS Secretary Burwell announced that the Department will engage in rulemaking related to the prescribing of buprenorphine-containing products approved by the FDA for treatment of opioid dependence to expand access to medication-assisted treatment for opioid use disorders. HHS will take a strategic approach in order to minimize diversion and ensure evidence-based treatment.
  - The CDC has been working over the last year with clinical experts and other stakeholders to develop new, peer-reviewed guidelines on prescribing opioids for chronic pain outside end of life settings to help improve the way opioids are prescribed and ensure patients have access to safer, more effective chronic pain treatment, while reducing opioid misuse and overdose.
  - HHS recently awarded $11 million in new grants to States to support medication-assisted treatment and $1.8 million to help rural communities purchase naloxone and train first responders in its use.
• **Enforcement and Supply Reduction**
  - The White House Office of National Drug Control Policy’s High Intensity Drug Trafficking Areas program is funding an unprecedented network of public health and law enforcement partnerships to address the heroin threat across 15 states.
  - In October of 2015, DOJ’s Office of Community Oriented Policing Services (COPS Office) awarded $6 million through the Anti-Heroin Task Force Program, which is designed to advance public safety by providing funds to investigate illicit activities related to the distribution of heroin or unlawful distribution of prescriptive opioids, or unlawful heroin and prescription opioid traffickers through statewide collaboration.
  - DOJ’s enforcement efforts include targeting the illegal opioid supply chain, thwarting doctor-shopping attempts, and disrupting so-called “pill mills.”
  - DOJ has cracked down on those who use the Internet to buy and sell controlled substances.
  - DEA agents and investigators are integrating with other federal, state, and local law enforcement officers in 66 Tactical Diversion Squads stationed across 41 states, Puerto Rico, and the District of Columbia. Outcomes of this effort include the largest pharmaceutical-related takedown in the DEA’s history in an operation that resulted in 280 arrests.
• Since 2007, through the Merida Initiative, the Department of State has been working with the Government of Mexico to help build the capacity of Mexico’s law enforcement and justice sector institutions to disrupt drug trafficking organizations and to stop the flow of illicit drugs including heroin from Mexico to the United States.


• The U.S. Department of Health and Human Services (HHS) has made addressing the opioid [use] problem a high priority and is committed to accelerating its work towards two broad goals: (1) decreasing opioid overdoses and overall overdose mortality and (2) decreasing the prevalence of opioid use disorder. Priority areas for action were identified through a Department-wide effort that tapped all the scientific, analytical and programmatic expertise contained in HHS agencies. The development effort also relied on discussions with states and other stakeholder organizations.

• The Secretary’s initiative targets three priority areas to combat opioid [use disorders]:
  o Opioid prescribing practices to reduce opioid use disorders and overdose
  o Expanded use and distribution of naloxone
  o Expansion of Medication-assisted Treatment (MAT) to reduce opioid use disorders and overdose

• A wide variety of possible interventions exists; however, Secretary Burwell directed officials and staff leading the initiative’s development to identify a small but targeted set of actions that have the highest likelihood of producing clinically meaningful outcomes—intermediate and long-term. Specifically, the actions and strategies in the initiative are grounded in the best research and clinical science available.

• These priorities—prescribing practices, naloxone, and MAT—will guide the Department’s targeted efforts to take steps that will reduce opioid-related morbidity and mortality.

White House Initiative on High Intensity Drug Trafficking Areas


• Today, Michael Botticelli, Director of National Drug Control Policy, announced $13.4 million in funding for High Intensity Drug Trafficking Areas (HIDTA). Of that, $5 million will be directed to a broad range of efforts that will reduce the trafficking, distribution, and use of heroin—a drug that has emerged as a serious threat to multiple regions of the United States.

• In particular, $2.5 million will fund the Heroin Response Strategy, an unprecedented partnership among five regional HIDTA programs—Appalachia, New England, Philadelphia/Camden, New York/New Jersey, and Washington/Baltimore—to address
the severe heroin threat facing those communities through public health–public safety partnerships across 15 states.

- “The High Intensity Drug Trafficking Areas program helps Federal, state, and local authorities to coordinate drug enforcement operations, support prevention efforts and improve public health and safety,” said Director Botticelli. “The new Heroin Response Strategy demonstrates a strong commitment to address the heroin and prescription opioid epidemic as both a public health and a public safety issue. This Administration will continue to expand community-based efforts to prevent drug use, pursue ‘smart on crime’ approaches to drug enforcement, increase access to treatment, work to reduce overdose deaths, and support the millions of Americans in recovery.”

- Nearly $4 million in HIDTA funds will support prevention efforts in 18 regional HIDTA programs, many of which draw upon key partnerships between law enforcement agencies and their counterparts in public health and education.

- In recognition of the unique drug challenges faced by law enforcement agencies in the region along the U.S.–Mexico border, $1.3 million in HIDTA funds will be directed to the five regional HIDTA programs along the Southwest border. These funds will be used to enhance investigative efforts against large-scale transnational criminal organizations, reduce the flow of dangerous drugs (including heroin and methamphetamine) across the border, and prevent drug use in border communities.

- Nearly $500,000 will be directed toward addressing drug threats on tribal lands. Regional HIDTA programs in six states will receive funding to investigate and dismantle the organizations that exploit tribal communities to traffic and distribute dangerous drugs.

- The Heroin Response Strategy will foster a collaborative network of public health–public safety partnerships to address the heroin/opioid epidemic from multiple perspectives. The Strategy will enhance the efficacy and efficiency of the criminal intelligence process in support of cooperative law enforcement operations. The five HIDTAs will create a 15-state network of experienced, connected law enforcement contacts and leverage these connections and information-gathering capabilities with a strong, complementary, analytical capacity.

- The five HIDTAs will select two centrally located Regional Coordinators, one with a public health focus and the other with a public safety focus, who will manage and oversee implementation and operation of the Heroin Response Teams. The Public Health Coordinator will oversee regional reporting of fatal and non-fatal overdose information and issuing of relevant alerts regarding dangerous batches of heroin and other heroin-related threats to health authorities. This will mobilize a rapid public health response to distribute naloxone or expand resources in the affected areas, helping to mitigate the number of overdoses and prevent deaths. The Public Safety Coordinator will oversee execution of public safety goals by ensuring case support is provided where needed and intelligence is being disseminated to relevant law enforcement authorities to enable disruption of the heroin supply.

- A heroin and prescription opioid training curriculum will be developed and used to prepare rural and municipal officers and first responders who are inexperienced responding to heroin and prescription opioid-related incidents. To assist communities in coping with this escalating problem, the five HIDTAs will develop Education & Training strategies that will increase awareness of heroin and [opioid] addiction,
create linkages to available prevention and treatment resources in the respective regions, and enable first-responders to know how to report all pertinent lead information developed from seizures and overdose responses.

- The **Heroin Response Strategy** builds upon the successes of the 2014 symposium hosted by the Washington/Baltimore HIDTA. Each year, the five HIDTAs will host two, two-day *State of the Region* symposia at a jointly nominated HIDTA. These symposia will build additional structure within each respective HIDTA region for the attendees to maintain regular contact and continue their public health–public safety partnerships between symposia. The aim will be to facilitate collaboration between public health and public safety partners within and across jurisdictions, sharing best practices, innovative pilots, and identifying new opportunities to leverage resources.

**Impact on Families**


- [Having a loved one with a substance use disorder] puts a lot of stress on parents, brothers and sisters, grandparents—anyone who is part of the home.
- When family members take drugs:
  - You can't count on them to do what they say they will do.
  - They may forget or get distracted because their focus is on getting and taking drugs.
  - They might lie or steal money to buy drugs.
  - They might get fired from their jobs.
  - They might not come home at night.
  - They may do bad things they would never do if they weren't [using] drugs.
- Family members might fight a lot because of the problems the drug [use] is causing. The drug user might do and say things that upset neighbors and friends, and make the family ashamed.


- When parents or other family members [use] drugs, the children get hurt.
- People with [substance use disorders] can forget to take care of the kids. There might not be anyone making meals or helping the kids get washed and dressed. There might not be anyone to buy clothes or do the laundry. There might not be anyone to take the kids to the doctor or help with homework.
- Drug [use] can use up the family's money and make parents unable to work and earn money. The kids might go without heat, food, electricity, or even a place to live.
- When family members with [substance use disorders] are at home, it may not be safe for the kids. They might not be alert enough to protect kids from accidents or from other adults who would harm them. There might be a lot of fighting. They might abuse or neglect the children.
- If someone at home is dealing drugs or doing other crimes, it's also dangerous for the kids, and the adults could end up in prison.
Panel 2: Treatment and Recovery from Opioid Misuse: Understanding the Options and Supporting Multiple Paths of Recovery

Key Questions

1. What is the number of treatment episodes related to opioids and heroin?
2. What are the available evidence-based treatments for opioid use disorder? How can people find treatment?
3. What is medication-assisted treatment (MAT) for opioid use disorder? Which medications are included in MAT?
4. What are some federal efforts to expand the use of MAT? What is SAMHSA’s role in these efforts?
5. What are some key elements of recovery support for people in recovery from opioid use disorder? What is the role of peer support in recovery from opioid use disorder?
6. How can family, friends, and support networks help promote recovery from opioid use disorder?
7. How has the Affordable Care Act affected coverage of treatment for opioid use disorder?
8. What are federal agencies doing to address prescription opioid misuse and heroin use? What is the White House initiative on High Intensity Drug Trafficking Areas?

Data on Treatment Episodes for Opioids and Heroin


- Five substance groups accounted for 97 percent of the primary substances reported by the 1,683,451 TEDS admissions aged 12 and older in 2013: alcohol (38 percent), [opioids] (28 percent), marijuana (17 percent), methamphetamine/amphetamines (8 percent), and cocaine (6 percent).
- In 2003, 15 percent of admissions aged 12 or older were for primary heroin. This proportion was fairly steady from 2003 to 2011, fluctuating between 15 and 13 percent; however, the proportion of primary heroin admissions aged 12 and older increased to 16 percent in 2012 and 19 percent in 2013.
- Seventy-one percent of primary heroin admissions reported injection as the usual route of administration and 23 percent reported inhalation.
- The proportion of admissions for primary [opioids] other than heroin increased from 3 percent of admissions aged 12 and older in 2003 to 9 percent in 2013.
- More than half (59 percent) of primary non-heroin [opioid] admissions reported oral as the usual route of administration, while 19 percent reported inhalation and 18 percent reported injection.
Individual paths to recovery differ, and packages of treatments and supportive services for mental and substance use disorders should be tailored to fit individual needs. For many people with behavioral health problems the most effective approach often involves a combination of counseling and medication. Supportive services, such as case or care management, can also play an important role in promoting health and recovery.

Treatments and supportive services are provided in a variety of locations, including:
- Specialty community behavioral health centers.
- Substance use disorder rehabilitation programs.
- Independent providers.
- Hospitals.
- Community health centers.
- Mutual support groups and peer-run organizations.
- Community-based organizations.
- Schools.
- Jails and prisons.
- At home through telebehavioral or home-based services.
- Inpatient service providers.
- Primary care programs with integrated behavioral health services.
- And a variety of other community settings.

**Individual and Group Counseling**—Individual and group counseling include a variety of treatments used to treat behavioral health problems. Counseling and more specialized psychotherapies seek to change behaviors, thoughts, emotions, and how people see and understand situations. Counseling is provided by trained clinicians such as psychologists, psychiatrists, social workers, and counselors.

Different clinicians have different orientations, or schools or thought, about how to provide these services. One common orientation is cognitive-behavioral; clinicians who use this approach provide Cognitive-Behavioral Therapy (CBT). CBT helps people in treatment seek their own solutions to problems by addressing behaviors, thoughts, and feelings with systematic goal-oriented strategies. It is important to understand that even within CBT, as with other orientations, there is a great amount of variability and most clinicians borrow on strategies from many different orientations when they provide counseling or psychotherapy. Finding the right therapist and developing a productive relationship is important for treatment to be successful. Treatment success may be more important than choosing a therapist based on a particular orientation.

Counseling can take a number of forms depending on the type of therapy being used, the goals of the treatment, and other factors in the life of the person receiving therapy. Some courses of counseling last for months or even years, while others can be brief. One brief, goal-oriented strategy, which may be used by itself or as a part of broader course of counseling is Motivational Enhancement Therapy (MET). MET is based on principles of motivational psychology and designed to produce rapid, internally motivated change. Rather than directing an individual through recovery, [treatment and service providers] make efforts to help to mobilize the person’s own resources and build their own motivation to address a goal, such as reducing alcohol use. Counseling is
usually provided on an individual basis, but can also be conducted with small groups of people addressing common issues.

- **Medication**—Prescription medications also are an important resource for treating mental and substance use disorders. Medications for mental and substance use disorders provide significant relief for many people and help manage symptoms to the point where people can use other strategies to pursue recovery. Medications work better for some people than others, even if they have the same disorders.

- Medication effectiveness can also change over time, so it is not uncommon for a person to find that the medication needs to be changed or adjusted even after it has been working. Medications also often have significant side effects. As a result, it is important for people receiving medications for behavioral health problems to have regular contact with the prescribing provider to ensure that the approach being used continues to be safe and effective.

- Medication tends to be most effective when it is used in combination with counseling or psychotherapy. There are many different types of medication for mental health problems, including anti-depressants, medication for attention issues, anti-anxiety medications, mood stabilizers, and antipsychotic medications. More information about these medications can be found at the National Institute of Mental Health (NIMH) website.

- Medications are also increasingly being used to treat substance use disorders. This practice, often referred to as Medication-Assisted Treatment (MAT), is the use of medications, in combination with counseling and behavioral therapies, to provide a whole-patient approach to the treatment of substance use disorders. Medications [(such as, methadone, buprenorphine, and naloxone)] exist that can reduce the cravings and other symptoms associated with withdrawal from a substance, block the neurological pathways that produce the rewarding sensation caused by a substance, or induce negative feelings when a substance is taken. More information about MAT is available through SAMHSA’s Addiction Technology Transfer Center Network.

- **Supportive Services**—Supportive services are critical components of a behavioral health system and can help people meet their treatment goals. Supportive services take a variety of forms. Case or care management can coordinate behavioral health services with housing, employment, education, and other supports. Frequently, when individuals are involved in multiple public systems it is important for a single point of contact to coordinate care and engage all the system partners in service planning and delivery. For young people, this is often done through a wrap-around process.

- Because people with mental and substance use disorders often have more physical health problems than the general population, assistance in coordinating care across behavioral and physical health care providers can be a valuable support. One important outcome for people with serious mental illnesses is employment, and supported employment services can be an important link to a job that not only supports independence, but also provides important social interaction. People may face barriers like lack of transportation or child care, so the ability to provide some flexible supports can be the difference between wellness and failure to receive treatment.

- Another important set of services is recovery supports. In combination with treatment, recovery support services can enable individuals to build a life that supports recovery as they work to control symptoms though traditional treatments or peer-support groups. These types of services support the goals of community integration and social inclusion.
for people with mental and/or substance use disorders and their families. SAMHSA also encourages the use of peer support services, or services designed and delivered by people who have experienced a mental and/or substance use disorder and are in recovery. Learn more from SAMHSA’s webinars and publications on peer support services and about the different types of services that support treatment at the Wellness [webpage].

- **Evidence-Based Treatments**—Individual and group counseling, medication treatments, and supportive services are evidence-based treatments that can be offered by providers individually or jointly. Depending on the type of service, some or all of these can be offered in a variety of settings.

- SAMHSA also seeks to support the most effective treatment methods possible through its programs; this includes support of evidence-based programs and treatments. Evidence-based programs are programs that have been shown to have positive outcomes through high-quality research. In addition to working with grantees to identify and implement appropriate evidence-based programs, SAMHSA funds the National Registry of Evidence-based Programs and Practices (NREPP). NREPP provides descriptive information and expert ratings for evidence-based programs submitted by researchers and intervention developers across the nation. NREPP assists states and communities in identifying and selecting evidence-based programs that may meet their particular requirements through its library of rated programs.

### Finding Treatment


- [The] Behavioral Health Treatment Services Locator [is] an on-line source of information for persons seeking treatment facilities in the United States or U.S. Territories for [substance use and/or mental conditions].

- Or Call SAMHSA’s National Helpline [1-800-662-HELP (4357) or 1-800-487-4889 (TDD)], [which offers] free and confidential information in English and Spanish for individuals and family members facing substance [use and/or mental conditions]. [The Helpline is available] 24 hours a day, 7 days a week.

### MAT Description and MAT for Opioid Use Disorder


- Medication-assisted treatment (MAT), including opioid treatment programs (OTPs), combines behavioral therapy and medications to treat substance use disorders.

### Medications Included in MAT for Opioid Use Disorder

[SAMHSA recognizes that treatment should be individualized for each patient.]
• Methadone has been used for decades to treat people who are addicted to heroin and narcotic pain medicines. When taken as prescribed, it is safe and effective. It allows people to recover from their addiction and to reclaim active and meaningful lives. For optimal results, patients should also participate in a comprehensive medication-assisted treatment (MAT) program that includes counseling and social support.

• Methadone works by changing how the brain and nervous system respond to pain. It lessens the painful symptoms of [opioid] withdrawal and blocks the euphoric effects of [opioid] drugs such as heroin, morphine, and codeine, as well as semi-synthetic opioids like oxycodone and hydrocodone.

• Methadone is offered in [tablet], liquid, and wafer forms and is taken once a day.

• As with all medications used in medication-assisted treatment (MAT), methadone is to be prescribed as part of a comprehensive treatment plan that includes counseling and participation in social support programs.

• Patients taking methadone to treat opioid addiction must receive the medication under the supervision of a physician. After a period of stability (based on progress and proven, consistent compliance with the medication dosage), patients may be allowed to take methadone at home between program visits. By law, methadone can only be dispensed through an opioid treatment program (OTP) certified by SAMHSA.

• The length of time in methadone treatment varies from person to person. According to the National Institute on Drug Abuse publication Principles of Drug Addiction Treatment: A Research-Based Guide – 2012, the length of methadone treatment should be a minimum of 12 months. Some patients may require treatment for years. Even if a patient feels that they are ready to stop methadone treatment, it must be stopped gradually to prevent withdrawal. Such a decision should be supervised by a doctor.

• Methadone can be addictive, so it must be used exactly as prescribed. This is particularly important for patients who are allowed to take methadone at home and aren’t required to take medication under supervision at an OTP.


• Approved for clinical use in October 2002 by the Food and Drug Administration (FDA), buprenorphine represents the latest advance in medication-assisted treatment (MAT). Medications such as buprenorphine, in combination with counseling and behavioral therapies, provide a whole-patient approach to the treatment of opioid dependency. When taken as prescribed, buprenorphine is safe and effective.

• Unlike methadone treatment, which must be performed in a highly structured clinic, buprenorphine is the first medication to treat opioid dependency that is permitted to be prescribed or dispensed in physician offices, significantly increasing treatment access.

• As with all medications used in MAT, buprenorphine is prescribed as part of a comprehensive treatment plan that includes counseling and participation in social support programs.

• Buprenorphine offers several benefits to those with opioid dependency and to others for whom treatment in a methadone clinic is not preferred or is less convenient.
• Buprenorphine has unique pharmacological properties that help:
  o Lower the potential for misuse.
  o Diminish the effects of physical dependency to opioids, such as withdrawal symptoms and cravings.
  o Increase safety in cases of overdose.
• Because of buprenorphine’s opioid effects, it can be misused, particularly by people who do not have an opioid dependency. Naloxone is added to buprenorphine to decrease the likelihood of diversion and misuse of the combination drug product. When these products are taken as sublingual tablets, buprenorphine’s opioid effects dominate and naloxone blocks opioid withdrawals. If the sublingual tablets are crushed and injected, however, the naloxone effect dominates and can bring on opioid withdrawals.
• The ideal candidates for opioid dependency treatment with buprenorphine:
  o Have been objectively diagnosed with an opioid dependency.
  o Are willing to follow safety precautions for the treatment.
  o Have been cleared of any health conflicts with using buprenorphine.
  o Have reviewed other treatment options before agreeing to buprenorphine treatment.
• Buprenorphine treatment happens in three phases:
  o The Induction Phase is the medically monitored startup of buprenorphine treatment performed in a qualified physician’s office or certified OTP using approved buprenorphine products. The medication is administered when a person with an opioid dependency has abstained from using opioids for 12 to 24 hours and is in the early stages of opioid withdrawal. It is important to note that buprenorphine can bring on acute withdrawal for patients who are not in the early stages of withdrawal and who have other opioids in their bloodstream.
  o The Stabilization Phase begins after a patient has discontinued or greatly reduced their misuse of the problem drug, no longer has cravings, and experiences few, if any, side effects. The buprenorphine dose may need to be adjusted during this phase. Because of the long-acting agent of buprenorphine, once patients have been stabilized, they can sometimes switch to alternate-day dosing instead of dosing every day.
  o The Maintenance Phase occurs when a patient is doing well on a steady dose of buprenorphine. The length of time of the maintenance phase is tailored to each patient and could be indefinite. Once an individual is stabilized, an alternative approach would be to go into a medically supervised withdrawal, which makes the transition from a physically dependent state smoother. People then can engage in further rehabilitation—with or without MAT—to prevent a possible relapse.
• Treatment of opioid dependency with buprenorphine is most effective in combination with counseling services, which can include different forms of behavioral therapy and self-help programs. Learn more about medication and counseling treatment.
• A number of factors affect whether buprenorphine is a good choice for someone who is currently receiving methadone. Patients receiving buprenorphine can possibly be switched to methadone. Patients interested in learning more about switching their treatment should discuss this with their doctor. Learn more about methadone.
• Naltrexone is a medication approved by the Food and Drug Administration (FDA) to treat opioid use disorder and alcohol use disorder. It comes in a [tablet] form or as [a long-acting] injectable.
• Naltrexone can be prescribed by any health care provider who is licensed to prescribe medications. To reduce the risk of precipitated withdrawal, patients are warned to abstain from illegal opioids and opioid medication for a minimum of 7-10 days before starting naltrexone. If switching from methadone to naltrexone, the patient has to be completely withdrawn from the opioids.
• Naltrexone blocks the euphoric and sedative effects of drugs such as heroin, morphine, and codeine. It works differently in the body than buprenorphine and methadone, which activate opioid receptors in the body that suppress cravings. Naltrexone binds and blocks opioid receptors, and is reported to reduce opioid cravings. There is no [misuse] and diversion potential with naltrexone.
• As with all medications used in MAT, naltrexone is to be prescribed as part of a comprehensive treatment plan that includes counseling and participation in social support programs.

Finding a MAT Provider


• [This site allows people to search for opioid treatment programs (methadone providers) by state.]


• [This website helps people] find physicians authorized to treat opioid dependency with buprenorphine by state.

Physician Training and Certification for MAT


• People who provide medication-assisted treatment (MAT) services work in a range of prevention, health care, and social service settings. They include psychiatrists, psychologists, pharmacists, nurses, social workers, counselors, marriage and family therapists, peer professionals, clergy, and many others.
Training a diverse and qualified behavioral health workforce is essential to meeting the nation’s needs. SAMHSA’s Division of Pharmacologic Therapies provides the following training materials for MAT professionals:
- Buprenorphine Training for Physicians.
- Opioid Prescribing Courses for Physicians.
- Webinars, Workshops, and Summits.
- Physician and Program Data.
- Publications and Research.
- Organizations that Support MAT.

Learn more about medication and counseling treatment.


To prescribe or dispense buprenorphine, physicians must qualify and apply for a waiver under the Drug Addiction Treatment Act of 2000 (DATA 2000).

Learn more about how to:
- Apply to increase patient limits.
- Update physician contact information.
- Verify physician waivers (for pharmacists).

Access online Waiver Notification Form SMA-167 or download and fax Waiver Notification Form SMA-167 (PFD | 62 KB).

Physicians can join the SAMHSA Buprenorphine Clinical Discussion Web Board to ask and discuss questions on the clinical use of buprenorphine.


SAMHSA’s Division of Pharmacologic Therapies (DPT), part of the SAMHSA Center for Substance Abuse Treatment (CSAT), oversees the certification of OTPs. OTPs must be certified by SAMHSA and accredited by an independent, SAMHSA-approved accrediting body to dispense opioid treatment medications. All OTPs also must be licensed by the state in which they operate and must register with the Drug Enforcement Administration (DEA), through a local DEA office.


[This website provides information for organizations that want to] apply to have [their] opioid treatment program (OTP) certified by SAMHSA to dispense medications for the treatment of substance use disorders.
• [PCSS-MAT is] a national training and mentoring project developed in response to the prescription opioid misuse epidemic and the availability of newer pharmacotherapies to address opioid use disorder. The overarching goal of PCSS-MAT is to make available the most effective medication-assisted treatments to serve patients in a variety of settings, including primary care, psychiatric care, and pain management settings.

Federal Efforts to Expand MAT


• Combating opioid [misuse, opioid use disorder], and overdose is a priority for Department of Health and Human Services Secretary Sylvia M. Burwell and the Obama Administration at large.
• As leaders within the Department, we want to share more information about these new actions to combat opioid [misuse].
  o First, the Health Resources and Services Administration (HRSA) will make $100 million in new funding available to approximately 300 Community Health Centers to expand services for those with substance use disorders, including medication-assisted treatment for opioid use disorder. Lack of access to such treatment is a growing problem nationwide and this infusion of funds will offer many people in need access to quality services.
  o Second, the Substance Abuse and Mental Health Services Administration (SAMHSA) [awarded] $11 million to 11 states to expand and enhance medication-assisted treatment services. These funds will enable state treatment service systems to more effectively address the needs of people with opioid use disorders. The grants promote comprehensive, coordinated, and evidence-based medication-assisted treatment and recovery support services. [Funding has continued for fiscal year 2016.]
  o Third, the Centers for Medicare & Medicaid Services (CMS) is releasing guidance to help states implement comprehensive, evidence-based service delivery approaches to substance use disorder treatment. It is estimated that 12 percent of all Medicaid beneficiaries ages 18–64 and 15 percent of uninsured individuals who could be eligible for Medicaid coverage have substance use disorder. Medicaid pays one out of every five dollars for substance use disorder treatment. CMS is establishing a new Medicaid demonstration initiative to states seeking to undertake significant improvements in the delivery of care to beneficiaries with substance use disorder.
• Untreated substance use disorders are associated with increased risks for a variety of costly health conditions. Medication-assisted treatment is an evidence-based, comprehensive approach that combines the use of medication with counseling and behavioral therapies to treat substance use disorders.
• MAT is a safe and effective strategy for decreasing the frequency and quantity of opioid use and reducing the risk of overdose and death. Studies have shown that the most effective treatments for opioid use disorders are those that include a set of comprehensive medical, social, psychological and rehabilitation services that address all the needs of the individual. Furthermore, recently published research indicates that the most prevalent forms of MAT, buprenorphine and methadone, are similar in terms of effectiveness. Although MAT has significant evidence to support it as an effective treatment, it remains highly underutilized, being used by an estimated 1 million of the 2.5 million Americans who might benefit from receiving it.

• Given expanded coverage of substance [use] treatment services in recent years through the Affordable Care Act and [the Mental Health Parity and Addiction Equity Act (MHPAEA)], there is a greater need to address barriers that hinder access to treatment including policy and regulations that limit eligible providers or the required training for delivering certain MAT services. Within the MAT priority area are two objectives:
  o Support research that informs effective use and dissemination of MAT and accelerates development of new addiction treatment medications.
  o Increase access to clinically effective MAT strategies.

• Some key actions include:
  o Research to support effective MAT strategies
  o Investments in MAT services

• Many activities that fall within the three priority areas of the Secretary’s initiative are currently or soon to be underway and represent significant additional investments in opioid drug-related activities proposed as part of the President’s FY 2016 Budget. The President’s FY 2016 Budget proposes an increase of $99 million above FY 2015 for targeted efforts to reduce opioid-related morbidity and mortality and the prevalence and impact of opioid use disorders, which includes both prescription opioids and heroin.

SAMHSA’s Role in the MAT Expansion


• The purpose of this program is to provide funding to states to enhance/expand their treatment service systems to increase capacity and provide accessible, effective, comprehensive, coordinated care, and evidence-based medication-assisted treatment (MAT) and recovery support services [for] individuals with opioid use disorders seeking or receiving MAT. As a result of this program, SAMHSA seeks to: 1) increase the number of individuals receiving MAT services with pharmacotherapies approved by the FDA for the treatment of opioid use disorders; 2) increase the number of individuals receiving integrated care; and 3) decrease illicit drug use at 6-months follow-up.
Key Elements in Recovery Support


- The process of recovery is highly personal and occurs via many pathways. It may include clinical treatment, medications, faith-based approaches, peer support, family support, self-care, and other approaches. Recovery is characterized by continual growth and improvement in one’s health and wellness that may involve setbacks. Because setbacks are a natural part of life, resilience becomes a key component of recovery.
- Resilience refers to an individual’s ability to cope with adversity and adapt to challenges or change. Resilience develops over time and gives an individual the capacity not only to cope with life’s challenges but also to be better prepared for the next stressful situation. Optimism and the ability to remain hopeful are essential to resilience and the process of recovery.
- Because recovery is a highly individualized process, recovery services and supports must be flexible to ensure cultural relevancy. What may work for adults in recovery may be very different for youth or older adults in recovery. For example, the promotion of resiliency in young people, and the nature of social supports, peer mentors, and recovery coaching for adolescents and transitional age youth are different than recovery support services for adults and older adults.
- The process of recovery is supported through relationships and social networks. This often involves family members who become the champions of their loved one’s recovery. They provide essential support to their family member’s journey of recovery and similarly experience the moments of positive healing as well as the difficult challenges. Families of people in recovery may experience adversities in their social, occupational, and financial lives, as well as in their overall quality of family life. These experiences can lead to increased family stress, guilt, shame, anger, fear, anxiety, loss, grief, and isolation. The concept of resilience in recovery is also vital for family members who need access to intentional supports that promote their health and well-being. The support of peers and friends is also crucial in engaging and supporting individuals in recovery.


- Wellness incorporates many dimensions of health: physical, emotional, financial, social, occupational, intellectual, environmental, and spiritual. It is essential for quality of life and recovery. For people with mental and/or substance use disorders, wellness is much more than the absence of disease or illness, it is the presence of purpose in life, active involvement in satisfying work and play, joyful relationships, a healthy body, and a safe living environment.
- SAMHSA promotes wellness for people with mental and substance use disorders by engaging, educating, and training providers, consumers/peers, and policy makers. SAMHSA also partners with other federal agencies to disseminate wellness messages and motivate individuals and community organizations to take action. Wellness promotion is important because people with mental and/or substance use disorders have high rates of co-morbidity and early mortality, and often die decades earlier than
the general population due to preventable medical conditions and modifiable risk factors.

Role of Peer Support in Recovery from Opioid Use Disorder


- Peer support services are delivered by individuals who have common life experiences with the people they are serving. People with mental and/or substance use disorders have a unique capacity to help each other based on a shared affiliation and a deep understanding of this experience. In self-help and mutual support, people offer this support, strength, and hope to their peers, which allows for personal growth, wellness promotion, and recovery.
- Research has shown that peer support facilitates recovery and reduces health care costs. Peers also provide assistance that promotes a sense of belonging within the community. The ability to contribute to and enjoy one’s community is key to recovery and well-being. Another critical component that peers provide is the development of self-efficacy through role modeling and assisting peers with ongoing recovery through mastery of experiences and finding meaning, purpose, and social connections in their lives.
- SAMHSA’s Recovery Community Services Program (RCSP) advances recovery by providing peer recovery support services across the nation. These services help prevent relapse and promote sustained recovery from mental and/or substance use disorders.
- Through the RCSP, SAMHSA recognizes that social support includes informational, emotional, and intentional support. Examples of peer recovery support services include:
  - Peer mentoring or coaching—developing a one-on-one relationship in which a peer leader with recovery experience encourages, motivates, and supports a peer in recovery.
  - Peer recovery resource connecting—connecting the peer with professional and non-professional services and resources available in the community.
  - Recovery group facilitation—facilitating or leading recovery-oriented group activities, including support groups and educational activities.
  - Building community—helping peers make new friends and build healthy social networks through emotional, instrumental, informational, and affiliation types of peer support.


- The M.A.R.S. Project is the only federally funded program that provides peer recovery support to patients in medication-assisted treatment (MAT) for opioid addiction. Funded by the Substance Abuse and Mental Health Services Administration, M.A.R.S. is conducted in collaboration with the substance abuse division of the Albert Einstein College of Medicine in New York City, Yeshiva University, and the National Alliance for Medication-Assisted (NAMA) Recovery.
Family, Friends, and Support Networks and Recovery


[SAMHSA’s Guiding Principles of Recovery include:]

- **Recovery is supported by peers and allies:** Mutual support and mutual aid groups, including the sharing of experiential knowledge and skills, as well as social learning, play an invaluable role in recovery. Peers encourage and engage other peers and provide each other with a vital sense of belonging, supportive relationships, valued roles, and community. Through helping others and giving back to the community, one helps one’s self. Peer-operated supports and services provide important resources to assist people along their journeys of recovery and wellness. Professionals can also play an important role in the recovery process by providing clinical treatment and other services that support individuals in their chosen recovery paths. While peers and allies play an important role for many in recovery, their role for children and youth may be slightly different. Peer supports for families are very important for children with behavioral health problems and can also play a supportive role for youth in recovery.

- **Recovery is supported through relationship and social networks:** An important factor in the recovery process is the presence and involvement of people who believe in the person’s ability to recover; who offer hope, support, and encouragement; and who also suggest strategies and resources for change. Family members, peers, providers, faith groups, community members, and other allies form vital support networks. Through these relationships, people leave unhealthy and/or unfulfilling life roles behind and engage in new roles (e.g., partner, caregiver, friend, student, employee) that lead to a greater sense of belonging, personhood, empowerment, autonomy, social inclusion, and community participation.

- **Recovery involves individual, family, and community strengths and responsibility:** Individuals, families, and communities have strengths and resources that serve as a foundation for recovery. In addition, individuals have a personal responsibility for their own self-care and journeys of recovery. Individuals should be supported in speaking for themselves. Families and significant others have responsibilities to support their loved ones, especially for children and youth in recovery. Communities have responsibilities to provide opportunities and resources to address discrimination and to foster social inclusion and recovery. Individuals in recovery also have a social responsibility and should have the ability to join with peers to speak collectively about their strengths, needs, wants, desires, and aspirations.

Affordable Care Act and Treatment

The Affordable Care Act put in place comprehensive health insurance reforms that will make health insurance available to many more people, lower health care costs, guarantee more health care choices, and enhance the quality of health care for all Americans.

The Affordable Care Act includes substance use disorders as one of the ten elements of essential health benefits. This means that all health insurance sold on Health Insurance Exchanges or provided by Medicaid to certain newly eligible adults starting in 2014 must include services for substance use disorders.

By including these benefits in health insurance packages, more health care providers can offer and be reimbursed for these services, resulting in more individuals having access to treatment. The specific services that will be covered are currently being determined by the Department of Health and Human Services, and will take into account evidence on what services allow individuals to get the treatment they need and help them with recovery.


The delivery and financing of health care has changed in response to recent legislation that aims to improve health care while also making it less expensive for individuals, families, and business owners. SAMHSA works to educate consumers about those efforts and help providers adapt to the new health care environment.

In March 2010, President Obama signed into law the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010, together referred to as the Affordable Care Act. This health care law makes health insurance coverage more affordable for individuals, families, and small business owners. It also includes prevention, early intervention, and treatment of mental and/or substance use disorders as an “essential health benefit” (EHB) that must be covered by health plans that are offered through the Health Insurance Marketplace.

The Affordable Care Act in conjunction with the Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 has already provided an opportunity for new or expanded behavioral health benefits to approximately 60 million Americans and has created programs designed to help states and communities prevent illness and promote health. Under the Affordable Care Act, most health plans must also cover certain preventive services without a copayment, co-insurance, or deductible.

MHPAEA has also contributed to expanding health coverage. The law requires health insurers and group health plans to provide the same level of benefits for behavioral health services that they do for primary care. SAMHSA works to ensure that behavioral health services covered by the Affordable Care Act and the MHPAEA are managed no differently from services for surgical and general medical issues.

• The cost of different medications used in MAT varies, and this may need to be taken into account when considering treatment options. The Affordable Care Act now requires most insurers to cover addiction treatment benefits. In addition, The Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 requires health insurers and group health plans to provide the same level of benefits for behavioral health services that they do for primary care. However, not all insurance plans cover every available addiction treatment medication. And some plans cap the number of dosages and prescription refills a MAT patient receives. These limitations also factor into how people pay for MAT.

• Learn more about health financing and how SAMHSA helps MAT professionals adapt to the new health care environment.

• A review of Medicaid policies in 2013 revealed that all 51 Medicaid programs include disulfiram and oral naltrexone and 31 programs include methadone on their Preferred Drug Lists (PDLs). If a medication is not included on the PDL, the prescriber must obtain permission from the member’s pharmacy benefit plan before the product can be prescribed, or the medication will not be covered. In 2013, only 13 state Medicaid programs included all available medications for treating alcohol and opioid use disorders in their Medicaid PDLs.

• The SAMHSA publication, Medicaid Coverage and Financing of Medications to Treat Alcohol and Opioid Use Disorders – 2014, explains Medicaid coverage of medications for substance use disorders.

• Medicare and Medicaid Coverage:
  o Substance use treatment may be covered under Medicare (1) if it is medically necessary; and (2) if it is provided in an inpatient or outpatient treatment center that is Medicare-certified as determined by the Department of Health and Human Services (HHS).
  o Medicare does not generally cover prescription medications that are prescribed or dispensed to patients on an outpatient basis. However, if buprenorphine is administered by a Medicare-certified program or facility as a component of inpatient or emergency treatment such as detoxification or early stabilization treatment, the cost could be covered, as with any other medication used in the treatment process. The reimbursement would only occur if the Medicare-certified facility had buprenorphine on its list of eligible medications and if the patient received the treatment at the facility.
  o Medicaid coverage of substance use treatment and medications such as buprenorphine varies considerably by state and whether or not a state’s Medicaid plan is offered under managed care or HMO arrangements. Coverage in many states is also subject to rules about prior authorization and medical necessity. For buprenorphine-naloxone, a review of Medicaid policies in 2013 revealed that 50 Medicaid programs include the treatment medication on their PDLs.

• Commercial Health Care Coverage:
  o Health insurance through a commercial insurance plan may or may not cover all parts of buprenorphine medication. Several factors determine coverage, including:
    o Medical necessity.
    o Whether medications are covered.
• If there is a required co-payment.
• If buprenorphine is on the plan’s approved medication list.

• Free Health Coverage at Community Health Centers, Clinics, and Hospitals:
  • Free care for low-income patients offered at community health centers, clinics, and hospitals may or may not have buprenorphine available. The availability of the medication in these facilities depends on:
    ▪ Whether they offer substance use treatment or emergency care of chemical dependency.
    ▪ If buprenorphine is on the list of eligible medications.
    ▪ If a qualified staff or an attending physician associated with the hospital is available to administer the medication.
    ▪ If the medication is medically necessary.

• People Who Are Uninsured:
  • People without insurance coverage who are neither eligible for Medicare or Medicaid nor impoverished must pay for buprenorphine and any associated treatment themselves.

Panel 3: Preventing Opioid Use Disorder and Opioid-Related Overdose and Infectious Diseases: Life-Saving Efforts

Key Questions

1. What are some key strategies for preventing opioid use disorder? How does SAMHSA support communities in their efforts to prevent opioid use disorder?
2. How will the CDC Guidelines for Prescribing Opioids for Chronic Pain (released on March 15, 2016) support health care professionals in preventing opioid pain reliever misuse and opioid use disorder?
3. How many people overdose from heroin in the United States? How have rates of heroin overdose changed?
4. Who can administer naloxone for opioid overdose prevention? How has expansion of naloxone use affected overdose deaths?
5. What are some federal efforts to expand the use of naloxone to prevent opioid overdose? What is SAMHSA’s role in these efforts? What is the SAMHSA Overdose Prevention Toolkit? Are there additional resources on naloxone?
6. What is the link between opioid use disorder and injection drug use? What are some of SAMHSA’s efforts to prevent HIV, hepatitis, and other infectious diseases among people with opioid use disorder?

Key Strategies for Preventing Opioid Use Disorder

• Reversing the epidemic requires changing the way opioids are prescribed.
• CDC’s Injury Center uses evidence-based practices to create real-world solutions to prevent prescription opioid overdose, while ensuring people have access to safe and effective pain treatment. To advance prescription opioid overdose prevention, CDC’s Injury Center is committed to giving providers and health systems the data, tools and evidence they need to improve how these are used and prescribed.
• CDC’s Injury Center is developing evidence-based guidelines for prescription opioid prescribing.
• CDC’s Injury Center is developing evidence-based guidelines for opioid prescribing for chronic pain outside the setting of end-of-life care. CDC’s Injury Center aims to get these guidelines into the hands of providers as soon as possible to ensure patients receive the safest, most effective treatment. Improving the way opioids are prescribed through clinical practice guidelines can promote safe, effective treatment while reducing opioid-related [misuse] and overdose.


• Improving the way opioids are prescribed through clinical practice guidelines can ensure patients have access to safe, effective treatment while reducing the number of people who misuse or overdose from these powerful drugs.
• CDC partnered with the National Institute on Drug Abuse (NIDA), the Substance Abuse and Mental Health Services Administration (SAMHSA), and the Office of the National Coordinator for Health Information Technology (ONC) to review existing opioid prescribing guidelines for chronic pain and identify common elements.
• The guidelines reviewed represent a sample of those developed before 2013 by professional societies, states, or Federal agencies for general practitioners (not for specific conditions, subpopulations, or specialists). Specific recommendations from each of the guidelines were reviewed, extracted, and coded into categories of common provider actions. The review of common elements found in guidelines can be seen here: Common Elements in Guidelines for Prescribing Opioids for Chronic Pain.
• This review is intended to enhance the use of evidence-based guidelines by:
  o Informing agencies, providers, and medical/professional organizations about evidence-based practices that can improve patient outcomes.
  o Providing states, federal agencies, and other organizations with a review of recommendations so that they can better develop implementation tools for providers, such as clinical decision support in electronic health records.


• Cities and states across the country have taken steps to improve pain [reliever] prescribing and prevent prescription misuse and overdose. These efforts include regulating pain clinics, using systems to identify fraudulent prescriptions, and improving
access to naloxone—the antidote to opioid overdose. Additionally, states can take steps to improve prescribing practices in public insurance programs, like Medicaid or Workers Compensation programs.


- States have broad authority to regulate the prescribing and dispensing of prescription drugs and do so in a variety of ways. CDC provides data to equip and inform states about putting into practice strategies that help prevent high-risk prescribing. [Promising strategies can be found here http://www.cdc.gov/drugoverdose/policy/laws.html].


- Prescription Drug Monitoring Programs (PDMPs) are state-run electronic databases used to track the prescribing and dispensing of controlled prescription drugs to patients. They are designed to monitor this information for suspected [misuse] or diversion (i.e., channeling drugs into illegal use), and can give a prescriber or pharmacist critical information regarding a patient’s controlled substance prescription history. This information can help prescribers and pharmacists identify high-risk patients who would benefit from early interventions.

- PDMPs continue to be among the most promising state-level interventions to improve pain [reliever] prescribing, inform clinical practice, and protect patients at risk. Additional research is needed to evaluate PDMP practices and policies to identify best practices.


- States play a central role in addressing and helping to reverse the heroin epidemic; states can:
  - Address the strongest risk factor for heroin [use disorder and pain reliever use disorder].
  - Make prescription drug monitoring programs (electronic databases that track the dispensing of certain drugs) timely and easy to use. Providers can analyze patient prescription-drug history and make informed decisions before prescribing opioid pain [relievers].
  - Look at the data and practices of state Medicaid and workers’ compensation programs to identify and reduce inappropriate prescribing.
  - Increase access to substance [use] treatment services, including medication-assisted treatment (MAT) for opioid [use disorder].
  - Work with Medicaid and other insurance companies to provide coverage for MAT.
  - Support adoption of MAT in community settings.
o Expand access to and training for administering naloxone to reduce opioid overdose deaths.

o Ensure that people have access to integrated prevention services, including access to sterile injection equipment from reliable sources, as allowed by local policy.

o Help local jurisdictions to put these effective practices to work in communities where drug [use disorders are] common.

**SAMHSA’s Support for Communities in Prevention Efforts**


- The SPF Rx grant program provides an opportunity for states, U.S. territories, pacific jurisdictions (herein referred to as “states”), and tribal entities that have completed a Strategic Prevention Framework State Incentive Grant (SPF SIG) to target the priority issue of prescription drug misuse. The program is designed to raise awareness about the dangers of sharing medications and work with pharmaceutical and medical communities on the risks of overprescribing to young adults. SPF Rx will also raise community awareness and bring prescription drug abuse prevention activities and education to schools, communities, parents, prescribers, and their patients. In addition, SAMHSA will track reductions in opioid overdoses and the incorporation of Prescription Drug Monitoring Program (PDMP) data into needs assessments and strategic plans as indicators of the program’s success.

- PDMPs are state-run databases used to track the prescribing and dispensing of controlled prescription drugs to patients. They are designed to monitor this information for suspected abuse or diversion (i.e., channeling drugs into illegal use), and can give a prescriber or pharmacist critical information regarding a patient’s controlled substance prescription history. State applicants must have a fully operational PDMP in order to apply for the SPF Rx program. Tribes must coordinate with the state run PDMPs to identify opportunities for collaboration that will limit overprescribing in tribal communities.

Center for Substance Abuse Prevention got $$ to deal with Epidemic- need to contact Richard – Fran Harding’s assistant to find out what they are doing...more current information


- SAMHSA’s efforts inform, alert, and educate the public, patients and their family members, and health care [providers] of the dangers of prescription drug misuse and abuse.

- Communities and workplaces can access a number of SAMHSA’s initiatives and resources to prevent prescription drug misuse and abuse:
  - The [Drug-Free Communities Support Program](http://www.samhsa.gov/dfcsp) is a collaborative effort between the ONDCP and SAMHSA to strengthen collaboration among community
coalitions to prevent and reduce substance use, including prescription drug misuse and abuse.

- The **2015 National Drug Control Strategy** serves as the Obama Administration’s blueprint for reducing drug use and its consequences, including a national framework for reducing prescription drug diversion and [misuse].
- The **2011 Prescription Drug Abuse Prevention Plan** expands upon the Obama Administration’s National Drug Control Strategy and includes action in four major areas to reduce prescription drug [misuse]: education, monitoring, proper medication disposal, and enforcement.
- The **Division of Workplace Programs (DWP)** provides oversight for the Federal Drug-Free Workplace Program and for the National Laboratory Certification Program.
- The **Center for the Application of Prevention Technologies (CAPT)** is a nationwide substance [misuse] prevention training and technical assistance system. It works with states, tribes, jurisdictions, and communities to develop and implement strategies to prevent the misuse and abuse of prescription drugs.
- In collaboration with SAMHSA, the **National Council on Patient Information and Education (link is external)** works to improve communication of information to consumers and health care providers on the appropriate use of medications.
- **National Prevention Week**, a SAMHSA-supported annual health observance dedicated to increasing public awareness of, and action around, mental and/or substance use disorders, included a day in 2014 devoted to prescription drug [misuse] prevention.

**WHEN AVAILABLE, ADD INFORMATION ON SOON-TO-BE-RELEASED SAMHSA SPF Rx GRANT PROGRAM.**


- Physicians play a critical role in prescription drug misuse and abuse prevention. They can screen their patients to identify signs of prescription drug [use disorders], and talk with patients about the negative effects of misusing prescription drugs. Physicians also can note rapid increases in amounts of medication needed and requests for frequent refills, which may signal “doctor shopping.” The **Prescription Drug Monitoring Program Training and Technical Assistance Center** provides assistance in identifying these behaviors among patients.
- In 2011, SAMHSA operationalized the Action Plan for Improving Access to Prescription Drug Monitoring Program through Health Information Technology by funding the **Enhancing Access to Prescription Drug Monitoring Programs Using Health Information Technology Project**, which is managed by the Office of the National Coordinator for Health Information Technology (ONC), in collaboration with SAMHSA, the Centers for Disease Control & Prevention (CDC), and the White House Office of National Drug Control Policy (ONDCP). The project explored opportunities to use health information technology (HIT) to integrate critical prescription drug history information
from prescription drug monitoring programs into provider and pharmacy systems to empower more informed decision making at the point of care.

- According to the CDC, prescribers may contribute to opioid misuse and overdose because of a lack of education and awareness about appropriate opioid prescribing practices. Most opioid analgesics in the United States are prescribed by primary care physicians and internists; most have little training in pain management or addiction. SAMHSA offers an in-person continuing education course, Clinical Challenges in Prescribing Controlled Drugs: Prescribing Opioids for Chronic Pain. The course, targeted to primary care providers, provides specific knowledge and skills associated with safely prescribing opioids for chronic pain, and clinical strategies for managing challenging patient situations. In addition, SAMHSA supports Providers’ Clinical Support System for Opioid Therapies (PCSS-O), which provides training and mentoring services for a variety of health care providers on the safe and appropriate prescribing of opioids.


- In 2012 and 2013 SAMHSA provided awards to 16 states to improve real-time access to PDMP data through integration into existing technologies, such as EHRs, to improve the ability of state PDMPs to reduce the nature, scope, and extent of misuse. CDC is evaluating the first cohort grantees and will report on the best practices developed and impacts of PDMP-EHR integration.
- SAMHSA also required its first cohort of grantees to expand interoperability with border states which has not been done in other PDMP-EHR Integration projects.
- While SAMHSA has been funding the ONC Enhancing Access Project for the last three years, this cooperative agreement differs from the work done previously because of its scale and charge to implement integration efforts throughout the state, not simply in one system. The ONC pilots which were on average 4 weeks in length, laid the groundwork and provided proof of concept for PDMP integration capability and provided a good segue for the SAMHSA grantees to implement these integration concepts throughout the state in multiple health IT systems.
- Additionally, SAMHSA has been funding the Enhancing Access to PDMPs Project for the last three years with the goal of using health IT to improve access to PDMPs in an effort to reduce prescription drug misuse and overdose. It is managed by the ONC in collaboration with SAMHSA, CDC, and ONDCP.


[This website describes and links to a number of SAMHSA-supported continuing medical education (CME) courses on prescribing opioids for chronic pain.]
CDC Guidelines on Prescribing Opioids for Chronic Pain


- This guideline provides recommendations for primary care clinicians who are prescribing opioids for chronic pain outside of active cancer treatment, palliative care, and end-of-life care. The guideline addresses 1) when to initiate or continue opioids for chronic pain; 2) opioid selection, dosage, duration, follow-up, and discontinuation; and 3) assessing risk and addressing harms of opioid use.
- CDC developed the guideline using the Grading of Recommendations Assessment, Development, and Evaluation (GRADE) framework, and recommendations are made on the basis of a systematic review of the scientific evidence while considering benefits and harms, values and preferences, and resource allocation. CDC obtained input from experts, stakeholders, the public, peer reviewers, and a federally chartered advisory committee. It is important that patients receive appropriate pain treatment with careful consideration of the benefits and risks of treatment options.
- This guideline is intended to improve communication between clinicians and patients about the risks and benefits of opioid therapy for chronic pain, improve the safety and effectiveness of pain treatment, and reduce the risks associated with long-term opioid therapy, including opioid use disorder, overdose, and death. CDC has provided a checklist for prescribing opioids for chronic pain ([http://stacks.cdc.gov/view/cdc/38025](http://stacks.cdc.gov/view/cdc/38025)) as well as a website ([http://www.cdc.gov/drugoverdose/prescribingresources.html](http://www.cdc.gov/drugoverdose/prescribingresources.html)) with additional tools to guide clinicians in implementing the recommendations.


- Importance: Primary care clinicians find managing chronic pain challenging. Evidence of long-term efficacy of opioids for chronic pain is limited. Opioid use is associated with serious risks, including opioid use disorder and overdose.
- Objective: To provide recommendations about opioid prescribing for primary care clinicians treating adult patients with chronic pain outside of active cancer treatment, palliative care, and end-of-life care.
- Process: The Centers for Disease Control and Prevention (CDC) updated a 2014 systematic review on effectiveness and risks of opioids and conducted a supplemental review on benefits and harms, values and preferences, and costs. CDC used the Grading of Recommendations Assessment, Development, and Evaluation (GRADE) framework to assess evidence type and determine the recommendation category.
- Evidence Synthesis: Evidence consisted of observational studies or randomized clinical trials with notable limitations, characterized as low quality using GRADE methodology. Meta-analysis was not attempted due to the limited number of studies, variability in study designs and clinical heterogeneity, and methodological shortcomings of studies. No study evaluated long-term (≥1 year) benefit of opioids for chronic pain. Opioids were
associated with increased risks, including opioid use disorder, overdose, and death, with dose-dependent effects.

• Recommendations: There are 12 recommendations. Of primary importance, nonopioid therapy is preferred for treatment of chronic pain. Opioids should be used only when benefits for pain and function are expected to outweigh risks. Before starting opioids, clinicians should establish treatment goals with patients and consider how opioids will be discontinued if benefits do not outweigh risks. When opioids are used, clinicians should prescribe the lowest effective dosage, carefully reassess benefits and risks when considering increasing dosage to 50 morphine milligram equivalents or more per day, and avoid concurrent opioids and benzodiazepines whenever possible. Clinicians should evaluate benefits and harms of continued opioid therapy with patients every 3 months or more frequently and review prescription drug monitoring program data, when available, for high-risk combinations or dosages. For patients with opioid use disorder, clinicians should offer or arrange evidence-based treatment, such as medication-assisted treatment with buprenorphine or methadone.

• Conclusions and Relevance: The guideline is intended to improve communication about benefits and risks of opioids for chronic pain, improve safety and effectiveness of pain treatment, and reduce risks associated with long-term opioid therapy.

Heroin Overdoses


- During 2013, 43,982 drug overdose deaths (unintentional, intentional [suicide or homicide], or undetermined intent) were reported. Among these, 8,257 (19 percent) were associated with heroin.

Changes in Rates of Heroin Overdoses


- From 2000 through 2013, the age-adjusted rate for drug-poisoning deaths involving heroin nearly quadrupled from 0.7 deaths per 100,000 in 2000 to 2.7 deaths per 100,000 in 2013. Most of the increase occurred after 2010.
- The number of drug poisoning deaths involving heroin was nearly four times higher for men (6,525 deaths) than women (1,732 deaths) in 2013.
- In 2000, non-Hispanic black persons aged 45–64 had the highest rate for drug-poisoning deaths involving heroin (2.0 per 100,000). In 2013, non-Hispanic white persons aged 18–44 had the highest rate (7.0 per 100,000).
From 2000 through 2013, the age-adjusted rate for drug poisoning deaths involving heroin increased for all regions of the country, with the greatest increase seen in the Midwest.

Who Can Administer Naloxone and Expansion of Approvals


A doctor can prescribe naloxone to patients who are in medication-assisted treatment (MAT), especially if the patient is taking medications used in MAT or considered a risk for opioid overdose. [In some states, non-physicians (e.g., pharmacists, physician assistants, and nurse practitioners) are also prescribing naloxone.]

- Candidates for naloxone are those who:
  - Take high doses of opioids for long-term management of chronic pain
  - Receive rotating opioid medication regimens
  - Have been discharged from emergency medical care following opioid poisoning or intoxication
  - Take certain extended-release or long-acting opioid medications
  - Are completing mandatory opioid detoxification or abstinence programs

- Pregnant women can be safely given naloxone in limited doses under the supervision of a doctor.
- A doctor or pharmacist can show patients, their family members, or caregivers how to administer naloxone. Intravenous injection every two to three minutes is recommended in emergencies.
- Patients given an automatic injection device or nasal spray should keep the item available at all times. Medication should be replaced when the expiration date passes.
- [Naloxone is only an antidote for opioids.]
- Naloxone is effective if opioids are misused in combination with other sedatives or stimulants. [However], it is not effective in treating overdoses of benzodiazepines or stimulant overdoses involving cocaine and amphetamines.
- [Naloxone is not a substitute for receiving appropriate medical care; medical care is needed immediately after an opioid overdose is successfully reversed.]

Impact of the Expansion of Naloxone Distribution on Opioid Overdose Deaths


- This study sought to answer the question, “Can police officers administer intranasal naloxone to [opioid] overdose victims to decrease the opioid overdose death rate?”
- This prospective interventional study was conducted in Lorain County, OH, from January 2011 to October 2014. Starting October 2013, trained police officers administered
naloxone to suspected opioid overdose victims through a police officer naloxone prescription program (NPP). Those found by the county coroner to be positive for opioids at the time of death and those who received naloxone from police officers were included in this study. The rate of change in the total number of opioid-related deaths in Lorain County per quarter year, before and after initiation of the NPP, and the trend in the survival rate of opioid overdose victims who were given naloxone were analyzed by linear regression.

- Data from 247 individuals were eligible for study inclusion. Opioid overdose deaths increased significantly before initiation of the police officer NPP with average deaths per quarter of 5.5 for 2011, 15.3 for 2012, and 16.3 for the first 9 months of 2013. After initiation of the police officer NPP, the number of opioid overdose deaths decreased each quarter with an overall average of 13.4. Of the 67 participants who received naloxone by police officers, 52 (77.6 percent) survived, and 8 (11.9 percent) were lost to follow-up.
- Intranasal naloxone administration by police first responders is associated with decreased deaths in opioid overdose victims.


- For many years, community-based programs have offered opioid overdose prevention services for laypersons who might witness an overdose, including persons who use drugs, their families and friends, and service providers.
- Since 1996, an increasing number of programs provide laypersons with training and kits containing the opioid antagonist naloxone hydrochloride (naloxone) to reverse the potentially fatal respiratory depression caused by heroin and other opioids.
- In July 2014, the Harm Reduction Coalition (HRC), a national advocacy and capacity-building organization, surveyed 140 managers of organizations in the United States known to provide naloxone kits to laypersons. Managers at 136 organizations completed the survey, reporting on the amount of naloxone distributed, opioid overdose reversals by bystanders, and other program data for 644 sites that were providing naloxone kits to laypersons as of June 2014.
- From 1996 through June 2014, surveyed organizations provided naloxone kits to 152,283 laypersons and received reports of 26,463 opioid overdose reversals. Providing opioid overdose training and naloxone kits to laypersons who might witness an opioid overdose can help reduce opioid overdose mortality.


- The leading cause of adult injury death in the U.S.A. is drug overdose, the majority of which involves prescription opioid medications. Outside of the United States,
by drug overdose are also on the rise, and overdose is a leading cause of death for drug users.

• Reducing overdose risk while maintaining access to prescription opioids when medically indicated requires careful consideration of how opioids are prescribed and dispensed, how patients use them, how they interact with other medications, and how they are safely stored.

• Pharmacists, highly trained professionals expert at detecting and managing medication errors and drug-drug interactions, safe dispensing, and patient counseling, are an under-utilized asset in addressing overdose in the United States and globally. Pharmacies provide a high-yield setting where patient and caregiver customers can access naloxone—an opioid antagonist that reverses opioid overdose—and overdose prevention counseling.

• This case study briefly describes and provides two U.S. state-specific examples of innovative policy models of pharmacy-based naloxone, implemented to reduce overdose events and improve opioid safety: Collaborative Pharmacy Practice Agreements and Pharmacy Standing Orders.


• In response to increasing rates of opioid overdose deaths in Rhode Island (RI), the RI Department of Health, RI emergency physicians, and Anchor Community Recovery Center designed an emergency department (ED) naloxone distribution and peer-recovery coach program for people at risk of opioid overdose. ED patients at risk for overdose are offered a take home naloxone kit, patient education video, and, when available, an Anchor peer recovery coach to provide recovery support and referral to treatment. In August 2014, the program launched at Kent, Miriam, and Rhode Island Hospital Emergency Departments.


• The challenge of addressing the epidemic of opioid overdose in Rhode Island, and nationwide, is only possible through collaborative efforts among a wide breadth of stakeholders. This article describes the range of efforts by numerous partners that have come together to facilitate community, and treatment-related approaches to address opioid-involved overdose and substance use disorder. Strategies to address this crisis have largely focused on increasing access both to the opioid overdose antidote naloxone and to high quality and timely treatment and recovery services. [Full text available at http://rimed.org/rimedicaljournal-2014-10.asp, free with no login].

**Federal Efforts to Expand Naloxone Availability**
The Secretary’s initiative targets three priority areas to combat opioid misuse, including expanded use and distribution of naloxone.

To support the important role of naloxone in opioid overdose prevention, the initiative focuses on three objectives:

- Expand utilization of naloxone
- Accelerate the development and availability of new naloxone formulations and user friendly products
- Identify and disseminate best practice naloxone delivery models and strategies

Some key actions include:

- Research trials on implementation and dissemination of opioid overdose prevention programs.
- Expanding utilization of naloxone through grants program to states

Several overdose education and naloxone distribution programs have been developed to issue naloxone and provide instructions on its use to opioid users, their friends and loved ones, and other potential bystanders.

An article in Morbidity and Mortality Weekly Report reported that as of 2010, programs that distribute naloxone to nonmedical personnel had reported more than 10,000 opioid overdose reversals nationwide since 1996. As of November 2014, 23 states have statutes that allow for “third-party” prescriptions of naloxone (i.e., the prescription can be written to friend, relative or person in a position to assist a person at risk of experiencing an opioid overdose).

An evaluation of Massachusetts’ overdose education and nasal naloxone distribution program found that opioid overdose death rates declined in communities where programs were implemented.

Given the effectiveness of naloxone in opioid overdose reversal, the Food and Drug Administration (FDA) has encouraged innovations in more user-friendly naloxone delivery systems such as auto-injectors, made particularly for lay use outside of health care settings. FDA approved such an auto-injector in 2014 [and a nasal spray in 2016].

**SAMHSA’s Role—Naloxone Expansion**

**WHEN AVAILABLE, ADD INFORMATION ON SOON-TO-BE-RELEASED SAMHSA NALOXONE (PDO) GRANT PROGRAM**


- In an effort to save more lives from opioid overdose, SAMHSA published the Opioid Overdose Prevention Toolkit—2014. The Toolkit equips communities and local
governments with material to develop policies and practices to help prevent opioid-related overdoses and deaths. It also serves as a foundation for educating and training:

- Communities
- Prescribers of opioid pain medications
- First responders
- Patients who are prescribed opioid medications
- Individuals and family members who have experienced an opioid overdose

- SAMHSA is also working with its federal partners and state and local law enforcement to expand the safe administration of naloxone by first responders.

- SAMHSA is working with emergency medical service professionals to:
  - Identify any state or local laws that permit or restrict naloxone use by certain types of first responders
  - [Recommends] the use of naloxone in emergency situations

- Naloxone is a regulated medication and must be administered properly.

SAMHSA’s Division of Pharmacologic Therapies (DPT) provides opioid prescribing courses for physicians, webinars, workshops, and summits, and publications and research.


- [This document explains funding and resources available to help communities expand naloxone programs, including training and acquiring naloxone.]


- The Substance Abuse Prevention and Treatment Block Grant (SABG) program provides funds to all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, 6 Pacific jurisdictions, and 1 tribal entity to prevent and treat substance [misuse].
- [SABG allows use of funds for naloxone training/education (20% prevention set-aside funds) and the purchase and distribution of naloxone.]

**SAMHSA’s Opioid Overdose Prevention Toolkit**


- [This resource] equips communities and local governments with material to develop policies and practices to help prevent opioid-related overdoses and deaths. [It] addresses issues for first responders, treatment [and service] providers, and those recovering from opioid overdose.
Components include facts for community members, essentials for first responders, safety advice for patients, information for prescribers, and resources for overdose survivors and family members.

**Additional Resources on Naloxone**


- The Bureau of Justice Assistance’s Law Enforcement Naloxone Toolkit is a clearinghouse of resources to support law enforcement agencies in establishing a naloxone program. The Law Enforcement Naloxone Toolkit was developed at the urging of the Attorney General in response to the growing opioid overdose epidemic.
- In the toolkit you will find answers to frequent questions about naloxone and sample documents and templates, such as data collection forms, standard operating procedures, training materials, press releases, community outreach materials, and memoranda of agreement (MOA) between first responders and medical directors. These templates can be downloaded and customized for your own agency.


- [This website provides basic information about the uses of naloxone, as well as precautions and side effects.]


- [This graphic summarizes the legal status of naloxone programs and Good Samaritan laws across the United States.]

**Link Between Opioid Use Disorder and Injection Drug Use**

• Injection drug use and needle sharing are responsible for about 10 percent of HIV cases annually, and one in six people with HIV/AIDS have used an illegal drug intravenously in their lifetime.
• The CDC recommends that people who inject drugs get vaccinated against hepatitis A and hepatitis B. Currently, there is no vaccination against HCV.
• Co-infection with HCV occurs in a quarter of Americans living with HIV.
• Most people with HCV are unaware of their infection and, for many, this can result in significant damage to the liver, including the development of life-threatening conditions.


• Research points to a trend in transition to drug injection among those misusing prescription opioids, where clusters of acute hepatitis C virus (HCV) infection are now being reported.
• Persons who report a recent transition to drug injection are characterized by high rates of HCV seroincidence.


• On January 23, 2015, the Indiana State Department of Health (ISDH) began an ongoing investigation of an outbreak of human immunodeficiency virus (HIV) infection, after Indiana disease intervention specialists reported 11 confirmed HIV cases traced to a rural county in southeastern Indiana.
• Historically, fewer than five cases of HIV infection have been reported annually in this county. The majority of cases were in residents of the same community and were linked to syringe-sharing partners injecting the prescription opioid oxymorphone (a powerful oral semi-synthetic opioid analgesic).
• As of April 21, ISDH had diagnosed HIV infection in 135 persons (129 with confirmed HIV infection and six with preliminarily positive results from rapid HIV testing that were pending confirmatory testing) in a community of 4,200 persons.

SAMHSA’s Efforts in HIV and Hepatitis Prevention


• SAMHSA addresses the issues of HIV, AIDS, and viral hepatitis by providing grant opportunities to support:
  o Coordinated mental health and addiction treatment services
  o HIV testing with pre- and post-test counseling
  o Referrals for treatment
Testing for other infectious diseases

- Collaborative efforts of community organizations, hospitals, academic institutions, and religious organizations are essential to effectively serve the multifaceted needs of the HIV, AIDS, and viral hepatitis population.

- A current, successful effort is the only national program that addresses the intersection of HIV and substance use treatment services: the **Targeted Capacity Expansion (TCE) Program: Substance Abuse Treatment for Racial/Ethnic Minority Populations at High Risk for HIV/AIDS (TCE-HIV)**. This program supports substance use treatment and HIV- and AIDS-related services in minority communities with the help of faith-based organizations in states with the highest HIV prevalence rates (at or above 270 per 100,000). The TCE-HIV program funds grantees that focus substance use treatment and HIV services on different racial and ethnic groups, high-risk populations including men who have sex with men (MSM), young MSM, and minority women including lesbians and transgender individuals. Past grantees have reported increases in a number of positive client behaviors at six months of participation, including decreased substance use, positive employment and housing statuses, and decreased contact with the criminal justice system. The same 2010 data also reported decreases in the use of injection drugs, unprotected sex, symptoms related to depression and anxiety, and suicide attempts.

- SAMHSA offers a wide variety substance use disorder treatment programs with HIV components. Past initiatives have involved the treatment of pregnant and post-partum women, as well as incarcerated individuals and people involved in the criminal justice system. For example, the Addiction Technology Transfer Center (ATTC) Network offers programs with a focus on lesbian, gay, bisexual, and transgender populations.

- The **Minority Serving Institutions (MSI) Partnerships with Community-Based Organizations (CBO)** grant program supports substance use prevention education and testing to equip and empower minority-serving institutions located in American communities at the highest risk of substance [misuse] and HIV and hepatitis C infections. The program supports evidence-based methodologies to increase access to comprehensive, integrated substance use and HIV and hepatitis C prevention services. The program aims to prevent and/or reduce substance use as a risk factor for the transmission of HIV/AIDS and viral hepatitis among African American, Hispanic/Latino, Asian American/Pacific Islander, and American Indian/Alaska Native young adult populations (ages 18 to 24) on Minority-Serving Institution campuses.

- The **Minority AIDS Initiative Targeted Capacity Expansion: Integrated Behavioral Health/Primary Care Network (MAI-TCE Program)** provides prevention, treatment, and recovery support services, and HIV testing for people with, and at risk for, mental and/or substance use disorders and those living with, or at high risk, for HIV infection. Targeted to the cities with the highest HIV impact, the MAI-TCE developed and expanded integrated behavioral health and primary care networks, including HIV and medical services, in 11 metropolitan statistical areas and metropolitan divisions in the United States.

- The **Minority AIDS Initiative (MAI) Program Using New Media to Prevent Substance Abuse & HIV/AIDS for Populations at High Risk** funds novel interventions to use new media to promote targeted substance use and HIV prevention messages to high-risk racial and ethnic minority populations. The program aims to decrease prejudice and discrimination by giving those at risk of contracting HIV the opportunity to share their
stories online, allowing for interaction with others in their communities, and encouraging healthy behaviors. In addition, volunteer peer mentors and coaches train and encourage racial and ethnic populations to engage in healthy lifestyles, and get tested or treated for HIV and viral hepatitis.

- In FY 2014, SAMHSA launched the Minority AIDS Initiative Continuum of Care Pilot. The purpose of this jointly funded program is to integrate care (behavioral health treatment, prevention, and HIV medical care services) for racial or ethnic minority populations at high risk for behavioral health [conditions] and at high risk for or living with HIV. The grant will fund programs that provide coordinated and integrated services through the co-location of behavioral health treatment and HIV medical care. This program is primarily intended for substance use treatment programs and community mental health programs that can fully integrate HIV prevention and medical care services. An important part of this program includes the use of set-aside funds for viral hepatitis prevention, vaccination, testing, and linkage to clinical care.

- Research suggests that simply knowing one’s HIV status can reduce risky behavior and thus help to reduce HIV transmission. SAMHSA works with a number of partners to increase access to rapid testing for HIV. Rapid testing can provide results in minutes, compared with traditional HIV test results that can take a week or more to obtain. The faster availability of results enables behavioral health professionals to quickly provide referrals to treatment when needed. A 2011 SAMHSA Advisory describes rapid HIV testing and reviews the benefits of its use in substance use treatment facilities.

- A 2010 report (PDF | 977 KB) by the National Survey of Substance Abuse Treatment Services noted that facilities that provide opioid treatment programs were more likely than other treatment facilities to offer special programs for people with HIV and AIDS, as well as provide counseling and early intervention. Sixty-three percent of these facilities provided testing, and 83 percent provided education, counseling, and support.

- [SAMHSA also has a 5 percent set aside from the Substance Abuse Prevention and Treatment Block Grant that is designated for early HIV intervention services.]

Panel 4: Addressing Opioid Misuse: Resources for Families, Professionals, States, and Communities

Key Questions

1. What are some prescribing guidelines and resources to support professionals in their efforts to reduce opioid use disorder and overdose? What are some resources for professionals to help their patients/clients better manage pain?
2. What are some patient and family resources for pain management? What are some resources to help people better understand and prevent prescription pain reliever misuse?
3. What are some opioid use disorder prevention resources for communities and states?
4. What are some resources for communities and states to prevent opioid overdose? What are some resources on naloxone for professionals and others in the community?
5. What are some HIV/hepatitis prevention resources?
6. What are some resources to help people access treatment for opioid use disorder? What are some resources to help people understand their treatment options for opioid use disorder (including MAT)?
7. What are some resources to help treatment and service providers better understand MAT?
8. What are some resources to support wellness and promote recovery?

Safe Prescribing Guidelines and Resources

[Please see “CDC Guidelines on Prescribing” section above.]


- [SAMHSA offers an in-person continuing education course, Clinical Challenges in Prescribing Controlled Drugs: Prescribing Opioids for Chronic Pain.]
- [SAMHSA supports Providers’ Clinical Support System for Opioid Therapies (PCSS-O), which provides training and mentoring services for a variety of health care providers on the safe and appropriate prescribing of opioids.]


- [This site offers six curriculum resources for medical schools and residency programs focused on prescription opioid misuse.]


- This [webinar raises] awareness about the value of SBIRT as a proactive solution for reducing opioid risk in patients being treated for pain. Participants will learn the components of a “universal precautions” approach when prescribing opioids and understand how SBIRT can play a key role in the treatment plan for patients on opioid medication. Valuable screening tools and brief intervention opportunities will be evaluated as part of a comprehensive treatment plan to improve functional goals and reduce opioid risk.

Pain Management Resources for Providers

[Please see information on PCSS-O described above.]
• [This resource] equips clinicians with practical guidance and tools for treating chronic pain in adults with a history of substance [misuse]. Discusses chronic pain management, including treatment with opioids, and offers information about substance [misuse] assessments and referrals.


• [This resource] provides clinicians with a quick reference guide for treating chronic pain in adults with a history of substance [misuse]. [It] covers patient assessment through treatment and includes an algorithm for managing chronic pain and a summary of non-opioid analgesics.


• This educational module is an introduction for health professions students to a standardized approach to the management of patients with chronic pain that integrates techniques for the prevention and detection of misuse of prescription opioids.


• Developed by NIDA and Medscape Education, with funding from the White House Office of National Drug Control Policy, these CME courses provide practical guidance for physicians and other clinicians in screening pain patients for substance use disorder risk factors before prescribing, and in identifying when patients are abusing their medications. The courses use videos that model effective communication about sensitive issues, without losing sight of addressing the pain. Click here to view the press release.

Safe and Effective Pain Management Resources for Patients/Family

• [This resource] equips people who have chronic pain and mental illness or addiction with tips for working with their healthcare provider to decrease their pain without jeopardizing their recovery. [It] explores counseling, exercise, and alternative therapy, as well as medications.


• There are ways to manage pain safely and effectively.
• You can talk to your health care provider about ways to manage your pain that do not involve prescription pain [relievers]. Options include:
  o Acetaminophen (Tylenol) or non-steroidal anti-inflammatory medications like ibuprofen (Advil).
  o Certain antidepressants and anticonvulsants for neuropathic pain.
  o Physical therapy and exercise.
  o Cognitive behavioral therapy.
• If your pain management plan includes prescription pain [relievers], you can
  o Have a conversation with your health care provider about the risks of taking these powerful medicines,
  o Make a plan with your health care provider on when and how to stop, and
  o Be sure to use them only as instructed by your health care provider.


• [This website provides] online videos and tools to help patients learn more about managing their pain.

Resources on Opioid Misuse


• [This resource] advises educators on how to talk with their students about the [misuse] of prescription drugs and its dangers. [It] gives facts about teen prescription drug [misuse], signs of [misuse], and how to encourage conversations with students about prescription drug [misuse] issues.

• [This resource] advises health care providers on screening questions to ask teen and adult patients about possible misuse of prescription drugs. [It] gives facts about teen prescription drug [misuse] and its dangers, how teens illegally obtain drugs, and resources for additional help.


• [This document] explains to teens the dangers of misusing and abusing prescription drugs and over-the-counter drugs. [It] reviews some of the myths of prescription drug [misuse], lists warning signs of substance [misuse], and explains what to do if someone has a problem and needs help.


• [This resource] arms parents with the information they need to explain the dangers of prescription drug [misuse] to their teens. [It] describes the risks of non-medical use of prescription drugs and offers practical advice to parents for talking with their teenagers.


• [This document] educates college-aged people about the risks with using prescription drugs or over-the-counter drugs non-medically. [It] explains how to keep them safely away from other students and offers tips for how to cope with the stress and pressure of college demands.


• [This website provides information on the misuse of prescription opioids.]


• [This website provides information on heroin and its misuse.]
[This document] informs teens about the dangers of heroin, including short- and long-term health risks and ways the drug affects the brain. [It] details signs of use, statistics about teen use of heroin, and answers questions about common myths. [The document] lists slang terms for heroin.

Opioid Use Disorder Prevention—Resources for Communities/States


- The 2011 Prescription Drug Abuse Prevention Plan (PDF | 306 KB) expands upon the Obama Administration’s National Drug Control Strategy and includes action in four major areas to reduce prescription drug [misuse]: education, monitoring, proper medication disposal, and enforcement.
- The Drug-Free Communities Support Program is a collaborative effort between the ONDCP and SAMHSA to strengthen collaboration among community coalitions to prevent and reduce substance use, including prescription drug misuse and abuse. [For more details on this program, see https://www.whitehouse.gov/ondcp/drug-free-communities-support-program.]
- The 2015 National Drug Control Strategy serves as the Obama Administration’s blueprint for reducing drug use and its consequences, including a national framework for reducing prescription drug diversion and misuse.
- The Center for the Application of Prevention Technologies (CAPT) is a nationwide substance [misuse] prevention training and technical assistance system. It works with states, tribes, jurisdictions, and communities to develop and implement strategies to prevent the misuse and abuse of prescription drugs.
- In collaboration with SAMHSA, the National Council on Patient Information and Education works to improve communication of information to consumers and health care providers on the appropriate use of medications.


- The Prescription Drug Monitoring Program Training and Technical Assistance Center (PDMP TTAC) at Brandeis University provides support, resources, and strategies to PDMPs, federal partners and many other stakeholders to further the efforts - and positive outcomes - of PDMPs.
[The Center addresses prescription drug misuse by collaborating with a wide variety of PDMP stakeholders.]

[This website provides information on prescription drug monitoring programs for states.]

[This website describes how health information technology can enhance access to PDMPs to address prescription drug misuse.]

[This website describes] a variety of promising legal and regulatory strategies [that] are available to states to address prescription drug misuse and overdose.

[This website describes the actions of states that have been successful at reducing prescription opioid misuse.]

[This resources offers sample logic models for states to reduce prescription opioid misuse.]

Overdose Prevention—Resources for Communities/States

• [This resource] equips communities and local governments with material to develop policies and practices to help prevent opioid-related overdoses and deaths. [It] addresses issues for first responders, treatment [and service] providers, and those recovering from opioid overdose.


• Prescription Drug Overdose: Prevention for States is a new initiative expanding on the work of the Prevention Boost Program that helps states combat the ongoing prescription drug overdose epidemic. The purpose of Prevention for States is to provide state health departments with resources and support needed to advance interventions for preventing prescription drug overdoses. [This webpage describes this initiative in detail.]


• [This website describes the efforts of one state to reduce opioid overdoses.]

Naloxone Resources


• [This webpage summarizes what can be done to prevent opioid overdose.]


• The Bureau of Justice Assistance’s Law Enforcement Naloxone Toolkit is a clearinghouse of resources to support law enforcement agencies in establishing a naloxone program.


• [This announcement describes the naloxone auto-injector for opioid overdose prevention.]

- [This announcement describes a naloxone nasal spray for opioid overdose prevention.]

HIV/Hepatitis Prevention Resources


- Helps clinicians improve care for people with HIV/AIDS and substance use problems. Discusses prevention, assessment, and treatment of HIV/AIDS; mental disorders; integrated services; case management; counseling; ethical/legal issues; and funding sources.


- [This resource] assists behavioral health professionals who treat people with substance use problems in understanding the implications of a diagnosis of hepatitis. [It] discusses screening, diagnosis, and referrals and explains how to evaluate a program's hepatitis practices.


- [This resource] describes rapid HIV testing and reviews the benefits of its use in substance use treatment facilities. [It] reviews testing regulations and outlines the procedures for implementing the testing, including factors associated with pretest and post-test counseling.


- [This website describes the elevated risk for infectious diseases among people who misuse drugs and explains how treatment for substance use disorders reduces this risk.]
[This website describes the elevated risk for HIV among people who misuse substances as well as prevention efforts.]

[This resource is designed to promote awareness and prevention of HIV/AIDS among people with substance use problems. It explains how drugs and alcohol are linked to HIV/AIDS and the importance of treatment for substance misuse and HIV/AIDS. It offers a list of resources.]

Resources on Accessing Treatment

[Please see information above on SAMHSA’s Behavioral Health Treatment Services Locator and SAMHSA’s National Helpline.]

[This resource presents information about Medicaid coverage of medication-assisted treatment for opioid and alcohol dependence. It covers treatment effectiveness and cost effectiveness as well as examples of innovative approaches in Vermont, Massachusetts, and Maryland.]

[This resource shows how social services can support treatment and recovery for people with substance use problems and their families. It discusses foster care, housing, job training, veterans support, and drug courts.]

Resources for Understanding Treatment Options (including MAT)

[This website describes the elevated risk for HIV among people who misuse substances as well as prevention efforts.]
• [This resource] describes methadone as part of medication-assisted treatment for addiction to heroin and other opioids. [It provides] facts about methadone maintenance treatment; starting, living with, and ending methadone therapy; and the dangers of mixing methadone with other drugs.


• [This resource] gives families and friends information about medication-assisted treatment for opioid addiction. [It] describes prescribed opioid medications, their proper use and side effects, withdrawal symptoms, and how medications fit with counseling in the recovery process.


• [This resource] gives patients information on buprenorphine and medication-assisted treatment for opioid addiction. Describes addiction and withdrawal, how buprenorphine works, its proper use, its side effects, and how it fits with counseling in the recovery process.


• [This resource] gives patients information on naltrexone and medication-assisted treatment for opioid addiction. [It] describes addiction and withdrawal, how naltrexone works, its proper use, its side effects, and how it fits with counseling in the recovery process.


• [This resource was] created for family members of people with [substance use disorders]. Answers questions about substance [use disorders], its symptoms, different types of treatment, and recovery. [It] addresses concerns of children of parents with substance use problems.

MAT—Resources for Providers
• Through the BRSS TACS project, SAMHSA is creating additional decision support resources [for medication assisted treatment for opioid use disorder.] This interactive, multimedia tool [will compare] three medications used for the treatment of opioid [use disorder]. It helps people consider whether using medication assisted treatment is the right approach for them and if so, which approach would best fit their situation.


• [This resource] gives an overview of data on the use of sublingual and transmucosal buprenorphine for the medication-assisted treatment of opioid use disorder. [It] discusses the implications of utilizing medication-assisted treatment [as part of] recovery support.


• [This resource] offers guidelines for physicians using medication-assisted treatment for patients with opioid use disorder. [It] discusses the various types of approved medications, screening and assessment tools, and best practices for patient care.


• [This resource] gives a detailed description of medication-assisted treatment for addiction to opioids, including comprehensive maintenance treatment, detoxification, and medically supervised withdrawal. [It] discusses screening, assessment, and administrative and ethical issues.


• [This resource] provides a training program for substance [misuse] treatment counselors and other clinicians on medication-assisted treatment for opioid [use disorder]. [It]
covers basic principles, best practices, history, and regulation. Includes scripted modules and handouts.


- [This resource] offers clinicians guidelines on using medication-assisted treatment in opioid treatment programs. [It] discusses screening, pharmacology of five medications, pharmacotherapy, phases of treatment, drug testing, patients with special needs, and administrative issues.


- [This resource] offers guidance on the use of medication-assisted treatment (MAT) with extended-release injectable naltrexone for the treatment of an opioid use disorder. [It] covers patient assessment, initiating MAT, monitoring progress, and deciding when to end treatment.


- Educates substance [misuse] counselors and clinicians about detoxification and withdrawal. Addresses patient placement, detox services for specific substances, co-occurring medical and psychiatric conditions, financing issues, and screening and assessment tools.


- [This resource] gives nurses information about buprenorphine for medication-assisted treatment of [opioid use disorder] and guidelines for working with physicians to provide office-based screening, assessment, supervised withdrawal (detoxification), and maintenance treatment.

[This resource] presents practice guidelines for physicians using buprenorphine therapy to treat opioid addiction. [It] gives protocols for medication-assisted treatment for short- and long-acting opioids and recommendations for baseline laboratory evaluations.


[These] practice guidelines help physicians make decisions about using buprenorphine to treat opioid addiction. [This resource] includes information on patient assessment; protocols for opioid withdrawal; and the treatment of pregnant women, teens, and polysubstance users.

Wellness/Recovery Resources


[This website provides information and guidance on wellness.]


[This website provides information on recovery support.]


[This website provides resources for diabetes management including toolkits, trainings, and other educational materials.]


SAMHSA’s Wellness Initiative raises awareness of health disparities among people with serious mental and/or substance use disorders and the general population.

- [This website provides resources for healthy eating.]


- [This website describes the types and amounts of physical activity that offer substantial health benefits.]


- [This website offers tobacco and smoking cessation resources.]


- [This website offers resources on stress management.]


- National Recovery Month is a national observance that educates Americans on the fact that addiction treatment and mental health services can enable those with a mental and/or substance use disorder to live a healthy and rewarding life.


- [This resource] introduces a working definition for recovery from mental disorders and substance use, along with 10 guiding principles intended to help advance recovery opportunities and help clarify these concepts for peers, families, funders, providers, and others.

Source: SAMHSA. (2013, August). Young adults in recovery: meeting the needs of the “millennial” generation. From http://store.samhsa.gov/product/Young-Adults-in-Recovery-
• [This Recovery Month webcast] focuses on young adults’ needs and preferences with regard to treatment and recovery for mental illness and substance use disorders. [It] explores strategies for the prevention of the initiation or escalation of substance use or developing mental disorders.


• [This resource] guides people with mental illness or disability in developing an action plan for prevention and recovery. [It] addresses wellness, daily maintenance, triggers, early warning signs, signs that things are breaking down, and crisis intervention.

A link check was run on all the external websites listed in the discussion guide to identify and fix any broken links as of 1/3/16. However, we acknowledge that website URLs change frequently and may require ongoing link checks for accuracy. Last Updated: 1/3/16.