**SAARA-CVA Advocacy White Paper**

**& Main Advocacy Pillars**

**Opiate Addiction & Overdose Epidemics**

The City of Richmond has been significantly impacted by the epidemic of heroin and prescription opioid use, and has seen an upward trend over the last two years in heroin overdoses. In March 2015, Richmond saw a cluster of individuals with serious health effects following heroin use; it was determined that the heroin used was contaminated with additional substances which caused chest pain, shortness of breath, heart palpitations, nausea, and vomiting.

According to the State Attorney General’s Office, between 2011 and 2013, every region of Virginia experienced an increase in heroin fatalities, with Richmond experiencing an increase of 50% (January, 2015). The fatalities increase when examining just the last year of that time period in which the number of fatal heroin overdoses in Virginia increased by 57.8% in 2013 compared to 2012, and represented 23.4% of all drug/poison deaths (Chief Medical Examiner’s Office 2013 Annual Report). As if these statistics were not substantial enough, the Chief Medical Examiner’s Office reports that many heroin deaths may be underestimated due to the fact that the drug is rapidly metabolized into morphine, causing many heroin cases to be missed.

The central region of Virginia had the highest number of fatal heroin overdoses in the state (78, 36.6%) with Richmond City having one of the highest rates of deaths from heroin overdose (21, rate of 9.8%). Geographically, Interstate 95 transverses the city and is known as the drug transportation corridor for the east coast. As illegal substances are being routed through this region, the opportunity and likelihood for illicit drugs to be distributed or sold in this community is increased. Not surprisingly, the metro Richmond area has been designated a HIDTA (High Intensity Drug Trafficking Area) along with the Washington, DC and Baltimore regions since 2005 (HIDTA, 2006). This unfortunate designation is to some degree confirmed by the disproportionate number of drug/narcotics arrests in Richmond as compared to rest of the state. This easy access to illicit drugs represents one of the greatest challenges to re-integration and maintaining sobriety for offenders when they are released from correctional confinement.

The National Survey on Drug Use and Health (NSDUH, 2013) indicates that illicit drug use is a significant problem throughout the Commonwealth of Virginia, estimating that 7.1% of individuals 12 or older have used illicit drugs within the past month. The numbers are even starker for particular age groups with estimates of 21% of individuals in Virginia ages 18-25 using illicit drugs in the last 30 days. For persons 18 and over, the number of arrests for drug/narcotic offenses in Richmond is 3% (1,655) of the state total (56,083; Virginia State Police, 2014).

**Prescription Drug Use Epidemic**

A significant part of the overdose problem results from prescription painkillers called opioids. Prescription drug deaths accounted for 42.3% of all drug/poison deaths in Virginia (Chief Medical Examiner’s Office 2013 Annual Report). These prescription painkillers can be used to treat moderate-to-severe pain and are often prescribed following a surgery, injury, or for health conditions such as cancer. In recent years, there has been a dramatic increase in the acceptance and use of prescription opioids for the treatment of chronic, non-cancer pain, such as back pain or osteoarthritis. The most common drugs involved in prescription overdose deaths include: Hydrocodone (e.g., Vicodin), Oxycodone (e.g., OxyContin), Oxymorphone (e.g., Opana), and Methadone (especially when prescribed for pain). People who take prescription painkillers can become addicted with just one prescription and once addicted, it can be hard to stop. In 2013, nearly two million Americans abused prescription painkillers. Each day, almost 7,000 people are treated in emergency departments for using these drugs in a manner other than as directed.

Certain groups are more likely to abuse or overdose on prescription painkillers:

* Many more men than women die of overdoses from prescription painkillers.
* Middle-aged adults have the highest prescription painkiller overdose rates.
* People in rural counties are nearly twice as likely to overdose on prescription painkillers as people in big cities.
* Whites and American Indian or Alaska Natives are more likely to overdose on prescription painkillers
* About 1 in 10 American Indian or Alaska Natives aged 12 or older used prescription painkillers for nonmedical reasons in the past year, compared to 1 in 20 white people and 1 in 30 black people.

Regarding prescription painkiller use, the Centers for Disease Control (CDC) report:

* In the United States, nearly 15,000 people die every year of overdoses involving prescription painkillers.
* In 2010, 1 in 20 people in the US (age 12 or older) reported using prescription painkillers for nonmedical reasons in the past year.
* Enough prescription painkillers were prescribed in 2010 to medicate every American adult around-the-clock for a month.
* Nearly half a million emergency department visits in 2009 were due to people misusing or abusing prescription painkillers.
* Nonmedical use of prescription painkillers costs health insurers up to $72.5 billion annually in direct health care costs.
* In addition, the Department of Behavioral Health and Developmental Services reports that Region 4 (including Richmond, Virginia) now leads the state with the highest rate of pain reliever use for nonmedical purposes (October 2015). This area is closely followed by Region 1 (Northwest Virginia).

Efforts have been made to address these figures. Healthcare professionals will increasingly be provided extended education on opioid abuse and appropriate prescribing practices. While prescriber training is critical, it is not guaranteed to interrupt the cycle of abuse and/or overdose at this source. Enforcing stricter prescribing guidelines and monitoring for doctors and nurse practitioners will potentially reduce the nonmedical use of prescription painkillers, thus reducing the often eventual use of heroin, the more inexpensive and easier to obtain opioid.

Increased efforts are also necessary, however, to address the issue of death-by-overdose rates; specifically, increasing the availability of Naloxone in Virginia. Naloxone works by reversing the effects that opioids have on the brain, allowing a person’s body to return to a stable respiration and heart rate. Naloxone has been used for years in emergency rooms and by paramedics and poses no threat if accidentally ingested, as it has no effect on the body (Department of Behavioral Health and Developmental Services, 2014). Naloxone’s administration by trained community members is gaining momentum, however a major barrier to individuals abusing prescription opioids is that access to these life-saving naloxone medication administration services is still “hit or miss” throughout most communities, as uptake on training and medication distribution has been slower than desired. With an increase in provider training (in both the community and prison systems) on Naloxone, decreased barriers to access, and administration of this drug, individuals at risk for death-by-overdose of opioid use are more likely to survive the potential overdose and have a better chance for recovery.

**SAARA is advocating for:**

* Increased prescriber education
* Increased prescription drug monitoring
* Increased access and decrease in barriers to MAT & naloxone
* Increased training for naloxone
  + Naloxone training for inmates & staff in jails
* Increased community education about nature of opiates & addiction
* Increased funding to support prescription drug addiction treatment & recovery
* Immediate access to treatment
* Decrease barriers for methadone clinics
* Health care
* Education and prevention (younger than 12)
  + Education of basic addiction behavior/cause, mental/emotional
* Increased naloxone training upon release
* Increased uptake training
  + City & rural
* Naloxone medication administration services – pharmacies
* College health care provider training

**Access to Care**

There are many challenges facing people with opioid dependence who wish to access treatment. The barriers they face include stigma, financial barriers, and institutional barriers, lack of access to primary care, and lack of social and family support.

Opioid dependence is a complex illness, and as such, merits a comprehensive treatment strategy. A shift in the treatment model for opioid dependence has begun in the past few decades, away from programs focused solely on physical abstinence and toward a model which incorporates more elements of a person’s life into recovery. Medication assisted treatment (MAT) refers to the use of medications, in combination with counseling and behavioral therapies, to provide a ‘whole patient' approach to the treatment of substance use disorders. Common types of MAT for opioid dependence include methadone, suboxone, and naltrexone for easing withdrawal and encouraging abstinence and naloxone to counter the effects opioid overdoses.

Despite growing evidence that MAT is effective, there are discriminatory regulations which reduce access to Medication-Assisted Treatment. One specific MAT, Methadone Treatment Services, are regulated more than any other treatment service within the health care arena, including discriminatory location limitations that limit access to MAT in denser, urban areas. Provider shortages also exist, as there are not enough physicians trained in how to deliver quality Medication-Assisted Treatment. Even fewer are willing to work in public sector treatment programs or with public sector consumers diagnosed with a substance use disorder. In addition, there is lack of recovery-supportive housing for people in early recovery from SUDs, especially those people who are enrolled in ongoing MAT. Supportive and recovery-supportive housing are largely lacking in our community today, largely due to a lack of funding streams that may be used to support these types of services.

However, in recent months there has been a push from the government and medical community toward wider implementation and improved access to MAT. This includes increased federal budget allocations for expanding access to MAT, expanding access to substance use treatment providers, and evaluating the effectiveness of programs using MAT. In recent months, there has also been increased availability of the lifesaving drug Naloxone in Virginia with new legislation permitting it to be carried by pharmacies with a standing order and providing it to law enforcement, along with training on use.

**SAARA is advocating for:**

* Increased training to reduce stigma
* Increased medical professional training
* Increased funding for treatment, prevention/community education, recovery support
  + Medicaid expansion
* Decreased regulation of methadone facilities/zoning
* Increased recovery supportive housing
  + Major focus on women with SUDs
* Increase ease and immediacy of access
* Increased access to MAT in jail system
* Education of community/families – 1) ease; 2) speed
* Wrap around support, peer-to-peer services
* Free clinic – VCC or MCV
* HRI

**Parity**

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) is a federal law that generally prevents group health plans and health insurance issuers that provide mental health or substance use disorder (MH/SUD) benefits from imposing less favorable benefit limitations on those benefits than on medical/surgical benefits.

The Affordable Care Act significantly extends the reach of the MHPAEA’s requirements. Starting in 2014, the Affordable Care Act will require all small group and individual market plans created after March 23, 2010, to comply with federal parity requirements. Qualified Health Plans offered through the Health Insurance Marketplace in every state must include coverage for mental and/or substance use disorders as one of the 10 categories of Essential Health Benefits, and that coverage must comply with the federal parity requirements set forth in the MHPAEA.

MHPAEA does not apply directly to small group health plans, although its requirements are applied indirectly in connection with the Affordable Care Act’s essential health benefit (EHB) requirements. The Protecting Affordable Coverage for Employees Act amended the definition of small employer in section 1304(b) of the Affordable Care Act and section 2791(e) of the Public Health Service Act to mean generally an employer with 1-50 employees, with the option for states to expand the definition of small employer to 1-100 employees. The Employee Retirement and Income Security Act and the Internal Revenue Code also define a small employer as one that has 50 or fewer employees. Some states may have mental health parity requirements that are stricter than federal requirements.

Key changes made by MHPAEA, which is usually effective for plan years beginning after October 3, 2009, include the following:

* MH/SUD benefits may not be subject to any separate cost-sharing requirements or treatment limitations that only apply to those MH/SUD benefits.
* If a group health plan or health insurance coverage includes medical/surgical benefits and MH/SUD benefits, and the plan or coverage provides for out-of-network medical/surgical benefits, it must provide for out-of-network MH/SUD benefits.
* Standards for medical necessity determinations and reasons for any denial of benefits relating to MH/SUD benefits must be disclosed upon request.

Some noted exceptions to the MHPAEA requirements include self-insured non-Federal governmental plans that have 50 or fewer employees as well as those self-insured small private employers that have 50 or fewer employees.

**SAARA is advocating for:**

* Affordability of copays and deductibles
* Community education about parity & rights
* Education about how to report denials of coverage
* Require annual report from insurance commissioner to DBHDS and General Assembly & DMAS
* Regulations to allow for “co-op” purchasing of health insurance for small businesses
* Requirements to small business → Medicaid expansion
* Health care reform
* Insurance positions
* Health navigation
* Co-pay affordability (lower co-pays)
* Community advocacy

**Restoration of Rights**

Virginia is one of only four states in the nation to permanently disenfranchise its citizens convicted of a felony and holds the second highest disenfranchisement rate in the nation. More than 450,000 of an estimated 6.4 million voting-age Virginian residents are banned from voting for the rest of their lives due to a felony conviction—nearly 7% of Virginia’s population. Over 350,000 disenfranchised Virginians have already completed their prison sentences and are living in the community, working, and paying taxes.

Twenty percent of African-Americans in Virginia are permanently banned from voting. African-Americans and other minorities are disproportionately impacted by the law - under the current law, their voting rights can only be restored by a discretionary act of the Governor.

Prior to May 2013, only an estimated 2.77% of people had their rights restored throughout Virginia because of strict restoration of rights application requirements. On December 18, 2014, the McAuliffe administration established a much easier application process for individuals convicted of serious felonies to restore their rights, reducing the thirteen page application to a one-page application.  It removes a number of requirements, including the requirement of a letter to the governor and three letters of recommendation as part of the application.

Additionally, as was declared in April 2014, ***all drug offenses will be considered non-violent instead of violent offenses,*** and processed under the less onerous criteria.  ***Non-violent offenders currently incarcerated in Virginia receive an automatic restoration of rights upon leaving prison and past offenders may apply for restoration***. Additionally, for those who have been convicted of a violent felony, the mandatory five year waiting period has been reduced to three years. As of June 2015, the McAuliffe administration announced the all ***outstanding court fines, fees, and restitution will no longer prohibit an individual from having his or her rights restored***. However, this does not remove the financial obligation to pay, but a person’s eligibility to have their rights restored is no longer conditioned on unpaid debt. Moreover, if an ex-felon moves to Virginia prior to their rights being restored for their home state, then that individual is required to complete the Virginia rights restoration process.

The civil rights restored to an individual whose application is approved are as follows:

* Right to register to vote
* Right to hold public office
* Right to serve on a jury
* Right to serve as a notary public

**SAARA is advocating for:**

* Rights to
  + Student loans
  + Pell Grants
  + Food stamps
  + HUD housing
* Increase Ban the Box for housing & employment
* Expand auto-restoration to felons who have paid debt
* Community education regarding restoration of rights
* Require annual state reports on demographics restored to people without rights
* Monthly workshops at SAARA on restoration of rights

**Conclusion**

The opiate overdose epidemic has far reaching and significant repercussions for the Commonwealth of Virginia and its citizens including physical, social, financial and legal consequences. While opiate addiction and overdose are severe problems, they are problems that can be treated given adequate and appropriate resources. It recent years, this has begun to be recognized, and some steps have been taken to address this issue on the state and federal level, yet much remains to be done to fully address opiate addiction and overdose in Virginia.