The Opioid Epidemic: A State and Local Prosecutor Response

October 12th, 2018

To the Readers:

On behalf of the National District Attorneys Association (NDAA), I am pleased to present the first national Working Paper from state and local prosecutors on the opioid epidemic. This document is the work product of 33 prosecutors from 30 states over eight months.

As the chair of the Working Group, I am grateful for the many hours of research, writing and conference calls among committee members that culminated in this document. Most of all, I am thankful for the tireless work of NDAA Executive Director Nelson Bunn, who was the glue that brought all these different ideas together from a large group of prosecutors representing the unique diversity of our great nation.

Our recommendations may surprise those who mistakenly see prosecutors as an arm of law enforcement solely concerned with convicting and punishing. One of the top goals for every prosecutor is to ensure safe communities, and that means understanding that we can't arrest our way out of an unprecedented opioid epidemic. Thus, in addition to law enforcement proposals, we have dedicated a large portion of this document to two other areas that are crucial to addressing this crisis: prevention and rehabilitation.

As this document demonstrates, our Working Group recognizes that harm reduction policies will play an important role in any government response to the opioid epidemic.

Although not included in the Working Group recommendations, Syringe Exchange Programs (SEPs) deserve recognition. Once highly controversial, SEPs now exist in 39 states and hundreds of local jurisdictions. These are community-based programs that provide sterile needles and syringes for free, along with the disposal of used needles and syringes. Such programs typically offer educational materials, drug treatment referrals, along with counseling and testing for HIV and Hepatitis C. A majority of our committee preferred deferring to states and local governments on whether SEPs should be used within their communities.

This Working Paper is designed to recommend proposals and best practices for prosecutors, law enforcement and policymakers at the local, state and federal levels. We hope these recommendations will lead to policy changes or, at the very least, spur much-needed conversations about how to address a growing national epidemic that now claims 136 lives per day.

Sincerely,

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Disclaimer: <u>The Opioid Epidemic: A State and Local Prosecutor Response</u> represents the National District Attorneys Association's stance on the issue as a whole and *does not* reflect the policy views of the individual members in the Opioids Working Group.

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I. Summary

In the Unites States, more people die from drug overdoses than from car accidents and homicides.[1] Reaching across the nation, this drug epidemic is forcing prosecutors to face challenging questions regarding their role in reducing its fatal consequences. The National District Attorneys Association (NDAA) created an Opioids Working Group to research and propose effective policy for prosecuting and diverting overdose related cases. The NDAA supports further research in this area and proposes the following to help combat these issues.

II. Enforcement

A. Expand Drug Courts

Drug Courts are far more effective than incarceration for reducing crime and promoting recovery. National research finds that 60 to 80 percent of people imprisoned for property or drug crimes will recidivate within two years of release, and up to 95 percent will begin using addictive substances again.[2] A study completed by the National Drug Court Institute over a 15-year period concluded that an effective drug court program teamed with treatment is six times more likely to keep individuals in treatment than voluntary treatment programs.[3]

Moreover, drug courts are cost-effective. National studies show that for every $1 invested in a drug court, $3.36 are saved elsewhere in criminal justice costs alone. When factoring in decreased victimization and reduced healthcare utilization, the savings increase to $27 for every $1 invested.[4]

NDAA endorses the use of drug courts as an evidence-based solution that saves lives and money while reducing recidivism. NDAA endorses the implementation of evidence-based best practices in the implementation of drug courts, including the Key Components published in the scientific literature made available via the National Drug Court Institute.

B. Forge Alliances with Federal Partners

State prosecutors engaged in the battle against opioid overdose deaths should strongly consider forging strategic alliances with federal partners. Federal drug laws provide a potent tool for the ongoing battle when distribution of an opioid is established as the but-for cause of an overdose death. In November 2017, the Attorney General of the United States ordered each of the 94

[1] Police Executive Research Forum. *The Unprecedented Opioid Epidemic: as overdoses become a leading cause of death, police, sheriffs, and health agencies must step up their response.* (2017): 5-6.
[2] *Id.*
[3] *Id.*
[4] *Id.*

United States Attorney's Offices to designate an opioid coordinator to oversee the district's opioid response. Under 18 U.S.C. § 841(a)(1), federal drug laws prohibit, among other things, the manufacture, distribution, or possession with intent to distribute listed drugs, including Fentanyl. In the context of opioid deaths, federal law provides that the defendant, "if death or serious bodily injury results from the use of such substance, shall be sentenced to a term of imprisonment of not less than twenty years or more than life." 18 U.S.C. § 841(b)(1)(C). Equally important, "[i]f any person commits such a violation after a prior conviction for a felony drug offense has become final, such person … if death or serious bodily injury results from the use of such substance shall be sentenced to life imprisonment." *Id*.

Prosecution of drug offenses in the federal system typically enhances cooperation by charged defendants, usually provides better tools for rewarding cooperation, may result in fewer discovery obligations and discovery practice, and often results in quicker resolutions. The easiest way to do this is to form or participate in a federal task force, under which state investigators become federal task force officers.

With regard to tackling the international aspects of the illegal distribution of opioids like Fentanyl, valuable partnerships can be formed with sometimes overlooked federal agencies in the fight against illegal opioids, including Homeland Security Investigations, Customs and Border Patrol, and the United States Postal Inspection Service. These agencies can conduct border searches of questionable packages coming into the country from opioid-origin countries.

Federal agencies can also provide meaningful assistance with complex financial and computer investigations that involve the dark web. J-CODE is the Joint Criminal Opioid Darknet Enforcement team that was established by the Attorney General in January 2018, bringing together DEA, Safe Streets task forces, drug trafficking task forces, Health Care Fraud Special Agents, and other assets, to double the FBI's investment in the fight against online drug trafficking. It dedicates dozens more Special Agents, Intelligence Analysts and professional staff to focus solely on opioid sales online. By partnering and fostering relationships with federal partners, state and local prosecutors can determine the best path forward to seek appropriate penalties for those distributing opioids, while tapping into other federal resources and best practices in an effort to stem the tide of dangerous drugs.

C. Address the Obstacle of Smartphone Encryption

With the advancement of smartphones, drug dealers have moved increasingly from the streets to the digital realm, setting up sales and conducting other illegal business behind a shield of encrypted data. Passcode protected smartphones are often difficult or impossible for law enforcement to access, which means prosecutors cannot retrieve evidence believed to be key to criminal investigations. Because criminals know this to be true, they have been emboldened to continue their illegal enterprises as the public and victims of crime are left to suffer.

Recent decisions by Apple and Google to employ what is referred to as "full-disc encryption" has made retrieving data on their devices completely inaccessible without a passcode, even with a judicially-issued search warrant. As it stands now, the only options available to prosecutors to deal with this problem involve time-consuming and costly workarounds that are not sustainable in the long-term.

Prosecutors will only continue to be hamstrung by this issue unless immediate legislative action is taken by Congress. Our leaders in government must work to enact a national solution that strikes the appropriate balance between privacy and public safety.

The most viable solution is to pass laws that require smartphone providers to comply with decryption orders issued by state and federal courts. Only then will law enforcement be guaranteed to have the much-needed tools to quickly solve cases and prevent crime before it happens.

What Lawmakers Can Do:

- Update the Communications Assistance for Law Enforcement Act (CALEA) of 1994.
    - Currently, CALEA states that no law enforcement agency or officer shall be able to instruct a telecommunications company, such as Apple or Google, on what features, including encryption of data, it is permitted to install on its devices. This has led companies to encrypt the data collected on their devices so even they are unable to access it.
    - This provision should be amended so that upon the order of a Court, the technology company that produced the device in question must provide the requesting Court, agency, or officer of the law with access to the relevant data as it exists as evidence in a criminal proceeding.
- Call on technology companies and other tech experts to answer questions about these policies and to provide information on the specific security and technological concerns.
- Mandate a reasonable response time following a judicially authorized search warrant, with fines for noncompliance that cannot be passed along to the consumer.
- Prohibit the sale of digital devices that cannot be accessed pursuant to court orders.
- Examine financial disincentives for noncompliance, such as revoking or eliminating tax credits and government contracts.

What Law Enforcement Can Do:

- Track cases and generate statistics to help demonstrate the threat posed to the law enforcement community and, consequently, everyday Americans.
- Consider using available software such as "GrayKey" that allows for computer forensic technicians to bypass the encryption of cell phones. "GrayKey" can get around Apple encryption, but time is crucial. If the phone shuts off, it takes much longer to bypass the

encryption and access to data is limited. (Note that the devices can still be wiped clean from remote locations if they are not stored in a Faraday Box.)

- Provide case examples that can be used to show the impact these decisions and policies are having for the safety of your constituents.
- Write op-eds or open letters to your local media.
- Discuss this issue with your elected officials and community leaders.

D. Increase the Prosecution of Drug Delivery Cases Resulting in Death

One shift in many jurisdictions around the country to address the opioid crisis has been to target dealers of opioids and other drugs through what is known as drug delivery in death statutes. Successful prosecutions under these statutes begin by having law enforcement and prosecutors place an emphasis on pursuing these types of cases. The potential of being charged with homicide also provides an added incentive for a dealer to cooperate with law enforcement and provide other actionable intelligence for broader distribution networks.

Law enforcement agencies and prosecutors should treat every overdose death as a homicide and assign homicide detectives to respond to these scenes. These cases should also be included in internal homicide review meetings for the given agency. Of particular importance in the homicide investigation of a fatal overdose is the individual's cell phone. In many instances, a user will engage in a series of calls and/or texts with the drug dealer shortly before death to arrange the purchase of the fatal dose of product. It's important as part of the investigative process to seek the proper legal process to obtain subscriber information that can provide valuable intelligence to pursue a case. Obtaining phone records can take time and are sometimes difficult to pursue, but it can be one of the most critical parts of an investigation and can hold key evidence to successfully pursue a drug delivery in death statute case.

One key partnership that can also prove helpful is with the coroner's office. Coroners may be able to perform a quick verbal assessment of causation based on the evidence at the scene. Many jurisdictions may not do full autopsies when the circumstances and case history support the opioid overdose death. Furthermore, prosecutors can encourage the coroner to establish a partnership with local hospitals so that all overdose results in an admission blood draw are preserved for the coroner in case the victim later dies as a result of the overdose.

Lawmakers should consider legislation that increases penalties for distribution of fentanyl, makes every person in the chain of delivery criminally liable for an overdose death, and requires hospitals to report overdoses to law enforcement. Prosecutors can be assigned to work these cases from investigation through prosecution, potentially through a task force model that could include federal partners. Family members of the victims and support groups can work with local media to educate the public on the benefit of these prosecutions and limit bias against the victim. Prosecutors may also need to develop proposed jury instructions to address any potential victim bias issue.

Although pursuing drug delivery in death statutes may not work for all jurisdictions, it can be a helpful tool in identifying and prosecuting dealers and distributors in an effort to create a deterrent and turn the tide of opioids flowing through communities.

E. Clarify the Bona Fide Employee Exception to Federal Anti-Kickback Law

The federal Anti-Kickback Statute (AKS), 42 U.S.C. § 1320a-7b(b) (2018), was designed to protect patients from being bought and sold like commodities. The buying and selling of per-head patient referrals could not be more antithetical to this goal. Those who wish to buy per-head patient referrals, however, are currently able to do so in plain sight by simply hiring patient brokers as "bona fide employees."

The "bona fide employee" safe harbor (BFE)[5] is based on the premise that because employers are liable for the acts of their employees, employers will assert appropriate control over the actions of their employees.[6] But in reality, an employer's control over employees does nothing to prevent the outright buying and selling of per-head patient referrals for the benefit of the employer. The BFE will continue to stand as the largest, inexplicable loophole to the AKS unless the same common-sense standards found in other exceptions[7] are added. These include a requirement that the aggregate compensation paid to the employee over the term of the employment is:

1. **set in advance**,
2. consistent with **fair market value** in arms-length transactions, and
3. not determined in a manner that takes into account the **volume or value** of any referrals or business otherwise generated between the parties.

In other words, marketers of health care services should not be paid commissions or given bonuses based on the volume or value of patients they bring in. The three standards above should equally apply to BFE marketers for the same reasons these standards apply to independent marketers and most of the other financial arrangements found in the safe harbors. Healthcare employers should always be able to pay in-house marketers a reasonable salary, but they should not be allowed to avoid the core purpose of the AKS to simply buy and sell per-head patient referrals from the marketers they employ. The payment standards above would serve to keep the BFE a workable exception to the rule rather than a loophole that defeats its purpose.

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[5] 42 U.S.C. § 1320a-7b(b)(3)(B); 42 C.F.R. § 1001.952(i) (2017).
[6] *Medicare and State Health Care Programs: Fraud and Abuse; OIG Anti–Kickback Provisions*, 56 Fed. Reg. 35,952, 35,981 (July 29, 1991).
[7] 42 C.F.R. §§ 1001.952**(a)**(Investment interests); **(b)** (Space rental); **(c)** (Equipment rental); **(d)** (Personal services and management contracts); **(f)** (Referral services); **(n)** (Practitioner recruitment); **(o)** (Obstetrical malpractice insurance subsidies); **(r)** (Ambulatory surgical centers); **(v)** (Ambulance replenishing); **(w)** (Health centers); **(x)** (Electronic prescribing); **(y)** (Electronic health records); **(bb)** (Local Transportation).

Adding these standards would also resolve the conflict between state and federal courts over the issue of whether the BFE allows employers to pay unlimited commissions and bonuses to employees for per-head patient referrals. There should be a clear national prohibition on payments for per-head patient referrals no matter how much control the employer has over the employee, since these payment practices impede patient freedom of choice, diminish competition among health care providers, and embody the very essence of utilizing financial incentives to influence provider decision-making regarding referrals.

F. Expand Anti-Kickback Laws to Private Treatment

The federal Anti-Kickback Statute (42 U.S.C. § 1320a-7b(b)) only applies to healthcare kickbacks to and from federally-assisted treatment programs. Thus, federal law enforcement agencies only have jurisdiction to investigate and prosecute healthcare kickbacks related to federally-assisted treatment.

But the purpose behind the AKS equally applies to *privately*-funded treatment programs.[8] In fact, the Office of the Inspector General's commentary acknowledged: "[T]he law does not make increased cost to the government the sole criterion of corruption….[K]ickback schemes can freeze competing suppliers from the system, can mask the possibility of government price reductions, can misdirect program funds, and, when proportional, can erect strong temptations to order more drugs and supplies than needed."[9]

Patients should be protected from the dangers of healthcare kickbacks regardless of whether the treatment is publicly funded or not. After all, when healthcare kickbacks harm private insurance we all lose through higher premiums and an overall higher cost of healthcare. Likewise, all states should adopt anti-kickback laws that apply to private treatment so that local state agencies can have jurisdiction to help combat the fight against patient brokering and protect the millions of patients receiving private treatment.

Senators Marco Rubio (R-FL) and Amy Klobuchar (D-MN) have introduced legislation, S. 3254, in the U.S. Senate to expand the DOJ's jurisdiction to prosecute patient brokering kickbacks involving private sector interstate commerce. We strongly support this legislation, entitled the Eliminating Kickbacks in Recovery Act, which would allow our federal partners to help stop the flow of cash for those involved in illegal paid referrals.

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[8] *See United States v. Patel*, 778 F. 3d 607, 612 (7th Cir. 2015) (AKS enacted to prevent fraud and "abusive practices resulting from provider decisions that are based on self-interest rather than cost, quality of care or necessity of services.").

[9] *Medicare and State Health Care Programs: Fraud and Abuse; OIG Anti–Kickback Provisions*, 56 Fed.Reg. 35,952, 35,954 (July 29, 1991).

G. Target Marketing Fraud Related to the Opioid Crisis

Many patient brokers induce patients with free flights and free or reduced rent. For years, many of these brokers (and some of the healthcare lawyers who advise them) have been under the impression that having the patient sign an IOU or promissory note for whatever benefit they offer up front sanitizes the benefit from being a kickback. Giving a free line of credit to someone with little or no credit for expensive airfare or rent can certainly be a kickback or bribe under the most basic sense of these words. This is especially true in the common circumstance where the debt is rarely ever attempted to be collected. This practice should be expressly prohibited by including the phrase "any line of credit" in the federal definition of remuneration in the Anti-Kickback Statute (AKS) under 42 U.S.C. § 1320a-7b(b).

In addition, the federal government can better target marketing fraud by excluding inherently coercive relationships from safe harbor provisions within the AKS. The AKS currently contains an exemption for "personal services and management contracts," which allows payment made by a principal to an agent as compensation for the services of the agent, as long as seven standards are met. *See* 42 CFR 1001.952(d). Although these standards provide some structure and transparency to the independent contractor relationship, none of these standards prevents inherently coercive relationships such as those between a sober home resident and the owner of the sober home.

Sober home residents pay week to week and can be kicked out at any time. Because of this power over the residents (who are typically from out-of-state with little to no resources), many sober home owners double as "marketers" for a substance abuse treatment center where they refer their residents for treatment. This unique relationship between a patient and a sober home owner is easily abused and has been for years. Thus, the exemption under the AKS for personal services and management contracts should expressly exclude this kind of relationship, which puts patients in an even more vulnerable situation.

H. Utilize Law Enforcement Assisted Diversion (LEAD)

Given the rise in opioid use and overdose deaths, law enforcement should utilize evidence-based criminal justice programs that will reduce the prison population while connecting people to much-needed public health programs.

One such program that has received a lot of attention over the last few years is LEAD – Law Enforcement Assisted Diversion. The program operates with the collaboration of law enforcement, public defenders, prosecutors, social workers and treatment experts. It is designed to provide an alternative to incarceration for those addicted to drugs who cycle in and out of the criminal justice system. In this program, when a law enforcement officer encounters an addict with drugs or committing a minor offense, rather than arrest that person, the officer can refer him

or her to the LEAD program. A case worker can respond to the location or the officer may take the person to the non-profit providing support. An assessment will be done of the individual's needs such as treatment, housing, and overdose prevention education. Whatever the need, the LEAD team is there to offer a solution that avoids jail and enables the person to get his or her life back on track.

The program began in Seattle in 2011, and now operates in over thirty states. It has a proven record of success. A University of Washington report found that participants were 58% less likely than people in the control group to be arrested for another offense.[10]

The framework of a LEAD program includes the following:

1) It is guided by harm reduction principles in which participation is voluntary and there is no required abstinence from drugs or alcohol. Service is provided without judgment, and there are no punitive measures if substance use continues.
2) LEAD is systems change-oriented because it builds on any existing law enforcement diversion programs and adds a new coordination component among all stakeholder agencies for a completely integrated approach to include a dedicated LEAD prosecutor.
3) It will utilize a psycho-social, public health approach – not a punitive approach. By creating a partnership among law enforcement, mental health clinicians and case management providers, the primary focus of LEAD is to meet the clients where they are and focus on meeting their immediate needs such as housing, employment and health.

A primary goal is to reduce overdose deaths and develop pragmatic solutions rather than retributive ones. Through the LEAD program, a local community will contract with one or more service providers to serve as many clients as possible. Offenders will have case managers who will help them get treatment and support services. While the program is not exclusively a prosecution program, the prosecutor's office plays a large role in assisting with intake and supporting the program.

III. Prevention

A. Increase Prescription Drug Take-Backs

The expanded use of opioids and other prescription medications has created disposal issues throughout the nation. The increased number of prescriptions left in homes and increased quantities of prescriptions due to overprescribing creates a temptation for abuse, as well as a strain on disposal systems. Although the United States Drug Enforcement Administration (DEA)

[10] University of Washington. *Innovative Law Enforcement Assisted Diversion (LEAD) Program Is Showing Success*. https://depts.washington.edu/harrtlab/wordpress/wp-content/uploads/2015/04/2015-04-08-LEAD-Press-Release-and-Evaluation-Summary.pdf.

conducts Prescription Take Back Days twice a year, it's simply not enough to keep up with the volume of unused prescriptions, creating burdens for communities looking to address the opioid crisis. To address the issue, communities need to establish innovative ways to encourage citizens to properly dispose of their prescriptions throughout the year.

One approach, which incorporates a wide range of stakeholders in the community, is being executed in Onondaga County, New York. A partnership between the medical community, law enforcement and the resource recovery agency called Sharps Needles and Drug Disposal (SNADD) was created in 2016, with over 5,000 pounds of collected medications being incinerated to date.

Local prosecutors are in an advantageous position to bring various stakeholders to the table to discuss innovative approaches to address this issue. By thinking outside the box, criminal justice leaders can create new mechanisms to dispose of excess medication as one positive step toward addressing the opioid crisis. The SNADD program has worked in Onondaga County because the organizations involved have been willing to go outside their comfort zones for the betterment of the community.

Collecting unused prescriptions without a proper disposal facility is a hurdle for all communities based on DEA regulations. The Opioids Working Group recommends expanding the number of prescriptions take back days through the DEA, while also looking at innovative ways to collect and dispose of excess medications in communities, including making sure that proper disposal facilities are available and any barriers to disposal are addressed.

B. Limit the Number of Days a Doctor Can Prescribe Opioids

The opioid epidemic is fueled by the economic principles of supply and demand. Typically, someone enters into opioid usage as a result of some medical necessity (i.e. acute injury, chronic pain), and is prescribed an opioid, such as oxycodone or hydrocodone. It is after this initial encounter that the individual too often develops an "addiction" to the opioid and seeks out supplemental pills. The supply component is fueled primarily by refill prescription opioids with few standard guidelines and no limitations. As the demands continue to rise throughout the country, addicts are constantly searching for supplies that are easily accessible. In response to the opioid epidemic, the Center for Disease Control (CDC) in 2016 set forth guidelines for prescribing opioids for chronic pain.[11] (*See* Attachment "A" for CDC's factsheet on the guidelines). The CDC Guidelines offers primary care providers a set of voluntary, evidence-based recommendations for prescribing opioids to patients 18 years or older in primary care settings.

[11] https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm.

This working group recommends that the CDC's guidelines or a similar evidence-based guideline be adopted that would be standard around the country. Prosecutors should familiarize themselves with the CDC standards and advocate for their legislatures to adopt them in their respective states. Further, the working group recommends setting a limit of up to a seven-day supply for initial (first-time) opioid prescriptions and between a three and seven-day limit for the subsequent follow up re-fill (with the understanding that certain exceptions would be granted, (i.e. cancer, hospice care).

C. Call for a National Database of Prescription Monitoring Programs

Prescription Drug Monitoring Programs (PDMP) and Prescription Monitoring Programs (PMP) track the prescribing of controlled dangerous substances. These programs are widely utilized to prevent overprescribing, inform clinical practices, and protect patients from overuse of addictive substances. These monitoring programs are widely used to advance both law enforcement objectives and public health objectives. At present, the effort to monitor prescriptions is led by the individual states with no mandate for interstate data sharing.

Because PDMPs and PMPs are enacted at the state-level, each program may have differences from one another. Most require health care providers to check the database before issuing a prescription for certain controlled substances. Methods of use, software integration, rules of interstate cooperation and protocols vary from jurisdiction to jurisdiction.

Because different jurisdictions do not consistently share data, the existing framework does not meet the needs of our interconnected communities. Without a national database of prescription monitoring programs, we fail to take the affirmative steps necessary to adequately make data available to all interested stakeholders.

Some states have already opted into a voluntary national network of data sharing run by the National Boards of Pharmacy. The benefits of joining this network are mutually beneficial for all jurisdictions, but the scope of this effort is limited until there is a complete national network of participants.

In announcing his initiative to stop opioid abuse and reduce drug supply and demand, President Trump prioritized the need to reduce the over-prescription of opioids, emphasizing the need to transition to a nationally interoperable Prescription Drug Monitoring Program network. On March 22, 2018, the National Association of the Boards of Pharmacy echoed the White House's call for a national PDMP database.

The NDAA supports efforts to implement a national database for interstate data sharing of the prescribing of controlled dangerous substances, including opioids. These programs are highly

effective in individual states, and a national database will close gaps in the existing framework, while simultaneously advancing the underlying goals of these important programs.

D. Expand the Use of Real-Time Overdose Data

There is no uniform or consistent tracking mechanism to determine where overdoses are occurring, how frequently they are occurring and what potential trends could be emerging from the overdose data. Without accurate and timely data, prosecutors, law enforcement and public health officials are unable to identify appropriate and effective responses in their communities.

To address the lack of real-time data and information sharing related to the opioid crisis, the Washington/Baltimore High Intensity Drug Trafficking Area (HIDTA) developed the Overdose Detection Mapping Application Program (ODMAP), which allows real-time data on overdoses to be compiled and shared across a platform to a variety of stakeholders. In the Baltimore HIDTA's case, it is able to populate data from Washington, DC, Virginia, Maryland and parts of West Virginia. (More information can be found at http://www.hidta.org/odmap/)

The NDAA Opioids Working Group recommends replicating and expanding the use of the ODMAP model through the 27 other HIDTAs across the country as a step toward providing the most accurate, real-time data available to all stakeholders addressing the opioid crisis. Particular attention must be paid to the input of the data to ensure its accuracy and timeliness.

IV. Treatment

A. Support Community-Based Medication-Assisted Treatment Programs

Many jurisdictions have adopted drug courts to address the opioid problem. Drug courts, however, are limited because they are only able to assist defendants with current criminal charges and generally are a one-chance opportunity. A community-based medication-assisted treatment program, such as a Vivitrol (naltrexone) program is more flexible and takes into consideration that there are multiple ways to treat offenders. [12] This program allows for coordination within the judicial system, treating first-time offenders, repeat offenders, and offenders on parole. Community-based Vivitrol programs provide a great alternative for prosecutors as they look to refer potential victims, defendants or witnesses in a particular case. These could be run by local non-profits or other county government entities. In some

[12] Vivitrol (naltrexone) is one of three Medication Assisted Treatment (MAT) drugs currently available to treat opioid use disorder. The other two are buprenorphine and methadone. Both buprenorphine and methadone contain opioids and are known as partial opioid agonists. However, Vivitrol is an opioid antagonist, meaning it contains no opioid.

jurisdictions, the local prosecutor is able to develop and administer a Vivitrol program, which could have some benefits.[13]

One example is in Athens County, Ohio, where the prosecutor-based Vivitrol program helps identify detox facilities, finds inpatient centers for those with dual-diagnoses or a need for additional stability, support, or local outpatient services. More importantly, a program based out of a prosecutor's office allows for treatment of witnesses, unindicted parties, parents working with child protective services, and the community at large. There are essentially no limitations as to whom the office can assist.[14]

In addition, participants in the prosecutor-based Vivitrol program are treated the same whether they participate voluntarily or by court order. The individual meets with a coordinator to review the program's conditions and expectations. A date is then set for assessment of treatment, blood work, and an initial Vivitrol shot, anticipating that he or she will be able to move forward as planned.

The program coordinator ensures each participant is attending group meetings, individual counseling, and medical appointments. Further, the coordinator works with participants on developing other life skills as necessary, including education and employment.

Some participants have had success in as few as nine months while others have exceeded two years of treatment. The use of Vivitrol is merely the vehicle that helps reduce opioid use while counseling is used to develop the skills to overcome the addiction.

Implementing a prosecutorial-based Vivitrol program relies on building relationships with local treatment providers and program referral sources. Successful drug treatment also often relies on funding from the Affordable Care Act and Medicaid expansion; forfeiture funds can also be used to help establish the program.

The Vivitrol Program should receive referrals through courts, probation services, child protective services, and the public. After successful completion of the program, there is a graduation ceremony where friends and family can recognize the journey and hard work completed.

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[13] When determining a proper governmental office, agency or non-profit organization to administer the program, a prosecutor must first ensure that the legislative framework within the jurisdiction permits the prosecutor to actively participate without creating potential civil liability.

[14] Limiting prospective patients to Vivitrol will reduce the pool of patients who can enter the program. For example, Vivitrol requires that a patient be completely detoxed before first use. Once appropriately initiated, studies have shown both buprenorphine and Vivitrol to be equally safe and effective. *Comparative effectiveness of extended-released naltrexone versus buprenorphine-naloxone for opioid relapse prevention (X:BOT): a multicenter, open-label, randomized controlled trial, Lee, Nunez, Jr., et. al., National Institute of Drug Abuse (NIDA), November 14, 2017.*

We have taken different approaches in dealing with people with substance use disorder and there will be continued debate about what works best. While some local prosecutor offices are able to administer Vivitrol programs from within their own offices, at a minimum, there should be a community-based Vivitrol program to provide an additional opportunity for prosecutors to divert individuals to get the treatment they need. These programs give users, their families, and our communities an excellent opportunity to address these serious problems in a comprehensive, workable manner.

B. Use Peer Recovery Specialists

The use of Certified Peer Recovery Specialists[15] is an essential component to combatting the heroin and opiate epidemic. Certified Peer Recovery Specialists (CPRS) are individuals in long-term substance abuse recovery who have received training to mentor individuals suffering from addiction with the goal of navigating the individual to a path of recovery. The CPRS training focuses on advocacy, ethics, mentoring, and recovery wellness support. Jurisdictions that use Peers have seen successful interventions where addicted individuals, because of the role the Peer plays, seek treatment and escape the constraints of addiction.[16]

Peers are often successful in accomplishing an intervention with an active drug user because of their shared life experiences. The Peer has a natural ability to build trust and develop a rapport with an individual who is actively using opiates because the Peer has previously made the journey from sickness to sobriety. After a successful intervention, the Peer can act as a navigator to assist the patient in accessing appropriate care. Successful Peer-centered interventions break the cycle of addiction to save lives and reduce associated crime in jurisdictions.

Peer Recovery Specialists work in partnership with prosecutors and local law enforcement to serve the community in different ways. One successful way is dispatching a Peer after law enforcement or emergency medical services (EMS) administration of live-saving naloxone. The Peers respond to the emergency department of the treating hospital and meet with the patient who just received a second chance at life. The Peers initiate a conversation with the patient, using their training and common experience, and steers the patient into treatment. This method represents a partnership

[15] A Certified Peer Recovery Specialist (CPRS) is credentialed after attending a 46-hour course, 500 hours of field work and passing a comprehensive exam for international reciprocity. The CPRS training provides people in long-term recovery with skills and knowledge needed to guide, mentor and support anyone who would like to enter into or sustain long-term recovery from substances. The CPRS is not a clinical practice credential but prepares participants to act as a skilled Peer Recovery Specialist in a wide variety of settings including treatment centers, hospitals, recovery centers, and faith-based organizations. A CPRS does not work independently but rather under the supervision of a community-based recovery center like CARES-NJ, (CARESNJ.ORG).

[16] In the first six (6) months of utilizing Peers in Morris County, New Jersey, 73% of patients approached by a Peer agreed to meet with a Peer and of that treated number, 42% entered substance abuse treatment and 58% agreeded to work with a CPRS on a recovery path.

among law enforcement, hospitals, and a community-based recovery center that provides the CPRS.

Peers can also be deployed directly to police departments and fire departments when individuals suffering from a substance abuse disorder seek assistance at these locations. In these instances, the participating agency will request that a Peer respond to the agency to initiate a recovery plan with the patient. This type of program facilitates medical intervention, access to treatment, and recovery support for those most at need in the community.

Certified Peer Recovery Specialists need to be available to every community in our country. Appropriate funding, through grants and other appropriations, are essential to train and fund Peer response in our communities.

C. Address Abuses in the Sober Home Industry by Clarifying the ADA and FHA

Sober homes (also known as "recovery residences") are a communal living space where residents usually attend outpatient rehab at a nearby facility. The best of these homes are the ones you never even notice are amongst you. The worst degenerate into flophouses, where unscrupulous landlords exploit people with substance use disorder for money or sex and encourage relapse over recovery.

The Americans with Disabilities Act of 1990 (ADA) requires state and local governments, including Homeowner Associations, to provide "reasonable accommodations" to individuals with disabilities, including recovering addicts who are not currently using drugs. In recent years, the cities of Newport Beach, California, and Boca Raton, Florida had to pay millions of dollars to sober home owners after city ordinances improperly regulated them in violation of the ADA.

Fearful of a similar fate, state and local governments have been reluctant to regulate sober homes, which means no mandatory registrations, certifications, or inspections.

Thus, the well-appointed recovery residence that's owned by a humanitarian to help individuals recovering from a substance use disorder transition back into society is protected by the ADA. But so is the con artist's co-ed dorm that stuffs nine individuals into three bedrooms without any standards or supervision, while receiving kickbacks from corrupt treatment providers.

That's why Congress should urge the U.S. Department of Justice (DOJ) and the U.S. Department of Housing and Urban Development (HUD) to issue a new Joint Statement on the ADA and the Fair Housing Act (FHA) to allow local governments to uphold national standards and best practices in sober homes for the protection of residents in recovery. The DOJ and HUD issued

such a clarification back in November 2016, but their joint statement was weak and ambiguous, and only added to the confusion.

In addition, Congress should pass H.R. 5100, the Recovery Home Certification Act of 2018, sponsored by Rep. Steve Knight (R-CA) and Rep. Anna Eshoo (D-CA), which would establish quality standards for sober homes.

D. Promote Aftercare and Follow-Up Services after an Overdose

Individuals recovering from substance abuse are at the highest risk of relapse for the first three to six months after completing a treatment program.[17] This is often because residential or full-time treatment programs make it difficult to acquire substances and reduce the temptations to use, but once out of the program, availability and temptation return. It is therefore unsurprising that relapse is less likely to occur when individuals receive aftercare, particularly when they receive follow-up contacts from trained counselors, nurses, and/or case managers.

While there are increased costs associated with providing follow-up services, programs that integrate aftercare are substantially more cost effective.[18] Studies have shown that a more effective approach is to provide longer, decelerated care: a recovery over 12 months has proven cheaper and more successful than an unending series of intensive short-term inpatient stays followed by brief, intensive outpatient treatment.[19]

Accordingly, to reduce the likelihood of recidivism and to raise the cost-effectiveness of treatment programs, we recommend treatment programs include 12 months of follow up in which trained personnel contact participants to check on progress, probe for potential relapse, offer advice and encouragement, and recommend further treatment if necessary.[20]

E. Amend the ACA to Fix Insurance Abuses that Plague the Treatment Industry

Today, big money in the drug treatment industry often comes through failure. Together, the Affordable Care Act (ACA) and the Mental Health Parity and Addiction Equity Act of 2008 ensure that drug relapse is always covered as an essential health benefit and cannot be excluded due to a pre-existing condition, and that children remain on their parents' policies

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[17] J.R. McKay, *Is there a case for extended interventions for alcohol and drug use disorders?* 100 ADDICTION 1594 (2005); G.A. Marlatt, *Relapse prevention: Theoretical rationale and overview of the model*, *in* RELAPSE PREVENTION 3–70 (G.A. Marlatt & J.R. Gordon, Eds., 1985).

[18] S.M. Carey *et al., What works? The 10 key components of Drug Court: Research-based best practices,* 8 *Drug Ct. Rev.* 6 (2012).

[19] https://www.ncbi.nlm.nih.gov/m/pubmed/20669601/; https://www.drugabuse.gov/sites/default/files/podat_1.pdf

[20] J.R. McKay, *Continuing care research: What we have learned and where we are going*, 36 *J. Substance Abuse Treatment* 131 (2009).

until age 26. This has provided a financial incentive for rogue providers to keep patients of all ages in a cruel cycle of relapse. Meanwhile, good providers who always seek sobriety grow frustrated as patients are poached away by unethical and ineffective programs with promises of free rent and other illegal gifts.

The ACA should replace its current fee-for-service reimbursement model for private drug rehabilitation to an outcome-based reimbursement model, similar to the current ACA reimbursement model for Medicare services at hospitals. An outcome-based reimbursement model would incentivize recovery rather than relapse; encourage success rather than failure. The best recovery centers would be rewarded while shuttering rogue operators who give false promises and illicit benefits to patients, then siphon precious resources into treating and then encouraging repeated relapses.

Working with insurance companies to reform the current fee-for-service model would improve patient outcomes. Substance use disorder is often a chronic and persistent illness, yet private insurance traditionally pays for unlimited cycles of short-term, acute rehab with only about a 10 percent success rate.[21] Studies have shown that a more effective approach is to provide longer, decelerated care: a recovery over 12 months has proven cheaper and more successful than an unending series of intensive 7- to 21-day inpatient stays followed by intensive outpatient treatment for four to six weeks, all marked by over-testing and overbilling.[22]

V. Conclusion

With the opioid epidemic now responsible for approximately 136 deaths per day,[23] significant action must be taken to address this unprecedented epidemic. The mission of prosecutors is to protect the communities we serve, and therefore implementing the proposed aspects of this document will help us achieve this goal. NDAA takes the position that changes need to be made to the ways in which prosecutors try overdose related cases through a greater focus on prevention and treatment and alterations to existing enforcement policies.

This document provides a roadmap for prosecutors throughout the country and important proposals for local, state and federal policymakers. The NDAA stands ready to assist our partners in all levels and roles of government, today and always.

[21] https://www.centeronaddiction.org/addiction-research/reports/addiction-medicine-closing-gap-between-science-and-practice.
[22] https://www.ncbi.nlm.nih.gov/m/pubmed/20669601/; https://www.drugabuse.gov/sites/default/files/podat_1.pdf.
[23] https://opioidinstitute.org/opioid-overdose-statistics/.