State Approaches to Addressing the Overdose Epidemic: Public Health Focus Needed

Corey Davis, Traci Green, Lindsay LaSalle, and Leo Beletsky

The overdose crisis, which claimed the lives of over 72,000 Americans in 2017 alone, is an ongoing public health emergency.[1] Opioids, often in combination with other drugs, were responsible for nearly 48,000 of these deaths — a six-fold increase over the past two decades.

While the federal government has taken some steps to increase access to evidence-based care for people with substance use disorders (SUD) including opioid use disorder (OUD), the overall federal response to the crisis has been disorganized and under-funded.[2] In the absence of strong federal leadership, states have adopted a number of policy responses to the ongoing epidemic of opioid-related harm. Some of these efforts facilitate evidence-based prevention and treatment, as in the proliferation of state laws increasing access to the overdose reversal medication naloxone and the reversal of the longstanding federal ban on funding for syringe service programs.[3] However, other state actions are likely to be net negatives for public health and health equity.

Ineffective and Counterproductive State Policies

States are increasingly adopting two approaches that are neither evidence-based nor equity-focused. The first, drug-induced homicide statutes, criminalize delivering drugs that contribute to overdose death. Nearly half of US states now have such laws, and in many others prosecutors seek a similar outcome by deploying existing murder or manslaughter charges. Though used relatively sparingly when they were introduced at the height of the war on drugs in the 1980s, these laws are increasingly being employed against individuals involved in drug-related deaths. While exact numbers of drug-induced homicide prosecutions are unknown, they appear to be increasing: in 2011 there were 363 unique news articles about individuals being charged with or prosecuted for drug-induced homicide, while by 2016 this number had increased by nearly 225% to 1,178.[4]

These numbers likely undercount the true number of such actions, which are pursued in states throughout the country. Since 2011, prosecutors in Wisconsin, Ohio, Illinois, and Minnesota have been the most aggressive in bringing drug-induced homicide cases, although use of such charges has rapidly expanded in such diverse states as New Jersey, New York, Louisiana and Tennessee as well.[5] Although many law enforcement officials appear to believe that these efforts deter illicit drug activity, research consistently shows that neither increased arrests nor increased severity of criminal punishment for drug law violations result in lower levels of either drug sales or drug use.[6]

Rather, the behavior that is likely to be deterred is the life-saving seeking of medical assistance by those who are present at an overdose.[7] In many cases, the person charged with drug-induced homicide is not a drug

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dealer as popularly envisioned, but rather a friend, acquaintance, or low-level seller supplying drugs to support their own drug dependence. Although many states have passed overdose Good Samaritan laws designed to encourage witnesses to seek help in an emergency, these laws are limited to low-level crimes and do not provide protection from homicide charges.[8] Increased criminalization of people who use and sell drugs increases drug-related harm, the very problem public officials claim to be trying to address. Instead, these prosecutions increase stigma, drive people away from needed care, and exacerbate the racial disparities now synonymous with other drug war tactics. Indeed, preliminary evidence suggests that the median sentence for drug-induced homicide charges is approximately double for defendants of color compared to white defendants.[9]

As opioid-related harm continues to pose a mounting public policy challenge, access to evidence-based, affordable, and patient-centered treatment remains all too sparse. Even at a time of extreme vulnerability, such as directly following non-fatal opioid overdose events, only one in four individuals report any engagement with evidence-based treatment.[10] Even though treatment on demand remains unavailable in most areas of the country, states are rapidly adopting a second form of misguided and ineffective laws: civil commitment statutes that force people with OUD to in-patient "treatment" facilities. Between 2015 and 2018, 25 jurisdictions either expanded existing laws or adopted new ones that authorize civil commitment for people with SUD, and the number of civil commitment petitions doubled nationwide between 2010 and 2017.[11]

The care provided in such custody often fails to meet basic standards for evidence-based treatment.[12] Aside from the obvious civil liberty concerns, patients committed under these systems face dramatically higher risk of relapse and overdose than those re-entering the community from voluntary treatment.[13] For instance, according to Massachusetts Department of Public Health data, patients re-entering the community from a period of civil commitment for SUD face 2.2 times the risk of fatal overdose compared to those completing a course of voluntary treatment, and a recent study reported that one third of people with SUD who were civilly committed in MA used drugs on the day they were released.[14] These data echo international evidence that compulsory treatment is a source of risk, rather than risk reduction.[15]

The involuntary commitment system is particularly problematic in light of pervasive barriers in accessing on-demand treatment voluntarily and at no cost. In contrast to the convoluted substance use treatment care system, involuntary treatment is typically provided at no charge to the individual, on demand, and requires no navigation or insurance coverage. To effectively and equitably address SUD, we must prioritize and adequately resource voluntary treatment, making coerced treatment an option of rare last resort.

While it has yet to be proven that this approach will effectively scale in larger states with more disjointed systems of incarceration, there is little reason to think that, given sufficient funding and commitment, evidence-based treatment could not be provided to all who need it, including those currently experiencing incarceration. Indeed, failure to provide MAT to incarcerated individuals is increasingly being recognized as a violation of federal law.

Evidence-Based State Policies

One state has taken a more evidence-based, equity-focused approach, with extremely promising results. The few weeks after leaving incarceration are an extremely high-risk period for overdose for people with OUD.[16] In 2015, an expert advisor-led strategic plan recommended to the Rhode Island Governor that the state embark on a treatment strategy that would create an equal-opportunity, patient-centered model of medication-assisted treatment (MAT) in the state's unified prison and jail system.[17] The plan recommended that individuals who enter the system be maintained on MAT if they are receiving treatment when they are incarcerated, and to start inmates on MAT if they are interested and medically indicated for receiving medication treatment.

Although several states have introduced legislation to adopt similar initiatives, no state-wide programs

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exist yet in the United States. However, the expert team pointed to numerous European and Australian studies that have demonstrated positive outcomes associated with incarceration-related MAT, including reduction in injection drug use, adoption of sterile syringe use, and reductions in suicides during incarceration and overdose deaths post-release.[18] The Rhode Island legislature, in concert with the Governor, invested 2 million state dollars to implement the proposed plan, creating a statewide MAT program to serve all incarcerated individuals who met established criteria indicating clinical need and consented to being treated. The results were astounding: within just 6 months of full-scale implementation, there was a 61% reduction in past 12 month incarceration-associated overdose deaths and an overall 12% reduction in overdose mortality across the state.[19]

While it has yet to be proven that this approach will effectively scale in larger states with more disjointed systems of incarceration, there is little reason to think that, given sufficient funding and commitment, evidence-based treatment could not be provided to all who need it, including those currently experiencing incarceration. Indeed, failure to provide MAT to incarcerated individuals is increasingly being recognized as a violation of federal law. Several cases demanding access to MAT within prisons have recently been settled favorably, and the Massachusetts US Attorney's Office is investigating the failure of some jails to provide MAT as a violation of the Americans with Disabilities Act.[20] However, for the near future it will be incumbent on states and municipalities to choose a public health-oriented approach over one that favors increased criminalization.

Conclusion

In this time of crisis, some states may be inclined to double down on failed punitive approaches to the epidemic of overdose-related harm, even when those strategies have shown no evidence of effectiveness or are known to cause harm. But this is not the only path forward, and is certainly not the best. Overdose is a public health crisis, and it needs to be met by public health actors utilizing public health tools focused on public health outcomes. States have a choice of how to spend the public's resources, and should choose to expend those resources on the evidence-based, equity-focused, public health-driven interventions that are most likely to improve and save lives.

Note

The authors have nothing to disclose.

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