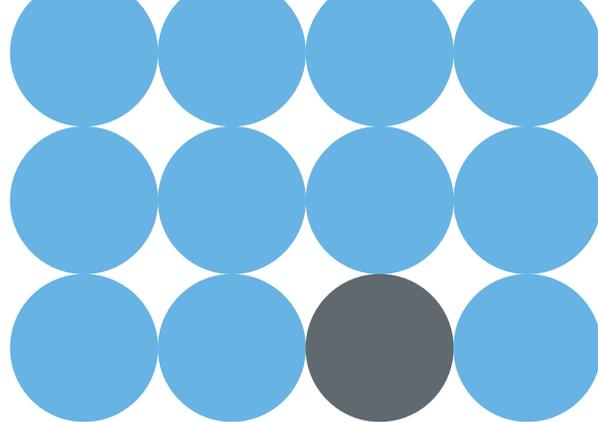


Social Justice Brief

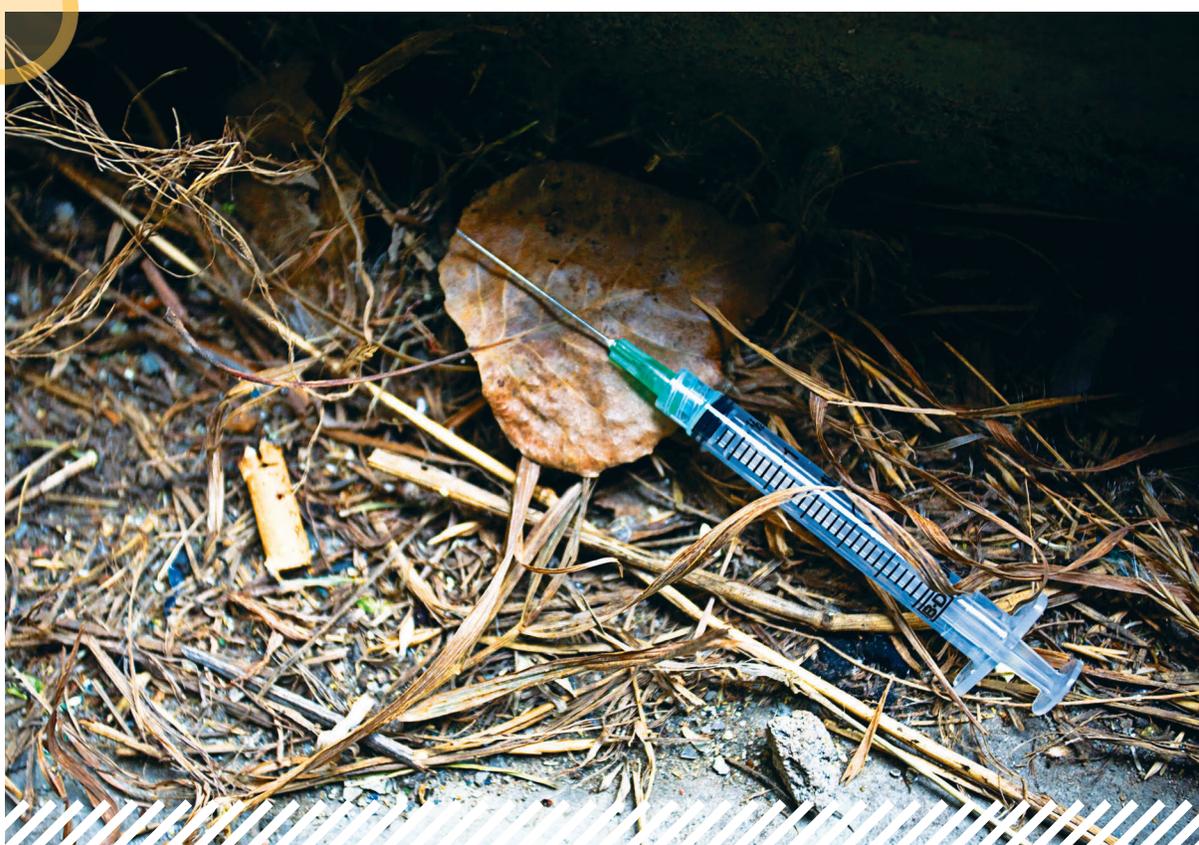
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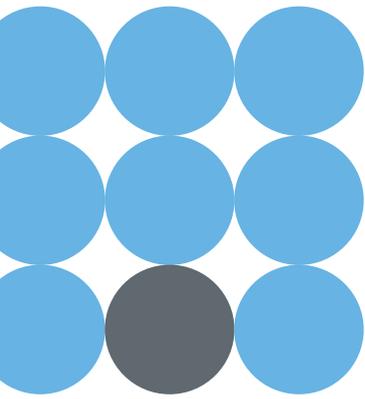
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Opiates in Our Backyard: Implications for Drug Policy

The primary mission of the social work profession is to enhance human well-being and help meet the basic human needs of all people, with particular attention to the needs and empowerment of people who are vulnerable, oppressed, and living in poverty.





Opiates in Our Backyard: Implications for Drug Policy

Over the last year or more, the cover of nearly every magazine, newspaper and electronic news media outlets, headlines have chronicled the fact that United States is in the midst of an opioid and heroin epidemic. While addiction to and abuse of prescription pain medications or to illicit drugs such as heroin is not new, the dimensions and complexities of this epidemic startled and alarmed most public health and addictions experts. This is because the epidemic has caused a high number of overdose deaths and hospitalizations. Secondly, public health officials realized that this explosion of heroin and opioid prescription pain medication was not isolated to one community or geographic area, gender, or to one particular race/ethnic group. It became clear that the crisis was pervasive and nation-wide in scope. It was unquestionable that the epidemic required a national mobilization of resources and collaborative public health planning from all levels of government.

This paper will look at the scope of the heroin-opioid epidemic, the bio-psychosocial implications of the crisis, and the national and international drug policy implications of the epidemic the important role that social work can play in joining other stakeholders in addressing this public health crisis, and will make a number of recommendations from an NASW perspective.

Nature of the Problem: Current Crisis Related to Opioid/Heroin Crisis in Perspective

To put this discussion in context, it should be mentioned that wide-spread use and abuse of legally prescribed and illicit opiates is not new to the United States. For example, here is a brief chronology of various periods when the

use of opiates in the United States reached crisis levels:

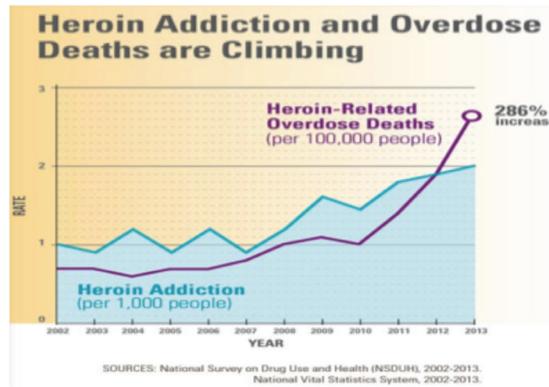
- » In the 19th century, opiates were popular as prescribed tonics and elixirs containing opium. (<http://to.pbs.org/1XZZL1>)
- » In 1803 the opium-based drug morphine was created and widely used as an injectable pain reliever, leading to the first wave of morphine addiction, particularly among the injured in the Civil War. (<http://to.pbs.org/1XZZL1>)
- » The drug heroin was introduced in the 1890s for medical use and marketed as an alternative to morphine addiction. Noting the drug's addictive properties after that time, heroin was made illegal in 1924. (<http://to.pbs.org/1XZZL1>)

- » The second major wave of opiate addiction in America, especially in America's inner cities, began in the 1930s through the 1950s. (<http://to.pbs.org/1XZZL1>)
- » During the Vietnam War, heroin became more accessible to military personnel and the American public, with frequent transports from Southeast Asia. As use surged, in 1973 President Nixon created the Drug Enforcement Administration (DEA) and launched the "war on drugs." (<http://to.pbs.org/1XZZL1>)
- » Heroin use increased in popularity in the 1990s after an increase in purity of heroin, which led to use through various means including smoking and snorting, in addition to intravenous use. (<http://to.pbs.org/1XZZL1>);

In addition, during the late 1990s, Food and Drug Administration (FDA)-approved opioids became a viable option for doctors to address chronic pain in their patients. At the time, prescription painkillers were advertised to the medical community as a non-addictive option and doctors were highly encouraged by pharmaceutical companies and their peers to prescribe it. Although research on long-term opiate medication use had not been rigorously studied, manufacturers and physicians groups reached out to doctors highlighting the benefits of long-term opiate use (<http://bit.ly/1UAmZiH>), most doctors felt that they had a safe option for addressing chronic pain in patients who did not necessarily have cancer or other terminal ailments (<http://bit.ly/1UAmZiH>).

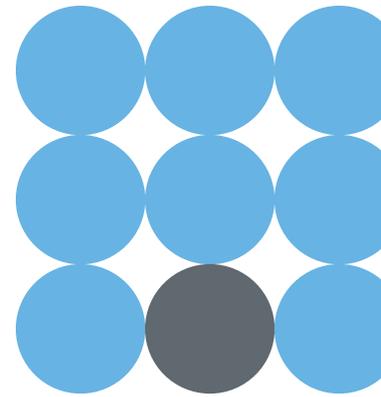
Progression to Current Opioid/ Heroin Epidemic

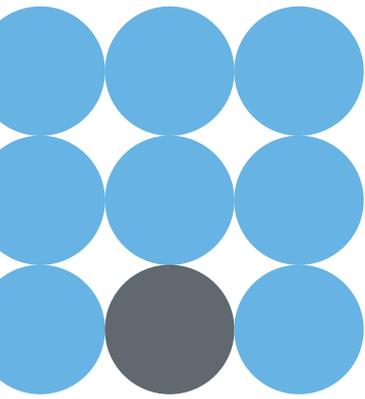
Over the past 15 years, trends in prescribing pain medication and the simultaneous abuse of opioids and heroin have skyrocketed.



Deaths from opioid use are at an all-time high in the United States. The following quote helps to put the situation in perspective, "Deaths from overdoses are reaching levels similar to the HIV epidemic at its peak. The death rate from drug overdoses is climbing at a much faster pace than other causes of death, jumping to an average of 15 per 100,000 in 2014 from nine per 100,000 in 2003. (<http://nyti.ms/1OXNTJz>)

Abuse of and addiction to opioids such as heroin, morphine, and prescription pain relievers is a serious global problem that affects the health, social, and economic welfare of all societies. It is estimated that between 26.4 million and 36 million people abuse opioids worldwide with an estimated 2.1 million people in the United States suffering from substance use disorders related to prescription opioid pain relievers in 2012—and an estimated 467,000 addicted to heroin. The number of unintentional overdose deaths from prescription pain relievers has soared in the United States, more than quadrupling since 1999. There is also growing evidence to suggest a relationship between increased non-medical use of opioid analgesics and heroin abuse in the United States (<http://1.usa.gov/1RjbuJU>).





A 2014 CDC report tied prescription opiate abuse with illicit heroin use. For example, there were 47,055 overdose deaths, more than half of which were related to prescription pain killer and heroin use (<http://1.usa.gov/1M9ZMSk>). One of the suspected reasons for this mortality increased is the easy access prescribed opioids and those obtained from friends and family, or on the *black market*, it is estimated that more than a million people will try prescription painkillers in a manner that is not medically indicated in a year (www.samhsa.gov/atod/opioids). Other data suggest trends among opioids users of transiting from prescription opioids to heroin in cases when prescription medication cannot be obtained or is too expensive. Those dependent on opioids may turn to heroin use as a cheaper alternative (www.samhsa.gov/atod/opioids).

Selected Opioid Data from CDC/ FDA Study

The Centers for Disease Control and the Food and Drugs Administration also undertook a research study on the emerging prescription opioid and heroin epidemic. It should be pointed out that the CDC/FDA study controlled for socio-economic status by focusing the following variables; rates of past-year heroin use per 1,000 persons aged 12 years and older stratified by:

- » Sex, age,
- » Race/ethnicity, place of residence,
- » Annual household income,
- » Insurance coverage, and
- » Substance use (past-year use of marijuana, cocaine, opioid pain relievers, other psychotherapeutics [tranquilizers, sedatives, and stimulants], and past-month binge drinking) for each study time interval; and
- » The percentage of past-year heroin users who also used at least one other drug in

the past year were calculated (<http://1.usa.gov/201bcKt>).

According to the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition*, past year nonmedical use of prescription drugs is defined as using prescription drugs without having a prescription, or using prescription drugs only for the experience or feeling it causes, during a 12 months period preceding the survey.

A selection of some of the findings of the study includes:

- » During 2002–2013, heroin overdose death rates nearly quadrupled in the United States, with a near doubling of the rates from 2011–2013;
- » Data from the National Survey on Drug Use and Health (NSDUH) indicate heroin use, abuse, and dependence have increased in recent years. In 2013, an estimated 517,000 persons reported past-year heroin abuse or dependence, a nearly 150% increase since 2007;
- » Most heroin users have a history of nonmedical use of prescription opioid pain relievers, and an increase in the rate of heroin overdose deaths has occurred concurrently with an epidemic of prescription opioid overdoses (<http://1.usa.gov/201bcKt>).
- » Increases in heroin overdose death rates were associated with increases in prescription opioid overdose death rates. In addition, a study examining trends in opioid pain reliever overdose hospitalizations and heroin overdose hospitalizations between 1993 and 2009 found that increases in opioid pain reliever hospitalizations predicted an increase in heroin overdose hospitalizations in subsequent years. (<http://1.usa.gov/201bcKt>).

- » The annual average rate of past-year heroin use in 2011–2013 was significantly higher than the rates for 2002–2004 represents a 62.5% increase since 2002–2004.
- » The overall rate of people meeting diagnostic criteria for past-year heroin abuse or dependence increased by 90% overall and 35.7% increase since 2008–2010;
- » During 2002–2013, past-year heroin use increased among persons reporting past-year use of other substances. The highest rate was consistently found among users of cocaine; during 2011–2013;
- » The largest percentage increase, 138.2%, occurred among nonmedical users of opioid pain relievers. (<http://1.usa.gov/201bcKt>);
- » Overall, 96% of past-year heroin users reported use of at least one other drug during the past year, and 61% reported using at least three different drugs. In addition, a significant percentage of heroin users met diagnostic criteria for past-year abuse of, or dependence on, other substances;
- » The percentage of heroin users with opioid pain reliever abuse or dependence more than doubled from 20.7% in 2002–2004 to 45.2% in 2011–2013. By 2011–2013, opioid pain reliever abuse or dependence was more common among heroin users than alcohol, marijuana, or cocaine abuse or dependence (<http://1.usa.gov/201bcKt>)

Linkage of Polysubstance Use to Heroin Addiction

The study found that the problem of poly-substance abuse including alcohol, marijuana, cocaine, and opioid pain reliever abuse or dependence were each risk factors for heroin abuse. The research also indicate that poly-substance use increases the risk for overdose death (most overdose deaths involve

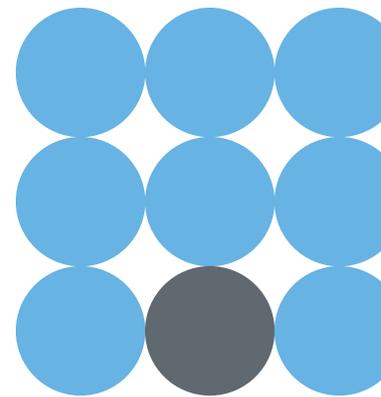
multiple drugs. The CDC data showed that the relationship between heroin and opioid pain relievers, as well as the relationship between heroin and cocaine was particularly strong. In fact, abuse or dependence on opioid pain relievers was the strongest risk factor for heroin abuse or dependence. (<http://1.usa.gov/201bcKt>).

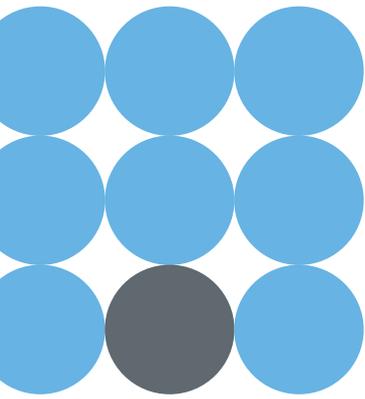
Demographic and Substance Use Trends Among Heroin Users

The CDC suggests that their research findings indicate significant increases in heroin use across a growing number of demographic groups. For instance, the data suggest that there is no longer a wide gap in the rate of heroin use between demographic groups such as men and women, persons with low and higher incomes. Recent research also indicates that there has been a significant demographic shift among those entering heroin addiction treatments over the last 40 to 50 years. (<http://1.usa.gov/201bcKt>).

Some of the more important demographic data associated with the heroin/prescription opioid morbidity, mortality and addictions crisis include:

- » The greatest increases in heroin use occurred in demographic groups that historically have had lower rates of heroin use: doubling among women and more than doubling among non-Hispanic whites (<http://1.usa.gov/201bcKt>);
- » Rates of past-year heroin use were higher among men than women for all time intervals;
- » Both men and women experienced significantly higher heroin use rates during 2011–2013 compared with 2002–2004 and 2005–2007;





- » Among age groups, persons aged 18–25 years experienced the largest increase (108.6%) between 2002–2004 and 2011–2013;
- » The rate of past-year heroin use among non-Hispanic whites increased 114.3%;
- » Between 2002–2014 and 2011–2013, past-year heroin use increased across the three annual household income levels of less than \$20,000; \$20,000–\$49,000; and greater than \$50,000;
- » Individuals with no health insurance as well as those with private or other insurance experienced statistically significant increases in heroin use rates between 2002–2004 and 2011–2013 (<http://1.usa.gov/201bcKt>);
- » Annual average rates of past-year heroin use increased from 1.6 per 1,000 persons aged 12 years and older in 2002–2004 to 2.6 per 1,000 in 2011–2013;
- » During 2002–2011, rates of heroin initiation were reported to be highest among males; persons aged 18–25 years, non-Hispanic whites, those with an annual household income less than \$20,000, and those residing in the Northeast. However, during this period heroin initiation rates generally increased across most demographic subgroups;
- » A November 2015 study by the National Academy of Sciences of the United States revealed that midlife mortality rates for white Americans ceased making gains that had been steadily improving for years. Researchers suggest that deaths related to this epidemic are contributing to higher mortality rates for middle-aged whites (<http://bit.ly/1qqhnvr>).
- » The increases in abuse or dependence and overdose deaths also highlight the urgent need to expand overdose recognition and

response training and broaden access to naloxone to treat opioid pain reliever and heroin overdoses (<http://1.usa.gov/201bcKt>).

Public Health Approach

By declaring the opioid/heroin epidemic a public health emergency, the country is inexorably moving more toward responding to opioid and other substance use disorders by prioritizing prevention, treatment over criminalization as the foundation for resolving the problem. We will discuss the decriminalization question later. However, for now let's briefly look at the efficacy of utilizing a public health model to manage and eventually diminish the current prescription opioid and heroin problem.

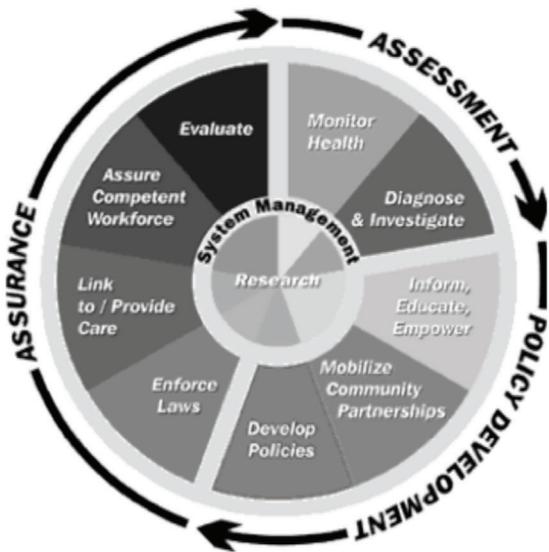
Approaching national health emergencies using a public health intervention strategy is a tried and true model with which most social workers are familiar, and in which social workers have a role. Therefore, when the Centers for Disease Control and Prevention (CDC) has declared prescription opioid and heroin abuse as one of its top ten public health priorities (<http://1.usa.gov/25uedai>), it almost immediately triggered the federal government to officially mobilize the nation using a public health problem solving paradigm.

The basic steps in the CDC approach to mobilizing the country to address public health emergencies such as the opioid crisis is depicted in the boxes to the left. This logic model helps to succinctly visualize the essential steps for managing a public health emergency. This model is a broad guideline that helps to keep federal, local and state officials to coordinate a response using defined and standardized objectives.

However, the next steps of ensuring widespread adoption of strategies to prevent a continued expansion of opioid and heroin abuse is an ongoing process that will require massive public education, population-based drug prevention messages and outreach, as well as expansion of drug treatment capacity throughout the country.

Source: <http://bit.ly/1qcGKk0>

Traditional Public Health Programs



Despite variations from state to state, most modern public health programs have a core focus on infectious disease, maternal and child health, and environmental monitoring (<http://bit.ly/1qcGKk0>). However, during major public health emergencies, federal agencies such as CDC closely collaborate with state and local jurisdiction to identify gaps in prevention, treatment, epidemiologic, and research resources to fully implement a full-scale mobilization to mitigate the problem.

Social Determinants of Health

The social work profession has a definable and essential role to play in the national public health mobilization to bring the current

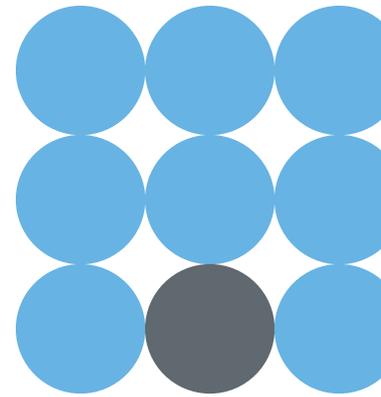
prescription opioid/heroin use crisis under control. As discussed in the National Academies of Science, Engineering, and Medicine publication entitled *A Framework for Educating Health Professionals to Address Social Determinants of Health*, a functioning and integrated public health workforce in responding to health and mental health challenges is critical. Social workers are identified in the report as a component of such a workforce. One of the tasks of a professionally integrated public health workforce is to examine the *social determinants of health* that must be addressed before a problem such as the opioid epidemic can become manageable.

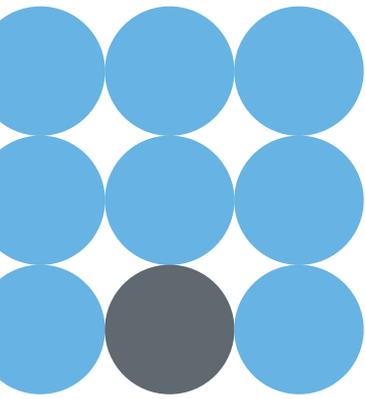
Public Health Social Work: A Component in Responding to Opioid/Opium Epidemic

In many ways, developing intervention strategies based on social determinants of health is an area for which social workers are trained. Therefore, the social work profession is a valuable and significant member of the nation's public health mobilizations effort. Public health policies and models are well-known to the profession. For instance, according to a leading public health social work expert:

Public health social workers approach their work from an epidemiological and a social perspective and have the benefit of training in both prevention and intervention. "Public health focuses on prevention at the community level, and social work focuses on intervention at the individual level" (<http://bit.ly/1WiAle7>).

Public health social work is highly adaptable to responding to the opioid/heroin crisis. An essential function of public health social





workers is to be to work within a collaborative multidisciplinary structure.

Treatment Implications Overdose Prevention

In the face of the fact that deaths overdoses exceed automobile deaths on an annual basis, the most immediate implication for treatment is to greatly reduce overdose deaths. One such possibility is the drug naloxone. Naloxone blocks or reverses the effects of opioid medication, including extreme drowsiness, slowed breathing, or loss of consciousness. It is used to treat a narcotic overdose in an emergency situation (www.drugs.com/naloxone.html). This medication has been so effective that cities across the nation, teams of medical professional, social workers and peers are being equipped with naloxone. Access to the drug is now expanding beyond medical professionals to pharmacies, service providers, family, friends and peers

Access to Heroin-Opioid Disorder Treatment

A recent study found that in the past 10 years only one-sixth of all people with opioid addictions actually received treatment. (<http://bit.ly/1VGaqn9>), it was further found that some of the deterrents to treatment were limited number of drug treatment slots, high cost of treatment, insurance companies rejecting coverage for treatment, and the high number of states that did not expand Medicaid which would have covered treatment for low income persons (<http://bit.ly/1VGaqn9>).

According to addiction specialists at Harvard-affiliated hospitals, curbing opioid addiction requires a “multilayered approach with medication, self-help, counseling, and family

support.” Providers have had positive results to treating addiction when a collaborative and coordinated effort is deployed. For example, at Brigham and Women’s Hospital in Boston, when a patient who is using opiates checks into the hospital for any reason, a dedicated team, including addiction physicians, a psychiatrist and a social worker are called to begin treatment immediately. The team connects the patient with outpatient treatment and community groups to aid in treatment after hospitalization (<http://bit.ly/1TVzpwu>). To successfully address addiction, a comprehensive-integrated care approach combining clinical evidence-based care and a sound social support system is required. Such integrated care approaches to treating opioid dependencies is a key to reducing the cost of care, generating positive treatment outcomes. The social work profession is well trained in providing services in integrated collaborative care settings.

Harm Reduction

In that the opioid/heroin problem involves the risk of contracting and transmitting communicable diseases, treatment protocols must include *harm reduction* interventions, of course, the two more significant communicable disease concerns are HIV and Hepatitis-C. For example, one of the alarms that alerted public health officials about the depths of the opioid epidemic was the unexpected reports of new cases of HIV infection in rural mostly White areas of Indiana. According to the Centers for Disease Control and Prevention, the number of new HIV infections in a rural Indiana county had grown, The HIV outbreak in that community spread among users of a prescription opioid called Opana.

CDC reported that the increase of the disease had been ongoing since mid-December of 2014. As of April, 2015, 142 people had tested positive for HIV. That is a high rate of infection for an area with a population of a few thousand people. The CDC and state health leaders collaborated to plan strategies to address the growing threat of the spread of disease from IV drug use (<http://cnn.it/1rP7Les>).

Public health social workers are trained-in and familiar with harm reduction programs having applied the concept in working with injecting drug using clients and those living with HIV/AIDS and/or Hepatitis-C. Social workers promote harm reduction as a part of *motivational interviewing* behavioral health approaches to advance the client's willingness to recognize the consequences of opiate addiction and enhance motivation to change. A harm reduction approach encourages individuals who use substances to do so in a safer manner that reduces health risks. Harm reduction interventions may include needle exchanges to access to clean supplies, and using among social circles that can provide assistance in case of an overdose. This model facilitates access to facts about drug use and mitigates risks, which can lead to safer practices, reduce overdose rates, and minimize the impact of drug use on families and communities (<http://1.usa.gov/1Xf3Djs>).

Revising Prescribing Practices

The Centers for Disease Control (CDC) has issued new guidelines for prescribing pain medications. Though the guidelines are meant primarily for physicians, CDC encourages some non-physicians to become familiar with them. As stated by CDC, "Although the focus is on primary care clinicians, because clinicians work

within team-based care, the recommendations refer to and promote integrated pain management and collaborative working relationships with other providers (e.g., behavioral health providers, pharmacists, and pain management specialists)." www.cdc.gov/media/modules/dpk/2016/dpk-pod/rr6501e1er-ebook.pdf). Therefore, social worker who practice in such setting could benefit from becoming familiar with the revised guidelines.

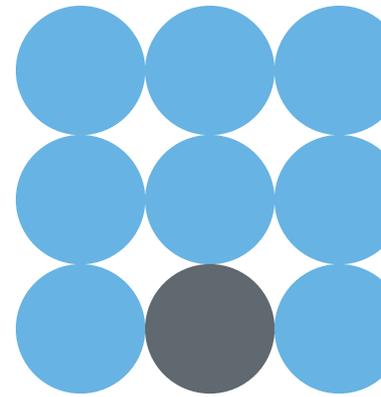
The CDC opioid prescribing recommendations are grouped into three areas for consideration:

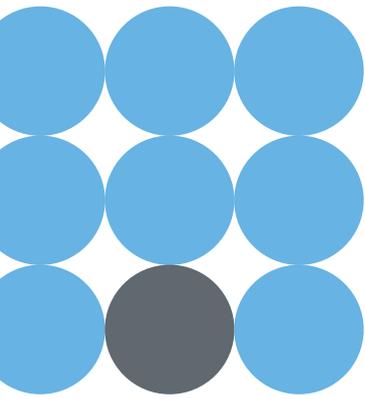
- » Determining when to initiate or continue opioids for chronic pain.
- » Opioid selection, dosage, duration, follow-up, and discontinuation.
- » Assessing risk and addressing harms of opioid use.

Other options for gaining more control over the gaps in opioid prescribing oversight include initiatives that would limit the number of pills given in prescriptions, and encourage use of prescription monitoring programs (PDMP) (www.cdc.gov/drugoverdose/pdmp/). PDMPs are systems that track when patients fill prescriptions. PDMPs are now operational in 42 states and the list is expanding.

Transitioning from Over-Criminalization to Public Health Drug Policy

It is an established fact that the opioid epidemic of 2016 not the first time that the United States has experienced pervasive drug-abuse on a national level. The distinction of this latest drug-use challenge is that the heroin epidemic of the 1950's and 60's, and the powder cocaine/crack cocaine epidemic of the 1980's





were, by and large, treated as anti-social behaviors endemic to poor urban black and brown communities.

Many in Middle America and non-urban settings were either disengaged from or openly hostile to the toll that illicit drugs exacted from urban neighborhoods of color. During those times, reacting to drug abuse from a social determinant of health perspective would have been categorically dismissed as “coddling juvenile delinquents and law-breaking adults. The national mood was *zero tolerance* for drug use. The criminalization and punishment response was justified with the rationale that drug abusers were suffering the consequences for not taking “personally responsibility for their behavior.”

Additionally, the proliferation of open-air drug markets and the lethal violence (connected with street gangs and international drug cartels) helped to reinforce the national sentiment was for increased law enforcement and criminalization of all drug-related violations.

Instead of drug treatment and prevention opioid and illicit drug users of the 80’s were met with the *War on Drugs* and the *Violent Crime Control and Law Enforcement Act of 1994* (<http://bit.ly/24u7Wtl>) which was primarily intended to reduce drug-related violent crime, but led to mass incarceration of non-violence low-level drug possession violators.

It should be stated that one of the most insidious legislation that criminalized drug-use, possession (as well as sales) was the *Rockefeller Drug Laws* (<http://n.pr/1TfJO8G>). The Rockefeller Drug Laws pre-dated the President Clinton’s Violent Crime and Law Enforcement Act by

over ten years. It was the signature anti-crime legislation of New York’s Governor Nelson Rockefeller was passed by the New York legislature and signed into law by the Governor in 1973. It is somewhat ironic that the impetus for introducing and passing the Rockefeller Drug Laws was related to public fears about heroin as a drug of choice in major cities such as New York City. The following statement summarizes the mood of the country:

“...But the political mood was hardening. President Richard Nixon declared a national war on drugs, and movies like *The French Connection* and *Panic in Needle Park* helped spread the sense that America’s cities were unraveling.” (<http://n.pr/1TfJO8G>).

Many other states quickly adopted laws similar to the Rockefeller Drug Laws thereby ushering in criminalizing drug policies that would last for 40 years, and disproportionately lead to the incarceration of many black and brown men and women (<http://n.pr/1TfJO8G>).

U.S. National Drug Policy

Much of what has been talked about in this brief intersects with national drug policy in the United States. Our national drug policy is developed by the White House and articulated through its Office of National Drug Control Policy (ONDCP). In the past, ONDCP has focused primarily on drug trafficking and interdiction. However, over the last five years, ONDCP (with support from the Obama Administration) incrementally modified its mission by taking a strong public stance in support of a public health policy for those with substance-use disorders. With the emergence of the current opioid/heroin crisis, ONDCP has been very vocal and public about the

Administration position on choosing prevention and treatment over criminalization.

U.S. Opioid Epidemic Parallels Worldwide Discussion on Drug Policy

We should all be reminded that the opioid crisis in the United States is symptomatic of a worldwide struggle to come to grips with the drug use and drug trafficking. In April of 2016, NASW staff attended a convening of a United Nations General Assembly Special Session (UNGASS) on the world drug problem. The event attracted government and non-governmental participants from around the world. As a demonstration of the level of seriousness that our country placed on UNGASS, the United States sent the head of the White House's Office of National Drug Control Policy (ONDCP) and the National Institute of Health (NIH) to argue for international acceptance of a public health approach to drug addiction. In their presentations, both officials used the current opioid/heroin crisis as a case in point for de-criminalizing certain drug-related behaviors.

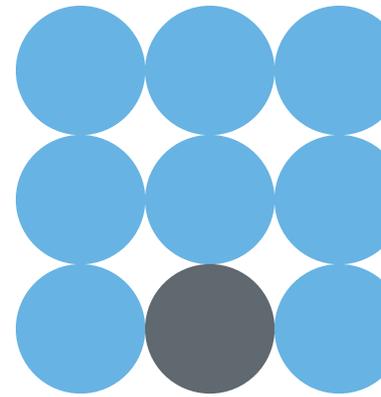
The "take away" from the UNGASS sessions and *side event* workshops that were held by non-governmental drug policy organizations was that there is an international context in which America's drug use challenges can be placed. That there is a worldwide recognition of the threat to community stabilization and public health that un-managed population-based drug use and drug trafficking. That the United States had a coordinated state and federal government epidemiological surveillance being in place and detecting the gravity of the opioid drug use problem can be seen, by the rest of the world, as a model for reacting to the prevention and treatment side of the situation.

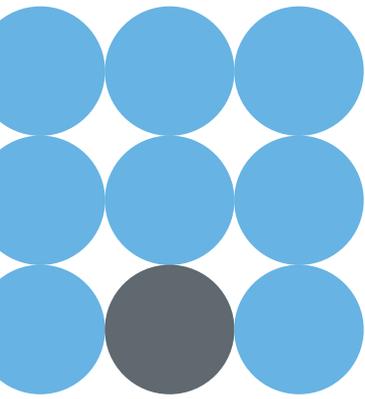
Simultaneously, the UNGASS countries also can see that it takes enormous resources and public health infra-structures to effectively mobilize a response to drug-use epidemics - resources that most of the UNGASS nations do not have. For example, President Obama's public declaration to use all available federal health and human services resources to bring the opioid epidemic under control was coupled to a request of \$1.1 billion from Congress specifically for the heroin-opioid crisis (<http://1.usa.gov/1VTdqg0>). Congress was a receptive to the President's request for financial resources and making this a major priority for the Department of Health and Human Services (HHS).

Major Legislation to Address Opioid Epidemic

As mentioned, the Obama Administration requested \$1.1 Billion from Congress to respond to the heroin-opioid epidemic. The Senate passed S. 524, the **Comprehensive Addiction and Recovery Act (CARA)** CARA is widely seen as the comprehensive opioid bill that would galvanize bipartisan support. It is expected that the House will pass a number of bills dealing with the opioid epidemic. These are separate pieces of legislation have been commonly referred to as the *House Opioid Package*. Some of the more relevant bills in the *Package* include: **Opioid Program Evaluation (OPEN) Act (H.R. 5052)** - Increases the transparency and accountability of the comprehensive opioid abuse grant program.

» **Good Samaritan Assessment Act of 2016 (H.R. 5048)**. Requires the Government Accountability Office to study state and local Good Samaritan laws that protect from criminal and civil liability caregivers, law enforcement personnel, and first





responders who administer opioid overdose reversal drugs or devices, as well as those who contact emergency service providers in response to an overdose.

- » **Transnational Drug Trafficking Act of 2015 (S. 32).** Combats drug trafficking and the importation of chemicals used to make illicit drugs in the United States.
- » **(H.R. 4641).** Establishes an inter-agency task force to update best practices for pain management and prescribing pain management.
- » **Opioid Use Disorder Treatment Expansion and Modernization Act (H.R. 4981).** Authorizes doctors to write more prescriptions for buprenorphine and other medications used to treat an opioid use disorder and authorize a qualified nurse practitioner or physician assistant to write prescriptions, as amended.
- » **Reducing Unused Medications Act of 2016 (H.R. 4599).** Allows prescriptions for certain opioid painkillers and similar drugs to be partially filled to reduce the volume of unused drugs.
- » **John Thomas Decker Act of 2016 (H.R. 4969).** Requires the Department of Health and Human Services to distribute informational materials and resources about the use of opioid painkillers to treat youth sports injuries.

It is hoped that, after conference meetings by the House and Senate, a comprehensive addictions and recovery bill will reach the President's desk by the summer of 2016.

NASW Activities and Direct Involvement in Addressing the Opioid Crisis

NASW has been actively involved with the issue of national drug policy and the intersection of behavior health with criminal justice system. Several years ago, NASW joined the Drug Policy Alliance in sponsoring a seminar on de-criminalization of possession of small amounts of illicit drugs and treating the issue of substance use disorders as a public health issue. As a follow-up to the partnership with DPA, NASW issued a social justice brief entitled *A Social Work Perspective on Drug Policy Reform: Public Health Approach* (<http://bit.ly/1reOzpn>). Over the years, NASW has continued to support drug-related legislation such as the Fair Sentencing Act which led to parity on sentences for convictions for crack-cocaine as compared to powder cocaine.

Our commitment to sensible drug policy continues with the current opioid/heroin crisis. NASW is a member of the *Coalition to Stop Opioid Overdose* a national coalition of over 50 diverse organizations. We also are members of the *Addictions Policy Forum* another national coalition that has an immediate objective of advocating for the passage of the Comprehensive Addiction Recovery Act. NASW has signed on to letters to Congress in support of passage of CARA.

Additionally, NASW is a member of a coalition that focuses on international drug policies through the United Nations General Assembly Special Session (UNGASS) on drug policy. NASW staff represented the association in the New York UNGASS meetings. We have joined the coalition in meeting with White

House's Office of Drug Control Policy, Health and Human Services, and the Department of Justice on advocating for the United States to emphasize public health and harm reductions as the cornerstone of world-wide drug policies.

NASW will remain vocal and active on resolving the opioid crisis from a public health and a social justice perspective. NASW is an adherent to the coalition model for advocating for policy and clinical practice changes that improve population-based substance use prevention, treatment services, and workforce training that will end this crisis.

Recommendations

Clearly, the opioid/heroin epidemic requires an immediate and comprehensive response from every level of government and non-governmental organizations. Along those lines, NASW would like to make the following recommendations for several suggested priorities:

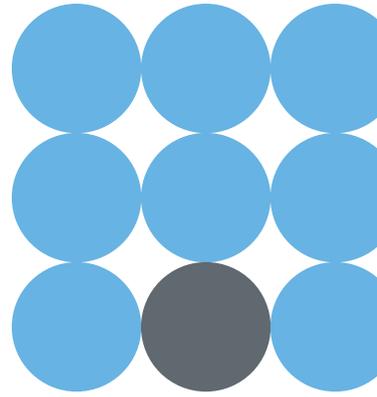
- » We recommend that National, States, and local public health entities continue to approach the opioid/heroin epidemic **from a public health perspective**, which includes awareness of the issue, development of prevention strategies, comprehensive treatment options and policy changes.
- » Being an essential component of the public health paradigm, NASW strongly recommends that **Harm Reduction** programs, including syringe exchange, be included in guidelines for treatment interventions.
- » In order to effectively treat substance use as a health issue and reduce its health consequences, we recommend that international bodies including the **UN Office on Drugs and Crime and the World Health Organization** also include **harm reductions** as an international policy objective.

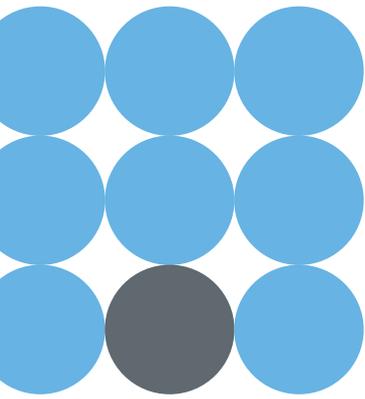
- » **Decriminalization and diversions from incarceration** drug policies should be embraced for persons arrested for possession of personal drug use quantities of prescription and illicit opioids.
- » NASW recommends that the **social work community become proactive** in asserting its role and expertise in working in an integrated-collaborative care environment.
- » In order for strong community involvement in addressing the heroin-opioid epidemic, it is recommended that **NASW and other social work organizations participate in local and national drug policy coalitions.**

Conclusion

That the heroin/opioid epidemic is real and poses a major crisis for the American public is indisputable. Many of us are old enough to recall that during the 1970's public health advocates were so outraged about the spiraling mortality and serious injury rates from car accidents that federal and state governments imposed mandatory seat-belt laws, and lowered the speed limits on major highways. Therefore, when we realize that in 2016 the mortality rate from opioid overdoses exceeds the annual rate of death from auto accidents we should be similarly alarmed. We should also support federal and state governments' efforts to mobilize their public health and treatment resources to combat this serious threat.

At the same time, we should not lose sight of the fact that, as a nation, if we manage to successfully bring the opioid/heroin problem under control, we will continue to have a far too high rate of drug addiction in the United States. We must seek to turn this particular tragedy into an opportunity to revise our





national drug policies and mobilize our public health resources to respond to all forms of drug and alcohol abuse, not just heroin and opioid prescription medications.

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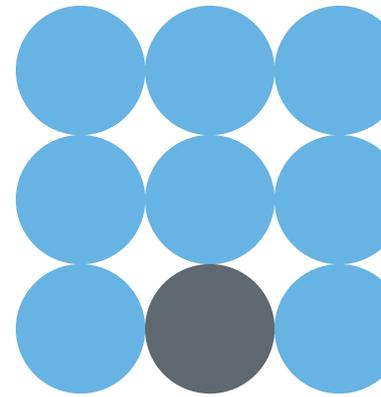
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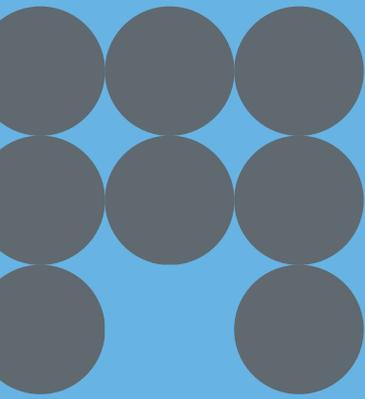
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NASW Resources

NASW » SocialWorkers.org

NASW Foundation » NASWFoundation.org

NASW Press » NASWPress.org

NASW Assurance Services, Inc. » NASWAssurance.org

NASW Center for Workforce Studies » Workforce.SocialWorkers.org

Help Starts Here » HelpStartsHere.org

Social Work Reinvestment Initiative » SocialWorkReinvestment.org

Social Work Policy Institute » SocialWorkPolicy.org

Social Work Portal » SocialWorkers.org/swportal

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