Prescription Opioids and Heroin Epidemic in Georgia
- A White Paper

2017 (Updated: December, 2017)
Executive Summary

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Introduction

The Substance Abuse Research Alliance (SARA) is a program of the Georgia Prevention Project (GPP). SARA initiated this study in April 2016 as the organization's first collaborative project with a primary goal to assist the Georgia State Senate Study Committee on Opioids and Heroin in its work.

With more than 110 participants, SARA includes researchers and practitioners with a wide spectrum of experience in substance misuse work. SARA participants represent the following organizations:

- Applied Research Services, Inc.
- Augusta University
- Carter Center Mental Health Program
- Centers for Disease Control and Prevention (CDC)
- Emory University – multiple departments and programs
- Georgia Council on Substance Abuse
- Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD)
- Georgia Department of Public Health (DPH)
- Georgia Prevention Project
- Georgia Southern University
- Georgia State University – multiple departments and programs
- Kennesaw State University Center for Young Adult Addiction and Recovery
- Lab Solutions, Inc.
- Mercer University School of Medicine
- Medical Association of Georgia Foundation (MAGF)
- Morehouse School of Medicine – multiple departments and programs
- Parkaire Consultants, Inc.
- Partnership for Drug-Free Kids
- Skyland Trail
- The Council on Alcohol and Drugs
- University of Georgia – multiple departments and programs

SARA believes that opioid and heroin use in Georgia seriously threatens the health, prosperity and general well-being of Georgians throughout the state, across almost all sectors of life and work.

Like Georgia, several other states struggle over how to ameliorate the suffering and death rates associated with prescription and illicit opioids and heroin, how to prevent citizens from intentional or unintentional misuse of these substances and how to intervene effectively to treat opioid use disorder and promote long-term recovery.

SARA stands ready to assist the Georgia Legislature, statewide elected officials, and State of Georgia agencies in any way that we can.

What you need to know now

**The U.S.**

- **>400 percent** increase in prescription opioid overdose (OD) deaths from 1999 to 2015
- **11.5 million** Americans who reported misusing prescription pain relievers in 2016
- **200 percent** increase in synthetic opioid (e.g., fentanyl) overdose deaths in 2016

**Georgia**

- **1,426** total overdose deaths in 2016
- **982** opioid drug overdose deaths in 2016
- **23.5 percent** increase in opioid drug overdose deaths from 2014 to 2016
Executive Summary

Georgia’s prescription and illicit opioid and heroin problem threatens the well-being of every Georgian at every socio-economic level and in every geographic region of the state.

This study by the Substance Abuse Research Alliance (SARA) seeks to educate public officials and the general public about the opioid epidemic that is devastating communities across the country and here in Georgia. We answer key questions and also offer a proposed legislative agenda to consider as Georgia legislators and state and local decision makers move to address this pervasive and growing challenge in our lives and communities.

What Are Opioids? How Do They Affect The Human Body?

Opioids are a class of drugs that act on the body’s opioid receptors including natural, semi-synthetic and synthetic opioids. Opioids include drugs such as morphine, which are derived from the resin of the opium poppy, semi-synthetic opioids such as hydrocodone and oxycodone, partial opioids such as tramadol, synthetic opioids such as fentanyl and methadone used pharmaceutically, and others such as carfentenil used in veterinary medicine for large animals, as well as U-47700 and manufactured fentanyl variants produced for illicit sale.

Opioids are used medically to relieve moderate to severe pain, but may also be used for other conditions – for example, to suppress cough, to treat diarrhea and to treat opioid use disorder. Until the late 1990s when they began to be used for chronic pain associated with conditions such as back pain or arthritis, opioids we primarily used to treat pain associated with cancer, postsurgery, or accident-related injuries. While opioids provide pain relief, they also cause physical dependence, respiratory depression, euphoria, reduced intestinal motility and other effects. Since these pharmacologic effects block pain and produce euphoria, opioids have a high potential for misuse.

Use of opioids for more than a short period of time leads to tolerance and physical and psychological dependence. This means opioid users must take larger doses of opioids over time to achieve the same effect. Additionally, persons using opioids should not stop taking these drugs abruptly, or they will experience withdrawal symptoms such as agitation, anxiety, muscle and bone pain, insomnia, vomiting or diarrhea. Withdrawal symptoms occur when the amount of opioids used decreases or stops.

How Did We Get To A U.S. Opioid Epidemic?

Opioid overdoses – including prescription opioids and heroin – kill 91 people daily. This number has quadrupled since 1999. In 2015 alone, opioids were involved in 33,091 deaths. Based on provisional CDC reporting, this number will increase for 2016 to over 40,000. CDC reports an overall increase in overdose deaths from 52,623 in 2015 to 63,940 in 2016, driven largely by the rapid rise in overdose from synthetic opioids (e.g., fentanyl) (CDC, 2017).

Despite these staggering statistics, the number of prescriptions written for opioid analgesics remains three times as high as those written in 1999. Since 2010, however, opioid prescribing
rates and dosage leveled off and declined, while number of days’ supply continued to increase. Large differences exist at the county level across the U.S. with 6 times the per capita rate of prescriptions in high prescribing counties than in low prescribing counties. Higher prescribing U.S. counties were those with more non-Hispanic whites, smaller towns and cities, more arthritis and diabetes, and more unemployment and Medicaid enrollment.

In 2016, approximately 11.5 million Americans reported misusing pain relievers in the previous year, and approximately 948,000 Americans reported use of heroin (SAMHSA, 2017). The costs of this epidemic of prescription opioid overdose, abuse, and dependence are high, estimated at $78.5 billion in 2013 alone (Florence et al., 2016).

Who Is At Greatest Risk?
The highest rates of prescription opioid overdose deaths from 1999 to 2014 were among non-Hispanic whites and American Indian or Alaskan Natives, persons aged 25 to 54 and men. Rates of prescription overdose deaths are on the rise for women (Centers for Disease Control, CDC, 2016). Risk factors for prescription opioid misuse and overdose include doctor shopping (i.e., receiving overlapping prescriptions from multiple providers and pharmacies), taking high daily doses of prescription pain relievers, having mental illness or a history of substance misuse, being low-income and living in a rural area (CDC, 2016).

According to the CDC, people at highest risk for heroin addiction are those addicted to prescription opioid painkillers, cocaine, marijuana and/or alcohol; people 18 to 25 years of age living in large metropolitan areas and people without insurance or enrolled in Medicaid (CDC, R, 2015).

What Is The Impact Of Opioid Use In Georgia?
Similar to national trends, deaths related to opioid overdose continue to rise in Georgia. Recent data from the Georgia Department of Public Health indicate that deaths related to drug overdose are now almost equal to deaths due to motor vehicle crashes (Figure 1).

Opioids, primarily prescription pain relievers and heroin, are the main driver of drug overdose deaths. Of the 1,426 drug overdose deaths in 2016 in Georgia (GaDPH, 2017), 982 or 69 percent were due to opioid overdoses including heroin (Figure 2; GaDPH, 2017). Further, drug overdose deaths more than quadrupled between 1999 and 2016.

Prescription opioid overdose deaths in Georgia increased more than tenfold to 595 deaths, or a rate of 5.7 per 100,000 age-adjusted deaths, between 1999 and 2016 (GaDPH, 2017).
**Figure 1:**

Deaths Related to Drug Overdose and Motor Vehicle Crashes, Georgia, 2002-2016

Source: Georgia Department of Public Health, Office of Health Indicators for Planning, Death files.

**Figure 2:**

Number of Drug Overdose Deaths Related to Opioids including Heroin in Georgia, 2008-2016

Source: Office of Health Indicators for Planning (OHIP), Georgia Department of Public Health.
What Is The Cost Of Opioid Use And Misuse In Georgia And The U.S.?

The economic burden of prescription opioid overdose, misuse and disorders in the U.S. is estimated at $78.5 billion in 2013 with over one-third of this amount coming from increased health care and substance use treatment costs ($28.9 billion). The health care costs associated with opioid misuse in Georgia alone were estimated at $447 million in 2007 with estimated per-capita costs at $44 (Florence et al, 2016).

Hospitalizations related to opioid use and misuse in Georgia also have skyrocketed, from about 302,000 in 2002 to about 520,000 in 2012. Similarly, the cost of opioid-related inpatient care more than doubled during the same time period, rising to $15 billion in 2012. (Matthew V. Ronan and Shoshana J. Herzig (2016). "Hospitalizations Related To Opioid Abuse/Dependence And Associated Serious Infections Increased Sharply, 2002-12," Health Affairs 35, no.5:832-837; doi: 10.1377/hlthaff.2015.1424).

What Has Congress And The White House Done?

Four major pieces of federal legislation addressed substance use disorders (SUD) in the past decade:

1. The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 requires private group health plans with 50 or more employees and Medicaid-managed care plans that cover SUD treatment do so in a manner that is no more restrictive than coverage of other medical and surgical procedures. Parity requirements have not been extended to private plans in state health insurance exchanges and Medicaid expansion plans.

2. The Patient Protection and Affordable Care Act (ACA) of 2010 provides greater access to SUD treatment through insurance coverage expansions, inclusion of SUD treatment as an essential health benefit, enhanced parity, and opportunities to integrate SUD treatment and mainstream health care. MHPAEA and ACA complement each other with MHPAEA addressing parity, and ACA defining SUD as a chronic illness and including SUD treatment (and mental health disorder treatment) as an essential health benefit.

3. Signed into law on July 22, 2016, the Comprehensive Addiction and Recovery Act (CARA) of 2016 is the most comprehensive effort undertaken by Congress to address the opioid epidemic.

While it authorizes over $181 million each year in new funding to fight the opioid epidemic over the next 10 years, monies must be distributed annually through the regular appropriations process. CARA establishes a comprehensive, coordinated and balanced strategy through enhanced grant programs that would expand prevention and education efforts, while also promoting treatment and recovery. The bill passed the U.S. Senate in March 2016, by a vote of 94-1. The bill passed the U.S. House of Representatives in May 2016, by a vote of 400-5.

4. The 21st Century Cures Act was signed into law on December 13, 2016. While CARA authorized many harm reduction strategies including distribution of naloxone, it did not provide funding for these. 21st Century Cures Act included authorization of $1.1 billion dollars over two years for grants to states to address the opioid epidemic.

What Should Georgia Do?

After a careful review of recent recommendations from the National Safety Council and the National Governors Association, SARA proposes a legislative agenda for Georgia as briefly outlined below. SARA provides detailed recommendations in the body of this study.

In addition to the legislative agenda outlined below, SARA recommends that the State conduct a comprehensive needs assessment specifically related to the opioid crisis and develop both a strategic plan and an implementation plan to guide the State’s response to this epidemic.

(Ed. Update: In the spring and summer of 2017, the Georgia Department of Public Health (DPH) embarked on the process of creating a statewide strategic plan for addressing the prescription opioid and heroin epidemic in Georgia. SARA members have been active participants in assisting DPH with the planning process. SARA also believes that the top elected officials in the state, particularly the Governor, should ensure that all state agencies and departments give the highest possible priority to participation in implementing the plan. This White Paper was first published in January of 2017, prior to the convening and deliberations of the Georgia General Assembly – which considered and passed some of the recommendations in this report. Specifically, laws were passed that 1) increased access to naloxone and 2) strengthened the PDMP.)

Phase I – Georgia’s most urgent needs

1. Increase access to naloxone.

More than 1,400 Georgians die each year from prescription opioid and heroin overdoses. Many of these deaths could be avoided with the use of naloxone, an opioid antagonist medication that reverses opioid overdose without significant negative side effects. First responders, parents, schools, commercial establishments and other public serving organizations should have easy access to naloxone and should have training in how to administer the drug. (Ed. Update: The Georgia General Assembly enacted SB121 in the spring of 2017, making naloxone available over-the-counter. In recent months, the Georgia Department of Public Health – with assistance from the pharmacy associations in the state – has worked to ensure that naloxone is widely available in pharmacies.)

2. Improve access to opioid use disorder treatment including medication-assisted treatment (MAT), evidence-based behavioral therapies and recovery support services.

Anyone dependent on or addicted to prescription opioids or heroin should have access to the full range of opioid use disorder treatment services including mental health and substance use assessment, medically managed detoxification/withdrawal management, behavioral therapy, opioid replacement medications and recovery support services. These services should include support for: 1) families who have members in recovery; 2) community organizations that focus on recovery and 3) programs that focus on recovery.

3. Increase funding for substance misuse prevention programs.

The Georgia Legislature significantly reduced funding to DBHDD in 2010 for substance misuse prevention programs and administration. While DBHDD distributes and manages Federal substance misuse prevention funds, total State spending on substance misuse prevention within DBHDD currently is only $232,000 per year. Prescription drug education programs should target children ages 8 through 12 when they are most open to such education, teens, young adults and parents and fund new and innovative programs incorporating recovery-informed education. Education is also needed for seniors, women of reproductive age and other populations.

(continued next page)
4. Increase funding and improve mechanisms to address neonatal abstinence syndrome (NAS).

Some hospitals in Georgia are overwhelmed with infants born with NAS. The problem is on the rise, and these hospitals need significant assistance in treating and managing the care of these infants.

Moreover, health care providers need better education and training on how to deal with NAS. Our recommendations focus on three areas: 1) reducing incidence of NAS; 2) reducing NAS severity and optimizing health outcomes and 3) leveraging resources and reducing costs of NAS.

5. Strengthen the prescription drug monitoring program (PDMP).

While Georgia implemented important changes and enhancements to its PDMP during the 2016 legislative session, much work remains to be done. The PDMP helps track the writing and filling of prescriptions of controlled substances, particularly opioid-based painkillers. (Ed. Update: See extended detail elsewhere in the White Paper that describes the 2017 enhancements to the PDMP program. In its 2018 session, the Georgia General Assembly should consider budget allocations that give the Department of Public Health the ability to improve various technical aspects of the program.)

6. Prohibit exploitive schemes that take advantage of vulnerable and addicted citizens.

Law enforcement and addiction treatment professionals report that exploitive schemes operate in Georgia that take advantage of citizens with substance use disorders by promising to assist them with treatment in other states such as Florida and California. Operators of these schemes provide airplane tickets to targeted persons with substance use disorders in order to entice them to come to clinics in other states. These bad actors then claim cash “bounties” from clinic operators for delivering the patients to the clinics while also defrauding insurance providers. The clinics receive federal and/or state funds for treating the new patients. These treatments can be very short term or non-existent, leaving the patient still addicted and without funds to return home to Georgia.

Phase II – Comprehensive and systematic approaches for Georgia

1. Increase oversight of pain clinics.

Georgia passed the Pain Management Clinic Act in 2013. Consistent with the National Safety Council and the National Governor’s Association recommendations, Georgia should do two things: 1) require pain clinics to register with and use Georgia’s PDMP and 2) conduct an evaluation of the legislation to determine if it is being enforced and what impact it has had on opioid prescribing and overdose deaths. (Ed. Update: Under HB 249 passed in 2017, pain clinics are required to register with and use Georgia’s PDMP.)

2. Create standards for prescriber education.

The Georgia Composite Medical Board should mandate that a minimum of five of the 40 hours of required biannual credit hours focus specifically on the Georgia PDMP, pain management and guidelines for prescribing opioid medications for chronic pain and/or substance use disorders. Requiring additional hours in addiction and recovery education should also be explored by the
GCMB. (Ed. Update: In 2017, the Georgia Composite Medical Board implemented a requirement that prescribers complete two hours of continuing medical education (CME) on addiction, pain management and palliative care. The CMB intends for this to be a “one-time trial” requirement until the CMB can evaluate its impact and effectiveness.)

Longer term, Georgia should create a task force to address more detailed methods of educating all levels of health professionals on pain management and incorporating technology that integrates the PDMP more directly with patient electronic health records (EHR).

3. Create a recurring “blue-ribbon” commission on substance use and recovery.

The Georgia Legislature, in collaboration with the Governor’s Office, should create a recurring commission that convenes every three to four years to establish strategy and statewide goals, recommend appropriations and review progress on reducing substance misuse and expanding local systems of recovery supports and treatment services in Georgia. Regardless of how often the commission meets, an annual report should describe progress against goals.

SARA believes that the current State Senate Study Committee has been a valuable and well-managed process for addressing many substance use and misuse issues, and the recurring commission structure could be implemented as a simple extension and expansion of the current committee’s work, with new agenda items and expanded participation. Alternatively, the recurring commission could take the form of 1) a joint Senate-House Study Committee, 2) a Governor’s commission or 3) a privately run and funded commission.

We believe that while any of the above scenarios can be successful, the best structure would include maximum participation from key lawmakers, the Governor’s Office and the heads of certain state agencies. Non-profit organizations, for-profit companies and private individuals should also be included as members of the commission since they can also add great value to the commission’s goals and outcomes.

A recurring commission structure gives everyone an opportunity to review progress against goals, plan appropriations over multiple years and continually re-educate the participants about the issues associated with the subject matter.


Georgia received $11.8 million in 2017 to accomplish programs under 21st Century Cures Act. While it may be too late to make any substantive changes as to how these funds are spent in 2017 in Georgia, we believe that stakeholders should have a chance to provide input into how any future CARA funds or other federal funds are spent in the state. This proposed Georgia Advisory Council could operate as a committee of the “blue ribbon” commission.
The Georgia Prevention Project

The Georgia Prevention Project – SARA’s host organization – is a statewide not-for-profit effort that focuses on reducing the use of dangerous substances among teens and young adults. We accomplish our work through awareness campaigns, educational programming and strategic partnerships with national and community-based organizations.

The Georgia Prevention Project evolved from the Georgia Meth Project founded in 2009. Created by the Siebel Foundation, the national Meth Project effort won more than 45 national and international awards for its hard-hitting educational campaigns that helped reduce first-time meth use by more than 65 percent in its first two years in Montana. Subsequent launches in Idaho and Wyoming saw similar results and led to the addition of Hawaii, Colorado and Georgia as part of the Meth Project family.

In Georgia, the campaign led to significant changes in teens’ perceptions of risk associated with meth. During the media portion of the campaign of 2010-2012, the Georgia Meth Project ran more than 26,000 radio spots, placed 23,000 television ads and placed more than 588 billboards all over Georgia. This saturation effort significantly changed teens’ perceptions of risk about the drug and produced results very similar to the Montana program.

Riding the momentum of the successful “Not Even Once” meth prevention campaign, the Georgia Prevention Project launched in 2014 capitalizing on the Meth Project techniques and expanding its focus to include prescription drug misuse and heroin use.

Through its Teacher Substance Abuse Training Program and Teen Advisory Council (TAC) peer-to-peer education, GPP works to ensure that large numbers of Georgia teens gain in-depth knowledge of the risks associated with the misuse of prescription drugs and the misuse of dangerous substances such as methamphetamine and heroin.

On nine Georgia college campuses, GPP administers its College Prevention Program (CPP) - a program funded by the Georgia Department of Behavioral Health and Developmental Disabilities Office of Behavioral Health Prevention (DBHDD - OBHP). The CPP works to correct misperceptions, attitudes, and behaviors of college students towards prescription drug abuse, to enhance access to prevention resources, and to promote drug-free lifestyles.

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Acknowledgments
Many SARA participants contributed to the hard work of writing and editing this report. We should all be grateful for the efforts of the following individuals:

Dr. Amanda Abraham
Dr. Lydia Aletraris
Dr. Moya Alfonso
Bianca Anderson
Dr. Amy Baxter
Amy Benson
George Braucht
John Bringuell
Lylli Cain
Neil Campbell
Dr. Hannah Cooper
Dr. Laura Edison
Emily Eisenhart
Dr. Karen Howell
Dr. Jayani Jayawardhana
Dr. Aaron Johnson
James Langford
Dr. Brigitte Manteuffel
Kaitlin Merchen
Mopdog Creative + Strategy
Lori Murphy
Cassandra Price
Dr. Gregg Raduka
Vlad Schorstein
Lerissa Smith
Brennan Swing, Mohawk Industries, Inc.
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I. Opioid Overview

1. What opioids are

Opioids are a class of drugs that act on the body’s opioid receptors including natural, semi-synthetic and synthetic opioids. Natural opioids include drugs such as

- **morphine**, derived from the resin of the opium poppy
- **semi-synthetic opioids** such as hydrocodone and oxycodone
- **synthetic opioids** such as fentanyl and methadone

Opioids are often used medically to relieve moderate to severe pain, but can also be used, for example, to suppress cough, treat diarrhea and even treat opioid use disorder. Opioids are effective for treating severe pain such as that associated with cancer, post-surgery or accident-related injuries. While opioids provide pain relief, they also cause physical dependence, respiratory depression, euphoria, reduced intestinal motility and other desired and undesired effects. Since these pharmacologic effects block pain and cause euphoria, opioids have high potential for misuse.

2. How opioids affect the human body

Opioid drugs mimic the body’s natural response to pain by stimulating the body’s opioid receptors, most prominently the Mu (µ) receptors. Mu receptors account for most of the effects of opioids and are primarily located in the brain, spinal cord, peripheral nervous system and intestinal tract.

By stimulating the Mu receptors, opioids reduce the perception of pain by slowing down and blocking pain signal transmission to the brain, while also triggering the release of dopamine, a neurotransmitter used in the brain’s pleasure or reward system. When activated, dopamine produces a pleasurable, often euphoric feeling, which contributes to opioid misuse, as people seek to repeat these sensations.

The use of opioids for more than a short period of time (e.g., a few days) leads to tolerance, physical and psychological dependence. This means opioid users must take larger doses of opioids over time to achieve the same effect. Additionally, once dependent, opioid users cannot stop taking these drugs abruptly or they will experience withdrawal symptoms including agitation, anxiety, muscle and bone pain, insomnia, vomiting or diarrhea. Withdrawal symptoms occur when opioids use decreases or stops.

“Substance use disorders are a chronic medical illness characterized by clinically significant impairments in health, social function and voluntary control over substance use (not a moral failing or character flaw),” according to Surgeon General’s Report, Facing Addiction in America, 2016.
3. The U.S. Opioid epidemic

In 2015, overdose deaths associated with prescription and illicit opioids increased to 33,091 from 28,647 in 2014 (CDC), equal to 91 people on average who died each day in 2015 in the U.S. from opioid overdoses. Based on provisional reporting for 2016 (CDC, 2017), this number increased by more than 17 percent during 2016. Over the past 15 years, overdose deaths related to opioids have reached epidemic proportions (Rudd et al., 2015). The rate of opioid-related overdose deaths has increased over 400 percent since 1999. Between 2010 and 2015, deaths related to heroin more than quadrupled to 12,990 (National Center for Health Statistics). Preliminary data indicate there were 15,446 overdose deaths related to heroin in 2016. Preliminary data also indicate a five-fold increase in overdose deaths involving synthetic opioids (excluding methadone) which increased from 3,105 in 2013 to 20,000 in 2016. Illicit fentanyl is the primary driver of this rapid increase. Deaths involving fentanyl analogs also increased during this time period.

Despite these staggering increases in deaths related to opioid overdose, the number of prescriptions written for opioid analgesics continued to increase until 2012 (Volkow et al. 2014). According to a 2015 report, sales of opioid analgesics quadrupled from 1999 to 2010 (Frenk et al., 2015. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3955827/). The number of written prescriptions for opioid medications rose from 43.8 million in 2000 to a peak of 259 million in 2012 (National Institutes of Health, 2014; CDC, 2016). Since then, opioid prescribing has declined to 214.9 million prescriptions in 2016 (CDC, 2017).

Misuse of prescription opioids and heroin use is also high. In 2016, approximately 11.5 million Americans reported misusing pain relievers in the previous year compared to 12.5 million in 2015, and 1.8 million Americans reported having a pain reliever drug use disorder (SAMHSA, 2016). In the same year, approximately 948,000 Americans reported using heroin and about 626,000 Americans met diagnostic criteria for a heroin use disorder (SAMHSA, 2017). The cost of prescription opioid overdose, abuse, and dependence is high, estimated at $78.5 billion in 2013 alone (Florence et al., 2016).

The highest rates of prescription opioid overdose deaths from 1999 to 2014 were among non-Hispanic whites and American Indian or Alaskan Natives, persons aged 25 to 54 and men. The rates of prescription opioid overdose deaths are on the rise for women (CDC, 2016).

Studies show a shift in the demographics of persons using heroin in recent years. In the 1960s, those initiating heroin use were predominantly young men from minority groups living in urban areas. Now those initiating heroin use tend to be somewhat older (mean age of first use is 22.9 years compared to 16.5 years), more concentrated in rural and suburban areas and white (Cicero et al., 2014).

According to the CDC, people at highest risk for heroin addiction are non-Hispanic, white, male, addicted to prescription opioid painkillers, cocaine, marijuana or alcohol, 18 to 25 years of age, living in large metropolitan areas, without insurance or enrolled in Medicaid (CDC, 2016 http://www.cdc.gov/vitalsigns/heroin/).

Risk factors for prescription opioid misuse and overdose:

- doctor shopping (i.e., receiving overlapping prescriptions from multiple providers and pharmacies)
- taking high daily doses of prescription pain relievers
- having mental illness or a history of substance abuse
- being low-income
- living in a rural area

(CDC, 2016).
4. Impact of opioid use

a. Overdose deaths in Georgia

Opioid overdose death rates including heroin in Georgia increased significantly – from 1.4 to 8.8 per 100,000 persons between 1999 and 2015. This rate of increase was greater than that of the U.S., which has shown an increase in opioid overdose death rates from 1.4 to 5.9 per 100,000 persons during the same time period. Opioid overdose death rates increased further to 9.5 per 100,000 in Georgia in 2016. Even more alarming, recent data from the Georgia Department of Public Health indicate that deaths related to drug overdose surpassed deaths due to motor vehicle crashes in 2014, and increased by 12 percent through 2016.

Figure 1:

Deaths Related to Drug Overdose and Motor Vehicle Crashes, Georgia, 2002-2016

Source: Georgia Department of Public Health, Office of Health Indicators for Planning, Death files.

Opioids, primarily prescription pain relievers and heroin, are the main driver of drug overdose deaths. Of the 1,426 overdose deaths in 2016 in Georgia (GaDPH, 2017), 982 – or 68.8 percent – were due to opioids.

Further, the state experienced a statistically significant 10.2 percent increase in the overdose death rate from 2013 to 2014 (CDC, 2016), and a tripling of overdose deaths between 1999 and 2016, with a statistically significant increase of 10.2 percent from 2013 to 2014. There was a 11.9 percent increase in the drug overdose death rate in Georgia from 2014 to 2016.
While 47 prescription opioid overdose deaths occurred in 1999 in Georgia, resulting in a rate of 0.6 per 100,000 age-adjusted deaths, the most recent available data show a more than tenfold increase to 595 deaths, or a rate of 5.7 per 100,000 age-adjusted deaths, in 2016.

5. Economic costs of opioid misuse in Georgia and the United States

The economic burden of prescription opioid overdose, misuse and dependence in the U.S. was estimated at $78.5 billion in 2013 with over one-third of this amount coming from increased health care and substance use treatment costs ($28.9 billion) (Florence et al., 2016). The health care costs associated with prescription opioid overdose, abuse, and dependence in Georgia alone were estimated at $447 million in 2007 and the estimated per-capita costs were $44 in Georgia.

Given the increase in overdose deaths and use of opioids in Georgia since 2007, some experts have estimated a rise in those costs of at least as 80 percent since that time. Those same experts agree that the state needs to monitor the escalation. Hospitalizations related to opioid use and dependence skyrocketed nationally from about 302,000 to about 520,000 in 2012. Similarly, the cost of opioid-related inpatient care more than doubled during the same time period, rising to $15 billion in 2012 (Ronan & Herzig, 2016).
What has Congress and the White House done?


1. The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 requires private group health plans with 50 or more employees and Medicaid-managed care plans that cover SUD treatment do so in a manner that is no more restrictive than coverage of other medical and surgical procedures. Parity requirements have not been extended to private plans in state health insurance exchanges and Medicaid expansion plans.

2. The Patient Protection and Affordable Care Act (ACA) of 2010 provides greater access to SUD treatment through insurance coverage expansions, inclusion of SUD treatment as an essential health benefit, enhanced parity, and opportunities to integrate SUD treatment and mainstream health care. MHPAEA and ACA complement each other with MHPAEA addressing parity, and ACA defining SUD as a chronic illness and including SUD treatment (and mental health disorder treatment) as an essential health benefit.

3. Signed into law on July 22, 2016, the Comprehensive Addiction and Recovery Act (CARA) of 2016 is the most comprehensive effort undertaken by Congress to address the opioid epidemic.

While it authorizes over $181 million each year in new funding to fight the opioid epidemic over the next 10 years, monies must be distributed annually through the regular appropriations process. CARA establishes a comprehensive, coordinated and balanced strategy through enhanced grant programs that would expand prevention and education efforts, while also promoting treatment and recovery. The bill passed the U.S. Senate in March 2016, by a vote of 94-1. The bill passed the U.S. House of Representatives in May 2016, by a vote of 400-5.

Key Provisions of CARA

- **Expand** prevention and educational efforts—particularly aimed at teens, parents and other caretakers and aging populations—to prevent the use of methamphetamines, opioids and heroin, and to promote treatment and recovery
- **Expand** the availability of naloxone to law enforcement agencies and other first responders to help in the reversal of overdoses to save lives
- **Expand** resources to promptly identify and treat incarcerated individuals suffering from substance use disorders by collaborating with criminal justice stakeholders and by providing evidence-based treatment
- **Expand** disposal sites for unwanted prescription medications to keep them out of the hands of our children and adolescents, and reduce the risk of medication sharing by adults
- **Launch** an evidence-based opioid and heroin treatment and intervention program to expand best practices throughout the country
- **Launch** a medication-assisted treatment (MAT) and intervention demonstration program
- **Strengthen** prescription drug monitoring programs (PDMP) to help states monitor and track prescription drug diversion and to help at-risk individuals access services
4. The 21st Century Cures Act was signed into law on December 13, 2016. While CARA authorized many harm reduction strategies including distribution of naloxone, it did not provide funding for these. 21st Century Cures Act included authorization of $1.1 billion dollars over two years for grants to states to address the opioid epidemic. The funds are to be used to “supplement activities pertaining to opioids undertaken by the State agency responsible for administering the substance abuse prevention and treatment block grant,” such as:

- Improving prescription drug monitoring programs (PDMPs)
- Implementing and evaluating prevention activities
- Training for health care providers on safe opioid prescribing, pain management, recognizing substance use disorders, referral to treatment and overdose prevention
- Supporting access to health care services
- Other public health-related activities

The Substance Abuse and Mental Health Services Authority (SAMHSA) released a funding announcement, State Targeted Response to the Opioid Crisis Grants (STR Grants), on December 14, 2016, and awards were made on April 19, 2017. Award summaries of each state’s approach can be found here: https://www.samhsa.gov/sites/default/files/grants/pdf/other/ti-17-014-opioid-str-abstracts.pdf.


The Commission has more than 56 recommendations. A few of the key ones are as follows:

- Increasing treatment capacity by granting waiver approvals for all 50 states to eliminate barriers to treatment resulting from the Institutes for Mental Diseases (IMD) exclusion within Medicaid;
- Mandating prescriber education initiatives to enhance prevention efforts, including mandating medical education training in opioid prescribing and risks;
- Establishing and funding a federal incentive to enhance access to medication-assisted treatment (MAT) and requiring that all modes of MAT are offered at every licensed MAT facility;
- Providing model legislation for states to allow naloxone dispensing via standing orders and equipping all law enforcement officers with naloxone; and
- Prioritizing funding to the Department of Homeland Security (DHS), Federal Bureau of Investigation (FBI) and the Drug Enforcement Administration (DEA) to develop fentanyl detection sensors and disseminate them to federal, state and local agencies.

The complete list of recommendations may be found on the White House website as described above. Agency (DEA) to develop fentanyl detection sensors and disseminate them to federal, state and local agencies.
II. Key Georgia Issues

1. Overdose reversal

Naloxone, available since 1971, is an opioid antagonist used to reverse opioid overdose through intravenous, intranasal (NARCAN® Nasal Spray) and intramuscular formulations. Intramuscular delivery is available by syringe in various generic forms or by auto-injector (EVZIO®).

Naloxone is highly effective, safe and quickly (within a few minutes) restores breathing. It binds to opioid receptors, blocking the effects of opioids and endorphins. Side effects include withdrawal symptoms in most cases; while they are uncomfortable, they are not life threatening. It produces no effect in persons who do not have opioids present. Naloxone is not designated as a controlled substance and does not produce tolerance.

Because the nature and concentration of the opioid causing the overdose is unknown, treatment may require multiple doses of naloxone depending on the severity of respiratory depression. Fentanyl (50 to 100 times more potent than morphine), Carfentanil (10,000 times more potent than morphine) or other powerful synthetic opioid formulations such as R-47700 may unknowingly be present in other substances (e.g., heroin, cocaine, marijuana, counterfeit benzodiazepines, counterfeit opioid medications, etc.), significantly increasing overdose risk due to high concentration of opioids in undetectable quantities (e.g., the size of a grain of salt or smaller) and require more doses to reverse overdose.

States can increase access to naloxone through a number of mechanisms including allowing naloxone to be prescribed with standing orders, allowing pharmacists to dispense naloxone and passing Good Samaritan legislation. The National Safety Council and Governors Association submitted recommendations in 2016 for increasing access to naloxone (NSC, 2016; NGA, 2016). See Appendix.

Georgia’s Naloxone Legislation

House Bill 965, the Georgia 911 Medical Amnesty Law (Georgia 911 Good Samaritan Law), signed on April 24, 2014, expanded access to naloxone. The law authorizes administration of naloxone by trained first responders (law enforcement, firefighters, EMS personnel) for overdose reversal. Additionally, the law allows for medical professionals to write naloxone prescriptions, in good faith, to those at risk of opioid-related overdose.

This law also allows for administration of naloxone by lay people to persons suspected of experiencing an opioid overdose and provides protection from arrest and prosecution for people who call 911 seeking medical assistance for those experiencing alcohol or other drug-related overdose.

Ultimately this means that neither the caller nor victim can be arrested, charged or prosecuted for small amounts of drugs, alcohol or drug paraphernalia if the evidence was obtained as a result of seeking medical assistance. This is important because the timely administration of naloxone has been proven to reverse the effects
of natural and synthetic opioids including heroin, hydrocodone, oxycodone, methadone, fentanyl and others drugs.

Victims of opioid overdose who receive naloxone in time are less likely to die or suffer long-term brain or tissue damage than those who do not. Removing barriers to health-seeking behavior is a crucial step in the fight against opioid-related deaths.

**Naloxone Availability in Georgia**

**Pharmacies.** Naloxone is available from some pharmacies in Georgia. With the signing of SB121 in 2017 authorizing the state standing order for naloxone, Georgia residents can ask for naloxone/Narcan without a prescription at Georgia pharmacies. Adapt Pharma, a manufacturer of naloxone, provides a naloxone prescription request form with a National Drug Code (NDC) number to facilitate filling the prescription by pharmacies. However, no centralized information exists on which pharmacies in Georgia carry naloxone. Individuals need to contact pharmacies directly to find out whether the pharmacy carries it and how to obtain it.

The Georgia Pharmacy Association participated in Project DAN (Deaths Avoided by Naloxone) to help make naloxone available to pharmacies and first responders. Georgia Pharmacy Foundation partnered with Medical Association of Georgia (MAG) Foundation's Think About It campaign to distribute naloxone to pharmacies in 13 northeast counties in 2015. This effort continues and includes working to encourage pharmacies to carry naloxone.

Community organizations that legally can hand out naloxone (syringe kits or Narcan) are those with a standing order prescription on file from a medical director and a pharmacy through which to order the prescription.

Three organizations meet these criteria – Georgia Overdose Prevention, the Davis Direction Foundation. Naloxone kits are distributed through the Atlanta Harm Reduction Coalition by the Georgia Prevention Project. Availability is supported by grant funding from DBHDD and donations.

**Georgia Overdose Prevention.** GOP (georgiaoverdoseprevention.org) is a grassroots organization of parents, health care professionals, harm reduction advocates and friends of those who have lost loved ones to accidental drug overdose. GOP formed to create and advocate for the passage of the Georgia 911 Medical Amnesty Law (Georgia 911 Good Samaritan Law) described above. The GOP provides overdose reversal training and a simple message based on the belief that when one is breathing, there is still hope: Don't run, call 911.

**First Responders.** The extent to which police departments, fire departments and emergency medical services have naloxone available across the state is unknown. The Georgia Department of Public Health Office of EMS and Trauma is available to assist in training first responders in the use of naloxone. Not all police precincts have naloxone, and precincts differ in the availability of naloxone to officers. Cost and the shelf life of naloxone are concerns.

**Medical Settings.** Naloxone availability or distribution from various types of medical settings is unknown. Autoinjectors have been distributed free of charge from EVZIO® donations to opioid treatment provider clinics.

**Schools.** Because overdose may occur in schools, naloxone availability in schools is receiving increasing attention. The National School Nurses Association sees naloxone availability in schools as an element of a school’s emergency and response plan for safe and effective reversal of opioid pain reliever overdose.

Adapt Pharma is offering NARCAN free to schools around the country. The Clinton Foundation’s Health Matters Initiative is a partner in this effort. Pennsylvania was the first state to make naloxone available in all public schools through this program. States such as Vermont, Delaware, Illinois, Maryland and New York have made naloxone available in schools.

**Home.** Naloxone availability at home provides for rapid overdose reversal. Overdose may occur not only from heroin use and non-prescription use
of opioid medications, but also from prescription use. Errors in use, sharing of medications and, for some, use according to prescription may result in overdose.


**Community**. Naloxone availability in the community for emergency use has been recommended to be included as a standard item in a first aid kit, like an epi-pen, (https://www.statnews.com/2017/06/27/opioid-epidemic-game-changers/) and through ADP-type boxes such as those used for defibrillators in public spaces. A person needing naloxone would call 911 and receive a code to open the box. This approach is being tested in Rhode Island (https://www.usnews.com/news/best-states/rhode-island/articles/2017-06-12/new-tool-for-overdoses-emergency-box-with-antidote).

**Escalating Naloxone Cost**

Naloxone costs have increased substantially over the past decade, particularly since 2014. Naloxone increased from $.92 per dose in 2005 to $15 - $17 per dose by one manufacturer in 2014 and up to $41 per dose in 2015 by another. Narcan costs $63 per single dose, but sells at about half that cost to government agencies, community organizations and those without insurance.

The cost of EVZIO® autoinjectors is substantially higher, having jumped in price from $287.50 in July 2014 to $375 in November 2015, with further increases in 2016 to $2,250 per single dose. Since scrutiny of these prices increases, manufacturers have responded with discounts and rebates. Adapt Pharma makes Narcan available free of charge to schools and has donated 50,000 doses, and Kaleo has donated 150,000 autoinjectors to first responders and non-profits.

Most insurance including Medicaid covers naloxone, and Kaleo EVZIO® promotes a zero co-pay option for EVZIO®.

**Naloxone Concerns**

Although Georgia has made progress in this area, additional efforts to increase access to naloxone are needed. General concerns about naloxone fall into the five areas: outline below.

1. **Possible perception as safety net for risk opioid use.** Some groups and individuals are concerned that availability of overdose reversal medication may be perceived as a safety net by opioid users at risk of overdose, and that naloxone availability does not directly address reducing opioid misuse. There is no evidence that availability of life-saving overdose reversal medication increases opioid overdose risk.

2. **Awareness, availability and training on use.** Limited awareness about the potential for overdose and the availability of overdose reversal medication is a concern for those who may encounter opioid overdose but who have not been properly trained on administration procedures.

3. **Cost of medication and medication expiration.** Providing naloxone to all first responders is a significant cost. Expiration dates of naloxone acquired in bulk to provide to first responders, and obtained by schools and others, must be monitored. Kits passing their expiration date will need to be replaced.

4. **Limited data on reversals.** The ability to track overdose reversals is limited to documentation by first responders and emergency rooms. Information from multiple sources needs to be collected and validated in a single system. When naloxone is administered by individuals without the involvement of first responders or medical services, no information on use is available.

A system for centralized data collection from entities that distribute naloxone would provide more accurate information. The Washington/Baltimore High Intensity Drug Trafficking Area (HIDTA) developed ODMAP (http://www.hidta.org/odmap/), which combines online, real-time mapping with an easy-to-use app for first responders to record overdoses and use of naloxone. Some communities in Georgia are beginning to use ODMAP: Cherokee and Forsyth County 911 services, and Doraville Police Department. Grady Hospital also is working on implementing ODMAP use with their EMS providers, as well as other communities.
5. **Linkage to services following reversal.** Successful overdose reversals without linkage to services to reduce or prevent future overdose of the same individual is a concern. First responders report multiple reversals on the same individual. Furthermore, subsequent overdoses may lead to death because intervention with reversal medication did not occur in time. Evidence-based, effective systems are needed to link individuals experiencing an overdose reversal to services preferably via assertive case management and warm and hot hand-offs.

Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD) is developing business-card size materials with information about the Georgia Crisis and Access Line (G-CAL) for distribution by first responders, emergency room staff and others when providing services to individuals who may have behavioral health needs, including those revived by overdose reversal. More effective measures for reducing repeat overdose are needed, such as creating linkage directly between individuals who can provide direct, culturally congruent support and ongoing recovery services. These efforts have been put in place in other communities.

Through the STR Grant, Georgia is implementing two demonstration projects that involve connecting persons at emergency rooms after an overdose reversal with certified peer recovery specialists through warm and hot hand-off models. Navigate Recovery Gwinnett in Gwinnett County and the Georgia Council on Substance Abuse with the Northeast Georgia Medical Center in Gainesville are implementing these projects.

DBHDD has also contracted with Atlanta Harm Reduction Coalition (AHRC) to train and educate community members, opioid users, and their families on the use and administration of Naloxone as means to reversal of an opioid overdose and distribute 4500 Naloxone starter kits. The DBHDD trained staff will facilitate trainings for first responders in high need areas, inclusive of Police Officers, Fire Fighters, National Guard, and Campus Police for example, and distribute 500 Naloxone starter kits.

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**SARA Makes the Following Recommendations Regarding Overdose Reversal Medications**

1. Increase awareness about overdose and overdose reversal medication.

2. Increase access to naloxone and training on use of the medication.
   
   *(Ed. Update: The State Targeted Response (STR) through DBHDD has begun two initiatives in 2017 - a Statewide Media Campaign and a Naloxone Training and Distribution Project.)*

3. Develop a plan to address naloxone cost.

4. Implement information technology systems to improve tracking of naloxone use.

5. Establish immediate linkages to recovery services following overdose reversal to:
   - reduce the potential for repeat overdose;
   - increase the likelihood of sustained recovery.
   
   *(Ed. Update: The State Targeted Response (STR) to Opioids grant supports two pilot programs to link individuals to certified peer recovery specialists immediately following an overdose reversal. These pilot programs are being implemented by the Georgia Council on Substance Abuse with the Northeast Georgia Medical Center in Athens, and by Navigate Recovery Gwinnett in collaboration with hospital Emergency Departments, Crisis Intervention Units and medical providers.)*

6. Mandate Insurance Coverage for Opioid Overdose-Reversal Medication: Naloxone revives an individual from a heroin or other opioid overdose and has saved thousands of Georgians’ lives. It has no psychoactive effects and concomitantly, no misuse potential. To expand access to this life-saving medication, the new legislation requires insurance companies to cover the costs of naloxone when prescribed to a person who is addicted to opioids and/or to his/her family member/s on the same insurance plan.
2. Medication assisted treatment and recovery support services

To meet the needs of patients with OUD, it is important for patients to have access to the full range of SUD treatment services including:

- outpatient treatment
- intensive outpatient treatment
- residential treatment
- detoxification
- medications
- recovery support services

(ASAM, 2016).

According to a National Safety Council report, Georgia does not meet the indicator for “meets need for OUD treatment,” measured by sufficient buprenorphine treatment capacity.

Ongoing treatment and recovery support of individuals affected by opioid use disorders involves addressing physical dependence (including overdose risk) and the behavioral and psychosocial skills required for managing recovery. Treatment decisions could depend upon a range of factors including substance use history (e.g., duration, substances used, prior recovery efforts), co-occurring disorders, treatment availability, cost/payment options, family support and legal requirements.


Key Terms and Implications

Medication-assisted Treatment (MAT)

Medication-assisted treatment (MAT) refers to multi-faceted individualized substance use disorder treatment models that employ both medications and other services and supports for recovery maintenance.

The DBHDD recognizes that MAT provides specific interventions for reducing and/or eliminating the use of illicit opioids and other drugs of misuse; while developing the individual’s social support network and necessary lifestyle changes; psychoeducational skills; pre-vocational skills leading to work activity (by reducing substance use as a barrier to employment); social and interpersonal skills; improved family functioning; the understanding of addictive disease; and the continued commitment to a recovery and maintenance program.

Medically Managed Detoxification/Withdrawal Management

Opioid withdrawal, whether from prescription medication or heroin, often produces extreme and extended discomfort. Symptoms include: sweating, shaking, chills, body aches, yawning, large pupils, headache, drug craving, nausea, vomiting, abdominal cramping, diarrhea, inability to sleep, confusion, agitation, depression, anxiety and other behavioral changes, and can last for days and weeks. Fear of withdrawal symptoms is a significant deterrent to discontinuing opioid use, and a frequent reason for relapse.

Because opioid withdrawal is not considered life threatening, detoxification is generally not covered by Medicaid and private insurance, making access to inpatient or outpatient opioid detoxification services and medication extremely limited in Georgia.
Medications to manage withdrawal symptoms during detoxification from opioids include methadone, buprenorphine alone or with naloxone (Suboxone®), milder opioids and clonidine. The length of the detoxification process varies by individual factors and goals. It may include use of multiple medications concurrently or sequentially. Individual differences may include level of tolerance, substances used, length of use and medical complications.

In addition to becoming opioid free, goals may include transition to methadone, buprenorphine, oral naltrexone or extended-release injectable naltrexone (Vivitrol®), each of which may affect length of time required. Transition to naltrexone requires a 7-10 day opioid-free period to avoid precipitating withdrawal.

Gaps in medication may make an individual vulnerable to using substances in their recovery process. Establishing systems for the most effective implementation of treatment protocols can lessen these vulnerabilities and provide greater supports for recovery.

Management of tapers or transitions from the opioid agonists, methadone or buprenorphine, to extended-release injectable naltrexone could be affected by state-approved usage of transitional medications.

Reduction in use of methadone and buprenorphine requires a long taper. The length of the taper can be reduced with use of alternative medications, such as milder opioids, which may not be approved for opioid tolerance management. Longer tapers increase cost and impact the viability of transitioning clients.

Access to medically managed detoxification for opioids and other substances differs broadly across the country, from no availability to free walk-in 24/7 for anyone, regardless of insurance status.

Both outpatient and inpatient options may be appropriate for opioid detoxification. Insurance coverage restrictions, as well as lack of available beds or outpatient services, limit access to detoxification for many individuals ready to stop using opioids. Publicly funded outpatient detoxification services, previously available in Georgia, were cut from the budget in 2010. See the ASAM National Practice Guideline For the Use of Medications in the Treatment of Addiction Involving Opioid Use (ASAM, 2015) for a more complete description of the treatment of opioid withdrawal.

**SARA Makes the Following Recommendations about Detoxification Services**

Detoxification services linked to housing, behavioral health treatment and recovery support can reduce the revolving door of recurring withdrawals, save money, unburden emergency rooms and jails and foster early recovery. Mary Hall Freedom House, Inc. proposes to open a 25-bed social model detoxification facility in Downtown Atlanta. The facility will be designed to receive females who are under the influence of alcohol and/or drugs, who also may have a co-occurring mental health disorder and who are not presenting life-threatening withdrawal symptoms.

1. Examine availability of detoxification/withdrawal management services, level of need and factors impacting access to assure sufficient available services.

2. Build a range of detox services in Georgia. Individuals needing detoxification are often “high system users” with unique health needs. Individuals with substance use disorders often experience co-occurring mental health disorders, which further complicate withdrawal. High system users can burden law enforcement and emergency rooms and can pose a threat to public safety.

3. Examine cost barriers to detoxification/withdrawal management, including insurance barriers to identify and implement solutions.

4. Examine barriers to treatment for those receiving detoxification/withdrawal management services to identify and implement strategies for overcoming these barriers.
Medication-Assisted Treatment/Medication-Assisted Recovery

MAT is the use of medications, in combination with behavioral therapies, to provide a “whole-patient” approach to the treatment of substance use disorders. Research shows that a combination of medication and therapy can successfully treat these disorders, and for some people struggling with addiction, MAT can help sustain recovery (SAMHSA).

Evidence-based effective treatment strategies for managing recovery from opioid use disorders combine opioid agonist (methadone, buprenorphine) or antagonist (naltrexone) medication, with behavioral therapies and psychosocial supports. Evidence-based behavioral therapies may be used alone or in combination with medication management, along with other services and supports. However, medication to assist recovery has been demonstrated to reduce relapse and extend opioid-free periods in combination with behavioral treatment services.

Services and supports to reduce or eliminate the use of opioids or other drugs of misuse address the whole person in recovery including development of social support networks, lifestyle changes, psychoeducational skills, improved access to employment, social and interpersonal skills, improved family functioning, knowledge of addictive disease and commitment to recovery and a maintenance program.

Long-term continuing care services have been demonstrated to be the most significant factor in extended sobriety and relapse prevention. Individualized management of treatment services should include the ability to address changes in medication and other treatment needs throughout the recovery process, without barriers such as lack of access to medications or other treatment services.

Because individuals with opioid use disorder may have co-occurring mental health conditions, a thorough assessment of both mental health and substance use should inform treatment decisions, and treatment providers should provide both types of services.

Because providers may not be cross-trained in both mental health and substance use disorders, treatment teams need to include professionals skilled in each, for both behavioral and medication treatment.

Medications Approved by the FDA for Opioid Treatment

Medication, coupled with behavioral therapy, is considered the gold standard in treatment of opioid use disorder. Currently four medications are approved by the U.S. Food and Drug Administration (FDA) for treatment of opioid use disorder or relapse to opioids — methadone, buprenorphine, oral naltrexone and extended-release injectable naltrexone. Medication alone is not considered effective practice for opioid use.

Methadone is a full mu-opioid agonist, approved by the FDA in 1972 for use in treating opioid dependence. While its effectiveness has been demonstrated in several studies, stigma associated with it (Barnett et al., 2001; Schwartz et al., 2008) and the daily dosing that is required (CSAT, 2005) are barriers to its use.

Methadone is available as liquid oral solution or diskettes. Methadone can only be provided for opioid use disorder management by licensed opioid treatment programs (OTPs). Research shows that methadone maintenance is more effective as an adjunct to individual and/or group counseling, with even better outcomes when combined with other needed medical/psychiatric, psychological and social services (e.g., employment or family services). Methadone clinics in Georgia can be located via http://www.opiateaddictionresource.com/treatment/methadone_clinic_directory/ga_clinics.

Buprenorphine is a partial mu-opioid agonist, approved by the FDA in 2002 for the treatment of opioid dependence. Unlike methadone, it can be used in office-based settings and outpatient treatment programs. Research indicates that the use of buprenorphine is associated with fewer withdrawal symptoms, a lower risk of misuse and overdose and increased treatment retention (Bell, et al., 20009; Fiellin et al., 2002; Ling et al., 2005; Amass et al., 2004).

Buprenorphine is prescribed either alone (Subutex) or in a combination form with naloxone (Suboxone). The brand name formulations are only available in sublingual strips. Generic and other formulations (e.g., Zubsolv) are available as sublingual tablets. In May 2016, the FDA approved the buprenorphine subdermal implant, probuphine, which delivers a constant low dose buprenorphine over a six-month period for maintenance treatment of opioid dependence. Probuphine is not considered appropriate for new entrants into treatment or those that have not achieved clinical stability.

Buprenorphine has a ceiling effect, which is a barrier to use as treatment for those with higher opioid tolerance. Those with higher tolerance cannot be transitioned directly to buprenorphine. In these cases, a waiting period of three to four days upon stopping opioid use, or transition to methadone with a step down to buprenorphine could be required to avoid precipitous withdrawal.

Buprenorphine can be prescribed in settings other than OTPs. Physicians prescribing buprenorphine must apply for a physician waiver from SAMHSA with demonstrated completion of eight hours of required training. Physicians may be approved to treat up to 100 patients (first year maximum approval is 30 patients) with buprenorphine in outpatient settings as of 2016 (SAMHSA 2016). After having had a waiver to treat 100 patients for one year, practitioners who have additional credentialing in addiction medicine or addiction psychiatry may request a limit increase to 275 patients. Nurse practitioners (NP) and physician assistants (PA) may also obtain training and apply for buprenorphine waivers to treat up to 30 patients at a time. Barriers for use of the waiver by NPs and PAs include variations in prescribing privileges by state. There are no limitations on use of buprenorphine in inpatient settings for managing withdrawal, or by licensed OTPs. Barriers to physician buprenorphine training and dispensing include stigma related to the patient population, limited behavioral health knowledge, lack of support, lack of connection to behavioral health services, staffing needs and required paperwork.

Naltrexone is an opioid antagonist. Unlike opioid agonists, naltrexone works by blocking the opioid receptors so that they are unable to be activated by opioids. Any health care provider licensed to prescribe medications can prescribe naltrexone. The oral formulation (ReVia®, Depade®) is generally taken once per day. Research suggested that patient compliance with oral naltrexone is a
significant problem (Gueorguieva et al., 2013; Kranzler et al., 2008; Swift et al., 2011; Volpicelli et al., 1997).

Extended-release injectable naltrexone (Vivitrol®) was developed to address the challenge of patient compliance, hence a single monthly injection. It was approved by the Food and Drug Administration (FDA) for relapse to opioids in 2010 after being initially approved as a treatment for alcohol use disorder in 2006.

The medication is intended for opioid patients who have gone through detoxification and are free of opioids or opioid-containing medications, including buprenorphine or methadone, for a minimum of 7-10 days. The use of extended-release injectable naltrexone for opioid use disorder has been linked to abstinence rates, longer duration of opioid-free days, improved treatment retention, less craving and lower relapse occurrence (Gastfriend, 2011; Syed & Keating, 2013). Yet, only 19.7 percent of all substance use disorder treatment programs in Georgia offer buprenorphine, 10.8 percent offer extended-release injectable naltrexone and 17.5 percent offer oral naltrexone (NSSATS, 2016).

Taking any of these medications as prescribed promotes employment, reduces crime and violence and minimizes exposure to HIV by stopping or decreasing injection drug use and drug-related high-risk sexual behavior. Patients stabilized on these medications also engage more readily in counseling and other behavioral interventions essential to recovery.

Substance Use Disorder Providers in Georgia

Georgia’s Department of Behavioral Health and Developmental Disability (DBHDD) contracts with two MAT providers, Southside Medical Center and Alliance Recovery Center (Decatur, Conyers). These clinics provide methadone, buprenorphine and counseling and other support services. There were 55 licensed OTPs in Georgia in 2015 (SAMHSA, 2017, NSSATS, 2015). According to the SAMHSA Treatment locator, 551 buprenorphine providers and 269 substance use disorder treatment providers were operational in Georgia in 2015 (NSSATS, 2015).

Buprenorphine providers are concentrated primarily in urban areas and there is limited access to buprenorphine providers in many rural areas of the state. For example, over half the state’s 159 counties (n=84, 53 percent) do not have a single physician who can prescribe buprenorphine for opioid use disorder, and an additional 22 counties (14 percent) have just one physician with a buprenorphine waiver (SAMHSA buprenorphine treatment physician locator - https://www.samhsa.gov/medication-assisted-treatment/physician-program-data/treatment-physician-locator).

Similarly, of the 85 rural Georgia counties, 54 (or 64 percent) have no access to buprenorphine providers and 11 (or 13 percent) have only one provider who can prescribe the medication. These numbers suggest that over two-thirds of all Georgia counties and 92.6 percent of rural counties have limited or no access to this important evidence-based practice for opioid dependence.

With the 21st Century Cures funding, Georgia is implementing a pilot program with injectable, extended-release naltrexone (Vivitrol®) with the Department of Community Supervision.

Georgia passed a bill in 2016 to suspend licensure of additional narcotic treatment clinics (SB 420). See Appendix Table XX for details of OTP and non-OTP services and coverage in Georgia in 2014.

In Georgia, fee for service (FFS) Medicaid covers methadone maintenance, buprenorphine/naloxone, oral naltrexone and extended-release injectable naltrexone. FFS coverage for substance use disorder counseling and documentation of buprenorphine/naloxone, oral naltrexone or extended-release injectable naltrexone counseling is unknown (ASAM, 2014).

Buprenorphine/naloxone (suboxone) and oral or extended-release injectable naltrexone are pharmacy benefits, and preauthorization is required for both types of medication. Maximum daily dose limits for buprenorphine after six months of therapy are 16.

Only six of the publicly contracted MAT providers accept Medicaid, and only limited subsidies to offset treatment costs are available. For individuals not covered by Medicaid, insurance or subsidies, cost of treatment is a barrier to recovery. Gaps in coverage caused by Georgia’s
rejection of Medicaid expansion affect these populations, particularly men, and women who do not have children. Medicaid 1115 waivers offer an approach to addressing gaps in coverage.

Requirements of the Commission on Accreditation of Rehabilitation Facilities (CARF) for programs providing methadone or buprenorphine treatment state that they must offer counseling. Georgia follows federal guidelines for OTPs requiring counseling, medical exams and other services. Counseling is not required with other types of medication-assisted treatment for opioid use disorder.

Georgians can find treatment on the SAMHSA treatment locator, which provides information on alcohol, drug and mental health treatment facilities, as well as physicians and treatment programs authorized to treat opioids including MAT (https://findtreatment.samhsa.gov, https://www.samhsa.gov/medication-assisted-treatment/physician-program-data/treatment-physician-locator).

Public Awareness

The State Department of Behavioral Health and Development Disabilities (DBHDD) Office of Addictive Diseases (OAD) collaborates with Opioid Treatment Providers of Georgia (OTPGA; https://www.otpgeorgia.org/) to increase awareness and provide education on treatment options, including MAT.

OTPGA is a non-profit organization of treatment providers, counselors and other interested persons concerned about treatment, recovery and traditional and alternative options for heroin and other opioid addiction.

During OTPGA’s annual November conference, abstinence-based and MAT providers share information and receive training about evidence-based MAT practices. The conference is open to the public. The Georgia School of Addiction Studies, held annually in August, also offers training on MAT.

With medically assisted treatment come these potential hurdles:

1. High cost of medications and limited access to private insurance or Medicaid coverage for medications.
2. Limited access to Medicaid billable MAT and challenges for those not Medicaid eligible to receiving medication.
3. Potential limitations to access to various types of medication that limit ability to develop and implement individualized treatment plans.
4. Limitations in access to comprehensive recovery support services that include medication.
5. Need for review of available MAT services, state of the art and approaches implemented elsewhere to improve programs in Georgia.
6. Stigma associated with the use of MAT among treatment providers, family and friends of opioid users and the general public.
7. Availability of physicians, nurse practitioners and physician assistants to prescribe medications and medically monitor patients receiving medications.
SARA Makes the Following Recommendations for Medication-assisted Treatment (MAT)

1. Review MAT approach in Georgia in relation to current recommendations for best practice, and compare to other effective programs to identify strategies for strengthening quality and effectiveness of Georgia programs.

2. Review availability and access to MAT and determine barriers and facilitators to develop strategies to improve access to MAT.


4. Increase access to Medicaid and insurance for services received from opioid treatment programs (OTPs) for MAT.

5. End prior insurance authorization to allow for immediate access to inpatient treatment for as long as such treatment is needed. People suffering from addiction who seek treatment need immediate access to services. However, prior authorization requirements by insurance companies are often a roadblock to admission to inpatient programs. This legislation requires insurers to cover necessary inpatient services for the treatment of substance use disorders for as long as an individual and his/her service provider says it is needed.
   - The legislation establishes that utilization review by insurers can begin only after the first 14 days of treatment, ensuring that every patient receives at least two weeks of uninterrupted covered care before the insurance company becomes involved.
   - Department of Community Health, Office of Healthcare Facilities Regulation, Drug Abuse Treatment and Education Programs, Section Client Referral, Intake, Assess, Admission, 290-4-2-.13(1)(b)1. is changed to ensure that barriers to access to intake are minimized.
   - End prior insurance authorization to allow for greater access to drug treatment medications. People seeking medication to manage withdrawal symptoms or maintain recovery must often request prior approval from their insurance company, which slows or stops the individual from getting needed medication. This legislation prohibits insurers from requiring prior approval for emergency supplies of these medications. Similar provisions will also apply to managed care providers treating individuals on Medicaid who seek access to buprenorphine and injectable naltrexone.

6. Require all insurance companies use objective state-approved criteria to determine the level of care for individuals with a substance use disorder. Insurance companies often use inconsistent criteria to determine the covered level of care for persons suffering from substance use disorder, which often prevents receiving care. This legislation will require all insurers operating in Georgia to use objective, state-approved criteria such as the American Society of Addiction Medicine (ASAM) Criteria (ASAM, 2017) when making coverage determinations for all substance use disorder treatment to make sure individuals get the treatment they need.

7. Activate the Medicaid codes for Screening, Brief Intervention, and Referral to Treatment (SBIRT). With more than half of Georgia’s youth enrolled in Medicaid or PeachCare, this is a critical strategy for ensuring that youth receive the preventive services they need. Provide professionals and mentors with training for motivational interviewing techniques that educate the individual about the potential consequences of substance use and identify ways to reduce subsequent risky use. Individuals demonstrating substantial risk on the initial screen are referred to mental health or substance use treatment and other prevention or recovery service providers.

(continued next page)
8. Expand the use of Screening, Brief Intervention, and Referral to Treatment (SBIRT) Medicaid codes to impact student’s use of alcohol and other drugs. On July 1, 2017, Georgia’s Medicaid codes for SBIRT for children and youth were activated in health care settings. Efforts are now being conducted to promote this news to providers around the state and will continue by Georgians for a Healthy Future and the Georgia Council on Substance Abuse. These agencies will expand the use of SBIRT in schools and health care settings through two parallel strategies.

- Activate the provider groups in the Preventing Youth Substance Use Disorders (PYSUD) coalition to promote SBIRT through their communication channels and educational events.

- Pursue a parallel strategy to embed SBIRT codes into the Georgia Department of Education’s (DOE) School Improvement model.

GCSA, in partnership with Marietta High School (MHS) and Kennesaw State University (KSU), funded by the Hilton Foundation and managed through the Center for Social Innovation, participated in a pilot project where adolescent SBIRT was provided to students at MHS’s Student Success Center. Initial results have been positive and GCSA will disseminate the final results to coalition partners, education leaders statewide and other stakeholders when they are available. The project will make use of the evidence-based models of peer and near-peer support already being implemented or planned in Georgia. The project team will highlight these examples and replicate them where possible.

The strategy of the adolescent SBIRT project at MHS was to train young people to screen, mentor and participate in recovery support groups with MHS students. GCSA will continue this relationship with KSU by engaging them and their peers in the next cohort. This model is being replicated with Decatur High School and neighboring Agnes Scott College. The project team will promote the successes of this model to decision-makers within the DOE by:

- Promoting the use of peers and non-physician counselors in carrying out the strategies above.

- Developing sustainable funding streams for SBIRT through Medicaid, private insurance and state and local funding that supports both services and ongoing provider training.

- Defending Medicaid coverage and benefits and private insurance that provide a platform for SBIRT.

- Shaping health system transformation initiatives to include screening, early intervention and successful referrals to treatment.

Medicaid is an important lever to help shape health system transformation in the next three years. As we work to expand the use of SBIRT to students across the state and continue to cultivate state officials from the Department of Community Health to promote utilization, we will proactively work to advance a broader health system transformation agenda that incorporates prevention. GHF has also developed stronger relationships with advocates in the housing sector, particularly supportive housing, as well as with stakeholders and advocates who work in the behavioral health arena. As we develop our approach and agenda for health system transformation in Georgia, we will incorporate a behavioral health component that looks across sectors to reduce substance use. SBIRT will be a major component.

9. Develop protocol and criteria for tracking behavioral therapies in conjunction with Medication-assisted Treatment (MAT). MAT is the use of medications, in combination with behavioral therapies, to provide a “whole-patient” approach to the treatment of substance use disorders. Research shows that a combination of medication and therapy can successfully treat these disorders, and for some people struggling with addiction, MAT can help sustain recovery (SAMHSA).
Recovery Supports
Effectively promoting recovery from addiction to heroin and/or prescription pain relievers typically involves one or more combinations of:

1. Peer recovery mutual support
2. Pharmacological interventions
3. Behavioral counseling/therapies

These are available in Georgia along a continuum of peer and professional recovery support services ranging from environmentally restrictive inpatient or residential programs to standard and intensive outpatient programs and least-restrictive, yet essential mutual support groups and recovery community organizations.

The likelihood of continuing abstinence-based recovery jumps from 36 percent for people with less than a year in recovery to 86 percent for those with four to seven years, showing that recovery takes time and effort. Importantly, sustained connections, not abstinence alone, are the opposite of addiction, and continuing care is a key challenge for acute or medical treatment models (Dennis and Scott, 2007).

Support for ongoing recovery services as an essential model of recovery, with the goal of sustained, prosocial engagement with the community, recovery community organizations (RCO) and people in long-term recovery are also addressed in Kaskutas, 1999 (numerons.files.wordpress.com/2012/04/7the-social-model-approach-to-substance-abuse-recovery.pdf) (dbhdd.georgia.gov/georgia%E2%80%99s-recovery-definition-and-guiding-principles-values).

Below is a representative, partial list of peer recovery supports available throughout Georgia. Those listed here are members of the Faces and Voices of Recovery (facesandvoicesofrecovery.org/) Association of Recovery Community Organizations (ARCO; http://facesandvoicesofrecovery.org/arco/about-arco.html).

- Navigate Recovery Gwinnett (https://www.navigatecoverygwinnett.org/).
- Recovery Consultants of Atlanta, Inc. (http://www.recoveryconsultants.org/).
- Davis Direction Foundation – The Zone (http://www.davisdirection.com/a_stub.php/the-zone).

Recovery-oriented Systems of Care Service Settings

<table>
<thead>
<tr>
<th>Mutual Support</th>
<th>Outpatient</th>
<th>Residential/Inpatient</th>
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<tbody>
<tr>
<td>Least</td>
<td>Environmentally Restrictive</td>
<td>Most</td>
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School-based Programs and Organizations

Recovery High Schools

The Association of Recovery Schools (ARS) defines recovery high schools as secondary schools designed specifically for students in recovery from substance use disorder or dependency. Although schools differ in their operation according to state standards, local needs and budgets, each school shares these goals: 1) educate all eligible and available students in recovery from substance use and co-occurring disorders; 2) meet state secondary school diploma requirements; and 3) support students in working a strong program of recovery.

Higher Education Collegiate Recovery Programs

A collegiate recovery program (CRP) is a college or university-provided, supportive environment within the campus culture that reinforces the decision to engage in a lifestyle of recovery from substance use. They are designed to provide an educational opportunity alongside recovery support to ensure that students do not have to sacrifice one for the other (ARHE).
The following universities in Georgia provide some level of peer-based recovery support services on campus:

- Dalton State University – Collegiate Recovery Community
- Georgia Southern University Center for Addiction Recovery
- Georgia Institute of Technology – Collegiate Recovery Program

Recovery Programs

Some universities offer comprehensive recovery programs for students. These universities and their programs include:

- Kennesaw State University – Center for Young Adult Addiction and Recovery
- University of Georgia – Collegiate Recovery Community

Recovery occurs via many pathways including “natural” or on your own, faith-based programs, medication and other treatment, physical health routines, meditation or mindfulness practices and others.

Alcoholics Anonymous (aa.org) and Narcotics Anonymous (na.org). In 12-step programs, 90 meetings in 90 days is the conventional wisdom for initiating recovery during which time one or more “sponsors” (experienced peers) assist with understanding and applying the Twelve Steps and Twelve Traditions. district8aami.org/assets/doc_12_12.pdf).

Recovery matures by serving others seeking or in recovery in roles that are valued by both the individual and the community, enhancing a sense of personal worth and belonging that counteracts pervasive stigma and discrimination.

Other faith-based and secular programs:

- Buddhist Recovery Network (buddhistrecovery.org/index.php/meetingslisting.htm).
- Celebrate Recovery (celebraterecovery.com).
- Double Trouble in Recovery (gmhcn.org/dtr.html)
- Dual Recovery Anonymous (draonline.org/meetings_dra/usa/georgia.html).
- Overcomers Outreach (overcomersoutreach.org/sitebuilder/Groups.html).
- Reformers Unanimous (rurecovery.com).
- SMART Recovery (smartrecovery.org).
- Georgia’s Certified Peer Specialists.

Georgia was the first state in the U.S. to develop a Medicaid billable peer support workforce in 1999. Since 2001, the Georgia Mental Health Consumer Network (GMHC; gmhcn.org) has trained over 1,400 Certified Peer Specialists (CPS; gacps.com) including Forensic Peer Mentors. CPSs implement peer support services that are Medicaid reimbursable under Georgia’s Rehab Option as part of Assertive Community Treatment (ACT) Teams, Community Support Individuals and in a variety of roles that assist peers in accomplishing personal recovery journeys for mental health, substance use and co-occurring conditions. The GMHC also oversees five (so far) Peer Support, Wellness and Respite Centers (gmhcn.org/wellnesscenter/index.html).

In 2011, the Georgia Council on Substance Abuse (GCSA; gasubstanceabuse.org) started to train over 450 Certified Addiction Recovery Empowerment Specialists (CARES aka CPS–AD). In 2017, SAMHSA funded Building Communities of Recovery program grantees. The GCSA received one of eight awards which will support statewide expansion of CARES. GCSA is also assisting with the development of Recovery Community Organizations (RCOs) operated by peers currently in seven cities (facesandvoicesofrecovery.org/who/arco).

The DBHDD Office of Children, Young Adults and Families (dbhdd.georgia.gov/office-cyf-services) initiated training for CPS-Youth/Young Adults (CPS-Y) in 2015 (33 young adults certified in 2017) and CPS-Parents (CPS-P) in 2013 (120 parents certified in 2017) who work in psychiatric residential treatment facilities, crisis stabilization units, care management services and resiliency support clubhouses serving children (5+ years old) and transition-aged youth and young adults (14-26 years old). As of October 1, 2017, the services of CPS-Y and CPS-P are Medicaid billable.
SARA Makes the Following Recommendations for Recovery Supports

1. Require hospitals to provide follow-up treatment and recovery support options to individuals upon hospital discharge.

2. Require hospital medical staff to provide discharge-planning and self-selected connections between patients who have or are at-risk for substance use disorder, and suitable treatment and recovery support options.

3. Provide funding for demonstration projects in two Georgia trauma centers or hospital-operated emergency departments to provide a pair of Certified Addiction Recovery Empowerment Specialists (CARES) who serve as initial recovery resources for individuals who present due to an overdose of alcohol or other drugs. The CARES will also sustain supportive interactions with the identified patient and or family to promote recovery, de-escalate tense situations and demonstrate the power and possibility of lived recovery. This was funded under STR Grant for pilot of these projects as described above.

4. (Ed. Update: Expand peer-based recovery support services to support long-term recovery. Individuals leaving treatment are at significant risk for relapse. A peer-based recovery support program would be optimal, to provide the services of a nationally certified recovery community organization (RCO), as individuals transition into and out of hospitals, treatment and juvenile and criminal justice programs.)

5. (Ed. Update: Expand peer-based recovery support services in higher education programs and in high schools to support long-term recovery. Individuals leaving treatment are at significant risk for relapse and are at high risk in substance-free hostile environments such as the college campus.)

6. Provide service linkages to: education and employment resources, legal services, social services, transportation assistance, childcare services and peer support groups. They could also fund family support navigators across Georgia who assist substance misusers and their families with locating and accessing treatment and other options for coping with addiction.

7. Restore 2010 cuts to funding for “non-medically necessary community services.” These funds would be used to build on DBHDD’s recovery community organization network by providing start-up and ongoing support for up to six RCOs across the state to help Georgians suffering from substance misuse disorder and to expand vital recovery resources - in addition, support the expansion of recovery-oriented systems of care including resources provided by members of the Georgia Association of Recovery Residences.
3. Prevention education

Definitions of Prevention

Prevention focuses on interventions that occur prior to the onset of a disorder and which are intended to prevent the occurrence of the disorder or reduce risk for the disorder. The foundation of substance misuse/abuse prevention is rooted in understanding behavioral health, the Continuum of Care, a public health approach, risk and protective factors, and the Strategic Prevention Framework (SPF).

Behavioral Health

Behavioral Health refers to “a state of emotional/mental begin and/or choices and actions that affect health and wellness”. Individuals engage in behavior and make choices that affect their wellness, including whether or not to use alcohol, tobacco or other drugs. Substance Misuse/Abuse is one of the problems associated with behavioral health.

Continuum of Care

The Institute of Medicine's continuum of care is a classification system that presents the scope of behavioral health services: promotion of health, prevention of illness/disorder, treatment, and maintenance/recovery.

Risk and Protective Factors

Many factors influence the likelihood that an individual will develop a substance misuse/abuse or related behavioral health problem. Effective prevention focuses on reducing the factors that put people at risk of substance abuse and strengthening those factors that protect people from the problem.

Public Health Approach

A public health approach to behavioral health involves working with allied health professionals, families, schools, social services, neighborhoods, and communities to create conditions that will foster well-being. In order to do effective prevention a planning process, the Strategic Prevention Framework, is used to determine what interventions will be most effective for a specific population group.

Strategic Prevention Framework

The Strategic Prevention Framework (SPF) is a 5-step planning process used to understand community needs and strengths, and to guide the selection, implementation, and evaluation of effective, developmentally and culturally appropriate, and sustainable prevention activities. Evidence-based prevention strategies consist of both individual level (traditional classroom type education) and environmental level which are tailored to local community characteristics and address the root causes of risky behaviors by creating environments that make it easier to act in healthy ways (ex: policy change, community awareness campaigns, and enforcement).

Prevention refers to actions or interventions that reduce risks or threats to a person's health and include primary, secondary and tertiary methods. Primary prevention methods prevent the incidence of disease or illness before it occurs, secondary prevention provides immediate responses when a disease or injury occurs to contain or minimize the negative effects and tertiary prevention, commonly referred to as treatment, intervenes on the impact of ongoing illnesses or injuries. In the case of a substance use disorder, tertiary prevention could include treating the physical (medical), emotional and mental consequences of drug use and facilitating entry into recovery-oriented systems of care so further disability is minimized.

Primary prevention methods often target children, adolescents and other at-risk groups. These programs exist at both the national, state and local community levels. Some are federal or state created and funded, while others originate with non-profit organizations that use government funding to, for example, create public service messages and promote positive alternatives to alcohol and other drug use. Primary prevention
methods and programs aimed at children, teens and young adults are discussed in more detail below.

Prescription Drug Monitoring Programs (PDMPs) may serve primary, secondary or tertiary prevention functions by contributing to reduced prescribing, identifying at-risk patients and initiating treatment for substance misuse with patients. PDMPs are state-run electronic databases that track the prescription and dispersion of controlled prescription drugs to patients.

These programs monitor the information for identified prescription drugs and diversion by assisting prescribers or pharmacists to identify high-use patients for early interventions. The CDC recommends that prescribers check the database at least once every three months and prior to writing every opioid prescription. More frequent checks of the database are recommended.

Another primary method is Prescription Drug Take-Back Programs funded through the Drug Enforcement Administration (DEA), which promotes appropriate disposal of medications to prevent medication use by individuals for whom the prescriptions were not written. The Drug Disposal Act of 2010 amended the Controlled Substances Act by providing drug take-back programs for the disposal of certain controlled substances as determined by the U.S. Attorney General.

The final rule of the Disposal of Controlled Substances Final Rule in September 2014 lists local programs, mail-back programs and collection receptacles for the proper disposal of medications (FRN, September 9, 2014).

Information regarding Georgia’s Statewide Prescription Drug Disposal Locations Directory can be found here: http://stoprxabuseinga.org/prescription-drug-disposal/. Most of these 200+ Drug Drop Boxes are available 24/7.

Finally, Screening, Brief Intervention, and Referral to Treatment (SBIRT) is a combined primary and secondary prevention methodology. SBIRT’s public health approach delivers early intervention and treatment services with individuals at risk of injury due to alcohol or other drug use or who display evidence of developing substance use disorders.

SBIRT provides opportunities for early intervention with at-risk substance users before more severe consequences occur, and it has been adapted for use in many different settings including two major hospitals in Georgia (Grady Health Systems and Medical Center of Central Georgia, Macon) and two high schools (Marietta High School and a high school in Dublin). Providing treatment referrals for patients whose assessment suggests a substance misuse disorder is a secondary prevention method.

For opioid misuse or dependence, medications, provided along with behavioral therapies, are the principal means of secondary and tertiary prevention. Detoxification medications are available for short-term use to relieve symptoms of opioid withdrawal. To prevent relapse to drug use, maintenance medications such as methadone, buprenorphine and naltrexone are available for longer-term use (see Appendix: CARA Title III: Treatment and Recovery provisions).

Primary Prevention Efforts: A Detailed View

Supported by Federal funds, the largest providers of local-level substance misuse prevention services are public schools, law enforcement agencies and community organizations.

Nearly 140,000 schools educate over 75,000,000 U.S. children with persistent messaging about safe and healthy lifestyles and not using drugs embedded within their health and family life curriculum. Many prevention classroom-based programs focus on developing the knowledge, attitudes and skills needed to make healthy choices or change harmful behaviors.

Universal prevention approaches include the use of environmental prevention strategies that are tailored to local community characteristics and address the root causes of risky behaviors by creating environments that make it easier to act in healthy ways.

Universal strategies may include changing the public’s demand for opioids and low perceptions of harm. The U.S. is the greatest consumer of opioids worldwide and reports higher levels of pain. Low perceptions of harm are, in part, demonstrated by sharing of prescription medications, and direct-to-consumer advertising creates pressure for over prescribing among 81 percent of physicians. Public awareness of changing attitudes toward pain and approaches to treating pain may contribute to reduced demand.
The successful execution of these strategies often involves lawmakers, local officials and community leaders, as well as the acceptance and active involvement of members from various sectors of the community such as the business, faith, school and health sectors.

Environmental change strategies have specific advantages over strategies that focus exclusively on the individual. The targeting of a broader audience has the potential to produce widespread changes in behavior at the social or group level. Further, they can create shifts in both individual attitudes and community norms that can have long-term, substantial positive effects.

National Primary Prevention programs are explored in the Appendix.

**State Providers**
- Department of Behavioral Health and Developmental Disabilities (DBHDD) and its Office of Behavioral Health Prevention (OBHP)

**Statewide Non-profit Providers**
- Atlanta Harm Reduction Coalition
- Emory Maternal Substance Abuse and Childhood Development Program
- Georgia Pharmacy Association
- Georgia Prescription Drug Abuse Prevention Collaborative (GADAPC)
- Georgia Teen Institute (GTI) - a statewide program of Gwinnett United in Drug Education (GUIDE)
- The Council on Alcohol and Drugs (The Council)

**Local Non-Profit Providers**
- Numerous local efforts under Drug Free Community Programs (DFCs)
- DBHDD’s Alcohol and Sub stance Abuse Prevention Project (ASAPP) funds 5 local providers that have demonstrated need and have chosen to address rx drugs:
  - Bulloch County Alcohol and Drug Abuse Council (Bulloch County)
  - Camden Family Connection (Camden County)
  - Family Connection of Columbia County (Columbia County)
  - Association of Village Pride (Fayette County)
  - Family Connection and Communities in Schools of Glascock County (Glascock County)

**GEN Rx Funded Local Providers**
- Catoosa Prevention Initiative (Catoosa County)
- Early Choices (Early County)
- CETPA (Gwinnett County)

**STR Funded Local Providers**
- Bulloch County Alcohol & Drug Coalition (Bulloch County)
- Association of Village Pride (Coweta County)
- GUIDE (Dekalb County)
- Augusta University Research Institute (Richmond County)

**SARA Offers These Recommendations for Substance Misuse Prevention Education**

1. Restore Substance Abuse Prevention Services that were cut in 2010 from the DBHDD budget. These programs promote the health and wellbeing of children, youth, families and communities through preventing the use and/or misuse of alcohol, tobacco and drugs.

2. Restore cuts to training initiatives that help fund public education programs: Make individuals, families and communities aware of the dangers associated with alcohol and drug misuse.

3. Mandate pharmacists provide easy to understand information on risks associated with drug addiction and misuse: Consumers may not understand the addiction and misuse risks posed by prescription opioids. To improve consumer awareness about these risks, the legislation requires pharmacists to provide educational materials to consumers about the risk of addiction, including information about local treatment and recovery support services.
### 4. Neonatal Abstinence Syndrome (NAS)

According to information published by the CDC’s Mortality and Morbidity Weekly Report (MMWR, 2015), more than one-third of reproductive-aged women enrolled in Medicaid (39 percent) and more than a quarter of those with private insurance (28 percent) filled a prescription for an opioid pain medication each year during 2008-2012. The most commonly prescribed opioids between both groups of women were hydrocodone, codeine and oxycodone.

The CDC researchers analyzed 2008-2012 data from two large health insurance claims datasets: one of women aged 15-44 years with private insurance and another of women in the same age group enrolled in Medicaid. Geographic region data available in the private insurance claims indicated that opioid prescription rates were highest among reproductive-aged women in the South and lowest in the Northeast.

Race/ethnicity information was available for the Medicaid data and indicated opioid prescriptions were nearly one and a half times higher among non-Hispanic white women of reproductive age compared to non-Hispanic black or Hispanic women.

Research studies on opioid use during pregnancy suggest that when these medications are used during early pregnancy, they can be associated with:

- congenital heart defects such as conoventricular septal defects, atrioventricular septal defects and hypoplastic left heart syndrome
- neural tube defects such as spina bifida
- abdominal wall defects such as gastroschisis

When opioids are used in later pregnancy, they are often associated with Neonatal Abstinence Syndrome (NAS), which is a cluster of symptoms that a newborn may experience when prenatally exposed to opioids.

**Symptoms of NAS include:**

- difficulty breathing
- extreme drowsiness
- poor feeding
- irritability
- sweating
- tremors
- vomiting
- diarrhea

Occasionally seizures and death have occurred in severe, untreated cases of withdrawal. With proper treatment, most babies can be supported through the withdrawal process.

The latest Georgia Department of Public Health records indicate a growing problem with NAS across our state. What follows below is the most recent DPH data gathered between 2010-2014, which is the latest data available. The commissioner of DPH announced that as of January of 2016, NAS is a mandated reportable condition across our state. This should address the issue of a more accurate count of the true nature of the impact of the current opioid epidemic and its impact on our newborns prenatally exposed to prescription opioids as well as heroin.

**Inpatient hospitalizations with any diagnosis of Neonatal Abstinence Syndrome, Georgia, 2010 - 2014**

N=1,365, charges=$52,856 per Baby
Numerator is number of inpatient hospitalizations where age < 1 year and any diagnosis (principal or otherwise) of neonatal abstinence syndrome (ICD9-CM 779.5). Data are of discharges and not unique patients. Denominator is total live births. Data are by county of residence.

The Association of State and Territorial Health Officials (ASTHO) published an NAS framework for prevention in 2017. The framework recommends 1) collaboration of multisector state, regional and local partners, 2) data use to understand the scope of the problem, 3) primary prevention – reducing the occurrence of in-utero opioid exposure, 4) secondary prevention – reducing severity of consequences by treating known in-utero opioid exposure and 5) tertiary prevention – ensuring positive long-term health outcomes for children with in-utero opioid exposure and their families.

Three examples of NAS programs in Georgia are those developed by the Northeast Medical Center in Gainesville, Northside Hospital in Atlanta, and Augusta University Medical Center.

SARA Recommends the Following for Neonatal Abstinence Syndrome

Look at model states, such as Tennessee, North Carolina, Arizona and California – almost all involve both primary and secondary/tertiary prevention strategies to address NAS such as:

1. Reduce incidence

   • Screen all pregnant women and then refer those testing positive for brief intervention and/or referral to treatment (SBIRT)
   • Professional education of all health care providers

2. Reduce NAS severity and optimize health outcomes

   • Encourage adoption of a standardized protocol for assessing and scoring of a newborn testing positive for opioids
   • Encourage adoption of standardized treatment protocol for all newborns testing positive for opioids
   • Universal developmental follow-up of all newborns testing positive for opioids

3. Leverage resources and reduce costs associated with NAS

   • Development of a statewide NAS Task Force
   • Collaboration across multiple stakeholders: primary care, obstetrics/gynecology, substance misuse treatment/MAT providers, behavioral health, the courts, child welfare, hospitals, insurers, etc.

   • Public health campaign to educate the public
   • Use of PDMP by all OB/GYN’s
   • Develop portfolio of “key messages” similar to the North Carolina Pregnancy and Opioid Exposure Project (POEP)
   • Encourage information sharing across state agencies to reduce costs and prevent redundancy
   • Facilitate best practice information sharing from promising programs within and outside of Georgia
5. Controlling access to opioids

a. Prescription Drug Monitoring Program

Prescription Drug Monitoring Programs (PDMPs) are electronic databases that track prescriptions of controlled substances (CDC, 2016). PDMPs promote safe prescribing and are considered effective tools for detecting prescription drug misuse.

PDMP data are utilized by a variety of end users, including practitioner licensure boards, law enforcement and drug control agencies, medical examiners, drug courts and criminal diversion programs, substance use disorder treatment programs, public and private third-party payers and other public health and safety agencies (Clark et al., 2012).

PDMPs are now authorized in all 50 states. While PDMPs are widely implemented, their features vary by state. For example, in 2015, 33 state PDMPs monitored at least four drug schedules and 48 state PDMPs updated program data at least weekly (Patrick et al., 2016).

According to a recent report, 40 states allow physicians and dispensers to appoint delegates or staff from their practice to access PDMP data (NSC, 2016). As of May 2016, 30 states had adopted some version of a prescriber use mandate. In some states, these mandates apply only to certain classes of practitioners and/or prescriptions (COE Briefing, 2016a).

A Prescription Drug Monitoring Program Center of Excellence report identified 35 potential PDMP best practices. The strongest evidence was identified for eight PDMP best practices:

1. Collecting data on all schedules of controlled substances
2. Instituting serialized prescription forms
3. Conducting epidemiological analyses
4. Providing continuous online access to automated reports
5. Sending unsolicited reports and alerts
6. Conducting promotional campaigns
7. Improving data timeliness and access
8. Conducting user education (Clark et al., 2012)

The National Safety Council and National Governors Association recommendations for state PDMPs are in the Appendix. (NSC, 2016; NGA, 2016).

Georgia’s PDMP

Georgia’s first version of its PDMP became effective in May 2013. The PDMP requires dispensers to electronically submit certain information to the Georgia Drugs and Narcotics Agency (GDNA) regarding prescriptions dispensed for Schedule II, III, IV and V controlled substances. The Georgia General Assembly enhanced the PDMP in 2017 to require dispensers to enter prescription information within 24 hours of filling a prescription for the designated substances. This will provide prescribers more efficient access to information with less wait time as they make the best clinical decisions possible for their patients.

The law also requires prescribers to register with the PDMP by January 1, 2018. Beginning July 1, 2018, prescribers will be required to check the PDMP before prescribing opiates or cocaine derivatives in Schedule II drugs or benzodiazepines. The law also specifies that database information access include (but is not limited to) law enforcement or prosecutorial officials pursuant to a search warrant, Georgia-licensed prescribers of controlled substances for the purpose of providing medical treatment to a specific patient and governmental and other entities for research purposes if all identifying information is removed.

Research on the effectiveness of PDMPs

Numerous research studies have examined the impact of PDMPs on opioid overdose deaths and prescribing behavior. While some studies have found little or no evidence of a relationship between PDMP implementation and opioid overdose deaths (Paulozzi, Kilbourne, and Desai, 2011; Li et al., 2014), other research has found a relationship between PDMP use and reduction of: doctor shopping, opioid diversion, inappropriate prescribing and deaths from opioid overdose (Clark et al., 2012; Boa et al., 2016; Patrick et al., 2016).
One recent study of PDMPs in 24 states found that implementation of a PDMP was associated with more than a 30 percent reduction in the rate of prescribing of Schedule II opioids (Bao et al., 2016). Another recent study found that implementing PDMPs with advanced features was associated with a reduction in opioid overdose deaths (Patrick et al., 2016).

Specifically, implementation of PDMPs that monitored four or more drug schedules and updated data at least weekly were associated with greater reductions in opioid-related overdose deaths than PDMPs without these characteristics (Patrick et al., 2016).

A 2016 report on mandatory PDMP prescriber use highlights the recent experiences of Kentucky, Tennessee, New York and Ohio. Data from these states indicate that mandated PDMP use can result in a rapid increase in enrollment and requests for prescription information, as well as a decrease in the rate of doctor shopping (i.e., multiple provider episodes, MPEs) and the number of prescriptions for opioid pain relievers (COE Briefing, 2016a).

b. Pain management clinics

Another strategy states can employ to address the opioid epidemic is the enactment of legislation that increases the oversight of pain management clinics. A “pain management clinic” can be defined

**SARA Recommends the Following for Prescription Drug Monitoring**

(Consistent with the PDMP best practices and research evidence)

1. Require all prescribers to check the PDMP before prescribing Schedule II, III, IV and V controlled substances.
2. Require dispensers to report to the PDMP within 24 hours.

   *(Ed. Update: The Georgia General Assembly enhanced the PDMP in 2017 (HB249) to require dispensers to enter prescription information within 24 hours of filling a prescription for the designated substances as of July 1, 2017. This will provide prescribers more efficient access to information with less wait time as they make the best clinical decisions possible for their patients. The new law also requires prescribers to register with the PDMP by January 1, 2018. Beginning July 1, 2018, prescribers will be required to check the PDMP before prescribing opiates or cocaine derivatives in Schedule II drugs or benzodiazepines.)*

3. Conduct an evaluation of the GA PDMP to determine: 1) whether the law is being enforced as intended; 2) whether the legislation is meeting its intended goals and 3) specifically whether the rate of doctor shopping, prescription drug misuse and abuse, opioid overdose deaths and other relevant outcomes have decreased as a result of the legislation.
4. Adopt unsolicited reporting of PDMP data to prescribers, dispensers, licensing boards and law enforcement agencies (COE Briefing, 2016b).
5. Publish quarterly reports summarizing de-identified, aggregate PDMP data on the Department of Public Health website. Georgia may be the only state in the nation that does not share such data with the public. It is difficult to curb an epidemic if the public does not know its extent.
6. Authorize the sharing of PDMP data across state lines.
7. Integrate PDMP data into physician and hospital electronic health record systems.
8. Continue to evaluate the use and effectiveness of GA’s PDMP; use evaluation results to better tailor the program to align with best practices.
as a physician practice that specializes in treating pain. On the other hand, a “pill mill” can be defined as a “pain management clinic whose providers operate outside the boundaries of standard medical practice by prescribing large quantities of opioids and other controlled substances with minimal medical oversight” (Lyapustina et al., 2016). Georgia law provides its own more specific definition of “pill mill” (see below). To date, 17 states, including Georgia, have adopted legislation that regulates pain clinics or pain management services. See the Appendix for recommendations of The National Safety Council and National Governors Association regarding pill mill legislation.

**Georgia’s pain management clinic legislation**

Georgia’s Pain Management Clinic Act (HB 178) became effective July 1, 2013. Georgia HB 178 defines a “pill mill” as a medical practice that advertises “treatment of pain” or a medical practice or clinic that has greater than 50 percent of its annual patient population being treated for pain for nonterminal conditions by prescribing Schedule II or III controlled substances.

The legislation requires all pain management clinics in the state to be licensed by the Georgia Composite Medical Board and requires clinics to biennially renew their license to continue to be eligible to operate at a specified location. Pain management clinics must also be registered with the Georgia State Board of Pharmacy, and owners of the clinics are required to meet continuing education and training requirements prior to renewing a license.

The law requires all pain management clinics to be owned by physicians licensed in the state, with the exception of pain management clinics that existed prior to June 30, 2013. The law also prohibits any person convicted of a felony from owning a pain management clinic.

**SARA Offers the Following Recommendations for Pain Clinics**

(Consistent with the NSC and NGA recommendations and research evidence)

1. Require pain management clinic providers to register with and use GA’s PDMP

   *(Ed. Update: As noted above, the Georgia General Assembly enhanced the PDMP with passage of HB249. This enhancement requires pain management clinics to register with and use Georgia’s PDMP.)*

2. Conduct an evaluation of GA’s pain management clinic legislation to determine: 1) whether the law is being enforced as intended; (2) whether the legislation is meeting its intended goals and (3) specifically whether the rate of opioid prescribing, opioid overdose deaths and related outcomes have decreased as a result of the legislation.

3. Continue to monitor and evaluate the implementation of GA’s pain management clinic legislation and enforcement efforts; use evaluation results to better tailor the legislation to align with best practices.
c. Prescriber education

Mandatory prescriber education

In May 2016, a joint meeting was held of the Drug Safety and Risk Management Advisory Committee and the Anesthetic and Analgesic Drug Products Advisory Committee of the Food and Drug Administration (FDA). At this meeting they discussed the Risk Evaluation and Mitigation Strategy (REMS) for Extended-Release (ER) and Long-Acting (LA) opioid analgesic medications.

The ER/LA Opioid Analgesics REMS was approved in July 2012 to address the serious adverse outcomes of overdose, addiction and death resulting from inappropriate prescribing, misuse and abuse of these products. The ER/LA Opioid Analgesics REMS is one of many national and state strategies to reduce the risk of abuse, misuse, addiction, overdose and deaths due to prescription opioid analgesics. The central component of the ER/LA Opioid Analgesics REMS is an education program targeted to prescribers—e.g., physicians, dentists, certified nurse midwives, nurse practitioners, physician assistants, podiatrists, optometrists.

Under the REMS, application holders of ER/LA opioid analgesics are required to make education programs available to health care providers who prescribe any of these agents. These programs are provided through educational grants to accredited continuing medical education (CME) providers who offer training to prescribers at no or nominal cost.

The FDA’s efforts to address prescription opioid misuse are part of a larger governmental response to the crisis. In 2011, the White House Office of National Drug Control Policy (ONDCP) launched a plan to reduce prescription drug abuse focused on four major areas: education, monitoring, proper medication disposal and enforcement.

The Secretary of the Department of Health and Human Services also launched a plan aimed at combating opioid misuse. Additionally, there are other critical federal efforts that FDA is supporting, including the draft National Pain Strategy, developed by the Interagency Pain Research Coordinating Committee and the Centers for Disease Control and Prevention (CDC) recently published Guidelines for Prescribing Opioids for Chronic Pain. Currently, 17 states, not including Georgia, have mandatory prescriber education regulations.

The training gap regarding appropriate prescribing of opioid medications is well documented. According to current research, practicing physicians receive fewer than 12 hours of pain management education in medical school and 60 percent of surveyed physicians did not receive training on “identifying prescription drug abuse and addiction” in medical school.

Opioid Prescribing Guidelines

According to the CDC, an estimated 20 percent of patients presenting to physicians with non-cancer pain symptoms or a pain-related diagnosis (including acute and chronic pain) received an opioid. In 2012, health care providers wrote 259 million prescriptions for opioid pain medication, equaling about one prescription per U.S. adult. Additionally, opioid prescriptions per capita increased 7.3 percent between 2007 and 2012, with opioid prescribing rates increasing more for primary care providers – family practice, general practice and internal medicine physicians – than other physician specialties.


Since opioid prescribing rates vary significantly across states in ways that are not related to the underlying health status of state populations, it is evident that there is a lack of consensus among clinicians on how to dispense opioids for pain management. As a result, CDC updated existing guidelines for prescribing opioid medications for chronic pain in 2016.

CDC’s guidelines for chronic pain management are intended for primary care clinicians.
prescribing opioids for chronic pain outside of active cancer treatment, palliative care and end-of-life care. Specifically these guidelines address: (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 harm in opioid management. CDC developed these guidelines using the Grading of Recommendations Assessment, Development, and Evaluation (GRADE) framework, and recommendations were made based on a systematic review of the scientific evidence and considerations of benefits and harms, values and preferences and resource allocation management.

Though Georgia does not have specific opioid prescribing guidelines, in May 2013, Georgia HB178 was signed into law making Georgia the ninth U.S. state to pass legislation regulating the ownership and operation of pain management clinics.

**SARA Recommends the Following for Prescriber Education**

1. Require ongoing education on addiction and pain management for all physicians and prescribers. Physicians and other opioid prescribers are important partners in preventing addiction linked to misuse of prescription opioids. To ensure that prescribers understand the risks presented by prescription opioids, legislation would mandate that these health care professionals complete three hours of education every two years on addiction, pain management and palliative care.

2. The Georgia Composite Medical Board mandate that a minimum of five of the 40 hours of required biennial CME credit hours focus specifically on the Georgia Prescription Drug Monitoring Program, pain management, guidelines for prescribing opioid medications for chronic pain and/or addiction disorders.

*(Ed. Update: In 2017, the Georgia Composite Medical Board implemented a requirement that prescribers complete two hours of continuing medical education (CME) on addiction, pain management and palliative care. The CMB intends for this to be a “one-time trial” requirement until the CMB can evaluate its impact and effectiveness.)*

3. Provide increased resources for educating medical students and residents on all aspects of addiction and pain management.

4. A Georgia specific task force, including but not limited to representatives from the Georgia Department of Public Health (DPH), health professional training institutions, health information technology (HIT) vendors and health professional subject matter experts be developed with the aims of: (1) incorporating training regarding the Prescription Drug Monitoring Program, guidelines for prescribing opioid medications for chronic pain, pain management and addiction disorders into all health professional training programs; (2) collaborating with HIT vendors to ensure seamless interoperability and connectivity between patient electronic health records (EHR) and the Georgia Prescription Drug Monitoring Program. Ultimately the goal would be to have a self-guided electronic prompt appear in patients EHR, which links directly to the PDMP encouraging physicians to check the database prior to writing opioid prescriptions for flags without having to close out their patients EHR and (3) developing and funding a grant to support academic detailing regarding appropriate opioid prescribing for health care providers across the state.
Since there are now evidence-based federal guidelines regarding opioid prescribing practices, it is critical that Georgia commit resources to support dissemination and integration of these guidelines in healthcare settings at the point of care.

While federal level guidelines are an important step in the right direction, by incorporating these guidelines in the physical space and EHRs, providers will have real-time prompts to promote evidence-based opioid prescribing at the point of care.

**SARA Recommends the Following for Controlling Access to Opioids**

1. Reduce prescription limits for opioids from 30 to seven days: there is a well-established link between the rise in opioid prescriptions and the current heroin crisis. To reduce unnecessary access to opioids, the legislation lowers the limit for opioid prescriptions for acute pain from 30-days to no more than a seven-day supply, with exceptions for chronic pain and other conditions.

   (Ed. Update: Since the publishing of the White Paper in January, 2017, prescribers have expressed strong concerns about setting any prescription limits. Prescribers view this kind of limitation as an intrusion into the doctor/patient relationship, and they say that it interferes with their ability to treat patients according to what their education and expertise should direct them to do.)

2. Georgia DPH should provide signage highlighting the main points for consideration in CDC’s guidelines for chronic pain management that can be posted in exam rooms and waiting rooms of prescribing providers’ offices.

3. A task force, including but not limited to representatives from Georgia DPH, health professional training institutions, HIT vendors and health professionals, should be developed with the aim of collaborating with HIT vendors to support integration of CDC opioid prescribing guidelines across treatment protocols and templates. This includes appropriate warnings and pop-up screens if prescriptions do not appear consistent with the underlying diagnosis.
III. Proposed legislative agenda for Georgia

What should Georgia do?

After a careful review of recent recommendations from the National Safety Council and the National Governors Association, SARA proposes a legislative agenda for Georgia as briefly outlined below. SARA provides detailed recommendations in the body of this study.

In addition to the legislative agenda outline below, SARA recommends that the State conduct a comprehensive needs assessment specifically related to the opioid crisis and develop both a strategic plan and an implementation plan to guide the State’s response to this epidemic. *(Ed. Update: In the spring and summer of 2017, the Georgia Department of Public Health (DPH) embarked on the process of creating a statewide strategic plan for addressing the prescription opioid and heroin epidemic in Georgia. SARA members have been active participants in assisting DPH with the planning process. SARA also believes that the top elected officials in the state, particularly the Governor, should ensure that all state agencies and departments give the highest possible priority to participation in implementing the plan.)*

*(Ed. Update: This White Paper was first published in January of 2017, prior to the convening and deliberations of the Georgia General Assembly – which considered and passed some of the recommendations in this report. Specifically, laws were passed that 1) increased access to naloxone and 2) strengthened the PDMP.)*

Phase I – Georgia’s most urgent needs

**1. Increase access to naloxone.**

More than 1,400 Georgians die each year from prescription opioid and heroin overdoses. Many of these deaths could be avoided with the use of naloxone, an opioid antagonist medication that reverses opioid overdose without significant negative side effects. First responders, parents, schools, commercial establishments and other public serving organizations should have easy access to naloxone and should have training in how to administer the drug.

*(Ed. Update: The Georgia General Assembly enacted SB121 in the spring of 2017, making naloxone available over-the-counter. In recent months, the Georgia Department of Public Health – with assistance from the pharmacy associations in the state – has worked to ensure that naloxone is widely available in pharmacies.)*

**2. Improve access to opioid use disorder treatment including medication-assisted treatment (MAT), evidence-based behavioral therapies and recovery support services.**

Anyone misusing prescription opioids or using heroin should have access to the full range of opioid use disorder treatment services including medically managed detoxification/withdrawal management, behavioral therapy, medications and recovery support services. These services should include support for: 1) families who have members in recovery; 2) community organizations that focus on recovery and 3) programs that focus on recovery.

**3. Increase funding for substance misuse prevention programs.**

The Georgia Legislature significantly reduced funding to DBHDD in 2010 for substance misuse prevention programs and administration. While DBHDD distributes and manages Federal substance misuse prevention funds, total State spending on substance misuse prevention within DBHDD currently is only $232,000 per year. Prescription drug education programs should target children ages 8 through 12 when they are most open to such education, teens, young adults and parents and fund new and innovative programs incorporating recovery-informed education. Education is also needed for seniors, women of reproductive age and other populations.
Phase II – Comprehensive and systematic approaches for Georgia

1. Increase oversight of pain clinics.

Georgia passed the Pain Management Clinic Act in 2013. Consistent with the National Safety Council and the National Governor’s Association recommendations, Georgia should do two things: 1) require pain clinics to register with and use Georgia’s PDMP and 2) conduct an evaluation of the legislation to determine if it is being enforced and what impact it has had on opioid prescribing and overdose deaths. (Ed. Update: Under HB 249 passed in 2017, pain clinics are required to register with and use Georgia’s PDMP.) (continued next page)
2. Create standards for prescriber education.

The Georgia Composite Medical Board should mandate that a minimum of five of the 40 hours of required biannual credit hours focus specifically on the Georgia PDMP, pain management and guidelines for prescribing opioid medications for chronic pain and/or substance use disorders. Requiring additional hours in addiction and recovery education should also be explored by the GCMB. (Ed. Update: In 2017, the Georgia Composite Medical Board implemented a requirement that prescribers complete two hours of continuing medical education (CME) on addiction, pain management and palliative care. The CMB intends for this to be a “one-time trial” requirement until the CMB can evaluate its impact and effectiveness.)

Longer term, Georgia should create a task force to address more detailed methods of educating all levels of health professionals on pain management and incorporating technology that integrates the PDMP more directly with patient electronic health records (EHR).

3. Create a recurring “blue-ribbon” commission on substance use and recovery.

The Georgia Legislature, in collaboration with the Governor’s Office, should create a recurring commission that convenes every three to four years to establish strategy and statewide goals, recommend appropriations and review progress on reducing substance misuse and expanding local systems of recovery supports and treatment services in Georgia. Regardless of how often the commission meets, an annual report should describe progress against goals.

SARA believes that the current State Senate Study Committee has been a valuable and well-managed process for addressing many substance use and misuse issues, and the recurring commission structure could be implemented as a simple extension and expansion of the current committee’s work, with new agenda items and expanded participation. Alternatively, the recurring commission could take the form of 1) a joint Senate-House Study Committee, 2) a Governor’s commission or 3) a privately run and funded commission.

We believe that while any of the above scenarios can be successful, the best structure would include maximum participation from key lawmakers, the Governor’s Office and the heads of certain state agencies. Non-profit organizations, for-profit companies and private individuals should also be included as members of the commission since they can also add great value to the commission’s goals and outcomes.

A recurring commission structure gives everyone an opportunity to review progress against goals, plan appropriations over multiple years and continually re-educate the participants about the issues associated with the subject matter.


Georgia received $11.8 million in 2017 to accomplish programs under 21st Century Cures Act. While it may be too late to make any substantive changes as to how these funds are spent in 2017 in Georgia, we believe that stakeholders should have a chance to provide input into how any future CARA funds or other federal funds are spent in the state. This proposed Georgia Advisory Council could operate as a committee of the “blue ribbon” commission.
The Georgia Prevention Project

The Georgia Prevention Project – SARA’s host organization – is a statewide not-for-profit effort that focuses on reducing the use of dangerous substances among teens and young adults. We accomplish our work through awareness campaigns, educational programming and strategic partnerships with national and community-based organizations.

The Georgia Prevention Project evolved from the Georgia Meth Project founded in 2009. Created by the Siebel Foundation, the national Meth Project effort won more than 45 national and international awards for its hard-hitting educational campaigns that helped reduce first-time meth use by more than 65 percent in its first two years in Montana. Subsequent launches in Idaho and Wyoming saw similar results and led to the addition of Hawaii, Colorado and Georgia as part of the Meth Project family.

In Georgia, the campaign led to significant changes in teens’ perceptions of risk associated with meth. During the media portion of the campaign of 2010-2012, the Georgia Meth Project ran more than 26,000 radio spots, placed 23,000 television ads and placed more than 588 billboards all over Georgia. This saturation effort significantly changed teens’ perceptions of risk about the drug and produced results very similar to the Montana program.

Riding the momentum of the successful “Not Even Once” meth prevention campaign, the Georgia Prevention Project launched in 2014 capitalizing on the Meth Project techniques and expanding its focus to include prescription drug misuse and heroin use.

Through its Teacher Substance Abuse Training Program and Teen Advisory Council (TAC) peer-to-peer education, GPP works to ensure that large numbers of Georgia teens gain in-depth knowledge of the risks associated with the misuse of prescription drugs and the misuse of dangerous substances such as methamphetamine and heroin.

On nine Georgia college campuses, GPP administers its College Prevention Program (CPP) - a program funded by the Georgia Department of Behavioral Health and Developmental Disabilities Office of Behavioral Health Prevention (DBHDD - OBHP). The CPP works to correct misperceptions, attitudes, and behaviors of college students towards prescription drug abuse, to enhance access to prevention resources, and to promote drug-free lifestyles.

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Prescription Opioids and Heroin Epidemic in Georgia

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2017 (Updated: December, 2017)
APPENDIX

Prescription Opioids and Heroin Epidemic in Georgia

I. Opioids Overview

National public policy strategies to address the prescription opioid and heroin epidemic:

- Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008
- Patient Protection and Affordable Care Act (ACA) of 2010
- Comprehensive Addiction and Recovery Act (CARA 2016)
- 21st Century Cures Act
- President’s Commission on Combating Drug Addiction and the Opioid Crisis

II. Key Georgia Issues and III. Proposed Legislative Agenda for Georgia

Georgia prevention programs

National primary prevention programs

The National Safety Council and National Governors Association recommendations for state PDMPs (NSC, 2016; NGA, 2016)

The National Safety Council and National Governors Association recommendations for pill mill legislation (NSC, 2016; NGA, 2016)

The National Safety Council and National Governors Association recommendations for increasing access to naloxone (NSC, 2016; NGA, 2016)

The National Safety Council and National Governors Association recommendations for expanding state capacity to treat opioid use disorder (NSC, 2016; NGA, 2016)

Georgia Medication-assisted Treatment Programs

Research on the effectiveness of pill mill legislation

Recurring Blue-Ribbon Commission on Substance Abuse and Recovery
I. Opioids Overview

Opioid Overdose Deaths by Type of Opioid: Heroin, 2015

Source: Kaiser Family Foundation's State Health Facts.

**National Public Policy Strategies to Address the Prescription Opioid and Heroin Epidemic**

Four major pieces of federal legislation addressed substance use disorders (SUD) in the past decade.

**Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008**

The Mental Health Parity and Addiction Equity Act (MHPAEA) requires private group health plans with 50 or more employees and Medicaid managed care plans that cover SUD treatment do so in a manner that is no more restrictive than coverage of other medical and surgical procedures. More specifically, the financial requirements applicable to SUD benefits and treatment limitations cannot be more restrictive than those for medical and surgical benefits and there cannot be separate cost-sharing requirements for SUD benefits.

**Patient Protection and Affordable Care Act (ACA) of 2010**

Historically, SUD treatment services either have not been covered under private and public insurance plans or had been limited through higher copayments, annual visit limits and placing medications on higher tiers than medication for other types of medical conditions. As a result, many Americans in need were unable to access affordable SUD treatment.
The Patient Protection and Affordable Care Act (ACA) dramatically changes this picture. The ACA provides greater access to SUD treatment through major coverage expansions, regulatory changes requiring coverage of SUD treatments in existing insurance plans and requirements for SUD treatment to be offered on par with medical and surgical procedures in conjunction with the Mental Health Parity and Addiction Equity Act (MHPAEA). The ACA enables states to address the opioid epidemic through four primary mechanisms: insurance coverage expansions, regulatory insurance reforms that require inclusion of SUD treatments, enhanced parity and opportunities to integrate SUD treatment and mainstream health care.

**Summary of the Affordable Care Act**

First, the ACA extends insurance coverage to millions of previously uninsured Americans through Medicaid expansion and state health insurance exchanges. An estimated 1.6 million Americans with SUD gained insurance coverage in Medicaid expansion states (Humphreys and Frank, 2014). As of January 1, 2017, 32 states including Washington, D.C. adopted Medicaid expansion. Additionally, seven states (Arkansas, Arizona, Iowa, Indiana, Michigan, Montana, New Hampshire) adopted 1115 waivers. Wisconsin covers adults up to 100 percent of the poverty line in Medicaid, but did not adopt expansion.

**Current Status of State Medicaid Expansion Decisions**

![Map of Medicaid Expansion Decisions](image)

The ACA extends coverage to children up to the age of 26 through their parent’s insurance, a population with high rates of opioid use disorders (Substance Abuse and Mental Health Services Administration, 2016), and prohibits insurers from refusing to sell insurance to individuals with pre-existing conditions. Specifically, those with a prior treatment admission for OUD can no longer be denied insurance.

Second, the ACA requires coverage of SUD screening and brief intervention on all insurance plans, and coverage of the Essential Health Benefit (EHB) package under Medicaid expansion programs and qualified health plans offered on state health insurance exchanges. While federal guidance on the EHB requires coverage of SUD treatment, it does not specify which services must be included. Thus, states have wide latitude in determining the optimal range of treatment services to cover for patients with SUD. However, under MHPAEA (see below), these services must be equivalent to medical and surgical services provided for other chronic health conditions. For the first time in history there are coverage requirements for SUD treatment. Given these requirements, which are largely funded by the federal government, states have the opportunity to address critical gaps in treatment services for Americans with OUD.

Third, the ACA extends the MHPAEA of 2008, which requires that insurers cover SUD treatment in a no more restrictive way than medical and surgical services. Federal parity rules now apply to all private plans including those offered on state exchanges and Medicaid expansion programs.

Fourth, the ACA offers newly expanded and newly reimbursable opportunities to improve care for Americans with SUD by promoting integration of SUD treatment and mainstream health care. Innovations such as Medicaid Health Homes, Coordinated Care Entities, Accountable Care Organizations and Patient Centered Medical Homes, promote a broad range of these reimbursable services under a unified budget – thus creating incentives to increase integration and coordination of care across SUD, mental health and medical care needs. Given the complex needs of most SUD patients, especially those with OUD, integrating services with primary and other specialty services, including community-based social supports, is considered crucially important.
Comprehensive Addiction and Recovery Act (CARA 2016)

On July 22, 2016, President Obama signed into law the Comprehensive Addiction and Recovery Act (CARA; P.L. 114-198). This is the most ambitious comprehensive effort undertaken to address the opioid epidemic. These encompass all of its six pillars of a coordinated response.

While it authorizes over $181 million each year in new funding to fight the opioid epidemic over the next 10 years, monies must be distributed annually, through the regular appropriations process. CARA establishes a comprehensive, coordinated and balanced strategy through enhanced grant programs that would expand prevention and education efforts, while also promoting treatment and recovery. The bill passed the U.S. Senate in March 2016 by a vote of 94-1. The bill passed the House of Representatives in May 2016, by a vote of 400-5. Funding must be appropriated through the annual appropriations process for the funds to be distributed in accordance with the law.

The CARA’s comprehensive, coordinated and balanced strategy expands prevention and education grants while also promoting treatment and recovery.

- Expand prevention and educational efforts—particularly aimed at teens, parents and other caretakers and aging populations—to prevent the abuse of methamphetamines, opioids and heroin, and to promote treatment and recovery.
- Expand the availability of naloxone to law enforcement agencies and other first responders to help in the reversal of overdoses to save lives.
- Expand resources to identify and treat incarcerated individuals suffering from SUDs promptly by collaborating with criminal justice stakeholders and by providing evidence-based treatments.
- Expand disposal sites for unwanted prescription medications to keep them out of the hands of children and adolescents.
- Launch an evidence-based opioid and heroin treatment and intervention program to expand best practices throughout the country.
- Launch a medication-assisted treatment and intervention demonstration program.
- Strengthen prescription drug monitoring programs to help states monitor and track prescription drug diversion and to help at-risk individuals access services.

Section-by-Section Summary of CARA Provisions

Title I: Prevention and Education

Sec. 101 – Develop Best Practices for Prescribing of Prescription Opioids: This section requires establishing an inter-agency task force, composed of representatives from HHS, VA, DEA, CDC and other federal agencies, as well as addiction treatment organizations and other stakeholder communities to develop best practices for pain management and pain medication prescribing. It also requires the Task Force to submit a report to Congress outlining a dissemination strategy and other recommendations.

Sec. 102 – Awareness Campaigns: This section requires HHS and the Attorney General to advance the education and awareness of the public of the risk of abuse of prescription opioid drugs if they are not taken properly. It also establishes a national drug awareness campaign led by the Office of National Drug Control Policy (ONDCP) to bring attention to the association between prescription opioid abuse and heroin use, as well as focus on the dangers of fentanyl.

Sec. 103 – Community-Based Coalition Enhancement Grants to Address Local Drug Crises: This section authorizes HHS, in consultation with the Director of ONDCP, to make grants to entities suffering from drug crises (experiencing above average rates of prescription drug, heroin or methamphetamines abuse for extended periods or sudden spikes) to implement community-wide prevention strategies.
Title II: Law Enforcement and Treatment

Sec. 201 – Treatment Alternative to Incarceration Programs: This section authorizes HHS, in coordination with the Attorney General, to make grants to states, local governments, Indian tribes or non-profits to develop, implement or expand treatment alternatives to incarceration under specific circumstances (including with the consent of prosecuting and defense attorneys, corrections officials and other appropriate stakeholders) for individuals who meet certain criteria. It requires periodic updates on the progress of individuals placed in alternative settings.

Sec. 202 – First Responder Training for the Use of Drugs and Devices that Rapidly Reverse the Effects of Opioids: This section authorizes HHS, in coordination with the Attorney General, to make grants to state, local and tribal law enforcement agencies for training in the use of naloxone and for the purchase of naloxone.

Sec. 203 – Prescription Drug Take Back Expansion: This section authorizes the Attorney General, in coordination with the Administrator of the Drug Enforcement Administration (DEA), the Secretary of HHS and the Director of ONDCP, to coordinate with State, local or tribal law enforcement agencies, as well as pharmacies and others, to develop or expand disposal sites for unwanted prescription medications.

Sec. 204 – Heroin and Methamphetamine Task Forces: This section authorizes the Attorney General to make grants to State law enforcement agencies to locate or investigate illicit activities related to the distribution of heroin or fentanyl or the unlawful distribution of prescription opioids.

Title III: Treatment and Recovery

Sec. 301 – Evidence-Based Prescription Opioid and Heroin Treatment and Interventions Demonstration: This section authorizes the Director of the Center for Substance Abuse Treatment to award grants to State substance abuse agencies, units of local government, Indian tribes or tribal organizations or non-profit organizations in geographic areas that have a high rate of—or have had rapid increases in—heroin or other opioids to expand activities (including those making available medication-assisted treatment) in the relevant areas.

Sec. 302 – Criminal Justice medication-assisted treatment and Interventions Demonstration: This section authorizes HHS, in coordination with the Attorney General, to make grants to eligible entities for the administration of medication-assisted treatment programs through criminal justice agencies.

Sec. 303 – National Youth Recovery Initiative: This section authorizes the Secretary of Health and Human Services, in coordination with the Secretary of Education, to make grants to eligible entities (including high schools, institutions of higher learning, non-profit organizations and others) to provide support for recovery from substance use disorders to individuals in high school or enrolled in institutions of higher learning.

Sec. 304 – Building Communities of Recovery: This section authorizes HHS to award grants to certain independent non-profit organizations for the development and expansion of recovery services.

Title IV: Addressing Collateral Consequences

Sec. 401 – Correctional Education Demonstration Grant Programs: This section authorizes the Attorney General to award grants to states, local governments, non-profit organizations or Indian tribes to design, implement and expand educational opportunities for people in jails, prisons and juvenile detention facilities. Grants under this section may be used to pay for basic education, secondary level education, high school equivalency examination preparation, career technical education and English as a second language education. They may also be used for instructor hiring and teaching and the screening and assessment of individuals to determine educational and other needs, risk and aptitude.
Sec. 402 – National Task Force on Recovery and Collateral Consequences: This section creates a task force made up of representatives from the health care, housing, employment, substance use disorder, law enforcement and legal communities to identify the collateral consequences faced by individuals with state or federal drug convictions and to recommend ways of reducing and, where possible, eliminating them.

**Title V: Addiction and Recovery Services for Women, Families and Veterans**

Sec. 501 – Improving Treatment for Pregnant and Postpartum Women: This section authorizes the creation of grants for the purpose of expanding a State's services for women offenders who are pregnant and women offenders with dependent children who are suffering from substance use disorder.

Sec. 502 – Report on Grants for Family-Based Substance Abuse Treatment: This section directs the Attorney General to submit to Congress an annual report that describes the number of grants awarded under section 2921(1) of the Omnibus Crime Control Bill that are used for family-based substance use treatment programs that serve as alternatives to incarceration for custodial parents to receive treatment and services as a family.

Sec. 503 – Veterans’ Treatment Courts: This section amends the Omnibus Crime Control and Safe Streets Act of 1968 to allow for veterans who were discharged or released from service under dishonorable conditions, if the reason for that discharge was attributable to a substance use disorder.

**Title VI: Incentivizing State Comprehensive Initiatives to Address Prescription Opioid and Heroin Abuse**

Sec. 601 – State Demonstration Grants for Comprehensive Opioid Abuse Response: This section authorizes the Attorney General, in coordination with the Secretary of Health and Human Services and the Director of the Office of National Drug Control Policy, to award planning and implementation grants to eligible state, units of local government, territories or Indian Tribes, or combination thereof, to prepare a comprehensive plan for, and implement, an integrated opioid abuse response initiative. The comprehensive response must include specific improvements to state prescription drug monitoring programs, as well as prevention/education efforts, expanded treatment programs and plans for reversing opioid overdoses.

**Title VII: Miscellaneous**

Sec. 701 – GAO Report on IMD Exclusion: This section requires GAO to publish a report, within 365 days, on the impact that the Medicaid Institutions for Mental Disease exclusion has on access to treatment for individuals with substance use disorders.

Sec. 702 – Funding: This section authorizes $62 million for each FY 2016 through FY 2020 in funding for the Attorney General and HHS to carry out the provisions of the bill.

Sec. 703 – Conforming Amendments: This section amends the Omnibus Crime Control and Safe Streets Act to include the heading “Comprehensive Addiction and Recovery.”

Sec. 704 – Grant Accountability: This section requires all grants awarded under the provisions of the bill to be subject to audits and other accountability measures.

Sec. 705 – Programs to Prevent Prescription Drug Abuse under the Medicare Program: This section authorizes amendments to the Social Security Act to ensure the prevention of prescription drug abuse within Medicare among at-risk individuals.
**Title VIII: Transnational Drug Trafficking Act**

**Sec. 801** – Short Title: This section names the Title of the bill as the “Transnational Drug Trafficking Act of 2015.”

**Sec. 802** – Possession, Manufacture or Distribution for Purposes of Unlawful Importations: This section makes it illegal to manufacture or distribute a Schedule I or Schedule II controlled substance with the knowledge that this will be imported into the U.S.

**Sec. 803** – Trafficking in Counterfeit Goods or Services: This section adds trafficking in a drug to the U.S. while knowingly using a counterfeit mark with the drug as a crime to be punished by fine or imprisonment (CARA, October 2016).

**21st Century Cures Act (2016)**

The 21st Century Cures Act was signed into law on December 13, 2016. While CARA authorized many harm reduction strategies including distribution of naloxone, it did not provide funding for these. 21st Century Cures included authorization of $1.1 billion dollars over two years for grants to states to address the opioid epidemic.

The funds are to be used to “supplement activities pertaining to opioids undertaken by the State agency responsible for administering the substance abuse prevention and treatment block grant,” such as:

- Improving prescription drug monitoring programs (PDMPs)
- Implementing and evaluating prevention activities
- Training for health care providers on safe opioid prescribing, pain management, recognizing substance use disorders, referral to treatment and overdose prevention
- Supporting access to health care services
- Other public health-related activities

The Substance Abuse and Mental Health Services Authority (SAMHSA) released a funding announcement, **State Targeted Response to the Opioid Crisis Grants (STR)**, on December 14, 2016, and awards were made on April 19, 2017. Award summaries of each state’s approach can be found here: https://www.samhsa.gov/sites/default/files/grants/pdf/other/ti-17-014-opioid-str-abstracts.pdf.

The **President’s Commission on Combating Drug Addiction and the Opioid Crisis** recommends:

- Increasing treatment capacity by granting waiver approvals for all 50 states to eliminate barriers to treatment resulting from the Institutes for Mental Diseases (IMD) exclusion within Medicaid;
- Mandating prescriber education initiatives to enhance prevention efforts, including mandating medical education training in opioid prescribing and risks;
- Establishing and funding a federal incentive to enhance access to Medication-Assisted Treatment (MAT) and requiring that all modes of MAT are offered at every licensed MAT facility;
- Providing model legislation for states to allow naloxone dispensing via standing orders and equipping all law enforcement officers with naloxone; and
- Prioritizing funding to the Department of Homeland Security (DHS), Federal Bureau of Investigation (FBI) and the Drug Enforcement Agency (DEA) to develop fentanyl detection sensors and disseminate them to federal, state and local agencies.
II. Key Georgia Issues

Georgia prevention programs

The Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD) and its Office of Behavioral Health Prevention (OBHP) is the state agency charged with providing prevention leadership, strategic planning and services to improve the mental/emotional well-being of communities, families and individuals in Georgia. DBHDD also provides support and funding for organizations involved in treatment and recovery (see Section 2 – Treatment and Recovery).

With substantial funding from SAMHSA, the OBHP develops and contracts for prevention services across the state specifically designed to reduce the risks and increase protective factors linked to substance abuse-related problem behaviors, suicide and mental health promotion.

OBHP adheres to the prevention priorities set by SAMHSA, so most of its programming focuses on the prevention of underage drinking and prescription drugs misuse and abuse. OBHP manages eight key programs that specifically address prescription drug misuse/abuse prevention: 1) Alcohol and Substance Abuse Prevention Project (ASAPP), 2) Generation Rx Project (GEN Rx), 3) Georgia Prescription Drug Abuse Prevention Initiative (GPDAPI), 4) Strategic Prevention Framework for Prescription Drugs (SPF-Rx), 5) State Targeted Response to Opioids (STR), 6) College Prevention Project (CPP), 7) Maternal Substance Abuse and Childhood Development/Fetal Alcohol Spectrum Disorders (MSCAD/FASD), and 8) Georgia Teen Institute (GTI).

1. The Alcohol and Substance Abuse Prevention Project (ASAPP) is a data driven statewide initiative aimed at preventing alcohol and other identified substances of misuse/abuse and promoting healthy lifestyles and choices among Georgians. ASAPP grew out of the Alcohol Prevention Project (APP), which began in 2011 and required providers to implement the Strategic Prevention Framework (SPF). ASAPP Providers are still required to utilize the SPF to target seven data driven statewide goals:
   - Reduce access to alcohol and binge drinking among 9 to 20 year olds.
   - Reduce the early onset of alcohol use among 9 to 20 year olds.
   - Reduce underage drinking rates.
   - Reduce binge drinking and heavy drinking among 18-25 year olds.
   - Reduce the use of specific additional substances (e.g. marijuana, tobacco, prescription drugs) targeted by individual providers.
   - Identify the most effective strategies for communities.
   - Build and increase the capacity of the prevention workforce.

ASAPP now allows communities to also address a second high priority substance of abuse and misuse identified through assessment data. ASAPP is funded through the SAMHSA Substance Abuse Block Grant (SABG). Five ASAPP providers have chosen to address prescription drug misuse/abuse in their respective target county (Bulloch, Camden, Columbia, Fayette, and Glascock Counties).
2. The GEN Rx Project was created when Georgia DBHDD OBHP was awarded the Partnership for Success II grant (PFSII) in 2011. PFSII ended three years later, and OBHP was awarded the Partnership for Success 2015 (PFS15) to continue GEN Rx for an additional five years. The goal of GEN Rx is to reduce prescription drug misuse and abuse among 12-25 year olds in three high need counties (Catoosa, Early, and Gwinnett). GEN Rx aims to decrease availability and access to prescription drugs, to increase peer and family norms that discourage prescription drugs misuse/abuse, and increase perception of prescription drug risk/harm.

3. The Georgia Rx Drug Abuse Prevention Initiative (GPDAPI) addresses four priority areas that were identified by the Office of National Drug Control Policy (ONDCP) and adapted by the GPDAPI as follows: 1) education, 2) advocacy, 3) proper medication disposal and 4) safe storage, all of which focus on reducing prescription drug abuse in Georgia. The success of the Initiative depends partly on collaborating with over 230 private and public sector partners via the Georgia Prescription Drug Abuse Prevention Collaborative (GPDAPI). This initiative is managed by the non-profit organization, The Council on Alcohol and Drugs (TCAD).

The GPDAPI is a statewide collaborative that focuses on the four priority areas named above. The GPDAPI includes organizations and individuals working collectively in Georgia to reduce prescription drug abuse, misuse and overdose. Collaborative members network via four priority area action teams with community and political leaders to raise awareness, monitor and provide policy education regarding prescription drug and opiate abuse prevention policy, and promote safe disposal and secure storage.

4. The SPF-Rx project was also created through a SAMHSA grant awarded to Georgia DBHDD OBHP in 2016. The goal of SPF-Rx is to prevention and reduce prescription drug misuse and abuse in Georgia. Specifically, SPF-Rx objectives are: 1. Increase community awareness on the risks associated with prescription drug misuse and abuse including dangers of sharing medications, 2. Increase medical and pharmaceutical communities’ awareness on the risk of overprescribing prescription drugs to young adults, 3. Improve and enhance access and usability of opioid overdose and PDMP data into state prevention assessments and planning. SPF-Rx will fund five high need communities to implement the SPF, Medical Association of Georgia and Georgia Pharmacy Association to increase prescribers’ and dispensers’ awareness of overprescribing and the PDMP, work towards improvement and enhancement of access and usability of the PDMP data, an updated Georgia Rx Drug Needs Assessment Report, and a SPF-Rx Public Education Plan.

5. The State Targeted Response to Opioids (STR) was awarded to Georgia DBHDD OBHP in April of 2017 to develop a targeted response to the opioid crisis in Georgia through prevention, treatment, and recovery initiatives. Prevention specific objectives are to increase awareness about opioid misuse and abuse, and to provide training for the public, communities, schools and first responders to prevention opioid misuse and abuse. STR funds four high need communities to implement the SPF (Bryan, Coweta, Dekalb, and Richmond Counties), a statewide media campaign, a naloxone education and training project, and a school mentoring transition pilot program.

6. DBHDD OBHP fund the Georgia Prevention Project to implement the College Prevention Project (CPP) to prevention and reduce prescription drug misuse and abuse on college campuses in Georgia. The goal of CPP is to correct misperceptions, attitudes, and behaviors of college students towards prescription drug abuse, to enhance access to prescription drug abuse prevention resources, and to promote drug-free lifestyles. Currently CPP includes nine colleges and universities in Georgia: Emory University, Emory at Oxford University, Georgia College, Georgia Southern University, Georgia State University, Georgia Tech, Kennesaw State University, Mercer University, University of Georgia. Each college/university formed a workgroup to address and prevent prescription drug abuse on their campus using the Strategic Prevention Framework (SPF) model. Workgroups have been trained on the SPF (Strategic Prevention Framework) and work to implement strategies and activities on campus.
7. Maternal Substance Abuse and Childhood Development/Fetal Alcohol Spectrum Disorders (MSCAD/FASD) program at Emory University is funded by DBHDD OBHP to reduce maternal substance use and/or abuse and child development issues in Georgia. Emory provides education and awareness about NAS across the state of Georgia.

8. The Georgia Teen Institute (GTI), a program of county-funded Gwinnett United in Drug Education, Inc. (GUIDE), focuses on youth leadership across several regions of Georgia. The institute begins with a summer training program and continues with year-round support. GTI is dedicated to providing young people in middle and high schools with opportunities to become strong leaders.

The goal of GTI is to provide education training and motivation to middle and high school students and adult advisors in an effort to assist them in:

- Developing or enhancing sound habilitation concepts and life skills.
- Designing and implementing effective prevention initiatives which will have a positive impact on alcohol, tobacco and other drug use and other health and safety problems within their communities.
- Promoting peer-led prevention in school and community activities.

GTI seeks to reduce the frequency of underage alcohol use, tobacco and other drug use and other self-destructive behaviors by guiding students to realize their leadership potential, learn new skills and become empowered to create change in their schools and communities.

Statewide Non-profit Providers

DBHDD funds multiple non-profit organizations that have statewide programs focused on prescription drug misuse/abuse. These organizations include:

- The Georgia Prevention Project (GPP),
- The Council on Alcohol and Drugs (TCAD)
- Emory Maternal Substance Abuse and Childhood Development
- Atlanta Harm Reduction Coalition
- Medical Association of Georgia
- Georgia Pharmacy Association
- Georgia Teen Institute (GTI)

National Primary Prevention Programs

The Substance Abuse and Mental Health Services Administration (SAMHSA) within the U.S. Department of Health and Human Services leads public health efforts to advance the behavioral health of the nation. SAMHSA's mission is to reduce the impact of substance misuse and mental illness on America’s communities.

Congress established SAMHSA in 1992 to make substance use and mental health information, services and research more accessible. Consequently, SAMHSA is the governmental authority and leading provider of funds for substance misuse prevention services both nationally and locally.

Furthermore, SAMHSA sets the priorities for what types of substance misuse prevention programs are funded. Depending on national trends at any particular time, the priority focus shifts from underage drinking to marijuana to prescription drugs to opioids.

Alcohol continues to be the most widely misused substance among America’s youth. Consumption of alcohol by anyone under the age of 21 remains a considerable public health challenge.
In recent years, all federal agencies have been tasked with addressing the opioid epidemic through their respective programs, and each agency has a unique role in the effort. In that light and despite continuing its substantial attention to underage drinking, SAMHSA has in the last couple of years shifted significant resources and attention to address the growing misuse of prescription drugs and, more specifically, illicit opioid use among 12 to 25-year-olds.

In December 2016, with the authorization of the 21st Century Cures legislation, SAMHSA announced the availability of $1.1 billion (State Targeted Response to the Opioid Crisis) to address the opioid crisis in all states and territories and the District of Columbia, and administers the awards made in April 2017. Georgia received $11.8 million. This funding includes a media campaign. In 2017, SAMHSA also funded building communities of recovery program grantees. The Georgia Council on Substance Abuse received one of eight awards.

**Office of National Drug Control Policy (ONDCP)**

A component of the Executive Office of the President, ONDCP was created by the Anti-Drug Abuse Act of 1988. ONDCP advises the President on drug-control issues, coordinates drug-control activities and related funding across the Federal government and produces the annual National Drug Control Strategy that outlines Administration efforts to reduce illicit drug use, manufacturing and trafficking, drug-related crime and violence and drug-related health consequences. ONDCP now also contains the Office of Recovery.

The Drug-Free Communities (DFC) Support Program, created by the Drug-Free Communities Act of 1997, is the Nation's leading effort to mobilize communities to prevent youth substance use. Directed by ONDCP, in partnership with SAMHSA, the DFC Program provides grants to community coalitions to strengthen the infrastructure among local partners to create and sustain a reduction in local youth substance use.

In FY 2016, $85.9 million was awarded to fund 92 new DFC grants, 585 continuation grants for coalitions already in a five-year cycle, three new DFC Mentoring (DFC-M) grants and 18 continuation DFC-M grants.

ONDCP awarded one new DFC grant in Georgia in FY 2017 to the Cobb Community Alliance to Prevent Substance Abuse in Marietta. This grant adds to the 16 grants previously awarded to the cities of Lawrenceville, Gainesville, Atlanta, Lagrange, Blakely, Richmond Hill, Grovetown, Conyers, Cumming, Rome, Holly Springs, Statesboro, Quitman and Fayetteville. These grants include two grants for the city of Atlanta, and one DFC-M (mentor) grant for Lawrenceville.

To date, only a small percentage of DFC grantee programs nationally or in Georgia, are focused on opioid misuse prevention programs. In Georgia, about half of DFC grantees have prescription drug-related strategies. While encouraged to use evidence-based strategies, and strongly encouraged by SAMHSA and CADCA (see below) training, Georgia DFCs are in the early stages of working collaboratively with each other.

**Community Anti-Drug Coalitions of America (CADCA)**

The mission of CADCA is to strengthen the capacity of community coalitions to create and maintain safe, healthy and drug-free communities globally.

CADCA represents more than 5,000 community coalitions nationwide working together to create a world of safe, healthy and drug-free communities. CADCA leads this vision by providing cutting-edge services in training, communications, youth empowerment, veteran’s programs, public policy and advocacy and the latest scientific research.

For the past several years, CADCA has set its focus on the prevention of alcohol abuse and prescription drug misuse.

CADCA urges coalitions to help raise awareness about the dangers of prescription and over-the-counter medicine abuse by taking part in National Medicine Abuse Awareness Month (NMAAM).
The campaign serves as an ideal launching pad for medicine abuse prevention efforts. A cornerstone of the NMAAM campaign is the CADCA 50 Challenge, an initiative designed to challenge coalitions to get medicine abuse on the radar screens of parents and others by holding an educational event or activity in their communities.

Through a partnership with the National Institute on Alcohol Abuse and Alcoholism (NIAAA), CADCA encourages advocates to demonstrate their social media acumen and inform on the topic of alcohol abuse.

They teamed up for a new communications challenge to share NIAAA’s scholarly facts with the masses by keeping information bite-sized to quickly understand and share with others. This is already a widely accepted marketing and communications strategy. CADCA has an online Medicine Abuse Prevention Toolkit: http://www.preventmedabuse.org/.

**Partnership for Drug-Free Kids**

The Partnership for Drug-Free Kids is a national non-profit committed to helping families struggling with their child’s substance use. Founded in 1986 as the Partnership for a Drug Free America, it is the longest running national non-profit that focuses on substance abuse prevention.

One important way it helps families find answers is by translating the science of substance use and addiction into support and tools for parents.

Another way the Partnership helps families find answers is through timely responses to emerging drug threats. With funding and support from the High Intensity Drug Trafficking Areas (HIDTAs) in the eastern United States, in May 2016 it launched a comprehensive resource to help families and communities address the country’s growing heroin and prescription drug abuse crisis. Titled “Heroin and Other Opioids: From Understanding to Action,” it provides parents with information, support for their family and treatment resources for their loved one.

Particularly helpful to parents is the Partnership’s Parent Support Network which provides an evidence-informed service available free of charge to parents through the Partnership helpline at (855)-378-4373.

The opioid epidemic is also the principal target of its multi-year national action campaign, The Medicine Abuse Project. The Partnership works with federal partners, numerous nonprofit and association partners and both public and private sector funders to help educate parents and the public at large about what they can do to end adolescent medicine abuse.

Other organizations participating with the Partnership include: federal partners such as the National Institute on Drug Abuse, the Drug Enforcement Administration, the Centers for Disease Control and Prevention and the Office of National Drug Control Policy; a large number of strategic partners including the American Academy of Pediatrics and the American Academy of Family Physicians; and private sector partners, including a number of pharmaceutical companies.

The most visible initiatives include its “Mind Your Meds” campaign, a teen-made documentary, “Out of Reach” and website at www.medicinabuseproject.org, which offers an array of best-in-class resources for parents, educators, health care providers and community leaders/law enforcement.

In addition, the Partnership is engaged in a five-year prescriber education effort, underwritten by the Food and Drug Administration, aimed at driving greater prescriber use of state-based Prescription Drug Monitoring Programs (PDMPs), which has been shown to significantly reduce doctor shopping when consistently applied.
The National Safety Council and National Governors Association recommendations for state PDMPs (NSC, 2016; NGA, 2016):

1. Require providers to check the PDMP before prescribing Schedule II, III and IV controlled substances
2. Require providers to report to the PDMP within 24 hours
3. Simplify the PDMP registration process, integrating and automating when possible with other licensing processes
4. Make PDMPs easier to use by integrating PDMP data into electronic health records and health information systems
5. Improve reporting response times and upgrade PDMP technology to facilitate data transfer into clinical workflows
6. Allow prescribers to establish delegate accounts
7. Allow the creation of institutional accounts
8. Use PDMP data to provide proactive analyses and reporting to professional licensing boards and law enforcement
9. Ensure PDMP interoperability with other states

The National Safety Council and National Governors Association recommendations for pill mill legislation (NSC, 2016; NGA, 2016):

1. Define what constitutes a pain management clinic based on the volume and types of services provided
2. Enforce prescription guidelines based on set standards and best practices of medical care by state licensing authorities and prevailing best practice standards
3. Define ownership requirements so owners of pill mills can be identified and held accountable if in violation of state policy
4. Require pain management clinics to register with the state or obtain a license or certificate from the state
5. Give the state health agency or licensing board authority to inspect pain management clinics and mandate unannounced inspections when receiving complaints of violations
6. Require pain management clinic owners and medical directors to meet training requirements
7. Prohibit non-law-abiding or restricted licensees from becoming owners or employees
8. Restrict the prescribing of controlled substances
9. Require PDMP utilization
10. Require a medical evaluation including adequate patient history and physical examination prior to prescribing medication
11. Conduct an appropriate patient risk assessment at each visit
National Governors Association Recommendations

1. Develop and update guidelines for all opioid prescribers
2. Limit new opioid prescriptions for acute pain, with exceptions for certain patients
3. Develop and adopt a comprehensive opioid management program in Medicaid and other state-run health programs
4. Remove methadone for managing pain from Medicaid preferred drug lists
5. Expand access to non-opioid therapies for pain management
6. Enhance education and training for all opioid prescribers
7. Maximize the use and effectiveness of state PDMPs
8. Use public health and law enforcement data to monitor trends and strengthen prevention efforts
9. Enact legislation that increases oversight of pain management clinics to reduce “pill mills”
10. Raise public awareness about the dangers of prescription opioids and heroin
11. Establish a collaborative information sharing environment that breaks down silos across state agencies to better understand trends, target interventions and support a comprehensive state response
12. Leverage assets from partner entities to improve data collection and intelligence sharing to restrict the supply of illicit opioids
13. Expand statutory tools for prosecuting major distributors
14. Expand law enforcement partnerships and data access to better target over-prescribers
15. In narcotics investigations, implement best practices and ensure intergovernmental cooperation
16. Establish and enhance stakeholder coalitions
17. Change payment policies to expand access to evidence-based MAT and recovery services
18. Increase access to naloxone
19. Expand and strengthen the workforce and infrastructure for providing evidence-based MAT and recovery services
20. Create new linkages to evidence-based MAT and recovery services
21. Consider authorizing and providing support to syringe service programs
22. Reduce stigma by changing the public’s understanding of substance use disorder
23. Empower, education and equip law enforcement personnel to prevent overdose deaths and facilitate access to treatment
24. Reinforce use of best practices in drug treatment courts
25. Ensure access to MAT in correctional facilities and upon reentry into the community
26. Strengthen pre-trial drug diversion programs to offer individuals the opportunity to enter into substance use treatment
27. Ensure compliance with Good Samaritan laws (NGA, 2016)
National Safety Council Recommendations:

1. Establish State requirements for medical education on effective pain management
2. Require CME for prescribers who apply for a new or renewed registration under the Controlled Substances Act of 1970. CME should be pertinent to the classes of controlled substances prescribed by the provider.
3. Adopt state opioid prescribing guideline.
4. Develop or strengthen state policy that stops the establishment and/or operation of pill mills that function outside prescribing standards for licensed, qualified physicians and whose primary treatment is prescribing opioids.
5. Make PDMPs easy to use:
6. Require the collection of prescription data within 24 hours
7. Simplify the PDMP registration process, integrating and automating when possible with other medical professional licensing processes
8. Improve reporting response times and facilitate data transfer into clinical workflows
9. Improve reporting of drugs involved in drug overdose fatalities
10. Expand access to naloxone and remove barriers to its purchase and use
11. Increase patient caseload caps for buprenorphine waivered physicians
12. Allow advanced practice nurses to obtain waivers to prescribe buprenorphine. Expand use of medication-assisted treatment, ensure it is offered and available at state-funded treatment providers.
13. Require public and private health insurers to cover medication-assisted treatment
14. Remove caps on the duration of medication-assisted treatment (NSC, 2016)

The National Safety Council and National Governors Association recommendations for increasing access to naloxone (NSC, 2016; NGA, 2016):

- Review and remove Medicaid barriers to naloxone, such as prior authorization, and consider placing naloxone on the preferred drug list
- Work to ensure that naloxone is covered by all insurance plans
- Pass “Good Samaritan” laws to protect prescribers, first responders and bystanders from liability when prescribing or administering naloxone
- Enact legislation allowing naloxone dispensing via standing orders, collaborative practice agreements, statewide protocols or pharmacist authority
- Train first responders to recognize the signs of opioid overdose and administer naloxone
- Partner with professional associations to promote co-prescribing of naloxone when clinically appropriate
- Permit third party prescribing of naloxone
- Create a centralized naloxone procurement and distribution process at the state level and consider negotiating with manufacturers to obtain a competitive pricing agreement
The National Safety Council and National Governors Association recommendations for expanding state capacity to treat opioid use disorder (NSC, 2016; NGA, 2016):

- Change payment policies to expand access to evidence-based MAT and recovery services
- Ensure that Medicaid and other state health programs adequately cover all FDA-approved MAT (methadone, buprenorphine, oral and extended-release injectable naltrexone) and evidence-based behavioral interventions. Encourage or require commercial health plans to adopt similar policies.
- Provide reimbursement for components of comprehensive evidence-based treatment and recovery, including medication, office visits, behavioral interventions and wrap-around services.
- Review and remove barriers to MAT, such as fail first and inappropriate prior authorization protocols, and encourage generic substitution when appropriate.
- Work with the department of insurance to enforce federal parity laws designed to ensure equal access to behavioral health care and medical/surgical care.
- Use payment strategies (e.g., pay for performance, quality metrics and separating behavioral health from payment bundles) to increase access to evidence-based MAT and behavioral interventions and promote integration of behavioral health and primary care.
- Require buprenorphine waiver training in primary care and other select medical residency programs.
- Establish a coordinated treatment system in which specialty treatment centers stabilize patients and refer to community providers for ongoing care (e.g., hub and spoke model).
- Provide ongoing education and support to primary care providers and other buprenorphine prescribers to expand MAT capacity (e.g., Project ECHO telehealth model).
- Increase the number of office- and community-based opioid treatment programs through collaboration with community health centers and new state funding.
- Expand the reach of peer and family support organizations (e.g., Learn to Cope) through Medicaid and other state funding.
- Begin MAT in emergency departments following an opioid overdose or related drug event, and ensure immediate linkages to behavioral services and community supports.
- Establish peer-based recovery programs in emergency departments to support individuals following an opioid overdose or related drug event.
- Train first responders to refer patients to high-quality MAT and harm reduction services following an overdose reversal.
- Provide information and assistance to help health care providers and the public identify treatment and recovery options in their communities (e.g., a call line).
Georgia Opioid Treatment Programs


The Opioid Treatment Providers of Georgia (OTPGA) is a non-profit organization of medication-assisted treatment providers, counselors and others interested in treatment, recovery and traditional and alternative options for heroin and other opioid addiction (otpgeorgia.org/otpg-member-treatment-facility-map).

Research on the effectiveness of pill mill legislation

Four studies have examined the effectiveness of pill mill legislation in Florida and Texas (Lyapustina et al., 2015; Rutkow et al., 2015; Chang et al., 2016; Kennedy-Hendricks et al., 2016). Rutkow and colleagues (2015) found that Florida’s pill mill legislation was associated with modest decreases in opioid prescribing (decrease in opioid prescriptions, opioid volume and morphine milligram equivalents (MME) per transaction).

These decreases were concentrated among prescribers and patients with the highest baseline opioid prescribing and use (Rutkow et al., 2015). A second study of the Florida legislature showed similar findings and indicated that high-risk prescribers were disproportionately responsive to state policies than low-risk prescribers (Chang et al., 2016). A third study of Florida state laws and law enforcement operations targeting pill mills found reductions in opioid overdose deaths (Kennedy-Hendricks et al., 2016).

A study of Texas’ pill mill legislation showed decreases in average morphine equivalent dose (MED) per transaction, monthly opioid volume, monthly number of opioid prescriptions and monthly quantity of opioid pills dispensed following implementation (Lyapustina et al., 2016). Consistent with the Florida studies, these decreases were greater among prescribers and patients with the highest opioid prescribing and utilization at baseline (Lyapustina et al., 2016).

Kentucky’s pill mill legislation

The major components of Kentucky’s pill mill legislation (HB1) include defining pain management facilities, licensure and regulation of pain management facilities, CME requirements prior to licensure, ownership requirements, licensing standards, interagency reporting requirements, reporting requirements for drug overdose deaths and insurance/payment requirements. More specifically, this legislation requires practitioners of pain management clinics to register with the KY PDMP (KASPER) and requires that illegal prescribing and dispensing of controlled substance be reported within three days. The legislation also includes requirements for the reporting of drug-related deaths.

Following the implementation of HB1, several pain clinics closed (Freeman et al., 2015). The closure of pain management clinics in KY may have resulted in decreases in the number of CS prescribers in the top decile, which decreased by over 14 percent from FY2012 to FY2013 (Freeman et al., 2015).

Results also suggest that strengthened regulations of pain management clinics in HB1 had a significant impact on inappropriate prescribing including a decrease in patients receiving concurrent prescriptions for an opioid, alprazolam and carisoprodol (OAC), decreases in the number of patients receiving high dose oxycodone, decreases in the number of patients and mean daily MME for patients receiving oxycodone, and decreases in doctor shopping (Freeman et al., 2015).
Table X: Substance Use Disorder Treatment Program Services and Coverage in Georgia in 2015 (NSSATS, 2016)

<table>
<thead>
<tr>
<th>Ownership</th>
<th>All SUD Treatment Programs (n=322) N (%)</th>
<th>Opioid Treatment Programs (n=55) N (%)</th>
<th>Non-Opioid Treatment Programs (n=267) N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private for-profit</td>
<td>157 (48.8)</td>
<td>52 (94.5)</td>
<td>105 (39.3)</td>
</tr>
<tr>
<td>Private non-profit</td>
<td>88 (27.3)</td>
<td>2 (3.64)</td>
<td>86 (32.2)</td>
</tr>
<tr>
<td>State government</td>
<td>46 (14.3)</td>
<td>0</td>
<td>46 (17.2)</td>
</tr>
<tr>
<td>Local, county, community government</td>
<td>22 (6.8)</td>
<td>0</td>
<td>22 (8.2)</td>
</tr>
<tr>
<td>Federal government</td>
<td>9 (2.8)</td>
<td>1 (1.82)</td>
<td>8 (3.0)</td>
</tr>
<tr>
<td>Methadone</td>
<td>63 (19.6)</td>
<td>55 (100)</td>
<td>NA</td>
</tr>
<tr>
<td>Buprenorphine with naloxone</td>
<td>54 (16.8)</td>
<td>17 (30.9)</td>
<td>37 (13.9)</td>
</tr>
<tr>
<td>Buprenorphine without naloxone</td>
<td>37 (11.5)</td>
<td>20 (36.4)</td>
<td>17 (6.4)</td>
</tr>
<tr>
<td>Extended-release injectable naltrexone</td>
<td>25 (7.8)</td>
<td>4 (7.3)</td>
<td>21 (7.9)</td>
</tr>
<tr>
<td>Oral naltrexone</td>
<td>43 (13.4)</td>
<td>4 (7.3)</td>
<td>39 (14.6)</td>
</tr>
<tr>
<td>Cash/self-pay</td>
<td>279 (86.7)</td>
<td>54 (98.2)</td>
<td>225 (84.3)</td>
</tr>
<tr>
<td>Medicare</td>
<td>101 (31.4)</td>
<td>1 (1.8)</td>
<td>100 (37.5)</td>
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<tr>
<td>Medicaid</td>
<td>174 (54.0)</td>
<td>3 (5.5)</td>
<td>171 (64.0)</td>
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<tr>
<td>State financed health insurance</td>
<td>132 (41.0)</td>
<td>2 (3.6)</td>
<td>130 (48.7)</td>
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<tr>
<td>Federal military insurance</td>
<td>116 (36.0)</td>
<td>6 (10.9)</td>
<td>110 (41.2)</td>
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<tr>
<td>Private insurance</td>
<td>157 (48.8)</td>
<td>6 (10.9)</td>
<td>151 (56.6)</td>
</tr>
<tr>
<td>Free to all (no payment accepted)</td>
<td>13 (4.04)</td>
<td>0</td>
<td>13 (4.9)</td>
</tr>
<tr>
<td>Uses sliding fee scale</td>
<td>165 (51.2)</td>
<td>6 (10.9)</td>
<td>159 (59.6)</td>
</tr>
<tr>
<td>Offers treatment at no charge for those who cannot afford to pay</td>
<td>135 (41.9)</td>
<td>3 (5.5)</td>
<td>132 (49.4)</td>
</tr>
</tbody>
</table>

**Substance Use Disorder (SUD) Treatment Programs in Georgia**

Table X describes SUD treatment programs in Georgia. SUD treatment programs are divided into two categories: Opioid Treatment Programs (OTPs) and non-Opioid Treatment Programs (non-OTPs). OTPs are licensed to dispense methadone and may also offer other medications to treat opioid and alcohol use disorders such as buprenorphine and oral and extended-release injectable naltrexone. All other SUD treatment programs are classified as non-OTPs and are not licensed to dispense methadone. Non-OTPs may offer medications other than methadone to treat substance use disorder (e.g., buprenorphine, oral and extended-release injectable naltrexone). Both OTPs and non-OTPs may offer a range of SUD treatment and recovery support services.

Georgians can find SUD treatment programs, including OTPs and non-OTPs, using the SAMHSA treatment locator (https://findtreatment.samhsa.gov/locator).
Recurring Blue-Ribbon Commission on Substance Abuse and Recovery

The Georgia Legislature, in collaboration with the Governor’s Office, should create a recurring commission that convenes every five to seven years to establish strategy and statewide goals, recommend appropriations and review progress on reducing substance use and expanding local systems of recovery supports and treatment services in Georgia.

Over the past 50 years, Georgia has had some experience with creating recurring commissions, particularly in the public education arena. These types of commissions can have great value when setting long-term strategies and gathering collaborative support among legislators, agencies, the Office of the Governor and the public.

Moreover, a recurring commission structure gives everyone a chance to review progress against goals, plan appropriations over multiple years and continually re-educate the participants about the issues associated with the subject matter.

A recurring commission structure would work well in addressing the current opioid and heroin problem and provide a forum for addressing other similar substance abuse problems that are likely to occur over any five or seven year period.

SARA believes that the current State Senate Study Committee has been a valuable and well-managed process for addressing many substance abuse issues, and the recurring commission structure could be implemented as a simple extension and expansion of the current committee’s work, with new agenda items and expanded participation. Alternatively, the recurring commission could take the form of: 1) a joint Senate-House Study Committee, 2) a Governor’s commission or 3) a privately run and funded commission.

We believe that while any of the above scenarios can be successful, the best structure would include maximum participation from key lawmakers, the Governor’s Office and the heads of certain state agencies. Non-profit organizations, for-profit companies and private individuals can also add great value to the work of such a commission.
REFERENCES

What you need to know now


I. Opioids overview


References for Economic costs of opioid misuse and abuse in GA and the U.S.


Link between prescription opioids and heroin:


II. Key Georgia Issues

PDMP and Pill Mills


Medication assisted treatment & recovery support services


Prevention Education


Prevention Education and Medications


