



Substance Use Disorders in Oregon – Prevention, Treatment & Recovery

**Oregon Substance Use Disorder Research Committee
November 2017**

TABLE OF CONTENTS

Executive summary	1
Approaches to treatment.....	1
Recommendations of the OrSUD Research Committee	2
Endorsements	4
About this report	5
The research committee	5
Methodology	5
Limitations.....	6
OrSUD Research Committee	7
Background	8
SUD as a medical condition.....	8
Chronic disease.....	8
Stigmatization.....	8
SUD in Oregon	9
Prevalence	9
Morbidity and mortality.....	9
Societal costs	9
Challenges for specific communities.....	10
Rural Communities	10
Communities of Color.....	10
LGBTQ.....	11
Veterans	11
Youth	11
Discussion, Findings & Conclusions	13
Contribution of trauma	13
Evidence-based prevention.....	14
Physicians and SUD	15
Inappropriate pain treatment	15
Inadequacies of Oregon’s Prescription Drug Monitoring Program.....	15
Improving physician training and resources	15
Promising new developments: ECHO & IMPACT	16
Access issues	17
Health insurance hurdles	17
Geographic challenges	17
Homelessness.....	17
Lack of culturally appropriate treatment.....	18

SUD and the law	18
Harm-reduction methods.....	18
Defelonization (HB2355)	19
Early diversion programs.....	19
Special burden on communities of color.....	19
Other states and nations	20
Funding issues	20
Underfunded at federal, state and local levels	20
Oregon tax issues	21
Legal action against pharmaceutical companies.....	22
Return on investment – systemic disincentives.....	22
Alcohol and Drug Policy Commission.....	22
Recommendations	24
Appendix I – Abbreviations	26
Appendix II – Overview of the Opioid Epidemic.....	27
How did we get here?	27
Why are opioids so addictive?.....	28
Treating Opioid Use Disorder (OUD)	29
Pharmacotherapies or Medication-Assisted Treatment (MAT)	29
Behavioral Supports	29
Oregon’s response to the epidemic:	30
Appendix III – Other States and Nations	31
Innovative approaches in the United States.....	31
Vermont.....	31
New Mexico.....	32
Gloucester, Mass.	33
Innovative approaches in other countries	33
Portugal	33
Switzerland	34
Czech Republic.....	35
The Netherlands	35
Uruguay	36
Witness List	37
Key references and data sources	38
End Notes	40

EXECUTIVE SUMMARY

It is difficult to overstate the negative and pervasive effects that alcohol and drug misuse has on Oregonians. Substance use disorder (SUD) is one of the largest public health challenges afflicting the state. About 1-in-10 Oregonians suffer from SUD, and it costs the state \$6 billion annually. Two-thirds of Oregonians know a friend or family member suffering from SUD. And SUD too often ends in tragedy, causing more deaths than traffic accidents, trauma and firearms.

SUD crosses all social and demographic strata in Oregon, but the effects are most acute among rural Oregonians, youth, LGBTQ, homeless, and communities of color. Lack of social services to support education, housing and employment increases risk, especially among those with genetic predisposition. Trauma of all kinds and at all stages of life further fuel the SUD epidemic.

Untreated SUDs increase health care and criminal justice spending; increase crime and violence; create more need for social services; reduce tax revenue by reducing employability; and devastate communities.

Unfortunately, due to the fragmented and underfunded statewide systems attempting to mitigate the impacts of SUD, the personal and societal costs continue to increase in Oregon. Compared with other states, Oregon ranks poorly in the prevalence of SUD for almost all types of substances.

Approaches to treatment

SUD is a disease, not a crime. Incarcerating people with SUD is not an effective tool for prevention, treatment or reduction of social harm. Just as we do not jail people with other chronic diseases, we need a better approach to helping people who suffer from SUD that goes beyond incarceration.

The goal of treatment is to reduce harm to patients and society. Neither eradication nor absolute abstinence are required for treatment to improve the lives of Oregonians suffering from SUD.

Like other chronic diseases, SUD is easier to prevent than to treat and easier to control than to cure. Most SUD begins in childhood and adolescence. Early intervention, therefore, especially in the lives of children and adolescents, is more likely to be effective. Moreover, treating SUD as a moral failing rather than a

‘SUBSTANCE USE DISORDER’ VS. ‘ADDICTION’

While researching and writing this report, the committee made an intentional decision to use the term ‘**substance use disorder**’ and not ‘**addiction**.’ Although the latter is more colloquial, it is value-loaded and fails to recognize that SUD is a medical condition, not a personal failing.

U.S. Surgeon General Vivek Murthy wrote in *The (2016) Surgeon General’s Report on Alcohol, Drugs, and Health*:

“We also need a cultural shift in how we think about addiction. For far too long, too many in our country have viewed addiction as a moral failing. This unfortunate stigma has created an added burden of shame that has made people with substance use disorders less likely to come forward and seek help. It has also made it more challenging to marshal the necessary investments in prevention and treatment. We must help everyone see that addiction is not a character flaw – it is a chronic illness that we must approach with the same skill and compassion with which we approach heart disease, diabetes, and cancer.”

controllable disease creates a stigma that drives use of addictive substances underground and deters people from seeking treatment.

Reversing Oregon's SUD epidemic requires abandoning traditional approaches that rely on the threat or reality of incarceration. Instead, Oregon must focus on the childhood and adolescent experiences that generate SUD, early prevention, improving physician practices that inadvertently generate SUD among patients with pain, and making SUD treatment accessible to everyone who seeks it, regardless of their insurance. Treatment programs must recognize the society in which individual patients live, and provide programs consistent with the patient's culture, neighborhood and social supports. Treatment only succeeds when it is culturally appropriate for the individual patient. Successful prevention begins in childhood. Successful treatment begins as soon as SUD is detected and continues for the life of the patient.

Seen in isolation, the costs of effective prevention and treatment programs are intimidatingly high. But compared to the medical, criminal and social costs without intervention, prevention and treatment are wise investments that pay for themselves many times over. They also allow Oregonians in recovery to return to normal lives in which they can contribute to the economic vitality of the state.

Oregon has failed to adequately respond to its SUD crisis. The state has not repaired the social conditions and physician practices that generate SUD and continues to view SUD mostly as a criminal justice matter rather than a medical condition. Oregon has not made treatment accessible to those in need, and it fails to facilitate physician practices that improve prevention and treatment.

To improve Oregon's response to this crisis, we recommend the following policy and practice changes. All address the priority of prevention over treatment and of treatment over incarceration.

Recommendations of the OrSUD Research Committee

Early childhood interventions as the most cost-effective option

1. To combat our SUD epidemic at the earliest, most cost-effective stage, the state of Oregon should increase funding of evidence-based school prevention programs.

Provide adequate health care access and benefits

2. Culturally appropriate treatment of SUD is an essential benefit that should be covered by every insurance policy.
Every health insurance policy in Oregon, public and private, should include SUD screening, treatment and recovery as essential benefits that are independent of a patient's financial status at time of need. Policies must provide treatment and recovery that is culturally appropriate, especially for youth and communities of color. When patients change insurance policies, they should be able to retain their original treatment or recovery provider.
3. Oregon should require geographically accessible services. Insurance companies should be required to pay for telemedicine services.
Until treatment and recovery facilities and providers are geographically accessible around the state to every Oregonian with SUD, all health insurance policies should include telemedicine for all patients and remote access technologies, such as ECHO, for physicians.
4. Oregonians should have rapid entry to support, care coordination and treatment services via a statewide hotline.
The state should create an "SUD Hotline" to provide immediate assistance to access SUD treatment. This one telephone call should include assessment of need for other social services, including housing, food and other medical care.

Improved physician practices

5. Oregon's physicians should follow best practices in prescribing.
All physicians who prescribe opioids should adhere to guidelines from state and national professional and governmental organizations. Guidelines are available from the U.S. Surgeon General, Centers for Disease

Control and Prevention, National Center on Addiction and Substance Abuse, National Institute of Drug Abuse and the Oregon Health Authority's Public Health Division. Physicians who vary from these guidelines should be prepared to answer to their peers.

6. Remove barriers and inefficiencies in utilizing the Oregon Prescription Drug Monitoring Program.

Oregon should revise PDMP software to allow interoperability with electronic medical records and add methadone and other controlled substances not currently included in the system. When new software meets these requirements, Oregon should mandate PDMP use for all physicians prescribing opioids and other addictive substances.

Defelonization and rapid diversion to treatment

7. Implement and monitor LEAD, Treatment First and other early diversion into therapy programs.

Building on the defelonization efforts enacted by Oregon's HB2355, law enforcement organizations in Oregon should implement experimental programs that encourage rapid entry into treatment programs for people with probable SUD encountering the criminal justice system. Examples of these programs are the LEAD and Treatment First programs. All early diversion programs require close monitoring to determine that they achieve their goals in a cost-effective manner.

Improved leadership from the Alcohol and Drug Policy Commission and from physicians

8. The ADPC should improve its efforts to lead and coordinate Oregon's campaign to address SUD.

Oregon should improve the organizational structure and funding of the ADPC to permit resumption of its original mission to provide policy leadership for the state's campaign to control SUD. The governor should demonstrate interest in this mission by providing specific goals for the ADPC. Interaction between the governor and the commission should be frequent enough to assure that the commission has sufficient resources, support and leadership.

9. Physicians should improve the relevance of their training and the rigor of their practice in addressing SUD.

Physician organizations in Oregon should amplify their efforts to guide education and practice to enable better training in SUD, incorporate SUD detection and treatment into routine practice, standardize treatment of acute and chronic pain, and improve physician prescribing practices. We do not recommend legislative intervention in physician practice unless physician leadership proves inadequate. Physician leadership should come from the Oregon Medical Board, Oregon Medical Association, and specialty and primary care physician associations.

The ADPC and physician organizations should integrate the recovery community into all levels of policy leadership.

Adequate Funding for Prevention, Treatment and Recovery Support Services

10. Oregon should create a dedicated funding stream sufficient to meet the state's needs for SUD prevention, treatment and recovery support services.

Oregon requires new tax revenues dedicated to SUD prevention and treatment. Examples of potential sources include increased taxes on alcohol and new taxes on prescribed opioids. Because neither of these taxes provide sufficient revenue, other taxes are essential.

11. Because investment now produces higher returns later, government, physicians, insurers and others involved in fighting the SUD epidemic should commit to working for long-term results and savings.

We are not prepared to suggest revisions to Oregon's tax code or to identify current state programs to be sacrificed to fund SUD prevention and treatment. That is the responsibility of lawmakers after a robust public dialogue. Nevertheless, Oregon should invest now to end the SUD epidemic.

ENDORSEMENTS

Prior to publication of this report, the OrSUD Research Committee shared its findings with a select group of organizations active in substance use disorder prevention, treatment and recovery. The following organizations have endorsed the report's recommendations at the time of publication:

Addiction Counselor Certification Board of Oregon

MetroPlus Association of Addiction Peer Professionals

4th Dimension Recovery Center

Endorsement of the recommendations does not imply endorsement of the entire report or any other part. The OrSUD Research Committee take sole responsibility for the complete report. The OrSUD Research Committee will announce additional endorsers as they become publicly available.

ABOUT THIS REPORT

This report reviews Oregon’s current programs for prevention and treatment of substance use disorder, and provides recommendations for improvement. We begin by briefly reviewing the committee’s charge, methodology and unique challenges in this section.

The research committee

Members of the Oregon Substance Use Disorder Research Committee (OrSUD) were selected through an open application process. Applicants were screened for conflict of interest.

The committee held its first meeting in December 2016. We were charged with recommending policies to improve the prevention and treatment of SUD and to reduce the damage caused to Oregon by this disease. The charge further directed us to focus on only illegal drugs and alcohol. We were not to address addiction to marijuana, nicotine, caffeine or gambling. Finally, we were to determine whether there is adequate funding for SUD treatment and, if so, potential sources of additional funding.

Within that scope, we learned that alcohol and opioids produce the most wide-reaching damage to Oregon’s communities. Consequently, the committee focused on those two classes of drugs, but it should be noted that prevention and treatment approaches for alcohol and opioids apply to other addictive substances as well.

We asked local nonprofits and advocacy groups knowledgeable about SUD to review our report and its recommendations. The endorsement of other groups working on SUD issues confirms both the importance of this report and its potential as a roadmap for changing how Oregon addresses its epidemic of SUD.

Methodology

This committee was formed to conduct rigorous, citizen-driven research. One medical professional served on the committee, but the remainder of the members possessed no special expertise in the subject other than what might be found in any other cross-section of the Portland community. We therefore approached the topic with open minds.

The committee found abundant literature on the science and current knowledge of SUD prevention, treatment and recovery. These national and state sources and the abbreviations used in this report are listed in the Bibliography and Appendix I. We refer readers to these documents as the primary sources of our data. Witnesses referred to these documents frequently, and none disputed their findings.

The committee met twice per week to interview 29 witnesses including a diverse group of clinicians, academics and others involved in SUD research, prevention and treatment. We also met with individuals in recovery. Because of time and scheduling limitations, our witness list is not exhaustive. Even so, our witnesses provided a multitude of policy changes to improve SUD prevention and treatment. The committee faced the challenge of choosing a limited number of those recommendations. We focused on those that we and witnesses deemed most feasible in the current political and social environment as well as being actionable in a short time. We heard many strategies for longer-term reform, but those must wait for subsequent research and evaluation.

OrSUD encourages Oregon to pursue all possible methods of ending our SUD epidemic and to use our witness list as a source of expertise for future action.

FOCUS QUESTION FOR THE OrSUD RESEARCH COMMITTEE

How effective is the state's overall system for the prevention and treatment of drug and alcohol addiction and what realistic steps can be taken by the Legislature and state agencies to improve outcomes for Oregonians?

Limitations

Witnesses who spoke with the committee frequently brought up concerning data about the disproportionate effect of SUD on communities of color, rural populations, native communities, veterans and youth. One witness also argued that in order to achieve best outcomes, people in recovery must be involved in making policy decisions.

Too often, inadequate access, stigma, cultural insensitivity and discrimination have prevented individuals and communities from participating in this important conversation.

As assembled, this committee lacked diversity that could have addressed those concerns. The committee sought to offset these shortcomings by reaching out to

representatives from disproportionately impacted communities, but had limited success.

We recognize that we do not know what we do not know. Without adequate representation at the table, there may be blind spots or cultural deficiencies in our research or body of knowledge.

Nevertheless, the committee conducted its research as best we could while acknowledging these limitations. We hope that future considerations of this topic will take steps to redress these limitations, but we believe that the importance and pressing nature of this topic merits moving forward with this report while simultaneously calling out those limitations. We believe that our findings, conclusions and recommendations are well researched and will positively impact all of Oregon.



Source: Official White House photo by Pete Souza

President Barack Obama and First Lady Michelle Obama meet with mothers regarding the Affordable Care Act in 2013. The ACA and Mental Health Parity and Addiction Equity Act ensured that health plans treated mental health and substance use disorders the same way that they treat other health issues.

OrSUD RESEARCH COMMITTEE

Members of the Oregon Substance Use Disorder (OrSUD) Research Committee are:

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*The OrSUD Research Committee thanks **Christian Trejbal** for editing this report, providing strategic advice and serving as press contact.*

Questions?

Please contact OrSUD@samuelmetz.com with questions about this report or about the Oregon Substance Use Disorder Research Committee.

OrSUD
Research Committee

BACKGROUND

SUD as a medical condition

Chronic disease

Substance use disorder (SUD) is a chronic medical condition comparable to hypertension, diabetes and coronary artery disease. Like other chronic diseases, SUD follows a pattern of remission and recurrence; therefore, the goal of treatment is control, not cure. The physiological underpinnings of SUD are also clear in terms of genetics – a family history of SUD increases the chances a patient will acquire the disease.

The most common reason that as many as 90 percent of Americans with SUD do not receive treatment is that they are unaware that they need it, making screening in general health care settings vital.¹ Due to the substance-induced changes to the brain circuits that control impulses, motivation and decision making, many people with SUD overestimate their ability to control their usage and might not be ready to stop.² In fact, one of the criteria for SUD in the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders (DSM-V) is continued use despite the knowledge of physical/psychological harm.³

In order to address the needs of those who are not yet ready or able to participate in treatment, harm reduction strategies have been developed to reduce the negative consequences to SUD sufferers and to the people around them. These strategies provide treatment to reduce, manage and stop substance abuse and include outreach and education programs, needle/syringe exchanges and access to naloxone to reverse opioid overdose. These public health-oriented, evidence-based supports offer a cost-effective alternative to abstinence-only or incarceration-focused approaches.⁴

Like any chronic illness, success in SUD treatment is measured by improved long-term health and the ability to reintegrate into family and society.

Stigmatization

SUD in the United States has frequently been attributed to moral failing due to a perceived lack of will-power or fortitude to stop using substances. This viewpoint has contributed to the stigmatization of SUD. Consequently, many individuals with SUD receive condemnation rather than medical care. This stigma likely contributes to the SUD problem in Oregon: few people with SUD seek treatment; few who seek treatment receive treatment; and successful treatment has been hampered by policies that regard people with SUD as social outcasts rather than individuals in need of treatment.

The medical community is slowly correcting this misperception. The DSM-V discontinued use of the words ‘abuse’ and ‘dependence’ and transitioned to the single classification of ‘substance use disorder.’ This cornerstone publication

joins other national scientific organizations in illustrating the impact of vocabulary in increasing the understanding of SUD as chronic brain disease rather than insufficient will-power.

In accordance with these findings, the OrSUD Research Committee uses vocabulary reflecting current medical and scientific use. We use ‘substance use disorder’ and ‘SUD’ rather than ‘addiction.’

We also use ‘opioids’ to include all morphine-like drugs, both naturally occurring and synthetic. While chemically and medically different from alcohol and opioids, other illegal substances like cocaine and methamphetamine respond to similar prevention and treatment policies, and our findings are thus also applicable to such substances.

“We want to stretch good days into weeks, weeks into months and months into decades– not throw in the towel when there is a relapse. Addiction is a chronic illness and relapses are best viewed as temporary disease exacerbations that can quickly be addressed.”

– Todd Korthius,
OHSU Addiction Medicine

SUD in Oregon

SUD devastates Oregon's communities, youth, finances and government. The consequences include direct costs of SUD treatment, premature deaths, increased medical costs, loss of employment, destabilization of families, violent crime, poor educational achievement among youth, need for state-sponsored social services and huge burdens on our criminal justice system. A recent survey found that 64 percent of Oregonians personally know someone who has struggled with SUD.⁵ Few families do not pay some penalty for Oregon's SUD epidemic.

Prevalence

Opioids have received much press recently both nationally and within Oregon for good reason. The prevalence and lethality of opioid-related SUD in Oregon have risen dramatically in recent years. (See Appendix II for a detailed discussion about the rise of the opioid epidemic and the opioid crisis in Oregon.) In 2014, the Oregon Health Authority reported that 4.7 percent of Oregonians (159,000 individuals) engaged in illegal use of opioids, the fourth highest rate in the country.

Alcohol, however, remains associated with far more SUDs in Oregon than opioids. In 2014, about 7 percent of Oregonians were dependent on or abused alcohol, a slightly higher rate than the national average of 6.5 percent.⁶ Of those Oregonians with alcohol dependence or abuse, approximately 8 percent received treatment in 2010-14. In the same year, 16.5 percent of Oregon teens reported binge drinking alcohol, compared to 14 percent nationally.⁷

Oregonians suffer more from SUD of almost every substance than the national average and most other states. Almost one of every 10 adults in Oregon depends upon or abuses illicit drugs or alcohol, as well as one of every 15 Oregon youth.⁸ However, only 11 percent of adult Oregonians with SUD received treatment, worse than the national average of 14 percent.⁹

Morbidity and mortality

There were about 40,000 Oregonians in treatment for SUD last year, but that does not reflect the full medical impact. Because tobacco, alcohol and drug use contribute to more than 70 other conditions requiring medical care – including cancer, lung disease, heart disease, HIV/AIDS, pregnancy complications, cirrhosis,

ulcers and trauma – the National Center on Addiction and Substance Abuse (CASA) estimates that nearly one-third of all hospital costs are linked to SUD.¹⁰

In 2016, approximately 1,500 Oregonians died from alcohol-related causes, including chronic diseases, acute poisoning, injury and perinatal cause.¹¹ In addition, the Centers for Disease Control and Prevention reports that 505 Oregonians died as a result of a drug overdose in 2015, including 102 heroin overdoses, 220 prescription opioid overdoses and 34 other synthetic opioid overdoses.¹² Opioid-related complications are an increasingly common cause of death in Oregon, higher than traffic accidents, firearms, and traumatic injuries.¹³

Societal costs

The financial impact of SUD on Oregon is massive. Ten years ago, ECONorthwest estimated the annual cost at nearly \$6 billion per year or \$1,615 per Oregonian:¹⁴

ESTIMATED ANNUAL SOCIETAL COSTS

Lost earnings:

Substance abuse	\$2 billion
Criminal conduct	\$1.2 billion
Premature death	\$978 million

Healthcare:

Medical & insurance admin.	\$506 million
Drug & alcohol treatment	\$307 million

Other costs:

Criminal justice	\$656 million
Motor vehicle accidents	\$271 million
Fire damage	\$26 million
Welfare costs for families	\$13 million

Total: \$6 billion

Alcohol accounted for \$3.2 billion of Oregon's annual SUD-related expenditures, or roughly 55 percent of the total.¹⁵

CASA reported in 2009 that Oregon spent more than 9 percent of the state government budget on the consequences of failure to prevent and treat SUD.¹⁶

Regardless of how the numbers are calculated, or by whom, Oregon pays a high social cost for its neglect of SUD prevention and treatment.

Challenges for specific communities

While no community in Oregon is immune to the impacts of SUD, several groups have unique and acute experiences and needs.

Rural Communities

Nationally and within Oregon, rural communities are experiencing the most rapid increase in SUD incidence, morbidity and mortality, and overdose occurrence and fatalities. This rural SUD epidemic is accompanied by increases in suicide and alcohol related deaths, contributing to an unprecedented decrease in life expectancy for rural residents.

Likely explanations for the rural SUD epidemic include inadequate access to healthcare, rising unemployment, decreasing social services, an aging population without economic resources, and the high cost of overcoming geographic distance from support services. Additionally, physicians who diagnose SUD in rural communities are less likely to have resources and training to provide follow up care. Finally, smaller communities may experience decreased privacy and increased potential for social stigma associated with SUD.

Technological advances can help bridge some of the resource and geographic barriers to providing better care to rural Oregonians. For example, the Oregon Health & Science University, along with Health Share of Oregon & Columbia Pacific, launched Project Extension of Community Health Outcomes (ECHO). This initiative utilizes technological tools to increase access to specialty treatment in rural and underserved areas by providing clinicians in those areas with collaborative medical education and care management via tele-consultation from specialists across the state.

Communities of Color

Oregon's communities of color, including African American, Latino and Native Americans, have unique SUD experiences and needs. Nationwide, 4.9 percent of

blacks, 6.4 percent of Hispanics/Latinos and 9.7 percent of Native Americans, meet the diagnostic criteria for SUD, compared with 6.1 percent of whites.¹⁷

SUD treatment for communities of color can be complicated by a relative lack of culturally aligned treatment providers. Treatment success is negatively impacted by a lack of providers with a shared culture and community as the patient. Treatment provided by a member of the same community as the patient improves success of treatment and recovery.

In addition, communities of color may have a shortage of aligned personnel with the specific technical expertise necessary to navigate complex medical, professional, billing and logistical requirements as well as obstacles associated with establishing and maintaining a viable treatment center.

Finally, communities of color, whose neighborhoods are disproportionately more likely to have deficient social services and education, face the additional challenge of greater interaction with Oregon's criminal justice system.

Different racial and ethnic groups also have unique experiences and circumstances with regard to SUD.

“Many black individuals come into treatment with fear and anxiety if no one looks like them. Relationship and community are very important. There cannot be a cold, clinical approach.”

*– Anthony Jordan
Addiction Services Manager,
Multnomah County Health Department*

African Americans

Although African Americans abstain from drugs and alcohol at higher rates than the national average, they are disproportionately represented in drug arrests and prison sentences nationwide, with prison sentences for African Americans increasing 500 percent between 1986 and 2004. In 2009, African American males were 6.7 times more likely to spend time in jail than their white counterparts. A study in 2015 found that African Americans in Oregon were convicted of felony drug possession at more than double the rate of white offenders.¹⁸

Native Americans

The data set regarding SUD and Native Americans is less complete compared to other minority groups. That said, existing research indicates that Native American populations are the most likely to meet the

clinical criteria for SUD and this population experiences the most significant gap between needs and provision of services. In 2017 a higher percentage of Native Americans (9.7 percent) met the diagnostic criteria for SUD in the past year than any other ethnic/minority group in the United States.¹⁹ Disparities also exist between urban residents and those who live on reservations. Native Americans experiencing SUD are more likely to benefit from assessment and treatment experiences that incorporate their unique family, community and cultural experiences, including experiences with inter-generational violence and historical trauma.²⁰

Latinos

The prevalence of SUD within Latino populations appears to reflect the national average, while treatment options are geographically limited and underutilized in part due to the cultural stigmatization that may accompany seeking support.²¹ As a result, treatment delivery requires a relevant cultural framework including Latino counselors and peers. Specific cultural components may include the value placed on dignity and respect,²² the tendency to rely on extended family for support,²³ *personalismo* (an emphasis on interpersonal relationships),²⁴ *simpatia* (downplaying conflict in relationships),²⁵ the value placed on spirituality and religion,²⁶ and gender roles emphasizing the public appearance of patriarchy.²⁷ Best practices for treatment of Latinos with SUD will vary by individual but will likely require the understanding and integration of their unique cultural characteristics.

LGBTQ

Individuals who are members of the lesbian, gay, bisexual, transgender and queer (LGBTQ) populations suffer higher rates of SUD and are more likely to enter treatment with a severe SUD than their heterosexual counterparts.²⁸ These trends hold true for LGBTQ youth as well.²⁹ When LGBTQ individuals seek treatment, they may encounter providers who lack familiarity with the developmental experiences of the LGBTQ community-

such as family ostracism, homophobia and social isolation. That, in turn, can interfere with effective SUD care.³⁰ One study found that just 7.4 percent of treatment centers offered an LGBTQ-specialized service.³¹ Amy Ruff, clinical program manager at a Portland youth assistance center estimated that 50 to 60 percent of the agency's clients identify as LGBTQ. Other witnesses corroborated the high numbers of LGBTQ youth who need specialized attention to benefit from treatment.

Veterans

The National Association of State Alcohol and Drug Abuse Directors published a report in 2009 detailing the SUD-related needs of returning veterans and their families.³² Oregon was one of nine states profiled. Although Oregon is not home to any military bases, at the time of its publication, Oregon had the second largest number of deployed soldiers per capita in the nation.³³ The report summarizes the need to improve

outreach and brief intervention services for veterans with SUD or co-occurring SUD and mental health disorders, some of whom have exhausted their medical benefits. It highlights the needs of rural veterans in Oregon and the lack of adequate SUD services in many parts of the state as well as the lack of services specifically

designed for women experiencing SUD who may need childcare services or specific care for sexual trauma.³⁴

This research regarding SUD and veterans echoes the findings of many studies in that it recognizes two factors related to veterans and SUDs – homelessness and post-traumatic stress disorder (PTSD).³⁵ Although correlations between SUD, homelessness and PTSD vary by individual, there is a significant body of research indicating that veterans are at significant risk for all three.³⁶ In Oregon, 70 percent of homeless veterans experience SUD.³⁷

Youth

Childhood and adolescence are intensely vulnerable times in the development of SUD. Most SUDs begin before the age of 25, and the earlier an adolescent samples his or her first addictive substance, the greater

“Residential treatment centers feel like jail. Treatment needs to feel relevant to brown people, queer people, the LGBTQ community and foster children.”

*– Jasmine Petit
ROSE Program*

the chance of subsequent SUD and the less likely their positive response to treatment.

Among adolescents and young adults in Oregon, 67 percent report using alcohol, 40 percent any illicit drug and 20 percent a prescription drug. Oregon ranks fifth in the United States in adolescent SUD in the past year and fourth in recent adolescent binge drinking.³⁸ More than half of incarcerated youth meet criteria for SUD.

Resources for detecting or treating adolescents with SUD in Oregon are minimal. Oregon ranks a dismal 48th in the nation for adolescent treatment access with just 144 community adolescent treatment beds in a state with 500,000 adolescents.³⁹ This lack of adequate detection or treatment of SUD among youth is especially

pronounced among African American, Native American and Hispanic youth.

One witness noted that adolescents are far more dependent than adults upon peers for behavior modification and recovery support.

“Peer services provide a connection of hope through identification,” said Tony Vezina of Fourth Dimension Recovery Center. He added that peer support services and dedicated drug-free high schools are particularly effective.

Several witnesses reinforced that mobilization of peer support is critical in the treatment and recovery of youth with SUD. Oregon offers few such peer support programs for youth.



SOURCE: CDC Vital Signs. January 2014. www.cdc.gov/vitalsigns. American Journal of Preventive Medicine, 2011; Volume 41.

DISCUSSION, FINDINGS & CONCLUSIONS

Contribution of trauma

Trauma occurs as the result of an event or set of circumstances that is experienced as physically or emotionally harmful or life threatening, has lasting adverse effects on an individual's functioning, and impacts mental, emotional or physical wellbeing.⁴⁰ Trauma is a nearly universal experience of people suffering from mental health concerns and SUDs.⁴¹ As a result, addressing trauma is fundamental to any efforts to prevent or treat SUD.⁴²

Adverse Childhood Experiences (ACEs)

Experts in the fields of SUD prevention and treatment use the term Adverse Childhood Experiences (ACEs) to describe the significant influence of childhood trauma on subsequent adult behavior, especially SUD.⁴³ Examples of ACEs include homelessness; hunger; physical, emotional and sexual abuse; domestic violence; mental illness; parental instability; family and neighbors with SUD; and neighborhood crime.

Multiple studies confirm a strong relationship between ACEs and development of SUD. ACEs interrupt a child's neuro-development, specifically decreasing the ability to cope with negative emotions or to regulate behavior.

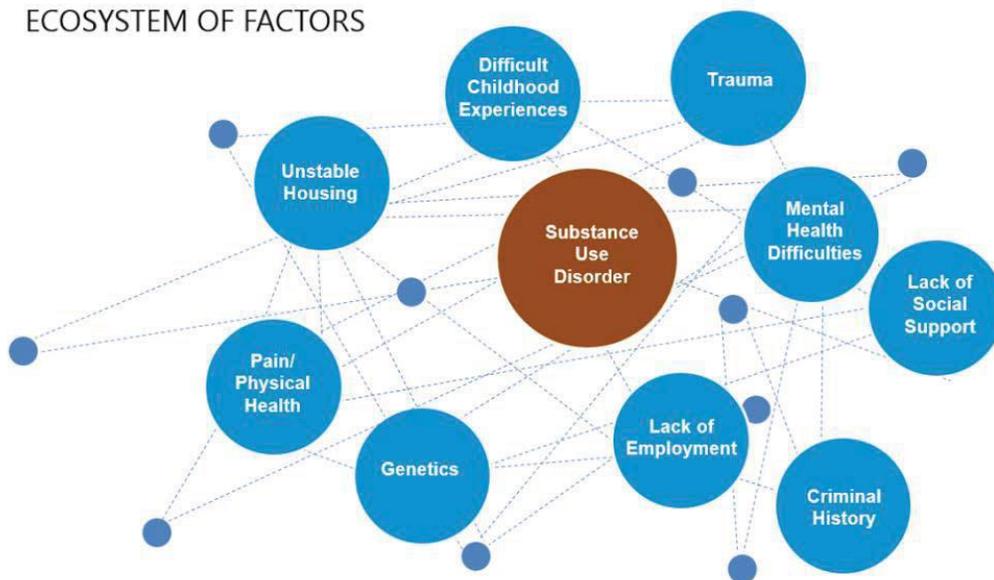
Other social contributors to SUD

Other social conditions are associated with increased SUD risk, including physical and sexual abuse, unstable family environments, homelessness, bad health, inadequate access to healthcare, mental health disorders, being a victim of violence and hunger. Social programs that mitigate these traumas can prevent the onset of SUD, and the effectiveness of SUD treatment improves when these conditions are mitigated.

Trauma: Findings and Conclusions

- Trauma is a nearly universal experience for individuals with SUD.
- Adverse Childhood Experiences (ACEs) such as homelessness, hunger, instability and abuse are strongly associated with SUD.
- Experiencing ACEs decreases the ability to cope with negative emotions and regulate behavior, increasing the probability of developing SUD.
- A unique ecosystem of factors contribute to the development of SUD for each individual.
- Social programs that mitigate the impact of ACEs and other trauma will decrease the development of associated SUDs.

ECOSYSTEM OF FACTORS



Evidence-based prevention

Prevention is more cost-effective than treatment, and treatment is more cost-effective than incarceration. Any prevention program that delays first-use of a substance decreases the likelihood of developing SUD. Intervening in the life of a child before development of an SUD, and especially before any exposure to addictive substances, is the most powerful tool to reduce the impact of subsequent SUD on Oregon’s residents and communities.

Evidence-based prevention programs are programs demonstrated through replicated research to effectively change behavior and outcomes.⁴⁴ Unfortunately, only 6 percent of individuals receiving prevention programming in Oregon were involved in evidence-based programs.⁴⁵ This appears to be the result of two factors.

First, is a specific institutional funding flaw. State law and regulations require 75 percent of state moneys to be spent on evidence-based practices, but 98.6 percent of such funding is spent on treatment, and that portion easily clears the threshold. Accordingly, little attention is paid to utilizing evidence-based prevention programming. Although a state regulatory requirement states that prevention practices should “incorporate evidence based practices,” it does not specify a minimum spending standard.⁴⁶

Second, overall funding for prevention programs remains scant, potentially causing the selection of cheaper, non-evidence based practices. Statewide, Oregon averages \$11.31 per capita, or \$57.92 per child, on prevention spending.⁴⁷ But county averages vary significantly. In Multnomah County, spending is 99 cents per capita and \$4.94 per child.⁴⁸ This is shortsighted, as evidence-based prevention offers the best opportunity for preventing SUD entirely, which benefits Oregon by improving health outcomes for individuals and communities and by leading to significant savings for every dollar spent. For example, some evidence-based prevention programs are calculated to save more than \$100 for every dollar spent.⁴⁹

The OrSUD research committee is not in the position to recommend specific evidence-based

prevention programs. Program selection requires diverse community partners to plan and deliver culturally appropriate, effective and sustainable prevention practices well-suited to specific communities. Information regarding such programs can be located in the Alcohol and Drug Policy Commission’s 2014 report.⁵⁰

Youth Programs

Most evidence-based youth prevention programs are delivered in school settings and are not focused specifically on substance use, but rather on fostering coping skills, problem-solving skills, resilience, self-esteem and self-regulation skills that can be used to counteract trauma and ACEs.

While the original formulation of D.A.R.E. is infamous within the SUD prevention field as ineffective and lacking evidence, there are many effective, evidence-based school interventions, some of which are implemented in Oregon. These include The Good Behavior Game and LifeSkills Training, two elementary school interventions that are calculated to save, respectively, \$64 and \$17.25 for every dollar spent.⁵¹

Adult Programs

Evidence-based prevention programs for adults can be very effective in reducing SUD and in improving response to treatment.⁵² Prevention programs in adults may be directed at specific communities or age groups, at children or adolescents with parents who suffer SUD, or at adults engaged in at-risk behavior but before developing SUD.⁵³

Several witnesses recommended public service announcements and a statewide advertising campaign to increase public awareness of alcohol consumption and SUD.

We are not aware of data corroborating that such campaigns prevent alcohol SUD, although witnesses did note historical benefits from similar campaigns to curb smoking and drunk driving.

Prevention in adults, as in children, is especially effective when the conditions generating SUD are improved by social services.

“Providing medication and counseling is not enough. People need a hopeful trajectory.”

*– Dr. Rachel Solotaroff
Central City Concern*

Evidence-Based Prevention: Findings and Conclusions

- Allocating funds to prevention is more cost effective than funding future interventions that include social services, medical treatment and incarceration for SUD.
- A small percentage of Oregonians are able to access evidence-based prevention programs.
- Prevention programs are not prioritized and are under-funded. There is no enforcement of the use of evidence-based programs.
- Preventatively increasing coping skills, problem-solving, and self-regulation skills, as well as delaying the first use of addictive drugs, reduce the chances of addiction. Often such programs are school-based.
- Evidence-based prevention programs that emphasize non-specific coping skills such as The Good Behavior Game are cost effective. These interventions, unlike specific anti-drug campaigns (such as D.A.RE.), have compelling evidence that they reduce subsequent development of SUD.
- Prevention programs or risk reduction programs for adults lack conclusive data but may be promising.

Physicians and SUD

Physicians play a unique and crucial role with regard to SUD prevention and treatment. We will briefly address challenges and opportunities arising as a result of this role.

Inappropriate pain treatment

Opioids are not an effective tool for long term management of chronic pain. Treating acute or chronic pain with opioids generates significant risk of creating an opioid SUD in patients with pain and of injecting millions of legally prescribed opioid pills into the general population which are then used illegally by others.

More than 290 million opioid pills are prescribed in Oregon each year, or approximately 70 pills per Oregonian. The Prescription Drug Monitoring Program (PDMP) indicates that over 918,000 Oregonians (about 22 percent of Oregon's population) received at least one prescription for an opioid in one year, with a mean of four prescriptions per person.

Opioids also cause spillover into SUD with other substances. Oregon's heroin epidemic grew in part from the widespread illegal availability of legally prescribed opioids. At the same time the costs and difficulty of illegally acquiring oral opioids was increasing, the cost of injectable heroin was decreasing.

By relying on opioids to treat chronic pain, physicians may inadvertently generate instances of SUD. Such reliance contrasts with guidelines published by the Centers for Disease Control and Prevention and with the 2016 prescribing guidelines from the Oregon Health Authority. Physicians should be familiar with and follow these guidelines, which are appropriately and increasingly advocated for by professional physician organizations. These organizations acknowledge that better physician prescribing practices will reduce subsequent SUD in patients who need opioids and reduce opioid SUD in others who illegally acquire legally prescribed opioids.

All patients with chronic pain deserve appropriate treatment. Pain patients may need continued prescriptions for opioids until non-opioid treatment allows pain control without opioids. Medical studies corroborate that many patients with chronic pain can maintain pain relief with tapering and eventual discontinuation of opioid therapy.⁵⁴

Inadequacies of Oregon's Prescription Drug Monitoring Program

Oregon's PDMP is part of a nationwide effort to enable physicians to track opioid prescriptions, allow state tracking of physician prescribing practices and generate guidelines to improve addiction prevention and treatment.⁵⁵ The Oregon PDMP fails to achieve these goals. Impediments include difficult clinician interface, lack of interoperability with other electronic medical records, absence of methadone from tracked medications and voluntary participation.

The committee views the PDMP as a potentially valuable tool if software corrects these deficits. Only after such improvements can the PDMP achieve its intended goal. This program should not be mandated until the implementation of such improvements.

Improving physician training and resources

SUD treatment – along with mental health treatment – historically has been segregated from physical health treatment in the United States. This

artificial delineation has caused many physicians and other physical health providers to consider SUD screening and treatment as beyond the scope of their practice, while also burdening individuals with SUD by impeding their access and entry into SUD treatment.

In addition, physician’s often lack training in SUD recognition and risk factors. The disease can therefore go unrecognized by physicians, missing opportunities for early intervention. Physicians also largely lack knowledge of appropriate treatment resources when SUD is recognized. Due to these gaps in knowledge and treatment resources, physicians may miss the often fleeting window of time in which a patient desires and is willing to enter treatment. “Patients are not consistently screened for SUD when presenting for medical care,” Dr. Dennis McCarty of OHSU told the committee.

Ideally, all SUD treatment should include supervision by a physician with training in addiction medicine. In addition to the broad utility of training in addiction medicine when treating patients with SUD, physicians and addiction medicine specialists play a crucial role in providing Medication-Assisted Treatment (MAT), which can be an essential component of treatment. The American Board of Addiction Medicine and our witnesses note that Oregon has fewer than 50 physicians certified in addiction medicine. Only six of them practice outside the Willamette Valley, with none on the coast and three in Eastern Oregon.

Given the high unmet demand for SUD treatment in Oregon and the relative lack of addiction medicine

specialists for current patients, Oregon would have to increase the number of addiction medicine specialists tenfold to meet statewide need.

Promising new developments: ECHO & IMPACT

Project ECHO (Extension for Community Healthcare Outcomes), extends resources, especially to physicians in rural areas who lack both facilities and staff with specialized training in SUD. With Project ECHO, physicians and other care providers collaborate with colleagues via a telehealth system, allowing those with in-depth knowledge to provide consultation to rural providers regarding complex treatment decisions.⁵⁶

OHSU’s Improving Addiction Care Team (IMPACT) provides an illustration of the potential for integration of SUD treatment into primary care. Dr. Honora Englander reports that the IMPACT program streamlines health care for individuals experiencing a SUD by providing an “in-reach” liaison to patients receiving treatment at OHSU. OHSU staff work with CODA Behavioral Health to provide hospital-based addiction medicine consultation and support prior to a patient’s discharge from OHSU. OHSU and CODA share a patient database and a cooperative working relationship to address patient SUD, thereby shifting focus from acute need to the underlying cause of poor health – the SUD.

“The result of this program is increased quality of care, reduced stigma of SUDs, eliminating the wait time to receive treatment, as well as a savings of 460 hospital days last year,” Englander said.

Physicians and SUDs: Findings and Conclusions		
<ul style="list-style-type: none"> Physicians in Oregon may inadvertently contribute to SUDs if they do not follow prescribing guidelines for acute and chronic pain published by OHA, CDC, the Surgeon General’s Report on Alcohol, Drugs, and Health, and the National Center on Addiction and Substance Abuse. Poor software design and lack of interoperability reduce physician participation in the PDMP. Correcting these deficits will increase physician participation and harness its potential to decrease the misuse of prescription drugs. 	<ul style="list-style-type: none"> Medical professionals require training in SUDs as a standard component of medical school curricula in all state medical, nursing, pharmacy, clinical psychology and naturopathy training programs. Primary care physicians frequently fail to detect SUD in their patients because this disorder is not included in routine screening. Oregon lacks an adequate number of MAT facilities which disproportionately impacts rural Oregonians. 	<ul style="list-style-type: none"> Rural Oregonians experience unique logistical challenges to receiving SUD treatment. Technological programs like ECHO provide useful avenues for increased quality and quantity of care. Project IMPACT provides an example of an integrated care initiative that utilizes a traditional health setting to provide culturally competent, community-based, streamlined care initiated in a medical setting.

Access issues

Only 11 percent of adult Oregonians with SUD received treatment, worse than the national average of 14 percent. Even fewer Oregonians with an alcohol SUD received treatment, about 8 percent. Several challenges prevent greater access to treatment.

Health insurance hurdles

Effective treatment for SUD begins with affordable entry and depends on continuous care. Patients who are uninsured or under-insured (i.e. covered by insurance but without money to pay deductibles, co-pays, out-of-pocket payments or for treatments not included in benefits) may be unable to complete treatment due to inability to access treatment, inability to remain in treatment after entry or inability to sustain a long-term recovery program.

Compounding these issues is high turnover in all insurance programs, both private and public. With an estimated annual churn rate of 20 percent, more than half of Oregonians will be in a different insurance plan or without insurance within four years. This complicates long term treatment of any chronic disease, including SUD.

Oregon's healthcare system, like the nation's, fragments patients into multiple risk pools, each with different benefits, physicians, services, electronic medical records and reimbursement for services. This fragmentation makes any consistent, statewide addiction treatment program inefficient.

Despite the expansion of coverage initiated by Affordable Care Act (aka Obamacare) and the Mental Health Parity and Addiction Equity Act, only one-in-10 Oregonians who need SUD treatment receive it. Additionally, 20 million Americans remain uninsured and another 20 million remain underinsured.

While the ACA has likely improved matters, there remain significant gaps in coverage and access to treatment, and the committee cannot endorse the ACA as a cure-all. Instead, several witnesses noted the potential value of a universal health care plan in Oregon that could provide (1) pre-paid access for everyone, (2)

treatment for all treatable conditions (including SUD) and (3) access to any provider by any patient.

Geographic challenges

A critical impediment to SUD treatment in Oregon is the paucity of treatment centers that offer medication-assisted treatment (MAT). Only 14 facilities offer MAT programs, all located along the I-5 corridor. Access to MAT for rural Oregonians with SUD is nearly non-existent.

Growing awareness of SUD spurred waves of new treatment centers. However, the stigmatization of SUD prompted institutional and geographic isolation from medical facilities. This created the challenge of attempting to find SUD treatment within completely

separate systems, challenges especially difficult for patients with multiple, sometimes related, medical conditions. The lack of integration further complicates administrative complexity, costs and poor medical follow-up.

"Treatment centers are located three miles down a dirt road, far removed from all other medical care facilities.

They need to be on main street. There should be no shame in addiction," said Tim Hartnett, executive director of CODA.

Homelessness

For people of all ages, relieving homelessness reduces subsequent SUD, allows those with SUD to respond better to treatment, and prolongs successful recovery. A recent study estimated that 17 percent of Oregon's 13,000 homeless individuals experience "chronic substance abuse."⁵⁷ This is consistent with national estimates.⁵⁸ Oregon ranked 49th in the nation for the rate of unsheltered homeless (60.5 percent) and has the second highest number of rural homeless.⁵⁹

"Instead of asking what do folks on the street need to do differently to integrate into society, we should be asking what are the ways that the society that is housed can become more accessible and be a meaningful choice for folks to join," said Amy Ruff, clinical program manager at New Avenues for Youth.

"If I had a magic wand, we would have a single payer system. Every Oregonian would have health care."

*– Jim Shames
Medical Director
Jackson County Health and Human*

Housing for the homeless saves \$8,700 in health care spending the first year.⁶⁰ Of particular relevance to this report, providing housing to individuals with SUD has a tremendous impact on their potential for recovery. Our witnesses who spoke of homelessness identified it as the single most important factor in predicting response to treatment and maintaining recovery. SAMHSA’s Definition of Recovery includes the following description: “Home: a stable and safe place to live.”⁶¹ “Without safe housing, all these recovery programs are merely academic,” said Rick Treleaven of the Oregon Coalition for the Responsible Use of Medication.

Lack of culturally appropriate treatment

Treatment among communities of color is hindered by historical distrust of mainstream medical institutions, a relative lack of treatment professionals from communities of color and treatment protocols that may be culturally inappropriate. Communities of color are further hampered by culturally inappropriate settings and protocols; geographic distribution of treatment centers, even within metropolitan areas; and complexities of enrolling in and using insurance.

Access Issues: Findings and Conclusions

- Insurance coverage in Oregon, both private and public, offers inconsistent and frequently inadequate access to SUD treatment. Extensive wait times, undependable quality and inefficient coordination among providers is common.
- Fragmented insurance coverage provides no incentive to invest in high quality SUD benefits.
- A single format for SUD treatment billing with consistent benefits among private and public insurance programs would allow more funds for patient care without increasing total investment.
- Stable housing is a key component in determining whether individuals with SUD have the ability to access and sustain treatment for their illness.
- Individuals from communities of color who are seeking treatment for SUD are often less likely than their white counterparts to have an implicit trust for the medical system and are more likely to complete treatment when culturally appropriate services are provided by individuals from their own communities who have also experienced addiction and recovery.

SUD and the law

Many of the committee’s witnesses as well as strong evidence in the academic literature confirm that incarceration neither prevents nor treats SUD. Unfortunately, the criminal justice system still bears the burden of being the first social attention received by many people suffering from SUD.

Unlike patients suffering from other chronic medical conditions, patients with SUD might encounter law enforcement before health care professionals when they lose control over their condition. One reason for this difference is that the conditions precipitating the disease are the same conditions that provoke criminal behavior: chronic life stress, homelessness, hunger, unemployment, lack of healthcare and a violent social environment. These conditions promote the social stigma associated with SUD, contributing to the false notion that SUD is a criminal justice problem, not a medical disease.

While Oregon recently defelonized first time possession of small amounts of controlled substances (see below), federal laws still mandate that individuals using illicit drugs be subjected to criminal processes, sometimes with, but often without, addressing the underlying SUD. As a result, drug violators are the largest single population of prisons, both nationally and in Oregon.

Harm-reduction methods

As an alternative to incarceration focused on abstinence-only strategies and in recognition of the chronic nature of SUD, some social interventions increasingly focus on harm-reduction strategies. A harm-reduction approach recognizes the permanence of drugs in society and, instead of trying to eradicate drug use, focuses on minimizing harm to the individual and society.⁶²

The harm-reduction approach emphasizes the measurement of health, social and economic outcomes as opposed to the measurement of drug consumption.⁶³ There is persuasive evidence from the literature that harm-reduction approaches greatly reduce morbidity and mortality associated with risky behaviors.⁶⁴ Strategies include outreach and education programs, needle/syringe exchange programs, overdose prevention education and access to naloxone to reverse potentially lethal opioid overdose.⁶⁵

Defelonization (HB2355)

The Oregon Legislature passed HB 2355 in 2017, and it was signed into law by Gov. Kate Brown. The law defelonizes possession of certain controlled substances, leading to a misdemeanor charge instead.

Building on defelonization efforts, law enforcement organizations in Oregon are increasingly experimenting with programs that encourage rapid entry into treatment programs for people with probable SUD encountering the criminal justice system.

Incarceration does not prevent SUD, does not treat SUD and is more expensive than treatment. Although incarceration provides an opportunity to connect with and provide treatment, only an estimated 11 percent of incarcerated individuals in need of treatment receive it in jail or prison.⁶⁶ When released, many of these former inmates find their lives still driven by SUD and often return to the same social stresses that generated and sustained their SUD initially.

In submitted testimony to the Oregon Legislature, Kevin Campbell, executive director of the Oregon Association of Chiefs of Police, wrote, “Too often, individuals with addiction issues find their way to the doorstep of the criminal justice system when they are arrested for possession of a controlled substance. Unfortunately, felony convictions in these cases also include unintended and collateral consequences including barriers to housing and employment and a disparate impact on minority communities.”

Our committee found no evidence, either in Oregon or other states, that treating SUD with incarceration is more cost-effective than medical treatment. On the contrary, our witnesses and evidence conclude that reducing the stigma of SUD and diverting people suffering from the disease into our healthcare system as early as possible is the best method for reducing SUD, reducing crimes associated with SUD, improving the lives of SUD patients and improving the quality of our communities.

Early diversion programs

Multnomah County has implemented two experimental programs to divert people with SUD into treatment early in their interaction with the criminal justice system.

The Law Enforcement Assisted Diversion (LEAD) pilot, based on the Seattle LEAD program, diverts low-level drug offenders into community-based treatment

and support services – including housing, healthcare, job training, treatment and mental health support – before entry into the criminal justice system.

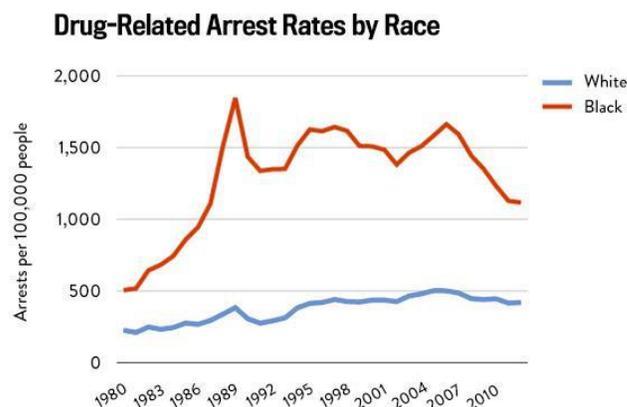
“The biggest win is a healthier person,” said Multnomah County District Attorney Rod Underhill.

Treatment First, meanwhile, is a countywide program that treats all drug possession cases as misdemeanors. Defendants thereby avoid felony convictions and the long-term negative consequences associated with them such as difficulty accessing housing and employment.

The OrSUD research committee was cautioned that these programs are relatively new and lack documentation of long-term effectiveness. This caution is appropriate. All early diversion programs require close monitoring to determine that they achieve their goals in a cost-effective manner. We were further cautioned that the byzantine format of federal subsidies for law enforcement may result in reduced funding in the face of fewer felony convictions, compromising the ability of local law enforcement agencies to fund alternative treatment programs other than incarceration.

Special burden on communities of color

Communities of color face additional and disproportionate burdens as a result of the interaction between SUD and Oregon’s criminal justice system. In fact, although African Americans abstain from drugs and alcohol at higher rates than the national average, they are disproportionately represented in drug arrests and prison sentences nationwide, with prison sentences for African Americans increasing 500 percent between 1986 and 2004. In 2009, African American males were 6.7 times more likely than their white counterparts to spend time in jail.



As a response to this imbalanced exposure of communities of color to police intervention, the DSM-V deliberately eliminated legal issues from the criteria for SUD diagnosis.⁶⁷

Arrest and incarceration disproportionately impact poor people and communities of color and may have long-lasting consequences on their lives with very little impact on their substance use.⁶⁸

Other states and nations

Given the failure of criminalizing possession of controlled substances to alter Oregon’s SUD epidemic and given the additional evidence that criminalization may in fact exacerbate the problem, Oregon should consider the experience of 16 other states as well as Washington, D.C., and the federal government that now treat personal possession without intent to sell as a misdemeanor. (See Appendix III.)

Treating SUD as a criminal violation also magnifies the inappropriate public stigma of people with SUD. Felony convictions for using or possessing controlled substances carry with them the burden of collateral consequences even after being released from prison following service of their sentence.

Oregon statutes include more than 800 collateral consequences on individuals convicted of felonies, affecting employment, government benefits, civic participation and housing.⁶⁹ These consequences make it far more difficult for individuals to rebuild their lives after a drug conviction.

SUD and the Law: Findings and Conclusions

- Incarceration is costly and neither prevents nor treats SUD.
- Life stressors such as homelessness, unemployment, and hunger are often associated with both SUD and engaging in criminal behavior.
- Harm reduction interventions reduce the morbidity and mortality associated with risky behaviors.
- Communities of color and poor communities have disproportionate experiences with the criminal justice system as a direct or indirect consequence of SUD.

- Oregon is in the initial phases of implementing early diversion/decriminalization that are in place in other states. Data is not yet available to determine which if any of these programs are effective.
- Federal convictions are often accompanied by collateral consequences including barriers to employment and housing making it more difficult for individuals with SUD to rebuild their lives after a conviction.

Funding issues

Oregon’s funding for SUD is fragmented, undependable and insufficient to meet the needs of people who suffer SUD. Despite the complex structure of funding SUD prevention and treatment, all witnesses interviewed indicated a lack of adequate funds as a core problem and many advocated new funding for SUD prevention and treatment.

Underfunded at federal, state and local levels

Federal funding

One indication of the fragmentation of funding for addiction services is the multiple sources of federal funding. Federal grant awards to reduce the availability and misuse of drugs in Oregon in 2012 originated from the departments of Agriculture, Defense, Education, Health and Human Services, Housing and Urban Development, Justice, Labor, Transportation, Veteran’s Affairs, and Office of National Drug Control Policy. Seventy-three percent of the total was from the Health and Human Services Division.⁷⁰

State Agencies and the budget

In addition to multiple federal sources, seven state agencies administer SUD prevention and treatment programs: Department of Corrections, Department of Human Services, Department of Education, Oregon Criminal Justice Commission, Oregon State Police, Oregon Youth Authority and Oregon Health Authority. Of the OHA budget, SUD and mental health’s share was \$1.1 billion, or 6 percent of the total OHA budget. That does not include programs within the Public Health Division aimed at reducing opioid misuse, such as the PDMP.⁷¹

Within the Department of Human Services, funding for SUD has multiple sources, many with their own restrictions, including federal grants; the general fund; beer, wine, marijuana and tobacco taxes; tobacco settlement; hospital tax; drug rebates; and lottery funds.⁷²

Local and county governments

Local and county governments, non-governmental organizations (NGOs) and private insurance companies add a final layer of complexity to the funding equation. In Multnomah County, SUD-related funding is “opaque,” according to County Commissioner Sharon Meieran. It comes primarily from Medicaid, but with additional county, state, local and federal funds. Most of these program funds pass through a subcontractor before reaching providers.

One indication of the inadequacy of SUD treatment funding in Oregon is the estimate of the Association of Oregon Community Mental Health Programs that 87,000 Medicaid patients in Oregon with SUD need treatment but receive either inadequate treatment or none at all.

Meeting the needs of these patients would require 330 more full time providers and \$44 million in annual funding.⁷³ These figures do not include patients with private insurance or no insurance.

Oregon tax issues

Although investment in prevention and treatment pays for itself several times over in the long run, identifying funds in the present often proves difficult. Investing current funds by creating new taxes or reducing spending on other programs is politically unpalatable even with the promise of reduced spending in the future.

Compounding this problem, even the current inadequate funding of SUD treatment is unreliable. Several witnesses noted that Oregon’s dependence upon personal income taxes, with little ability by the state to save or borrow money, makes all general

revenue, and therefore funding for SUD prevention and treatment, volatile and undependable.

Several witnesses promoted the utility of somehow generating a new revenue stream via sales of beer, wine and marijuana. Studies corroborate our witnesses.⁷⁴ These studies demonstrate that increased alcohol taxes reduce the number of children who drink alcohol; reduce crime, violence and traffic accidents; reduce morbidity and mortality; and increase tax revenue.

Perhaps most important, higher alcohol taxes plus new taxes on prescription opioids would potentially generate a consistent revenue stream that could be directed at statewide programs to improve prevention and treatment of SUD.

“Oregon needs to raise taxes on alcohol, especially beer. We haven’t raised taxes since the 1970s. This would generate revenue and evidence suggests it has an impact on reducing the likelihood of addiction,”

said Tony Biglan of the Oregon Research Institute.

Several witnesses advocated new state taxes on prescription opioids. No state has yet implemented such a tax, though California is considering the possibility.⁷⁵

Marijuana sales also could be an effective tax source. In 2016, Colorado generated almost \$200 million in tax revenue from \$1.3 billion in sales of marijuana.⁷⁶ In comparison, Oregon raised \$60 million on about \$241 million worth of sales.

But that revenue is not dedicated to SUD prevention and treatment, rather going toward a number of state programs including education. The Legislature could refocus those funds. Marijuana taxes remain a potentially valuable source of funding for SUD prevention and treatment.

The witnesses who spoke with the OrSUD research committee supported these taxes to provide some background funding for SUD prevention and treatment. Some witnesses were especially adamant that industries profiting from sales of addictive substances should contribute to programs that prevent and treat the consequences of SUD. We agree.

“We need an increased, unique revenue. We need to challenge beer, wine, cannabis and opioid industries to be part of the solution.”

*– Mike Marshall
Oregon Recovers*

Legal action against pharmaceutical companies

In 2017, Multnomah County has filed a lawsuit against nearly two dozen pharmaceutical companies seeking \$250 million damages for the companies' role in fueling the opioid epidemic. The suit alleges that the companies misrepresented the risks and benefits of opioids.

If the county prevails in this lawsuit or a settlement is reached, the OrSUD committee urges county officials to dedicate those funds to improving SUD prevention and treatment. Although this would not be a sustained source of funding, it would provide important bridge support and help many county residents in the short-term.

Return on investment – systemic disincentives

School-based prevention programs are the most cost-effective method of stopping Oregon's SUD epidemic. These programs require investment now to assure future returns. There is no controversy about the relationship between prevention costs now and future savings in social services. The future costs of SUD are high compared to the lower costs of prevention.

Viewing investment in prevention and treatment through the lens of return on investment is critical as additional investment in SUD prevention and treatment only becomes attractive if the much larger future savings are acknowledged.

The challenge with this framework is that the agency, company or taxpayer that invests today might not be the agency, company or taxpayer that enjoys the later return.

Even within health care provider organizations, the division that implements the most effective prevention and treatment programs may see the future savings enjoyed by other divisions within that provider organization or by entirely different organizations.

With an estimated average turnover rate among public and private insurance programs of 20 percent, there is little financial incentive for a specific insurance program to fund effective SUD programs if a patient might be insured by a different company in three years. Because the returns on investment may be splintered across different agencies, companies and insurers, comprehensive, statewide action is needed to capture the return of investments in SUD prevention and treatment.

Our committee urges Oregon as a state and community to invest now in preventing and treating SUD in order to benefit years later from lower costs associated with future SUD, even if those benefits will ultimately be spread across a number of public and private institutions.

Funding Issues: Findings and Conclusions

- Funding and expenditures for the prevention and treatment of SUDs are complex, fragmented, inconsistent and undependable. This seriously cripples the ability of any state-funded program to treat SUD.
- Funding for SUD prevention and treatment requires a steady source of tax-funded revenue that is not dependent on fluctuating general revenue. Witnesses uniformly support new and increased taxes on alcohol and prescription opioids.
- Collaboration with the alcohol and pharmaceutical industries in Oregon is mandatory.
- Prevention and treatment programs for SUD have a demonstrated Return on Investment but the future savings is often realized by a different agency/individual than the one that made the initial investment.

Alcohol and Drug Policy Commission

The Oregon Alcohol and Drug Policy Commission (ADPC) was created in 2009 to lead Oregon's addiction prevention and treatment services by monitoring programs, generating evidence-based recommendations, establishing standards and coordinating programs among multiple state agencies. The ADPC has failed to achieve these goals.

Witnesses concurred that this failure is a consequence of lack of leadership from the office of the governor, a bureaucratic structure impeding effective action and inadequate staffing and funding.

"The ADPC is the best organization to compile and analyze existing data," said ADPC Executive Director Daniel Ward. "We need the political will to do this. We need someone at the governor's level to ask that data analysis is assigned to the commission. No one is

monitoring the epidemic of drug use. There is no charge to gather and analyze data.”

The ADPC should lead Oregon’s campaign to improve SUD prevention and treatment by providing essential leadership, generating a strategic plan, and operating closely with public health agencies.

ADPC: Findings and Conclusions

- Because of poor administrative design and lack of leadership from the governor, the ADPC has failed in its mission to collect and analyze SUD data, to supervise use of evidence-based treatment and to recommend public policy to improve the prevention and treatment of SUD.



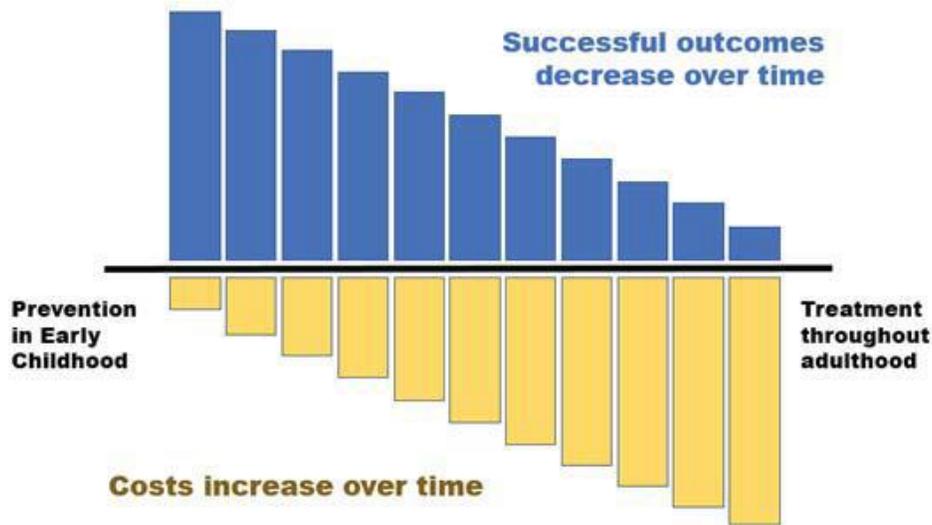
Source: Oregon Recovers

Oregonians rally in Portland on Sept. 30, 2017 to urge state lawmakers to spend less on jailing people for drug crimes and more on providing SUD prevention, treatment and recover. The Oregon Recovers coalition organized the rally.

RECOMMENDATIONS

Early childhood interventions as the most cost-effective option

1. To combat our SUD epidemic at the earliest, most cost-effective stage, the state of Oregon should increase funding of evidence-based school prevention programs.



Provide adequate health care access and benefits

2. Culturally appropriate treatment of SUD is an essential benefit that should be covered by every insurance policy.
Every health insurance policy in Oregon, public and private, should include SUD screening, treatment and recovery as essential benefits that are independent of a patient’s financial status at time of need. Policies must provide treatment and recovery that is culturally appropriate, especially for youth and communities of color. When patients change insurance policies, they should be able to retain their original treatment or recovery provider.
3. Oregon should require geographically accessible services. Insurance companies should be required to pay for telemedicine services.
Until treatment and recovery facilities and providers are geographically accessible around the state to every Oregonian with SUD, all health insurance policies should include telemedicine for all patients and remote access technologies, such as ECHO, for physicians.
4. Oregonians should have rapid entry to support, care coordination and treatment services via a statewide hotline.
The state should create an “SUD Hotline” to provide immediate assistance to access SUD treatment. This one telephone call should include assessment of need for other social services, including housing, food and other medical care.

Improved physician practices

5. Oregon’s physicians should follow best practices in prescribing.
All physicians who prescribe opioids should adhere to guidelines from state and national professional and governmental organizations. Guidelines are available from the U.S. Surgeon General, Centers for Disease Control and Prevention, National Center on Addiction and Substance Abuse, National Institute of Drug Abuse and the Oregon Health Authority’s Public Health Division. Physicians who vary from these guidelines should be prepared to answer to their peers.

6. Remove barriers and inefficiencies in utilizing the Oregon Prescription Drug Monitoring Program.

Oregon should revise PDMP software to allow interoperability with electronic medical records and add methadone and other controlled substances not currently included in the system. When new software meets these requirements, Oregon should mandate PDMP use for all physicians prescribing opioids and other addictive substances.

Defelonization and rapid diversion to treatment

7. Implement and monitor LEAD, Treatment First and other early diversion into therapy programs.

Building on the defelonization efforts enacted by Oregon's HB2355, law enforcement organizations in Oregon should implement experimental programs that encourage rapid entry into treatment programs for people with probable SUD encountering the criminal justice system. Examples of these programs are the LEAD and Treatment First programs. All early diversion programs require close monitoring to determine that they achieve their goals in a cost-effective manner.

Improved leadership from the Alcohol and Drug Policy Commission and from physicians

8. The ADPC should improve its efforts to lead and coordinate Oregon's campaign to address SUD.

Oregon should improve the organizational structure and funding of the ADPC to permit resumption of its original mission to provide policy leadership for the state's campaign to control SUD. The governor should demonstrate interest in this mission by providing specific goals for the ADPC. Interaction between the governor and the commission should be frequent enough to assure that the commission has sufficient resources, support and leadership.

9. Physicians should improve the relevance of their training and the rigor of their practice in addressing SUD.

Physician organizations in Oregon should amplify their efforts to guide education and practice to enable better training in SUD, incorporate SUD detection and treatment into routine practice, standardize treatment of acute and chronic pain, and improve physician prescribing practices. We do not recommend legislative intervention in physician practice unless physician leadership proves inadequate. Physician leadership should come from the Oregon Medical Board, Oregon Medical Association, and specialty and primary care physician associations.

The ADPC and physician organizations should integrate the recovery community into all levels of policy leadership.

Adequate Funding for Prevention, Treatment and Recovery Support Services

10. Oregon should create a dedicated funding stream sufficient to meet the state's needs for SUD prevention, treatment and recovery support services.

Oregon requires new tax revenues dedicated to SUD prevention and treatment. Examples of potential sources include increased taxes on alcohol and new taxes on prescribed opioids. Because neither of these taxes provide sufficient revenue, other taxes are essential.

11. Because investment now produces higher returns later, government, physicians, insurers and others involved in fighting the SUD epidemic should commit to working for long-term results and savings.

The OrSUD research committee is not prepared to suggest revisions to Oregon's tax code or to identify current state programs to be sacrificed to fund SUD prevention and treatment. That is the responsibility of lawmakers after a robust public dialogue. Nevertheless, Oregon should invest now to end the SUD epidemic.

APPENDIX I – ABBREVIATIONS

ACA: Affordable Care Act of 2010
ACE: adverse childhood experience
ADPC: Oregon Alcohol and Drug Policy Commission
AMA: American Medical Association
CARA: Comprehensive Addiction and Recovery Act of 2016
CASA: National Center on Addiction and Substance Abuse at Columbia University
CCO: Oregon Health Plan Coordinated Care Organizations
CDC: Centers for Disease Control and Prevention
DARE: Drug Abuse Resistance Education
DEA: U.S. Drug Enforcement Agency
DSM-V: Diagnostic and Statistical Manual of Mental Disorders
ECHO: Extension for Community Healthcare Outcomes
IMPACT: Improving Addiction Care Team at Oregon Health Sciences University
LEAD: Law Enforcement Assisted Diversion
LGBTQ: lesbian, gay, bisexual, transsexual, and queer
MAT: medication-assisted therapy
NIDA: National Institute of Drug Abuse
NSDUH: National Survey on Drug Use and Health
OHA: Oregon Health Authority
OHSU: Oregon Health Sciences University
OMA: Oregon Medical Association
PDMP: Prescription Drug Monitoring Program
ROI: return on investment
SAMHSA: U.S. Substance Abuse and Mental Health Services Administration
SUD: substance use disorder
WSIPP: Washington State Institute for Public Policy

APPENDIX II – OVERVIEW OF THE OPIOID EPIDEMIC

As of 2015, the most recent data available, the opioid epidemic was killing 91 Americans a day,⁷⁷ and nearly half of those overdose deaths involved a prescription opioid.⁷⁸ Drug overdose is also a major contributor to the rise in premature death and decline in longevity across the United States.⁷⁹ In addition, for every death there are an estimated 26 non-fatal overdoses and about 100 additional people suffering from opioid dependence and addiction,⁸⁰ leading to an estimated \$78.5 billion in annual economic costs.⁸¹ The role of prescribing physicians in the epidemic,⁸² its rapid and accelerating rise,⁸³ and its disproportionate impact on white suburban and rural communities⁸⁴ have encouraged public health and media attention.

Although Oregon’s opioid overdose death rate is currently 12 per 100,000, well below the national average of 16 per 100,000,⁸⁵ the state has the fourth highest rate of prescription pain medication abuse and above average use of heroin.⁸⁶ Oregon also has a high rate of opioid-related hospitalizations with 307 per 100,000 in 2014 compared with the national average of 225 per 100,000, and the highest hospitalization rate in the U.S. for adults aged 65+ at 600 per 100,000 (more than double the U.S. average of 248 per 100,000).⁸⁷

According to Dr. Daniel Ciccarone, an expert on heroin use at the University of California, San Francisco,⁸⁸ the reason that the heroin death rate in Oregon and other Western states is not as high as the

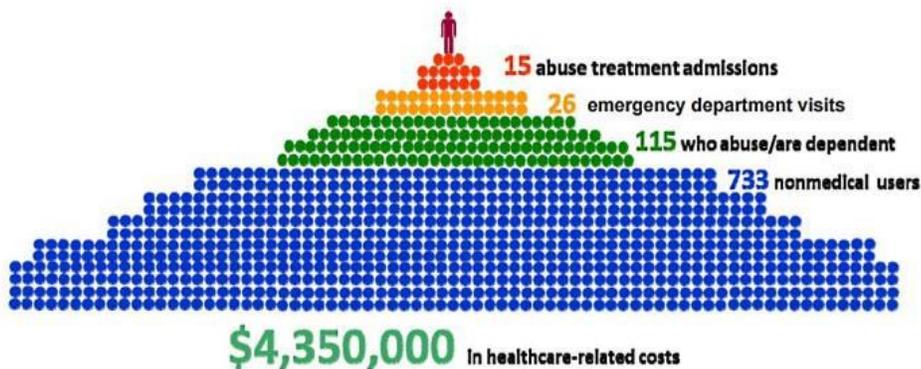
rest of the country is in part due to a historical divide between powdered, water-soluble heroin from Colombia and Asia found primarily east of the Mississippi River and low-solubility “black tar” heroin from Mexico found in the West.⁸⁹ Powdered heroin is more easily mixed or substituted with fentanyl, a man-made opioid that is 50 times more potent than heroin and 100 times more potent than morphine,⁹⁰ or carfentanil which is 100 times more potent than fentanyl. If drug traffickers switch to selling powdered heroin in the West⁹¹ or counterfeit fentanyl-based pain pills become more widespread⁹² Oregon’s opioid overdose rates are likely increase.

How did we get here?

As recently as 1991, 88 percent of U.S. medical board members believed that extended opioid prescribing for non-cancer pain was unlawful and unacceptable medical practice.⁹³ Then, in 1995, Oregon passed the Intractable Pain Act (amended in 2003 and 2007), which allows physicians to prescribe controlled substances for treatment of chronic pain without sanction from the Oregon Medical Board.⁹⁴ At the same time, in response to national concern about undertreated pain, the Joint Commission on Accreditation of Healthcare Organization issued Pain Management Standards in 2001 that included the concept of pain as the fifth vital sign.⁹⁵ The increased

Overdose deaths are the tip of the iceberg

For every **1** opioid overdose death in 2010 there were...



SAMHSA NSDUH, DAWN, TEDS data sets
Coalition Against Insurance Fraud. Prescription for Peril. <http://www.insurancefraud.org/downloads/drugDiversion.pdf> 2007.

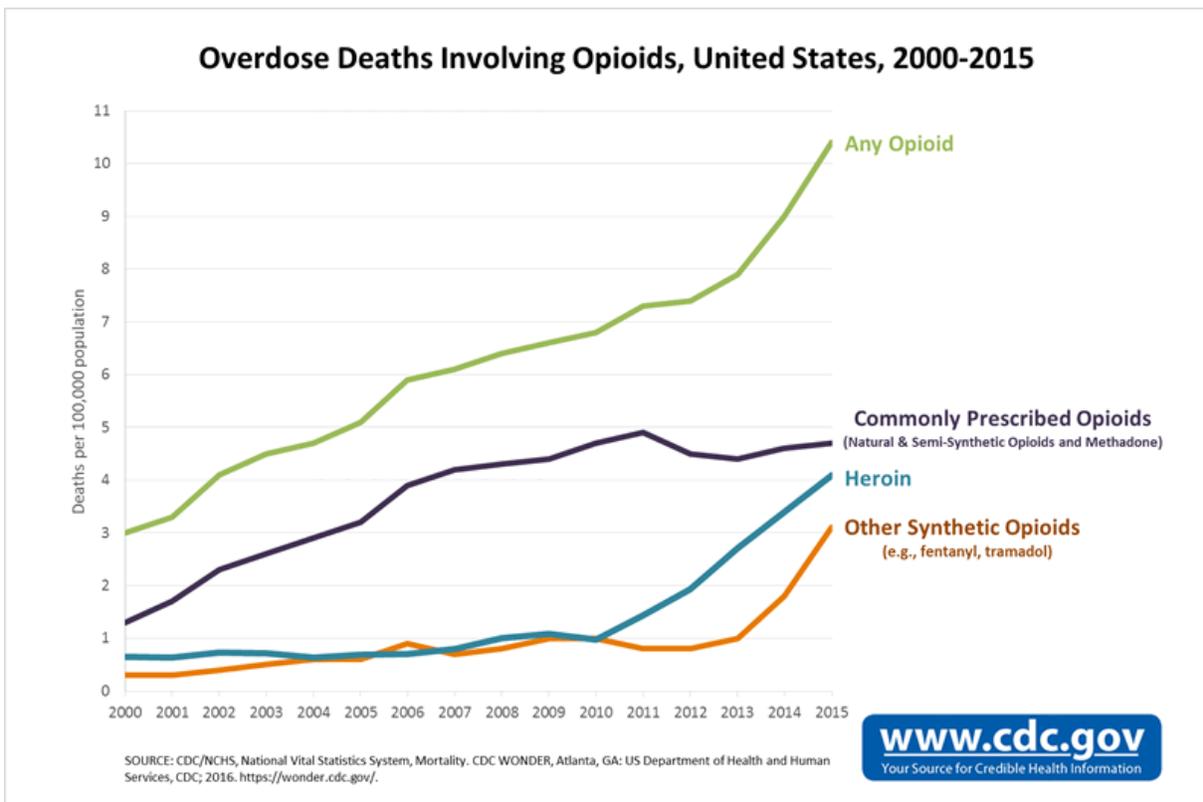
focus on pain coincided with Purdue Pharma’s sales of OxyContin, a time-release form of the powerful opiate oxycodone which went on sale in 1997 and was marketed as having a lower abuse potential than other formulations of the drug. In 2007, Purdue Pharma pleaded guilty in federal court to criminal charges of misleading regulators, doctors and patients about the drug’s addiction risk and abuse potential, agreeing to pay \$600 million in fines and payments to patients, one of the largest amounts ever in such a case.⁹⁶ A new, abuse-deterrent version of OxyContin was released in 2010, leading to a decrease in the misuse of the drug. However, a January 2017 study by the University of Pennsylvania and Rand Corporation found a corresponding rise in heroin overdoses after the release of the new formulation and no net reduction in overdose deaths⁹⁷ (illustrated in the CDC graph below). Purdue Pharma and other prescription opioid producers and distributors are now being sued by at least 25 cities and states for their role in the epidemic.⁹⁸

The good news is that opioid prescribing is decreasing, according to the CDC.⁹⁹ Opioid prescriptions peaked in 2010 and have decreased each year since. However, the per capita dosage is still three times higher than it was in 1999, and rates vary widely from county to county. In Oregon, while most counties have shown a

drop in prescribing rates, Malheur, Morrow, Union and Wallowa counties saw rates in 2015 that were higher than in 2010. Prescribers in Curry County distributed the most opioids per person, followed by Baker and Malheur counties.¹⁰⁰ Taking opioids for longer periods of time or in higher doses increases the risk of addiction, overdose and death.¹⁰¹

Why are opioids so addictive?

According to the National Institute on Drug Abuse (NIDA),¹⁰² prescription opioids, heroin and synthetic opioid drugs like fentanyl all reduce the perception of pain by binding to opioid receptors in the brain and other organs in the body. Binding to receptors in the reward centers of the brain leads to feelings of wellbeing, but binding to receptors elsewhere in the brain results in drowsiness and respiratory depression which can cause overdose deaths. With repeated use, the body decreases production of endogenous opioids (such as endorphins), which can cause withdrawal symptoms when the drugs are discontinued. Also, when used repeatedly over time, opioids tend to induce tolerance, necessitating a higher dose to feel the same effect. However, tolerance decreases during abstinence, contributing to the high risk of overdose for a returning user ingesting their prior dose.



An estimated one-third of Americans struggle with chronic pain. While prescription opioids can be effective for short-term acute pain relief and for chronic cancer and end-of-life cases, according to our witnesses there is little or no evidence that they are effective for long-term chronic pain and there is significant evidence of harm. Discontinuation studies show that 60 percent of patients on opioids for 3 months will still be taking opioids 5 years later,¹⁰³ and 47 percent of patients on opioids for 30 days in the first year of use will be on opioids 3 years later.¹⁰⁴

Treating Opioid Use Disorder (OUD)

Best practices in treating SUDs include multiple phases: comprehensive assessment, stabilization, acute care, chronic disease management and support services.¹⁰⁵ Successful treatment requires the provision of care in a model based on long-term chronic disease management – not episodic interventions.¹⁰⁶ Two classes of treatment (used individually or together) are the current gold standard: pharmacotherapies and behavioral approaches.¹⁰⁷

Pharmacotherapies or Medication-Assisted Treatment (MAT)

Individuals with OUD can benefit from an array of drugs performing as either agonists or antagonists. An agonist is a drug that activates certain receptors in the brain while an antagonist blocks opioids by attaching to the opioid receptors without activation.¹⁰⁸

Pharmacotherapies or MAT include using methadone, buprenorphine or naltrexone, among others.

Methadone is a long-acting synthetic opioid agonist that can safely activate receptors while also preventing withdrawal and reducing cravings. It must be administered with medical supervision and is most effective when combined with behavioral supports, group counseling, and other social services.¹⁰⁹

Buprenorphine, an agonist, imitates the effects of an opioid in a safe manner. It can reduce or eliminate withdrawal symptoms and has a low overdose risk. It may be taken in pure form or more commonly as **Suboxone** – a combination of buprenorphine with an opioid blocker. If an addicted individual attempts to inject Suboxone the “blocker” – naloxone – will produce severe withdrawal symptoms, making it less likely to be abused or diverted. This MAT may be provided in an office setting by physicians credentialed by the Drug

Enforcement Agency.¹¹⁰ The DEA allows any physician to apply for a license to prescribe opioids, but requires an additional eight hours of training and certification before allowing physicians to prescribe buprenorphine.

Naltrexone is a synthetic opioid blocker that is best known for its ability to reverse overdoses. It can also be used as a MAT when an individual is medically stable (not in acute withdrawal). It requires a willing patient to take the medication daily or three times per week. As a result, noncompliance can be an obstacle to successful treatment.

There is a continuing stigma that the use of MAT is merely swapping one addiction for another.¹¹¹ This misconception extends to some policymakers and treatment providers who adhere to an abstinence only philosophy that avoids the use of medications, especially those that activate opioid receptors.¹¹² The Surgeon General’s report on addiction notes, however, “These views are not scientifically supported; the research clearly demonstrates that MAT leads to better treatment outcomes compared to behavioral treatments alone.”¹¹³

All of these medical interventions are more effective when combined with behavioral therapies.¹¹⁴

Behavioral Supports

Counseling and therapeutic support may help individuals to better understand and manage contributing factors to their substance use, including life stressors, attitudes and behaviors, underdeveloped coping mechanisms, and other life skills.¹¹⁵ There are several types of behavioral therapies with evidence to support their use with a wide range of SUDs. Therapies shown to work with OUD include the following:¹¹⁶

- **Community Reinforcement Plus Vouchers** is an approach that includes counseling, MAT and skill building, paired with vouchers of increasing value over time for retail goods. This approach has proven effective with individuals misusing alcohol, cocaine and opioids.
- **Twelve Step Facilitation Therapy** consists of self-help groups promoting abstinence through acceptance, surrender, and active involvement in 12-step meetings and has been proven effective for some individuals misusing alcohol, stimulants and opioids.

It is important to note that the most effective evidence-based treatment will vary by individual. For example, patients with previous trauma involving feelings of powerlessness may not be receptive to 12-step programs that emphasize surrender to a higher power.¹¹⁷ As a result, medication or behavioral supports might be the primary treatment or a combination of the two approaches might result in the most significant and lasting change in an individual's substance use. It is most important that the selection, implementation and monitoring of treatment is evidence-based and conducted by a trained professional.¹¹⁸

Oregon's response to the epidemic:

In 2012, Oregon's Alcohol and Drug Policy Commission (ADPC) created a nine-member Prescription Drug Taskforce to participate in the National Governors' Association Policy Academy on Reducing Prescription Drug Abuse. Following the Policy Academy meeting and stakeholder meetings in Oregon, the taskforce released a strategy with five action statements:

- Oregon needs fewer opioid pills in circulation.
- Oregon needs public education on the risks and limits of opioids.
- Oregon needs ways to safely dispose of unwanted prescription opioids.
- Oregon needs to provide treatment for people addicted to prescription opioids.
- Oregon needs continued leadership from the governor, health plans and coordinated care organizations.¹¹⁹

To implement this strategy, the governor's office and Oregon Health Authority asked Lines for Life to

launch the Oregon Coalition for Responsible Use of Meds (OrCRM), a statewide coalition to prevent the misuse and abuse of amphetamines and opioids, both prescription and illicit.¹²⁰ OrCRM includes leaders from state agencies, health care, education, substance abuse agencies and other organizations who come together at regional summits around the state to develop specific action plans that identify barriers and solutions and generate community support for implementation.¹²¹

Prescription Drug Monitoring Programs (PDMPs) are state-run electronic databases used to track the prescribing and dispensing of controlled prescription drugs to patients.¹²² Oregon's program began operating in June 2011 under Senate Bill 355 which was signed into law in July 2009.¹²³ Pharmacists are required to input data on prescriptions for controlled substances, but neither pharmacists nor physicians are required to use the system before prescribing or dispensing drugs.¹²⁴

The Oregon Attorney General reached a \$1.1 million settlement in 2015, with the pharmaceutical company Insys, over unlawful promotion of the schedule II opioid drug Subsys. Oregon was the first government entity to settle with Insys for marketing Subsys, FDA-approved for cancer pain, for off-label uses such as non-cancer neck and back pain, as well as for providing improper financial incentives to some doctors. Under the settlement, Insys paid \$533,000 to the state and \$567,000 divided between OHSU and OrCRM, to help prevent opioid abuse and misuse.

In 2016, the Centers for Disease Control and Prevention (CDC) published guidelines for primary care clinicians prescribing opioids for non-cancer chronic pain.¹²⁵ An Oregon task force reviewed the guidelines and created an Oregon-specific version.¹²⁶ The Oregon guidelines emphasize the need for compassionate care for patients currently taking high doses of opioids.¹²⁷

APPENDIX III – OTHER STATES AND NATIONS

Backed with support from the medical community, countries and states have begun experimenting with various approaches to decriminalizing low-level drug offenses in an effort to better address substance use and abuse.¹²⁸ These efforts are consistent with viewing SUD as a chronic medical condition and may offer a more effective manner of preventing and treating SUD, thereby reducing the personal and societal costs associated with these disorders.

According to the United Nations Office on Drugs and Crime’s 2014 World Drug Report, the global prevalence of SUDs is generally stable and commensurate with the growth of the world population. Between 16 million and 39 million people worldwide have an SUD. Only one-in-six people worldwide receive or have access to treatment.

Drug policy in the United States has been slowly changing, with a move away from the “war on drugs” and criminal punishment toward treatment of SUD as a chronic disease. However, the United States continues to prioritize funding for the criminal justice system over

investment in prevention and treatment. Meanwhile, some countries in Europe have made significant moves toward increasing funding for prevention and treatment, with impressive outcomes.

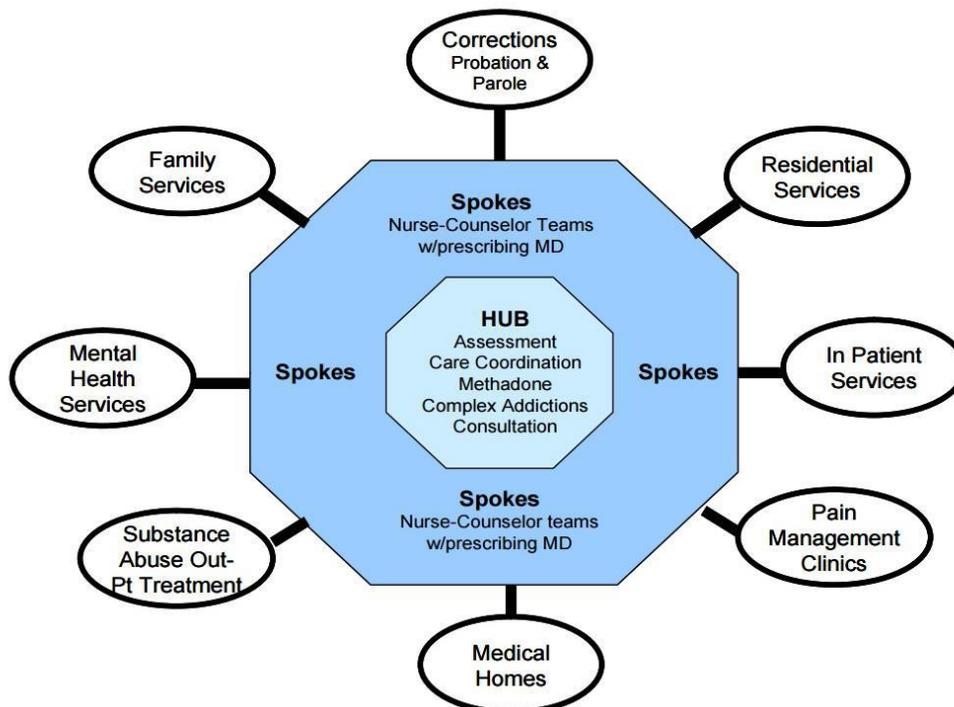
The following is a survey of a few innovative approaches utilized by municipalities, states and other countries that have to varying degrees experimented with efforts to decriminalize drug possession.

Innovative approaches in the United States

Vermont

Vermont’s opioid treatment system, referred to as a “hub-and-spoke” system, was implemented by Gov. Howard Shumlin in 2014 after devoting his entire state of the state address to the opiate drug scourge ravaging his state. Within six months of his speech, Shumlin had signed bills and executive orders that included \$6.7 million for a hub-and-spoke treatment program of central facilities and small treatment outposts, a medication-assisted treatment program, tougher sentences for drug traffickers and new

Integrated Health System for Addictions Treatment Vermont's Hub-and-Spoke System



regulations for prescribing and monitoring prescription drugs.¹²⁹ One of the most important changes gave people who are picked up by police for possession of opioids the choice of treatment instead of criminal prosecution, effectively decriminalizing possession of small amounts of opioid and other drugs.

Using Affordable Care Act funding, the hub-and-spoke system includes two components:

- **The Hub** – Opioid treatment programs, and
- **The Spokes** – Office-based opioid treatment providers, e.g., physicians who prescribe buprenorphine or other MAT drugs throughout the state.¹³⁰

The Vermont system was based on a finding that most office-based physicians had little or no experience treating addiction and had difficulty stabilizing new patients. Because buprenorphine induction requires that the patient be in mild withdrawal, a situation especially uncomfortable for primary care doctors in their offices, the hub-and-spoke model made it possible to have the opioid treatment programs, the experts in assessment and induction with either buprenorphine or methadone, decide along with the patient which treatment would be better, methadone in a treatment program or buprenorphine in an office setting.¹³¹

Vermont's hub-and-spoke model began with a hub in central Vermont that was charged with performing inductions and stabilizing people. The state also developed buprenorphine regulations that were stronger than the federal regulations for office-based treatment and required that an assessment be conducted to see if counseling would be necessary.¹³²

According to Barbara Cimaglio, deputy commissioner of the Vermont Department of Health, while the program might work for other states, Vermont's program is dependent on the ACA infrastructure, Medicaid and the private insurance companies in Vermont that cover the hub bundle of services, a situation not in place in many states that did not expand Medicaid. Thus, although there could be a partnership between an opioid treatment provider and a group of physicians, and they could form the same kind of model in other states, the hub-and-spoke initiative is costly without the kind of waivers Vermont received from the federal Department of Health and Human Services.¹³³

A 2015 Vermont legislative report demonstrates substantial progress made since 2013, including:

- more comprehensive care with the addition of supportive health home services;
- 40 percent increase in people receiving care, with majority remaining in treatment longer;
- those remaining in treatment more than 90 days show improved overall functioning at discharge;
- 75 percent of those completing treatment showed improved functioning over time.¹³⁴

New Mexico

Project Extension for Community Healthcare Outcomes (ECHO) was developed by Dr. Sanjeev Arora, a University of New Mexico gastroenterologist in order to find a way to bring his expertise to thousands of Hepatitis C patients unable to come to Albuquerque to see him. He decided to offer videoconferences in which interdisciplinary experts gave training and advice to primary care providers in managing complex cases. By 2011, the program's success allowed it to branch out into other areas of chronic disease including opioid addiction. The Integrated Addictions & Psychiatry TeleECHO Clinic was created to expand access to high-quality and effective medical and behavioral treatment for addiction and mental illness in communities throughout New Mexico.¹³⁵

With a grant from the GE Foundation, Project ECHO now uses nurse practitioners or physician assistants, who have broad areas of practice under New Mexico law, to serve as each team's medical lead. At each of the clinics, primary care physicians provide oversight and write some prescriptions, including for medications used for opioid addiction. The family nurse practitioners are paired with community health workers that have also received specialized training and focused practice experience. They learn to screen for, diagnose and treat depression and bi-polar depression, anxiety disorders, post-traumatic stress disorder, psychotic disorders, and SUDs for alcohol, opioids and tobacco. Community health workers assist with tasks such as screening, conducting brief interventions to improve treatment adherence, basic case management and health education.¹³⁶

Participation in TeleECHO Clinics is free. Participants are able to join the TeleECHO conference from their personal computer or mobile device. TeleECHO clinic sessions occur once per week for two hours. The hub that participants join by video is located at UNM-HSC at Project ECHO.

The facilitators/specialists of the TeleECHO clinic typically include an addiction specialist, psychiatrist, licensed clinical social worker with addiction expertise, psychiatric nurse or psychiatric nurse specialist, and community health worker. Participants include physicians (family medicine, internal medicine, pediatrics, preventive medicine and psychiatry) and nonphysicians, including nurses, nurse practitioners, physician assistants, community health workers, counselors, social workers, pharmacists, public health officials, epidemiologists and administrators.

Gloucester, Mass.

Leonard Campanello, Police Chief of the 60-person police force of Gloucester, Mass., garnered national attention in 2016 when he wrote on Facebook that the old war on drugs was “lost and over.” Because he is convinced that SUD is a disease, not a crime or moral failing, he instead offered heroin users an alternative to prison. “Any addict who walks into the police station with the remainder of their drug equipment (needles, etc.) or drugs and asks for help will NOT be charged,” he wrote. “Instead we will walk them through the system toward detox and recovery” and send them for treatment “on the spot.”¹³⁷

As a result, Gloucester now has The Angel Program. When an someone with an SUD comes to the police station, someone calls an “angel,” one of the 55 local volunteers in recovery or otherwise familiar with SUDs, to come and listen to the person and offer moral support. Meanwhile, an officer takes a history and starts calling treatment facilities, where clinicians determine the most suitable treatment plan. They have found beds in as little as 17 minutes and as much as a couple of days, some as close as Gloucester, others, as far as California.¹³⁸

Many local businesses support the program. One pharmacy in Gloucester began discounting naloxone, and CVS and Walgreens followed. Taxi companies began providing free rides to treatment facilities or the airport. The ambulance service offers a reduced rate.

Campanello told The New York Times that the department spends an average of \$55 for each

individual who participates in the program, compared with \$220 spent to arrest, process and hold an addict in custody for a single day. Most of the costs are covered by the Police Assisted Addiction and Recovery Initiative, which was founded by Campanello along with John E. Rosenthal in 2015. The police initiative has raised hundreds of thousands of dollars and received millions in in-kind contributions, including placement in treatment centers.

Since the program’s inception, 391 individuals with SUDs have turned themselves in at the city’s police station — 40 percent from the Gloucester area, the rest from all over the country — and all have been placed in treatment. In addition, as of January 2016, 56 police departments in 17 states have started programs modeled on or inspired by Gloucester’s, with 110 departments more preparing to do so.¹³⁹

Notwithstanding the success of the program, local prosecutors have complained about Campanello’s approach. For example, although the chief and other law enforcement officers insist that the police have discretion when it comes to arrests, Jonathan W. Blodgett, the district attorney of Essex County where Gloucester is located, warned that Campanello lacked authority to offer amnesty for the crime of heroin possession. Similarly, Elizabeth D. Scheibel, a former district attorney for the Northwestern District of Massachusetts in Northampton, complained about “selective enforcement” of the law, which “could well have a disparate impact on the constitutional rights of other offenders.” Furthermore, The New York Times reported that she said promising amnesty removed an incentive for people to complete treatment and could complicate investigations into people who surrender to police after being involved in some other serious crime.¹⁴⁰

Although Gloucester has had good outcomes by *de facto* decriminalizing possession of opioids, it is not representative of the path taken by Massachusetts. Despite some innovations in training and insurance reform, in 2017, the commonwealth ranked fifth highest in adults with unmet treatment needs.

Innovative approaches in other countries

Portugal

In the 1990s, Portugal had one of worst drug epidemics in Europe. In 1998, Portugal appointed a special commission of doctors, lawyers, psychologists

and activists to assess the problem and propose policy recommendations. Within the year, the commission recommended a radically different approach: that Portugal decriminalize all drugs and focus instead on prevention, education and harm-reduction.¹⁴¹ Instead of the zero-tolerance legislation and an emphasis on law enforcement in many countries at the time, Portugal's government passed the commission's recommendations into law and became the first country in Europe to decriminalize possession of all drugs.

There is an important distinction between decriminalization and legalization. Legalization removes all criminal penalties for producing, selling and possessing drugs whereas decriminalization eliminates jail time for drug users, but dealers are still criminally prosecuted. Roughly 25 countries have removed criminal penalties for the possession of small amounts of certain or all drugs. No country has attempted full legalization.

According to João Goulão, Portugal's top drug official, the goal of the new policy was "to fight the disease, not the patients."¹⁴²

Portugal complemented decriminalization with expanding and improving prevention, treatment, harm reduction and social reintegration programs. These measures coincided with an expansion of the Portuguese welfare state that included a guaranteed minimum income.

Portugal's drug situation improved significantly in several key areas. Most notably, HIV infections and drug-related deaths decreased. Meanwhile, the dramatic rise in use feared by some failed to materialize.¹⁴³ Other outcomes included:

- levels of drug use below the European average;
- drug use declined among those aged 15-24, the population most at risk of initiating drug use;
- lifetime drug use among the general population increased slightly, in line with trends in comparable nearby countries;
- rates of past-year and past-month drug use among the general population – which are seen as the best indicators of evolving drug use trends – decreased;

- between 2000 and 2005 (the most recent years for which data are available) rates of problematic drug use and injecting drug use decreased;
- drug use among adolescents decreased for several years following decriminalization, but has since risen to around 2003 levels; and
- rates of continuation of drug use (i.e. the proportion of the population that have ever used an illicit drug and continue to do so) have decreased.¹⁴⁴

In addition, since inception of program, arrests went from 14,000 people per year for drug offenses to just around 6,000, and the percentage of drug-related offenders in Portuguese prisons decreased from 44 percent in 1999 to less than 21 percent in 2012.¹⁴⁵

Researchers concluded that while decriminalization likely played an important role, it was difficult to attribute any specific positive outcomes, to decriminalization as opposed to the broader health and social reforms implemented by Portugal.¹⁴⁶

Switzerland

The number of Switzerland's heroin users skyrocketed from just 3,000 in 1975 to 30,000 by 1992. In the early 1990s, people suffering from SUD took over Zurich's Platzspitz Park. Law enforcement was overwhelmed by the sheer size of the problem and prisons were at capacity.¹⁴⁷

After admitting its policy was a failure, Switzerland developed a drug policy based on four pillars — policing, prevention of drug use, treatment of drug use and harm reduction.¹⁴⁸ It developed a new approach that emphasized therapy and treatment, as well as giving heroin prescriptions to heavy and long-term opiate users for whom other substitutes would not work. It also worked to re-integrate addicts back into the community. In a public vote in 1997, Swiss voters approved the new, less punitive approach and in 2008 voted to put the strategies developed in the 1990s into law.¹⁴⁹

According to Thilo Beck, chief of psychiatry at Arud Centers for Addiction Medicine, a nonprofit founded by Swiss physicians in 1991 to provide SUD sufferers with adequate therapy, almost 70 percent of heroin abusers in Switzerland are in substitution therapy, the highest ratio in the world, and most substitution patients in Switzerland receive methadone, while about 8 percent —

1,400 patients — receive heroin. Noteworthy is that most of those in substitution treatment today started using heroin during the drug crisis.

“We see almost no new heroin users in Switzerland,” Beck says. “The comprehensive policies Switzerland adopted in the face of the heroin crisis 20 years ago were very important in that respect.”¹⁵⁰

In addition, both the number of drug injectors with HIV and the overdose mortality among injectors declined by more than 50 percent over 10 years.¹⁵¹ Delinquency related to drugs has also been reduced enormously.¹⁵²

Czech Republic

The Czech Republic’s National Drug Policy Strategy 2010-18, originally focused solely on illicit drugs. It was revised in 2014 and 2016 to address alcohol, tobacco and gambling as well.

Similar to Switzerland, the Czech strategy has four pillars: prevention, treatment and re-socialization, harm reduction, and supply reduction. With regard to illicit drugs, the strategy has four key objectives:

- i. Reduce the level of experimental and occasional drug use;
- ii. Reduce the level of problem and intensive drug use
- iii. Reduce potential drug-related risks to individuals and society
- iv. Reduce drug availability, particularly to young people.

Each of these objectives has an action plan. A network of 14 regional drug coordinators manages the implementation of the national drug policy.¹⁵³

Although trafficking, and possession of large quantities of various drugs is still punishable by fines and imprisonment, drug use is not an offense in the Czech Republic, and possession of small quantities for personal use is a noncriminal offense. For example, individuals can grow up to five marijuana plants and are allowed to possess: 1 ounce of marijuana, 1 gram of cocaine, 2 grams of methamphetamine, 40 psychedelic mushrooms, five peyote plants and five tabs of LSD.

The Czech Republic also has an expansive medical marijuana program. The harm reduction programs include needle exchanges, counseling and free tests for

infectious diseases. Drug use and the number of overdoses have gone down since inception.¹⁵⁴

The Netherlands

The Netherlands takes a pragmatic approach to drug policy: when a problem is unsolvable, it is better to control it than to try to eradicate it and fail.¹⁵⁵ Drugs are neither legal nor encouraged in the Netherlands but there is a tolerant policy which means citizens will not be prosecuted for having up to 5 grams of cannabis.

Cannabis can be purchased and smoked in small doses in coffee shops. The coffee shops are governed by strict laws. The government’s view is that if people are only smoking small amounts in a safe and regulated environment, they will not feel the need to seek out drugs from those who are also selling hard narcotics as well. The shops are not allowed to advertise, and children under the age of 18 are not allowed to enter. As a result of these policies, the use of various types of drugs is no greater than in other countries, and the number of drug-related deaths is the lowest in Europe.¹⁵⁶

In 2011, the government decided to ban tourists from marijuana use in coffee shops, but after protests from the coffee shop community and other tourism-based industries, the law was altered to allow cities to decide how to handle it. Amsterdam got rid of the restrictions altogether, while other cities deny tourists access. This policy effectively decriminalized possession and use of cannabis. It enabled cannabis consumers to avoid exposure to hard drug scenes and markets and the profound costs of carrying a criminal record and incarceration for minor offenses.¹⁵⁷

With respect to heroin and other hard drugs, the Dutch government at the national and municipal levels emphasized reduction of individual and social harm by investing in comprehensive health and social services, low-threshold methadone clinics, safe consumption rooms and needle exchange programs, which greatly reduced the dangers of an open drug scene, including exposure to uncontrolled criminal elements. The Netherlands was spared the major drug-linked HIV epidemic that devastated drug users and their families in other European countries.¹⁵⁸

According to the Open Society Global Drug Policy Report issued in 2013, “Far fewer arrests for minor drug offenses occur. While it was recently reported that someone is arrested for marijuana possession in the U.S. every 42 seconds, Dutch citizens have generally been

spared the burden of criminal records for minor, nonviolent offenses. According to one comparison, in 2005 there were 269 marijuana possession arrests for every 100,000 citizens in the United States, 206 in the United Kingdom, 225 in France, and just 19 in the Netherlands.

Lighter enforcement did not lead to more drug use. About 25.7 percent of Dutch citizens reported having used marijuana at least once, which is on par with the European average. In the comparatively strict United Kingdom, the rate is 30.2 percent and in the United States it is a whopping 41.9 percent.”¹⁵⁹

Uruguay

Uruguay is one of the few countries that never criminalized the possession of drugs for personal use.

The law establishes no quantity limits with regard to determining what is for personal use, leaving it to the judge’s discretion to determine intent. There are no sanctions if the judge determines that the amount in possession was meant for personal use.^{160, 161}

In 2013, Uruguay became the first country in the world to formally legalize, not just de-criminalize, marijuana.¹⁶²

Regulations, which apply to all Uruguayan citizens and permanent residents over the age of 18, allow individuals who register with the government to purchase up to 40 grams of the drug a month, grow six female flowering cannabis plants per household for personal consumption and join cooperatives to grow cannabis with others.

WITNESS LIST

The Oregon Substance Use Disorder Research Committee thanks all of the witnesses who generously gave their time to answer our questions and inform this report. It would not have been possible without the breadth of expertise and insights they provided.

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- Rod Underhill, District Attorney, Multnomah County.
- Tony Vezina, Executive Director, 4th Dimension Recovery Center.
- Daniel Ward, Former Executive Director, Oregon Alcohol and Drug Policy Commission.

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