



UNIVERSITY of MARYLAND
SCHOOL OF NURSING

One Step Forward, Two Steps Back: Overview of U.S. Drug Policy

UMSON's All Alumni Reunion 2018

April 28, 2018

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Objectives—

Participants will be able to describe:

1. At least three (3) major recommendations of **The President's Commission on Combating Drug Addiction and the Opioid Crisis**
2. The impact that a potential repeal of the **Affordable Care Act** would have on access to treatment for people with substance use disorders
3. Three (3) major pillars of the **War on Drugs** and their disproportionate impact on African American communities:
 - a) School-to-prison pipeline;
 - b) Racialized mass incarceration; and
 - c) For-profit prison system
 - d) Viewed through a Critical Race Theory Lens

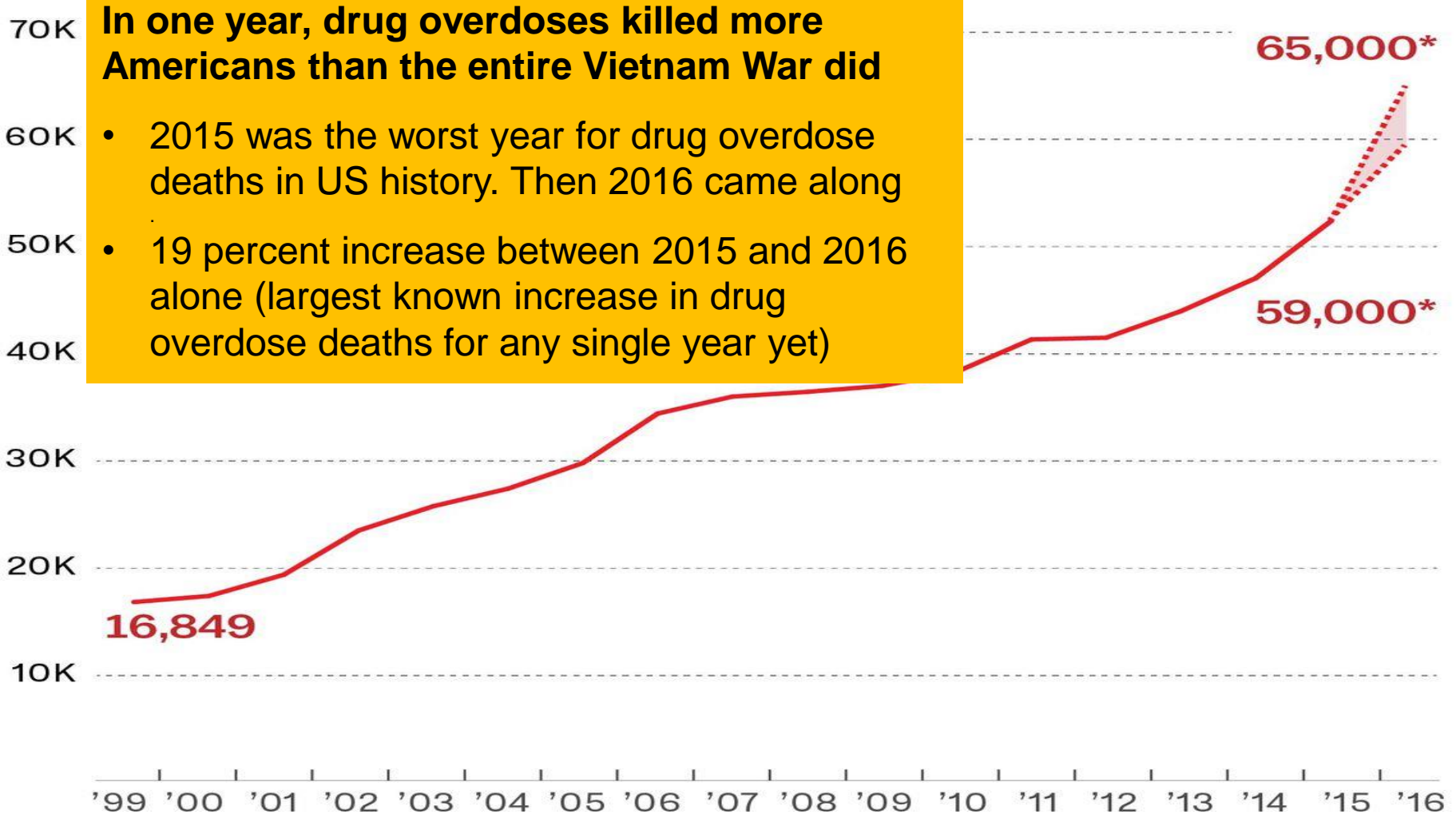


Introduction:

The Opioid Drug Overdose Epidemic

- Prevalence statistics**
- Expectations about pain relief**
- Influence of the opioid pharmaceutical industry**

Drug overdose deaths



*Estimate based on preliminary data

SOURCE: National Institute on Drug Abuse, The New York Times

Soaring opioid drug deaths cause U.S. life expectancy to drop for 2nd year

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Leading cause of death for Americans under age 50

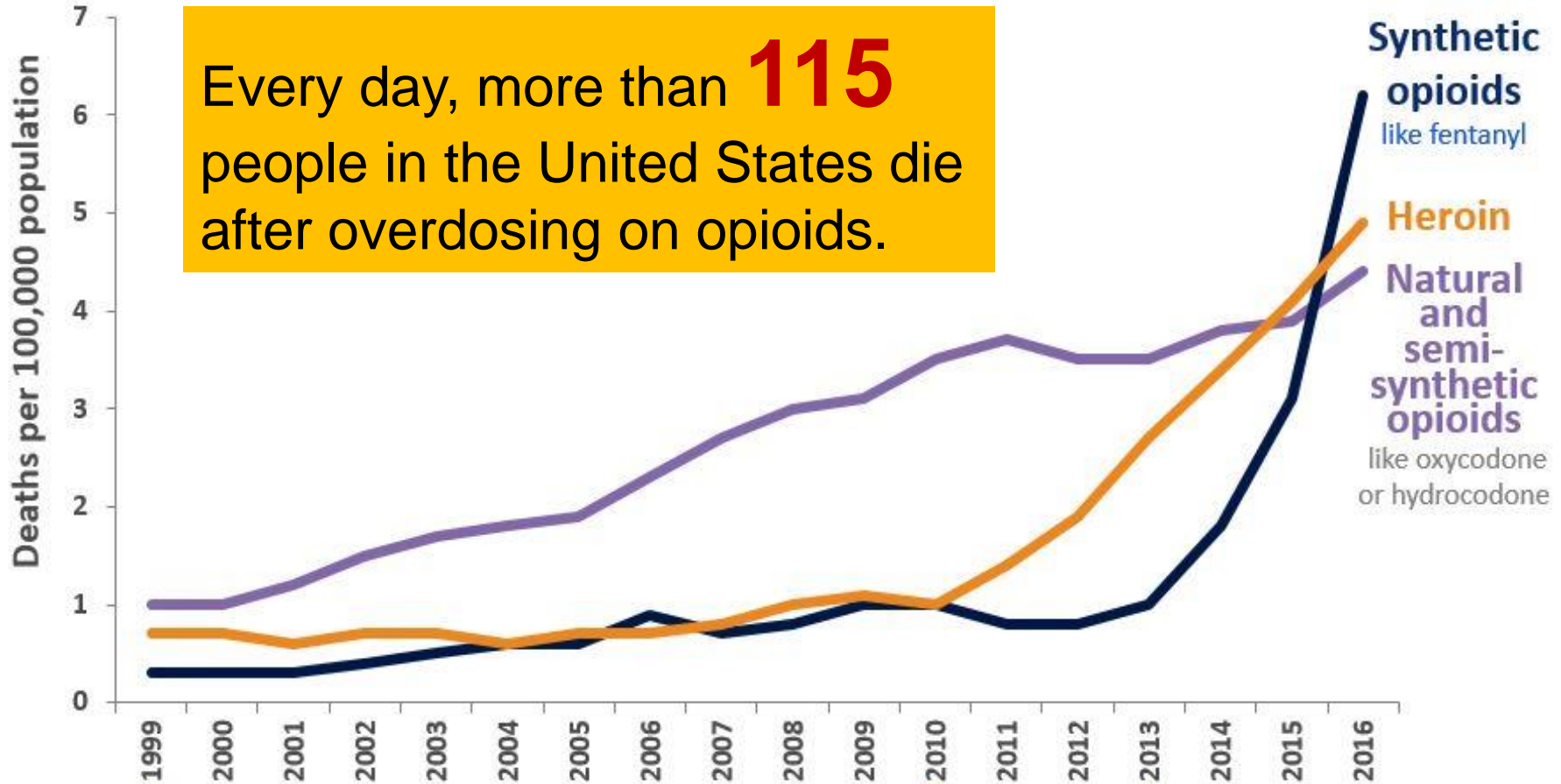
Last Updated Dec 21, 2017 7:52 PM EST

NEW YORK — U.S. deaths from drug overdoses skyrocketed 21 percent last year, and for the second straight year dragged down how long Americans are expected to live.

The government figures released Thursday put drug deaths at 63,600, up from about 52,000 in 2015. For the first time, the powerful painkiller fentanyl and its close opioid cousins played a bigger role in the deaths than any other legal or illegal drug, surpassing prescription pain pills and heroin.

3 Waves of the Rise in Opioid Overdose Deaths

Every day, more than **115** people in the United States die after overdosing on opioids.

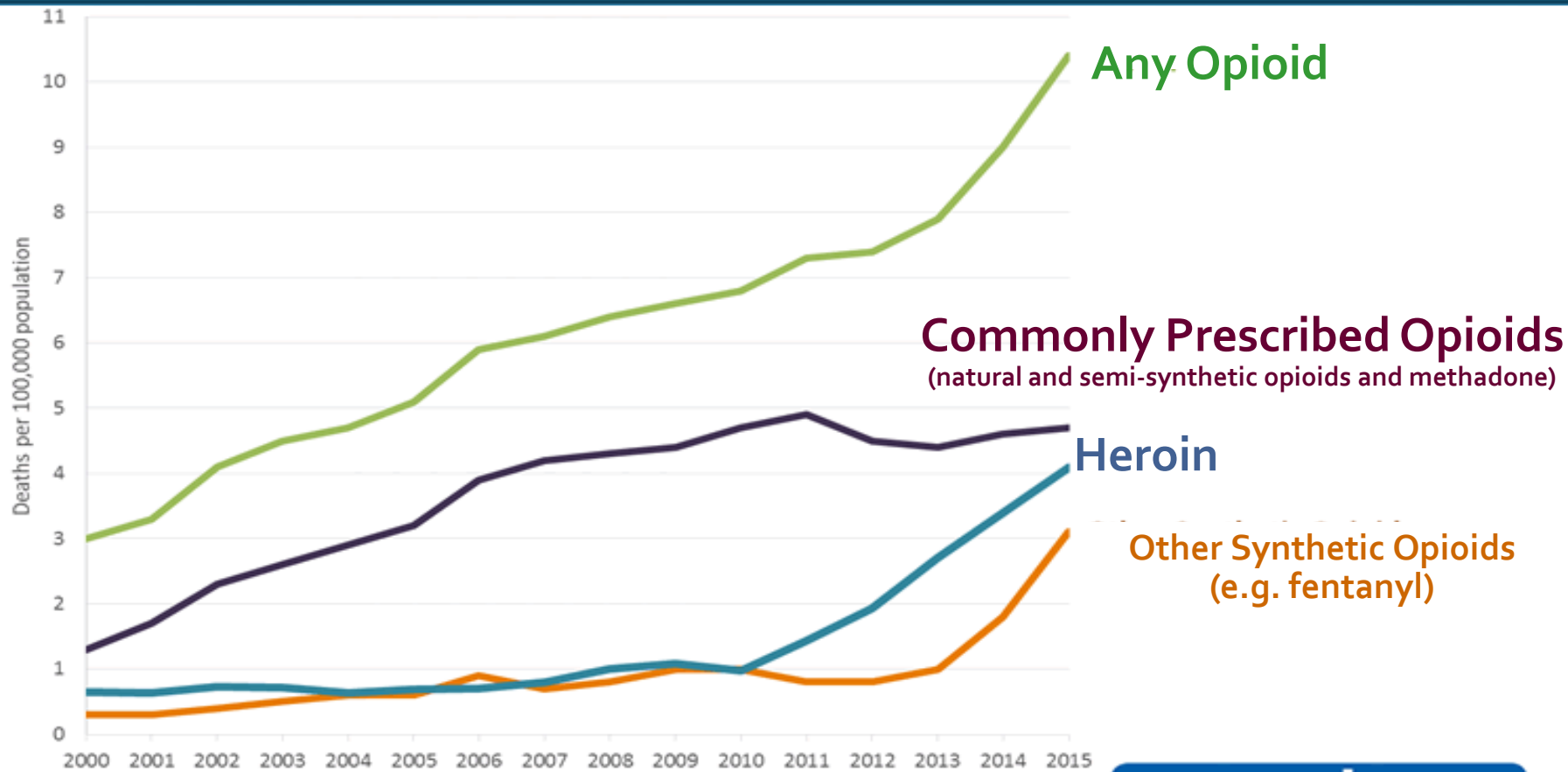


Wave 1: Rise in Prescription Opioid Overdose Deaths

Wave 2: Rise in Heroin Overdose Deaths

Wave 3: Rise in Synthetic Opioid Overdose Deaths

Overdose Deaths Primarily from Opioids: Prescription Drugs, Heroin and Synthetics (i.e. Fentanyl and similar)



SOURCE: CDC/NCHS, National Vital Statistics System, Mortality. CDC WONDER, Atlanta, GA: US Department of Health and Human Services, CDC; 2016. <https://wonder.cdc.gov/>.

www.cdc.gov
Your Source for Credible Health Information

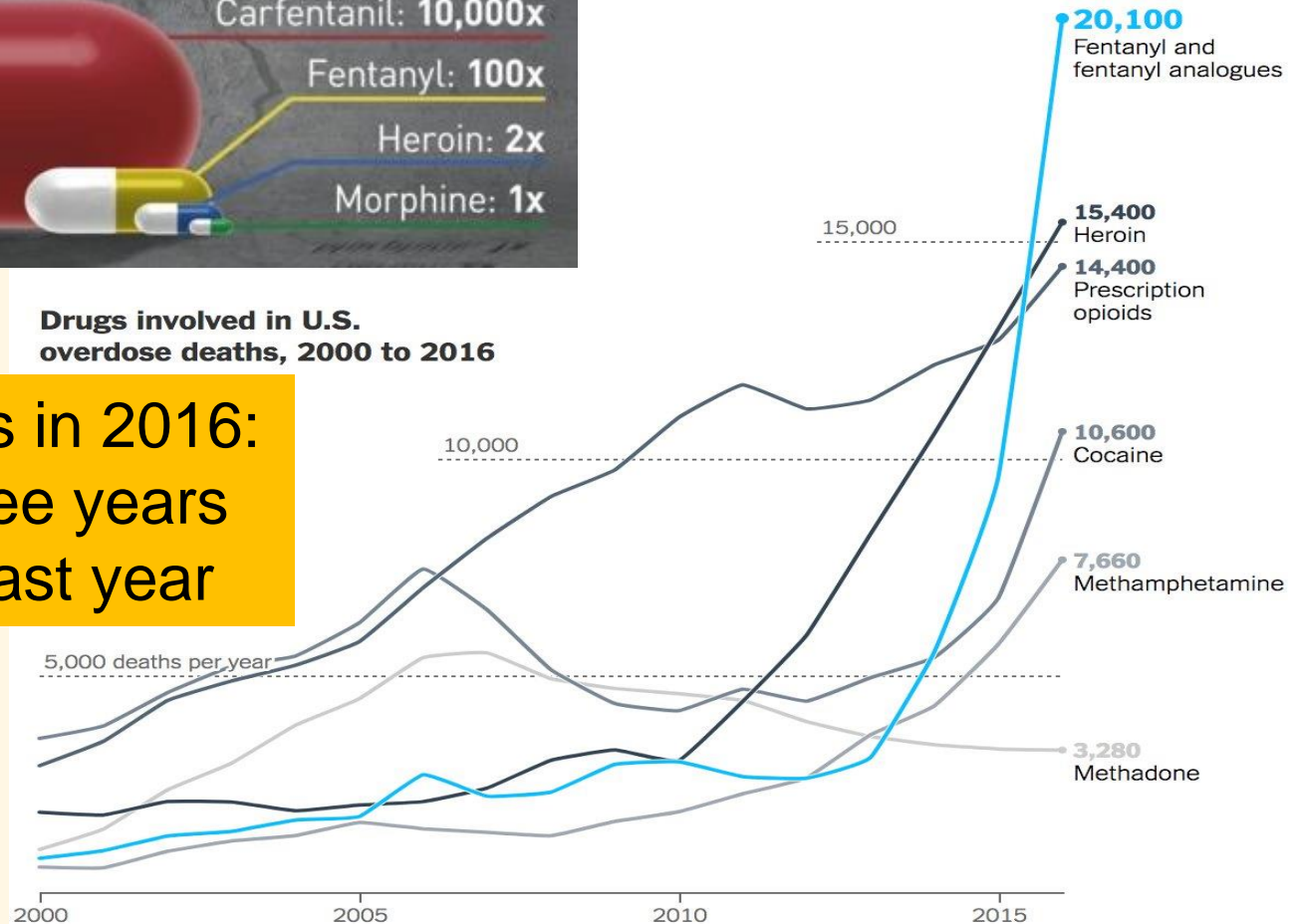
2016 Fentanyl-Related Deaths Surpassed Heroin or Rx

(W. M. Compton, NIDA, 2017)



Drugs involved in U.S. overdose deaths, 2000 to 2016

Fentanyl deaths in 2016:
Up 540% in three years
Up 22% since last year



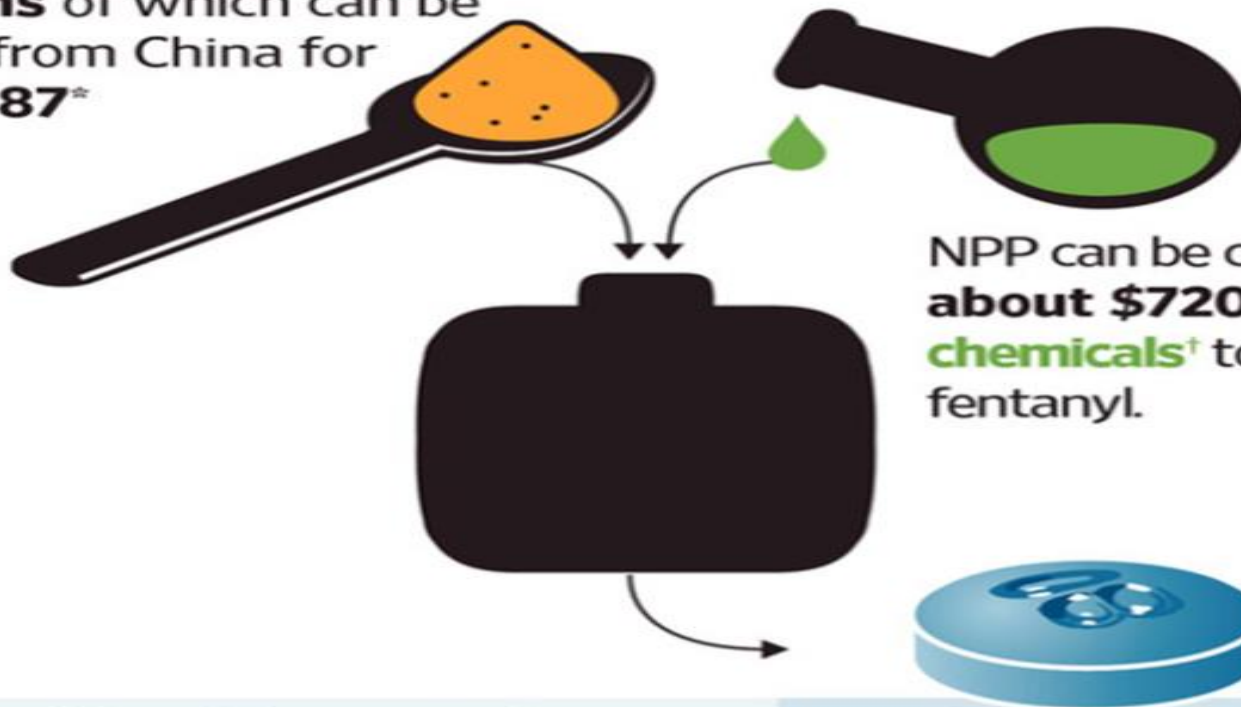
Graphs from [NY Times Article](#) based on [CDC MMWR Report](#) 2017

ECONOMICS: CHEAP Fentanyl Precursor Chemicals

Criminal Chemistry

Traffickers manufacturing fentanyl often purchase the key ingredient from China, which doesn't regulate its sale. Here's how the chemical building blocks become a highly profitable street drug.

The key ingredient is **NPP**, 25 grams of which can be bought from China for about **\$87***



NPP can be combined with about **\$720** of **other chemicals**[†] to produce fentanyl.

The resulting 25 grams of fentanyl cost about **\$810** to produce...

...and are equivalent to up to **\$800,000** of pills on the black market.

*Average current price from Chinese suppliers

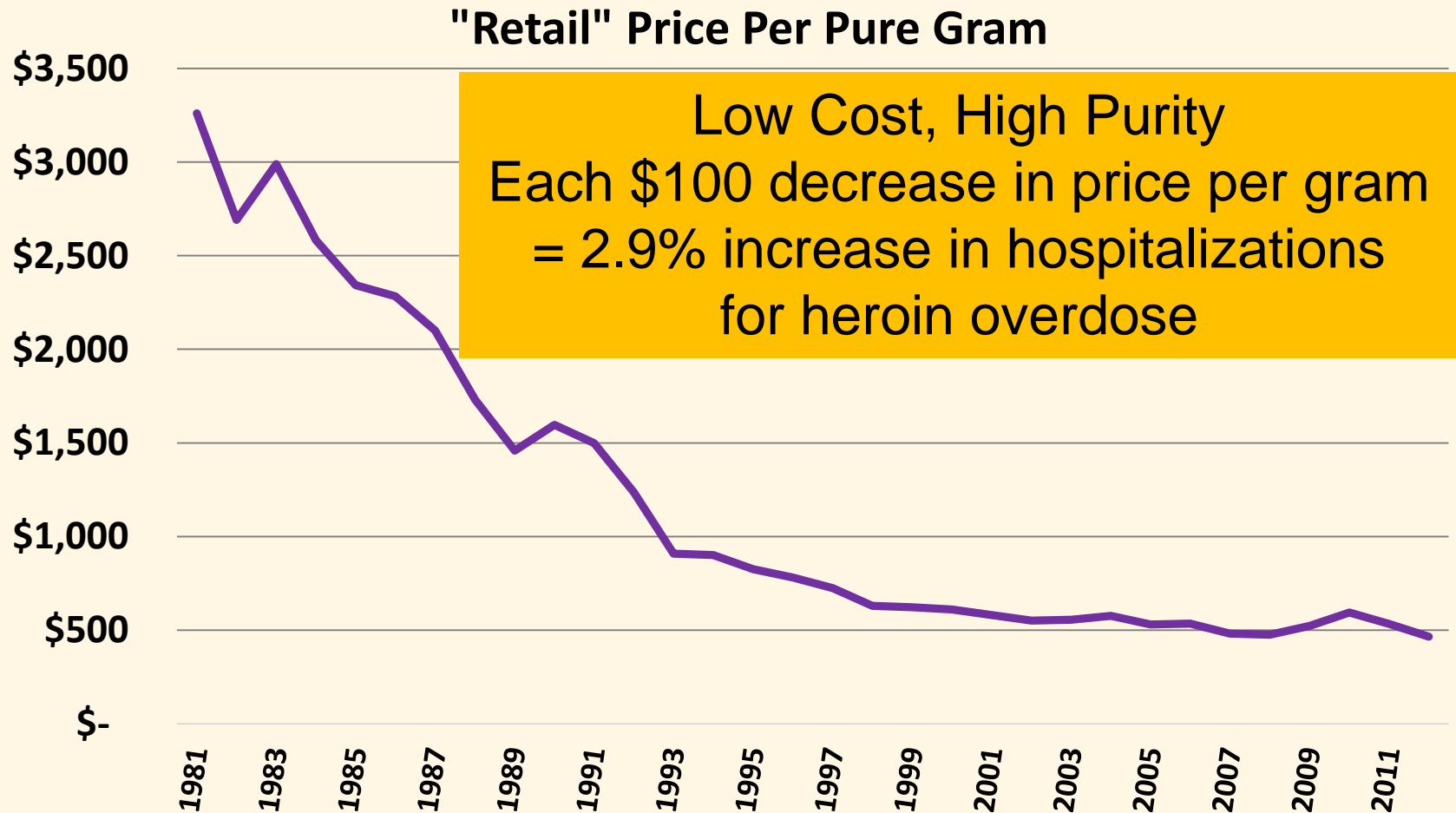
†Prices from U.S. suppliers

Sources: NES Inc.; Drug Enforcement Administration; Calgary Police

ECONOMICS:

Heroin Increases Due to Lower Price and Greater Availability

(W. M. Compton, NIDA, 2017)



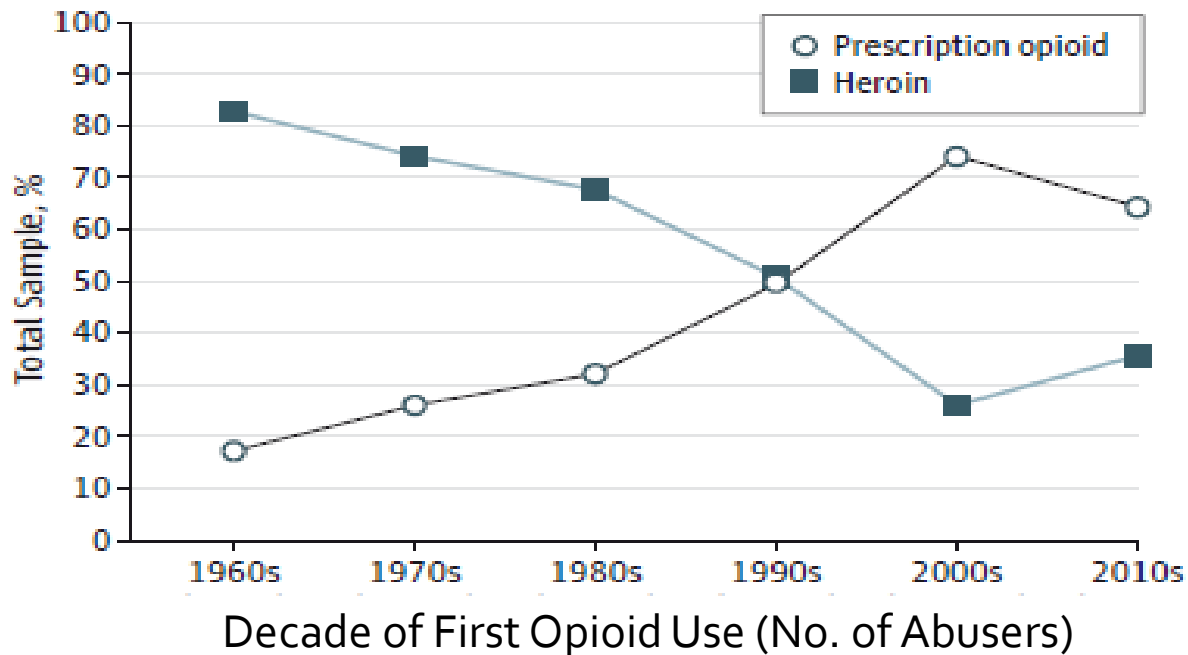
National Drug Control Strategy--Data Supplement 2014.

https://www.whitehouse.gov/sites/default/files/ondcp/policy-and-research/ndcs_data_supplement_2014.pdf

Rx Opioid Misuse has been a Risk Factor for **Heroin Use**

(W. M. Compton, NIDA, 2017)

% Heroin Treatment Admissions that Used Heroin or Rx Opioid First



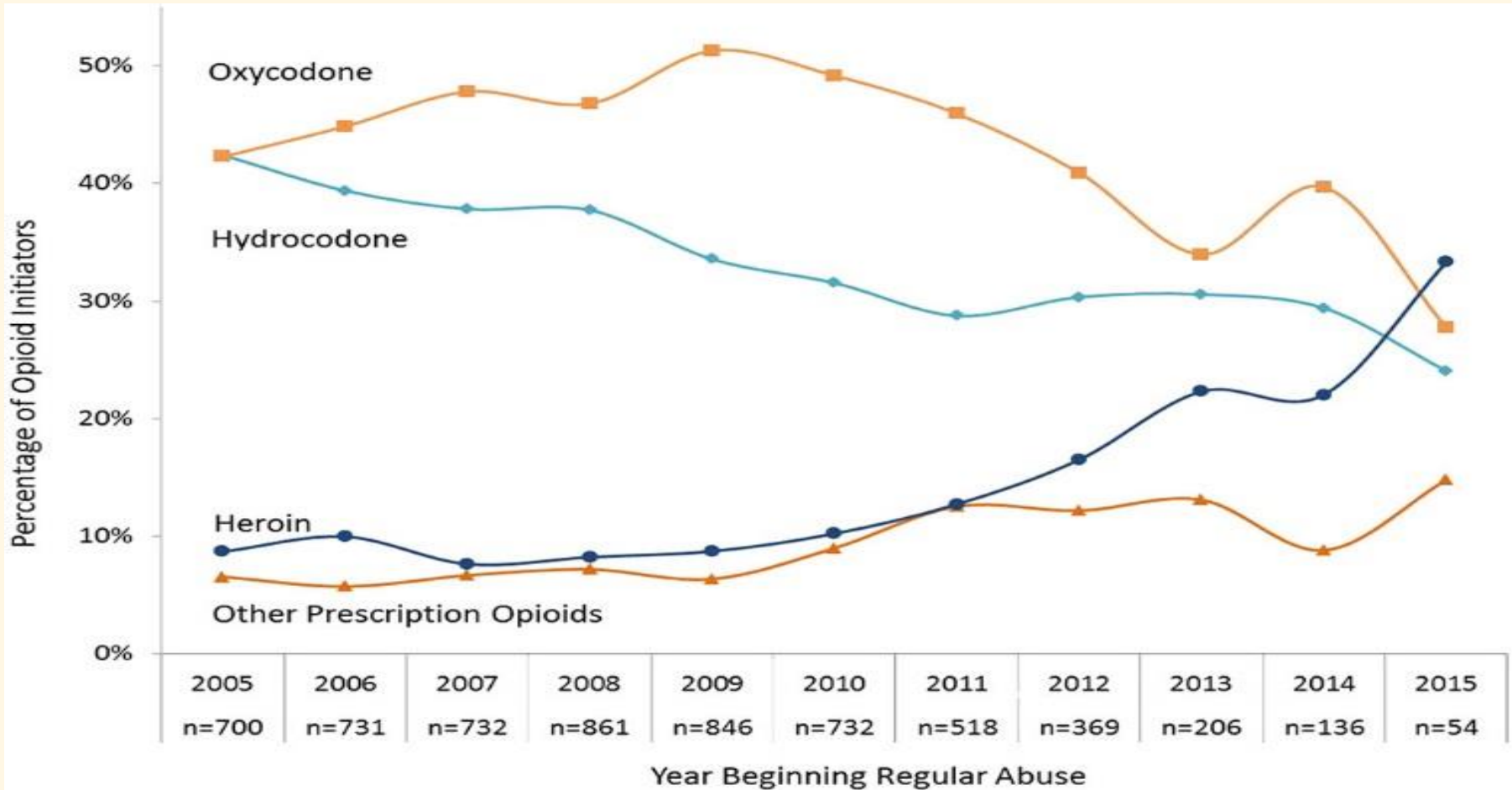
1990 – 2010
Most current heroin users **started opioid use with prescription opioids.**

Source: Cicero et al. JAMA Psychiatry. 2014;71(7):821-826.

HEROIN USE:

2010 – Now: First Opioid Likely to be Heroin

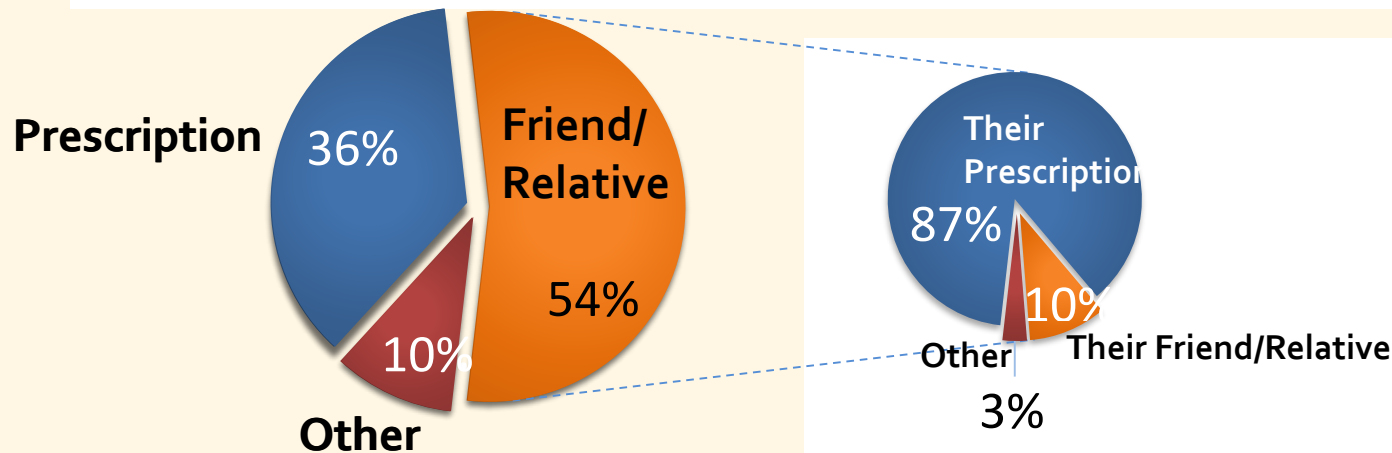
(W. M. Compton, NIDA, 2017)



People Misusing Analgesics Obtain them *Directly & Indirectly* by Prescription

(W. M. Compton, NIDA, 2017)

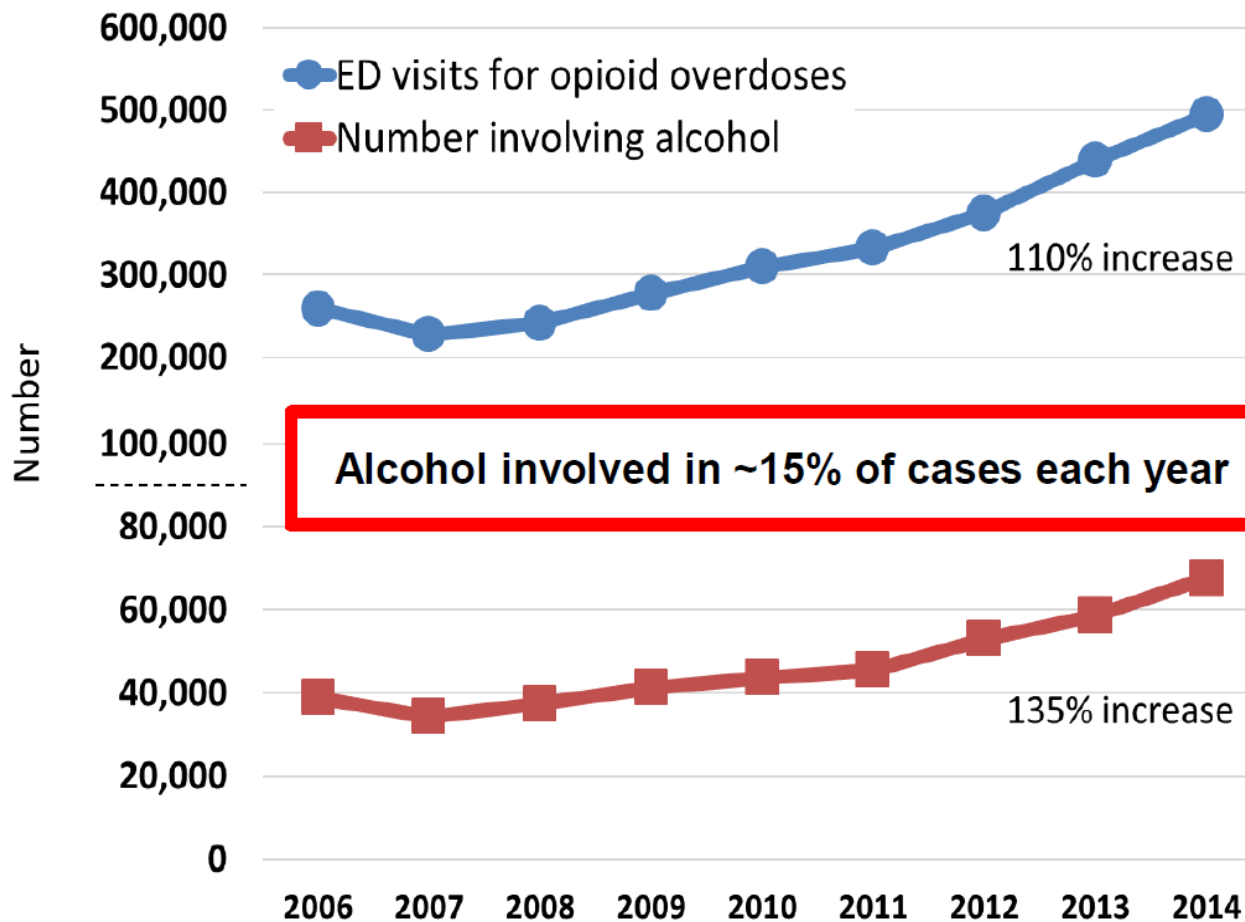
Source where pain relievers obtained for most recent misuse



Source: Han, Compton, et al. *Annals of Internal Medicine* 2017;167(5):293-301

Alcohol and Opioids: A Dangerous Combination

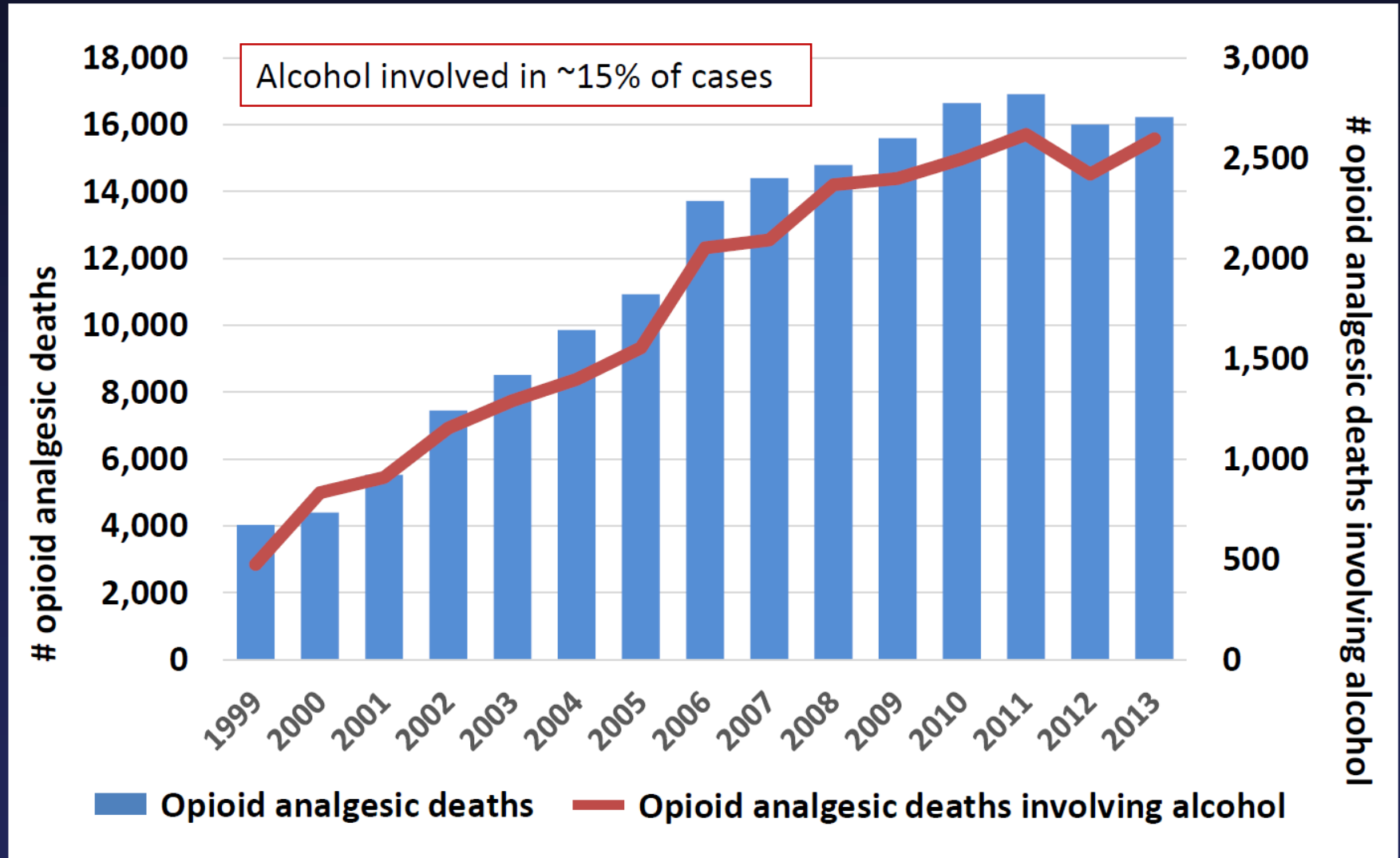
Increase in Emergency Department Visits



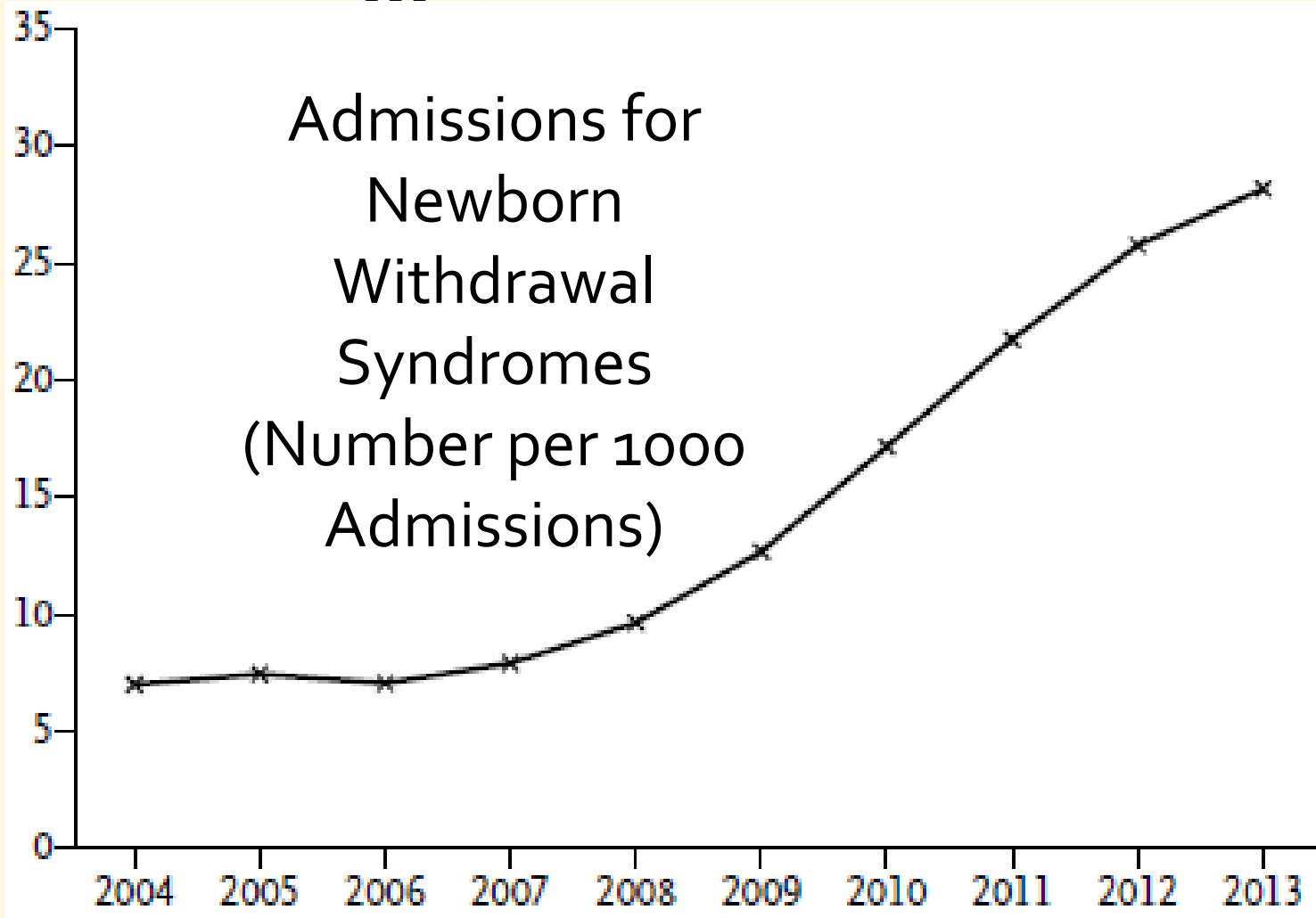
Source: Nationwide Emergency Department Sample (NEDS), unpublished

Alcohol and Opioids: A Dangerous Combination

Increase in Prescription Opioid Overdose Deaths



Increasing Prenatal Exposure



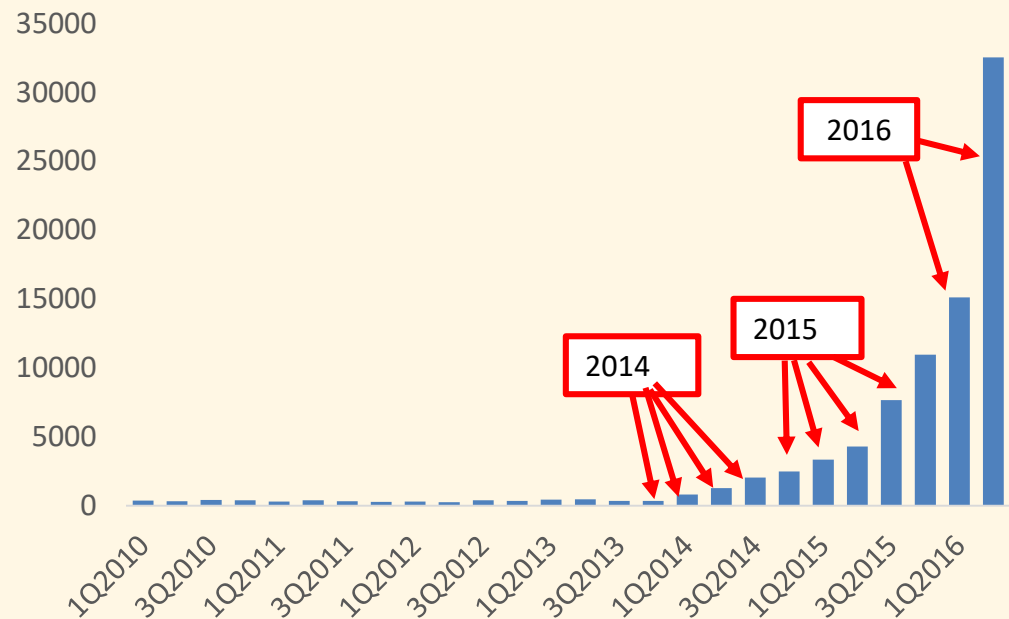
Source: Tolia VN, Patrick SW, et al. NEJM 2015;372:2118-2126

**Science =
Solutions**

Retail Pharmacy Prescriptions for **Naloxone** Increase Markedly

(W. M. Compton, NIDA, 2017)

- Retail prescriptions show an increase of **9520%** from the 4th quarter of 2013 to 2nd quarter 2016.
- Outpatient prescribing of naloxone may complement community-based distribution and first responder access.

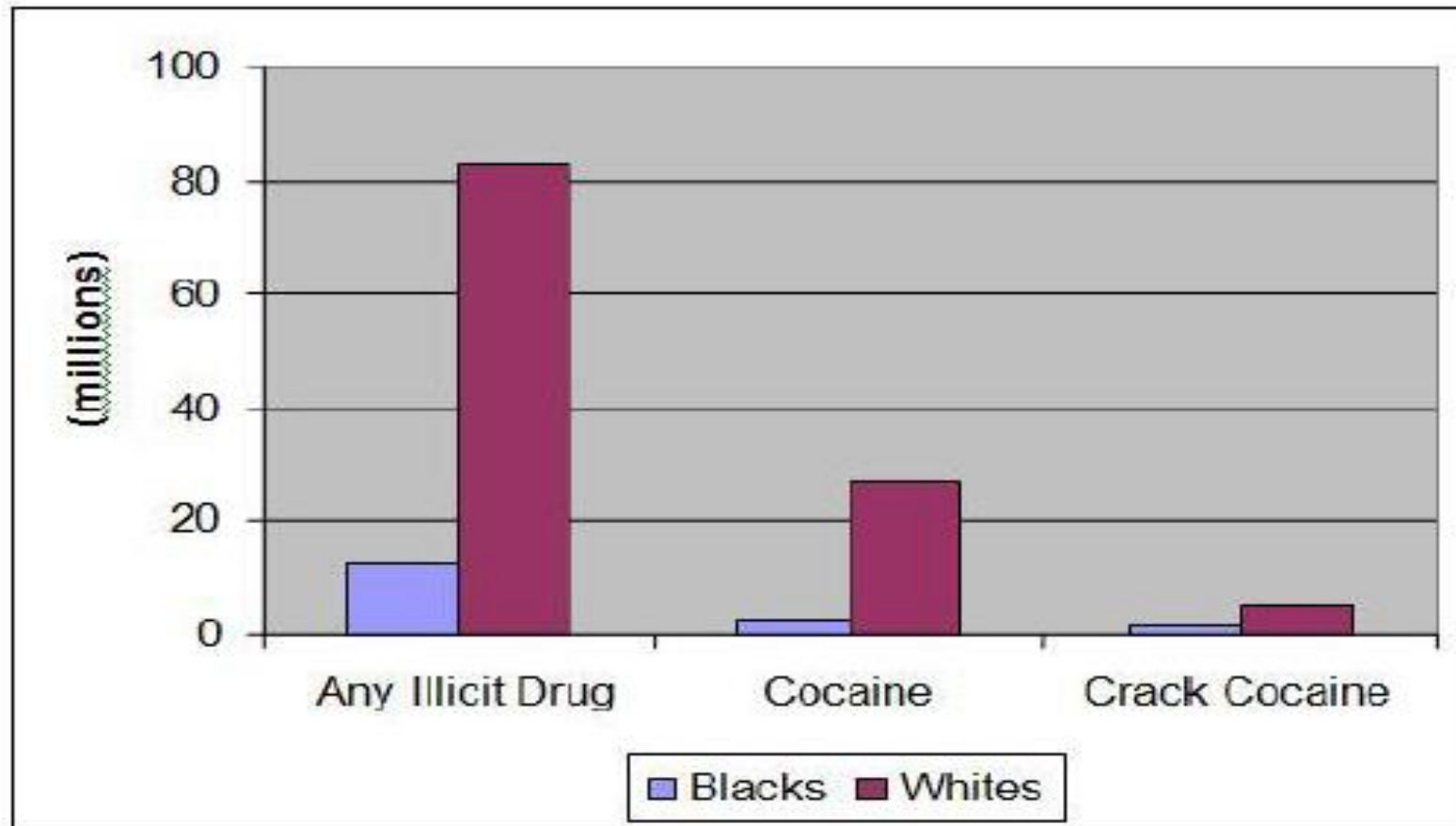


Science = Solutions

Sources: Jones CM, Lurie PG, Compton WM. Am J Public Health. 2016;106(4):689-690; IMS Health, published <https://www.performance.gov/content/reduce-opioid-related-morbidity-and-mortality>

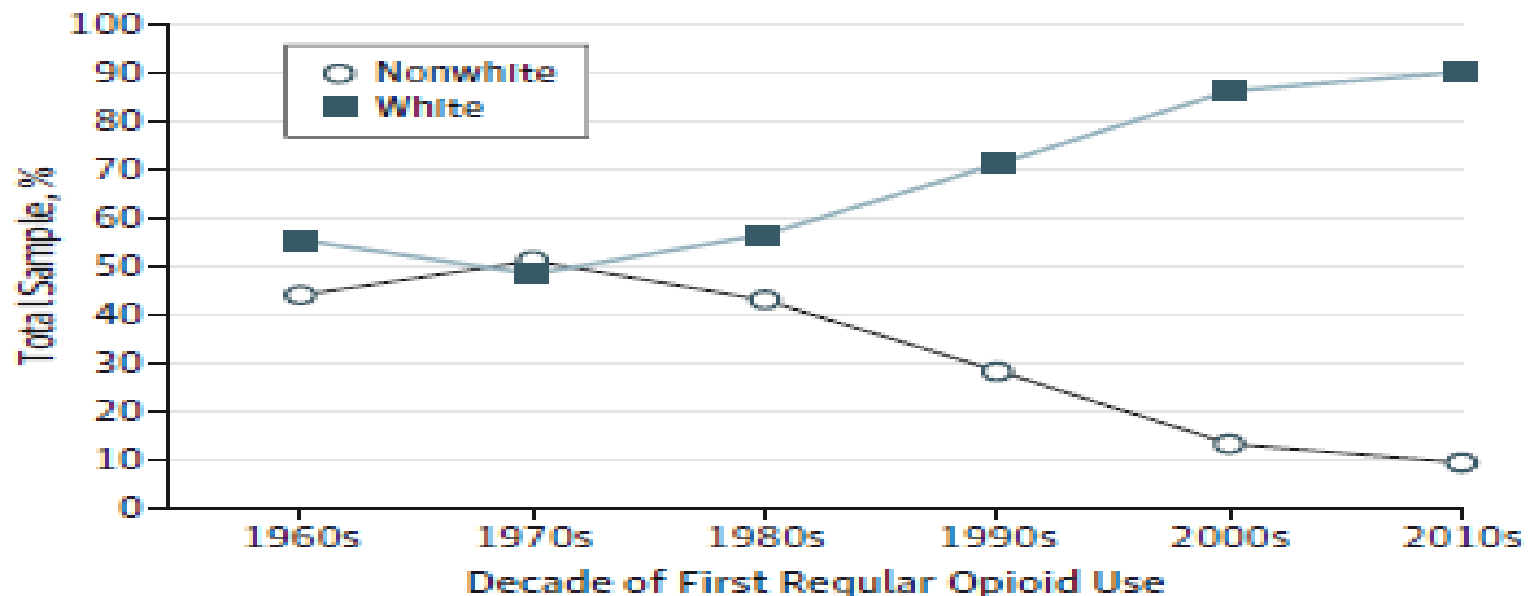
Race and Illicit Drug Use:

FIGURE 1: Lifetime Drug Use by Race, Ages 12 and Older
(Estimates for drug use by persons age twelve and older from SAMHSA)



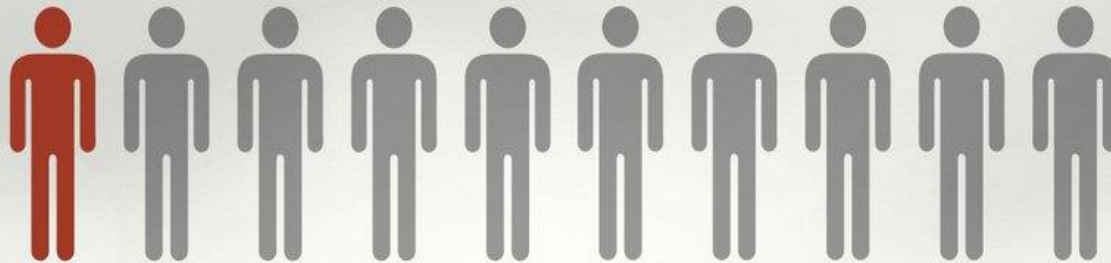
Race and Heroin Use:

Figure 3. Racial Distribution of Respondents Expressed as Percentage of the Total Sample of Heroin Users



Data are plotted as a function of decade in which respondents initiated their opioid abuse.

“Treatment Gap” — Needing but not receiving treatment



ONLY
1 in 10

people suffering from a substance use disorder receives any type of treatment.

THAT MEANS
90%

of people needing help are not getting it.



It's much easier in America to get high than it is to get help.



Opioid Use Disorders and Opioid Overdose Epidemic

**INFLUENCE OF THE OPIOID
PHARMACEUTICAL INDUSTRY**

Increasing Rates of Chronic Pain & Use of Opioids in U.S. Healthcare

- Prior to mid 1980's—cautious limited role
 - **Surgery**—managing perioperative pain
 - **Pain management** following severe injury
 - **End of life pain relief** and comfort, especially for cancer pain

Development of Pain Management as Subspecialty

- **Anesthesiology**—American Society of Regional Anesthesia and Pain (1975)
- **Pain Management as a subspecialty** — Recognized by American Board of Psychiatry and Neurology, American Board of Physical Medicine and Rehabilitation and American Board of Anesthesiology (1998)
- **Opioids became a commonly prescribed, low cost management approach to many patients with chronic pain**

Archives of Physical Medicine and Rehab 2001; 82(4):564-565

Regulatory Pressure to Improve Pain Relief and Increase Patient Satisfaction

- **1996** President of American Pain Society advocated use of pain as “**fifth vital sign**”
- **1999** Veterans Administration--Measurement and documentation of pain as 5th vital sign (P5VS)
- Expectation: Pain score of 4 or higher would trigger “comprehensive pain assessment and prompt intervention”
- **2001**—the Joint Commission on Accreditation of Hospital Organizations rolled out similar Pain Management Standards for non-VA settings
- **2016:** Physicians for Responsible Opioid Prescribing (PROP) letters to Joint Commission & CMS
 - “Fifth vital sign policies lead to overprescribing
 - Asked CMS to remove from patient satisfaction questionnaires and calculation of reimbursement rates

Promotion & Marketing of Opioids for Non-malignant Pain

- Purdue Pharma introduced Oxycontin in 1996
- Marketed 1996-2001 to >5,000 MDs, nurses & pharmacists at 40 national all-expense-paid pain management and speaker training conferences in CA, AZ and FL
- Targeted MDs who were highest prescribers of opioids (esp. Primary Care)
- Patient starter coupons for free 7 to 30 day supply of Oxycontin (34,000 coupons redeemed)
- Promoted aggressively for use in non-cancer pain, resulting in 10 fold increase in Rx to 6.2 million in 2002
- Reached blockbuster status by 2001 (\$3 billion in sales 2001-2002)
- Total profits of >\$35 billion

Criminal Misrepresentation of Risk of Addiction by Purdue

- *Trained sales force to describe risk as “< 1%” for patients with chronic pain, based on 2 retrospective studies from 1980s*
- **Actual risk now known to be 8-12%**, based on systematic review & data synthesis (Vowles et al, 2015)
- **May 2007 3 Purdue executives pled guilty** to claiming Oxycontin was less addictive and less subject to abuse & diversion than other opioids
- Paid \$634 million in fines
- **Marked increases in abuse, diversion, non-medical use & overdoses in early 2000’s**
- 2004 most frequently abused opioid in US

New Evidence Of Collusion By Congress, Lobbyists And Drug Distribution Industry

- Reported by 60 Minutes and Washington Post Oct. 17, 2017
- Authored by Bill Whitaker of CBS News
- Based on information provided by Joe Rannazzisi, former head of DEA's Office of Diversion Control

Role of Distributors (Middlemen)

- Cardinal Health, McKesson and Amerisource Bergen are Fortune 500 companies with significant money and influence
- Control distribution of 85-90% of prescription drugs in the retail U.S. market.
- Ship drugs manufactured by companies like Purdue Pharma and Johnson & Johnson to drug stores all over the country.

Consistent Failure to Report Suspicious Orders

- Under Controlled Substances Act, distributors must report “suspicious orders” to the DEA.
- Consistently failed to report unusually large or frequent shipments
 - In Kermit, West Virginia, a town of 392 ordered 9 million hydrocodone pills over 2 years
 - Mid-sized distributor shipped more than 28 million pills to WV over 5 years, with 11 million sent to Mingo County (population 25,000)
- In 2008 DEA assessed fines of \$13.2 million to McKesson and \$34 million to Cardinal Health for filling hundreds of suspicious orders for millions of pills
- Total of distributors’ fines >\$341 million over the last seven years.

Industry Struck Back at DEA

- Over the past decade recruited and hired at least 46 investigators, attorneys and supervisors from DEA into high-paying jobs with drug industry and law firms representing them
- Pressured top DEA lawyers to take a softer approach
- DEA bosses demanded more and more evidence
- Key leaders in DEA enforcement were reassigned to other duties
- **By 2013 caseloads slowed down dramatically and success against suspicious shipments virtually stopped**

Industry Appealed to Congress

- In 2013 began working with members of Congress to create legislation that would strip the DEA of its most potent tool in fighting opioid distribution
- **“Marino Bill” promoted as way to ensure that patients had access to pain medication they needed**
- Spent \$102 million lobbying Congress, claiming DEA was out of control

Impact of Industry Influence on Legislation

- The “Marino Bill”
 - written by Linden Barber, ex-Director of DEA litigation and now Sr. VP with Cardinal Health
 - Introduced by Congressman Tom Marino and Congresswoman Marsha Blackburn
 - Presented to Senate in March 2016 & passed by unanimous consent by House and Senate with no objections and no recorded votes
 - **Actual impact: has prevented the DEA from freezing suspicious shipments of opioids**
 - **No distributor shipments of narcotics have been frozen now for almost 2 years**

Pharmaceutical Ties of Nominees for Major Washington Posts

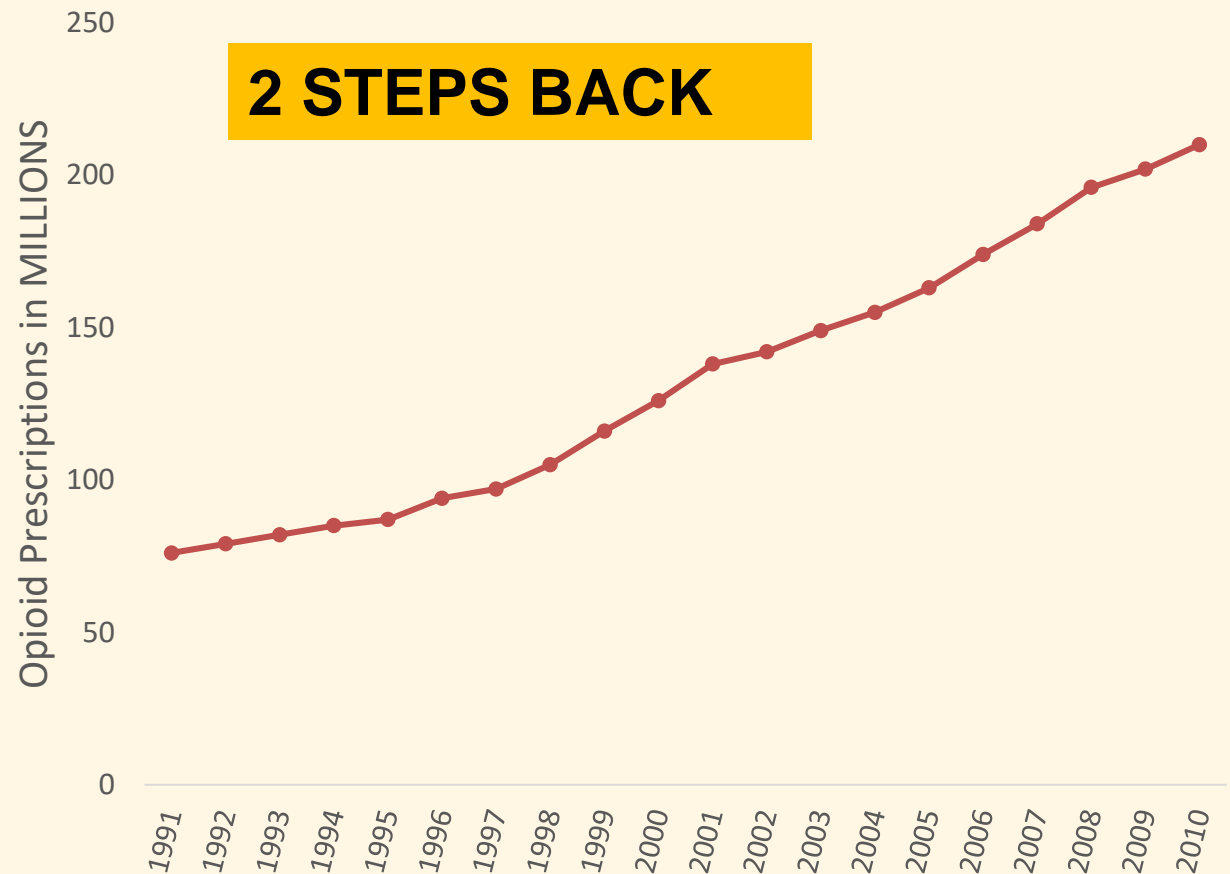
- Nomination of Senator Marino as Head of ONDCP (“Drug Czar”) was announced Sept. 2, 2017 by White House
- Marino withdrew his name from consideration October 18, one day after the airing of the “60 Minutes” investigation
- Former pharma executive was under consideration for nomination as head of Health and Human Services

ENVIRONMENTAL AVAILABILITY:

Current Opioid Crisis Originated with Prescribing Increases

(W. M. Compton, NIDA, 2017)

**Opioid
prescriptions
*Tripled to MORE
THAN 200
MILLION
prescriptions in
recent years***





**Opioid Use Disorders and Opioid Overdose Epidemic
FEDERAL HEALTH SYSTEM PRIORITIES**

White House Office of National Drug Control Policy (ONDCP) National Drug Control Strategy Priority Areas



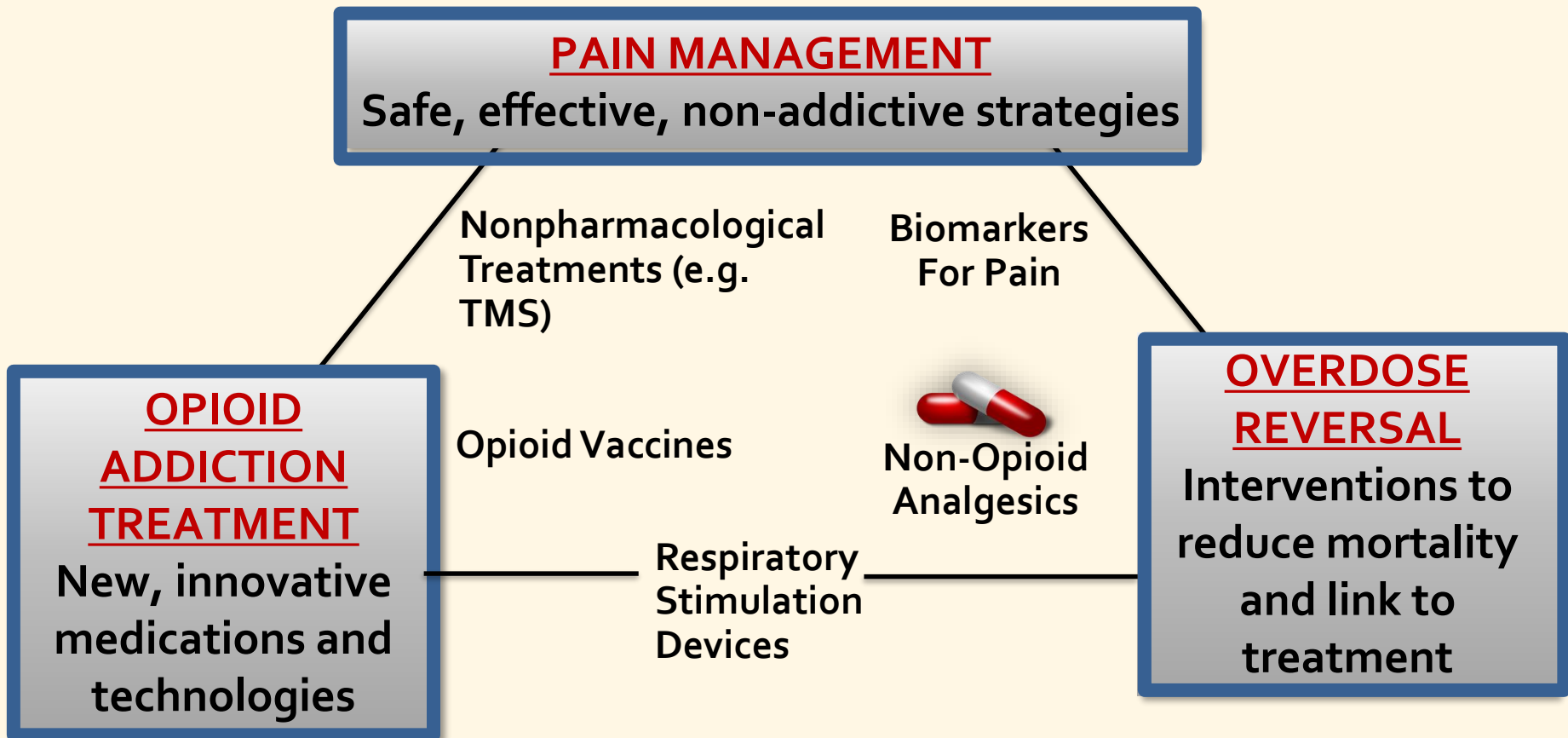
- Preventing drug use in communities
 - Seeking early intervention in health care
 - Integrating treatment for substance use disorders into health care and supporting recovery
-
- Breaking the cycle of drug use, crime and incarceration
 - Disrupting domestic drug trafficking and production
 - Strengthening international partnerships
 - Improving information systems to better address drug use and its consequences

“A substance use disorder is not a moral failing but rather a disease of the brain that can be prevented and treated”

NIH Opioid Research Initiative

Using Research to End the Opioid Crisis

(W. M. Compton, NIDA, 2017)



Science = Solutions

Dept. of Health and Human Services:

3 Priority Areas for Opioid-Drug Related Overdoses and Deaths



1. Improved opioid prescribing practices
2. Expanded use and distribution of Naloxone
3. Expansion of Medication-Assisted Treatment (MAT)

Safe Opioid Prescribing

— Atlanta, GA • March 28-31, 2016 —
NATIONAL
Rx DRUG ABUSE & HEROIN
SUMMIT

Centers for Disease Control and Prevention

MMWR

Early Release / Vol. 65

Morbidity and Mortality Weekly Report

March 15, 2016

CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016



FACING ADDICTION IN AMERICA

*The Surgeon General's Report on
Alcohol, Drugs, and Health*

CARA 2016: Waiver Requirements for Medication-Assisted Treatment

- Waiver Notification to SAMHSA
- Submission of Training Certificate
- Special DEA Identification Number



Medication-Assisted Treatment

Qualify for Nurse Practitioners (NPs) and Physician Assistants (PAs) Waiver

Learn how nurse practitioners (NPs) and physician assistants (PAs) can train and apply to become DATA-waiver practitioners.

<https://www.samhsa.gov/medication-assisted-treatment/qualify-nps-pas-waivers>

CARA 2016: Nurse Practitioners

(Prescriptive Authority for Advanced Practice Nurses)

- Includes a provision that expands office-based treatment-
 - Permits **Nurse Practitioners and Physician Assistants** to prescribe buprenorphine for the first time.
 - Expands prescribing privileges for 5 years until 2021.
 - NPs and PA must complete 24 hours of training to be eligible to apply for the waiver to prescribe buprenorphine.
 - If the NP resides in a state which requires MD collaboration or supervision, they must be supervised by a qualifying physician.
 - The HHS secretary has 18 months to provide guidance through updated regulations on office based opioid addiction treatment.



The President's Commission on Combating Drug Addiction & The Opioid Crisis

- Prescribing Guidelines, Regulations & Education**
- Addiction, Treatment & Recovery**



THE PRESIDENT'S COMMISSION ON COMBATING DRUG ADDICTION AND THE OPIOID CRISIS

Roster of Commissioners

Governor Chris Christie, Chairman
Governor Charlie Baker
Governor Roy Cooper
Congressman Patrick J. Kennedy
Professor Bertha Madras, Ph.D.
Florida Attorney General Pam Bondi



Commission
Established
March 2017

Final Draft
Report
November 1,
2017

Mission of the White House Commission:

To study Federal response & make recommendations to the President for improvements:

- (a) Identify and describe existing Federal funding**
- (b) Assess access to treatment services & overdose reversal**
 - Identify underserved areas
- (c) Identify best practices for addiction prevention:**
 - Healthcare provider education
 - Evaluation of prescription practices
 - State prescription drug monitoring programs
- (d) Evaluate effectiveness of educational messages for youth and adults**
- (e) Identify and evaluate existing Federal programs**
 - Recommendations for improving these programs

Informed Patient Consent Prior to Opioid Prescription for Chronic Pain

- *The Commission recommends HHS, the Department of Labor (DOL), VA/DOD, FDA, and ONDCP work with stakeholders to develop model statutes, regulations, and policies that **ensure informed patient consent prior to an opioid prescription for chronic pain.** Patients need to understand the risks, benefits and alternatives to taking opioids. This is not the standard today.*

(The President's Commission on Combating Drug Addiction & The Opioid Crisis, Nov. 2017)

National Curriculum and Standards of Care

- *The Commission recommends that HHS coordinate the development of a **national curriculum and standard of care for opioid prescribers.***
- *An updated set of **guidelines for prescription pain medications** should be established by an expert committee composed of various specialty practices to supplement the CDC guideline that are specifically targeted to primary care physicians.*

(The President's Commission on Combating Drug Addiction & The Opioid Crisis, Nov. 2017)

Relicensing Prescribers that Prescribe Opioids

- *The Commission recommends the Administration work with Congress to amend the Controlled Substances Act to allow the DEA to require that **all prescribers desiring to be relicensed to prescribe opioids show participation in an approved continuing medical education program on opioid prescribing.***

(The President's Commission on Combating Drug Addiction & The Opioid Crisis, Nov. 2017)

Prioritizing Treatment Knowledge Across All Health Disciplines

- *The Commission recommends the Health Resources and Services Administration (HRSA) prioritize addiction treatment knowledge across all health disciplines. Adequate resources are needed to **recruit and increase the number of addiction-trained psychiatrists and other physicians, nurses, psychologists, social workers, physician assistants, and community health workers and facilitate deployment in needed regions and facilities.***

(The President's Commission on Combating Drug Addiction & The Opioid Crisis, Nov. 2017)

Quality Measures that Address Addiction Screening & Treatment Referrals

- *The Commission recommends HHS, CMS, Substance Abuse and Mental Health Services Administration, the VA, and other federal agencies incorporate quality measures that address addiction screenings and treatment referrals.*
- *There is a great need to ensure that health care providers are screening for SUDs and know how to appropriately counsel, or refer a patient. HHS should review the scientific evidence on the latest OUD and SUD treatment options and collaborate with the U.S. Preventive Services Task Force (USPSTF) on provider recommendations.*

(The President's Commission on Combating Drug Addiction & The Opioid Crisis, Nov. 2017)

Removal of Reimbursement & Policy Barriers to SUD Treatment

- The Commission recommends HHS/CMS, the Indian Health Service (IHS), Tricare, the DEA, and the VA **remove reimbursement and policy barriers to SUD treatment**, including those, such as patient limits, that limit access to any forms of FDA-approved medication-assisted treatment (MAT), counseling, inpatient/residential treatment, and other treatment modalities, particularly fail-first protocols and frequent prior authorizations.
- **All primary care providers employed by the above-mentioned health systems should screen for alcohol and drug use and, directly or through referral, provide treatment within 24 to 48 hours.**

(The President's Commission on Combating Drug Addiction & The Opioid Crisis, Nov. 2017)

“Public Health Emergency”

NOT “National State of Emergency”

(SO NO NEW FUNDING)



The Washington Post

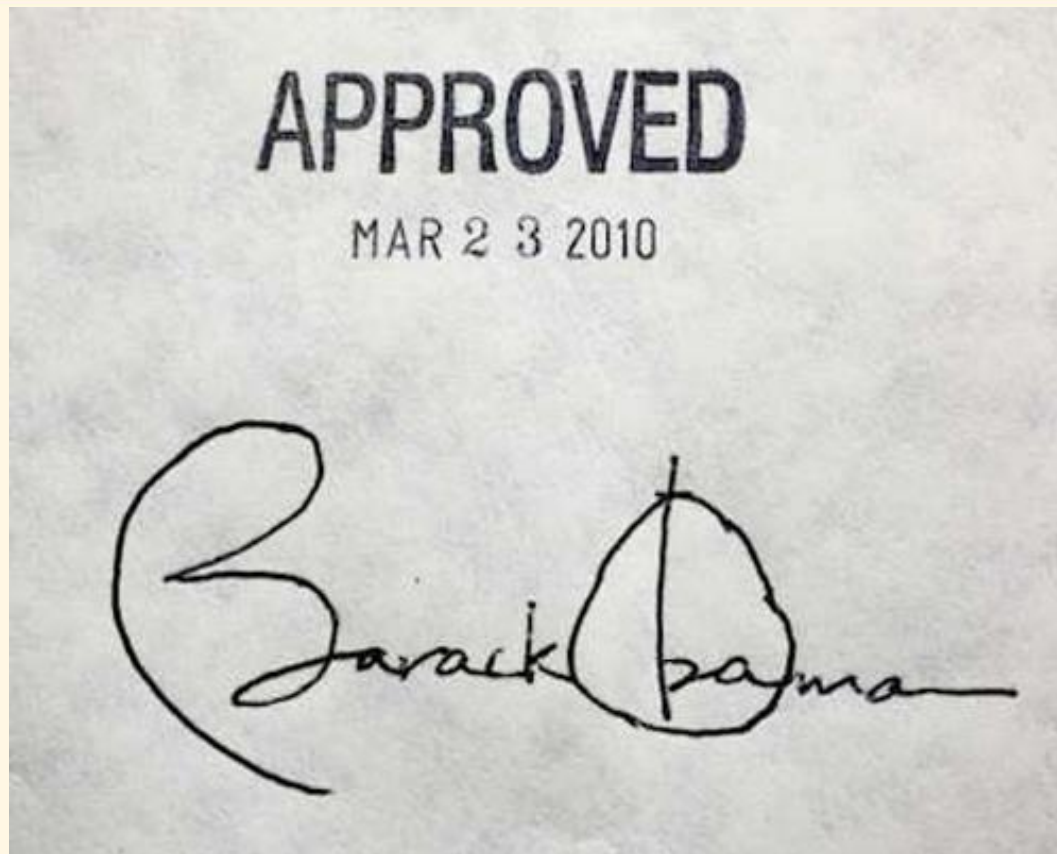
Post Politics

Trump declares the opioid crisis a public health emergency

2 STEPS BACK

By Jenna Johnson and John Wagner October 26

President Trump said Thursday that the opioid epidemic — which is killing more than 100 people each day — is the “worst drug crisis in American history” and said his administration is declaring it a public health emergency, pledging the nation's full resolve in overcoming it.



Affordable Care Act and Access to Treatment

- ACA-related treatment access improvements**
- Medication expansion & treatment access**
- Estimated impact of a potential repeal of the ACA**

Historically speaking.....

- **Addiction treatment has always been segregated** from the rest of healthcare, and almost always provided in separate specialty care addiction treatment programs.
- **Financing** for addiction treatment was also separated from other healthcare coverage, **typically “carved out”** and managed separately from the larger healthcare plan.
- Many private **insurance plans have not covered** addiction treatment at all. Over 80% of addiction treatment financing has come from government sources (Block grants, VA, etc.)
- Whether public or private, coverage has always been **restricted to only the most advanced and severe form of substance use problem: addiction**. Coverage for less severe but far more common forms of substance use disorders has never been included.

Substance Use and Mental Health Disorders: Impact of Potential Repeal of the ACA.....

- **Medicaid is single largest source of care for people with mental health and substance use disorders (SUDs)**
- **Approx. 29% of people with insurance coverage through Medicaid expansion have one or both disorders**
(Buck, 2011; Dey, et al., 2016; Miller, 2013; Paradise, 2017; Toledo, 2017; Fornili, 2017)
- **Medicaid-eligible individuals with SUDs more likely to experience:**
 - Higher levels of medical & psychiatric comorbidity
 - Greater problem severity
 - Have more need for higher-complexity treatment

Affordable Care Act - ACA

- Uninsured people with substance use disorders (SUDs):
Est. 1.6 million
- Medicaid Expansion: to cover SUD treatment in alternative benefit plans
- Mental Health Parity & Addiction Equity Act of 2008:
 - Enrollees in alternative benefit plans, Medicaid managed care plans, and the Children's Health Insurance Program.
 - All state Medicaid programs must ensure that coverage and limits on the use of treatment for SUD are no more restrictive than those placed on other medical and surgical services.

ACA-Related Improvements (along with Paul Wellstone and Pete Domenici Mental Health Parity & Addiction Equity Act of 2008

- **Expanded MH and SUD treatment access**
(Medicaid, marketplace, & employer-based insurance)
- **Expanded Medicaid eligibility**
- **Young people on parents' plans up to age 26 years**
- **Financial subsidies to help people afford insurance**
- **Closed gaps in insurance coverage**
 - Eliminated annual & and lifetime benefit limits on behavioral health services
 - Ended discrimination based on preexisting conditions

(Bailey, 2017)

ACA-Related Improvements (along with Paul Wellstone and Pete Domenici Mental Health Parity & Addiction Equity Act of 2008

- **Prohibited higher co-pays** for behav. health svcs than for physical health services; and
- **Prohibited insurance plans from imposing more restrictive caps** on the number of behav. health treatment visits than on similar physical health benefits

(Bailey, 2017)

6 Ways “Obamacare” is Already Changing Behavioral Health Coverage

1. Pre-existing conditions now covered.
2. Insurance plans must offer **parity** of mental and physical health coverage.
3. Limits on out-of-pocket spending.
4. Insurers must cover prescription drugs.
5. More people getting treatment.
6. The already strained system isn't keeping up.

<http://www.thefiscaltimes.com/Articles/2013/11/26/6-Ways-Obamacare-Changing-Mental-Health-Coverage>

IOM Consensus Recommendations for Essential Health Benefits (EHB)

1. Ambulatory Patient Services
2. Emergency Services
3. Hospitalization
4. Maternity & Newborn Care
- 5. Mental Health & Substance Use Disorder Services, including Behavioral Health Treatment**
6. Prescription Drugs
7. Rehabilitative and Habilitative Services
8. Laboratory Services
9. Preventive and Wellness Services & Chronic Disease Management
10. Pediatric Services, including Oral and Vision Care

Continuing Progress on the Opioid Epidemic: The Role of the ACA

Key Findings

- The share of hospitalizations for substance use or mental health disorders in which the patient was uninsured fell from 22 percent in the fourth quarter of 2013 (just before the ACA's major coverage provisions took effect) to about 14 percent by the end of 2014.
 - In states that expanded Medicaid under the ACA, the uninsured share of substance use or mental health disorder hospitalizations fell from about 20 percent in the fourth quarter of 2013 to about 5 percent by mid-2015.
- Between 2010 and 2015, the share of people foregoing mental health care due to cost has fallen by about one-third for people below 400 percent of the federal poverty level.
- The states with the highest drug overdose deaths also are projected to experience dramatic increases in their uninsured rates if the ACA were repealed:
 - The top three – West Virginia, New Hampshire, and Kentucky – would see their uninsured rates nearly or more than triple if the ACA were repealed, as would Massachusetts.

Repeal Obamacare and the opioid epidemic will get much worse

Updated: JANUARY 17, 2017 – 6:42 PM EST

2 STEPS BACK

by [Antoinette Kraus](#), Director of the Pennsylvania Health Access Network

 [@ATK2003](https://twitter.com/ATK2003) (<http://twitter.com/ATK2003>)

Repealing the Affordable Care Act without a replacement plan is dangerous for the health and economic well-being of our Commonwealth. A new Harvard Medical School and New York University [study](https://www.hcp.med.harvard.edu/sites/default/files/Key%20state%20SMI-ODU%20v3.pdf) (<https://www.hcp.med.harvard.edu/sites/default/files/Key%20state%20SMI-ODU%20v3.pdf>) shows that repealing the ACA would have tragic consequences for millions of Americans affected by mental illness and by the devastating opioid epidemic. [180,526](#)

<http://www.philly.com/philly/blogs/health-cents/Repeal-Obamacare-and-the-opioid-epidemic-will-get-much-worse.html>

Substance Use and Mental Health Disorders: Impact of Potential Repeal of the ACA.....

2 STEPS BACK

- **About 30 million more people will lose insurance coverage (CBO, 2017)**
- **Increase “Treatment Gap” by over 50% (Frank & Glied, 2017)**
- **Approx. 217,000 additional deaths over next decade (Roberts et al, 2017)**



Disproportionate Impact of the War on Drugs on Minority Communities

Opinions

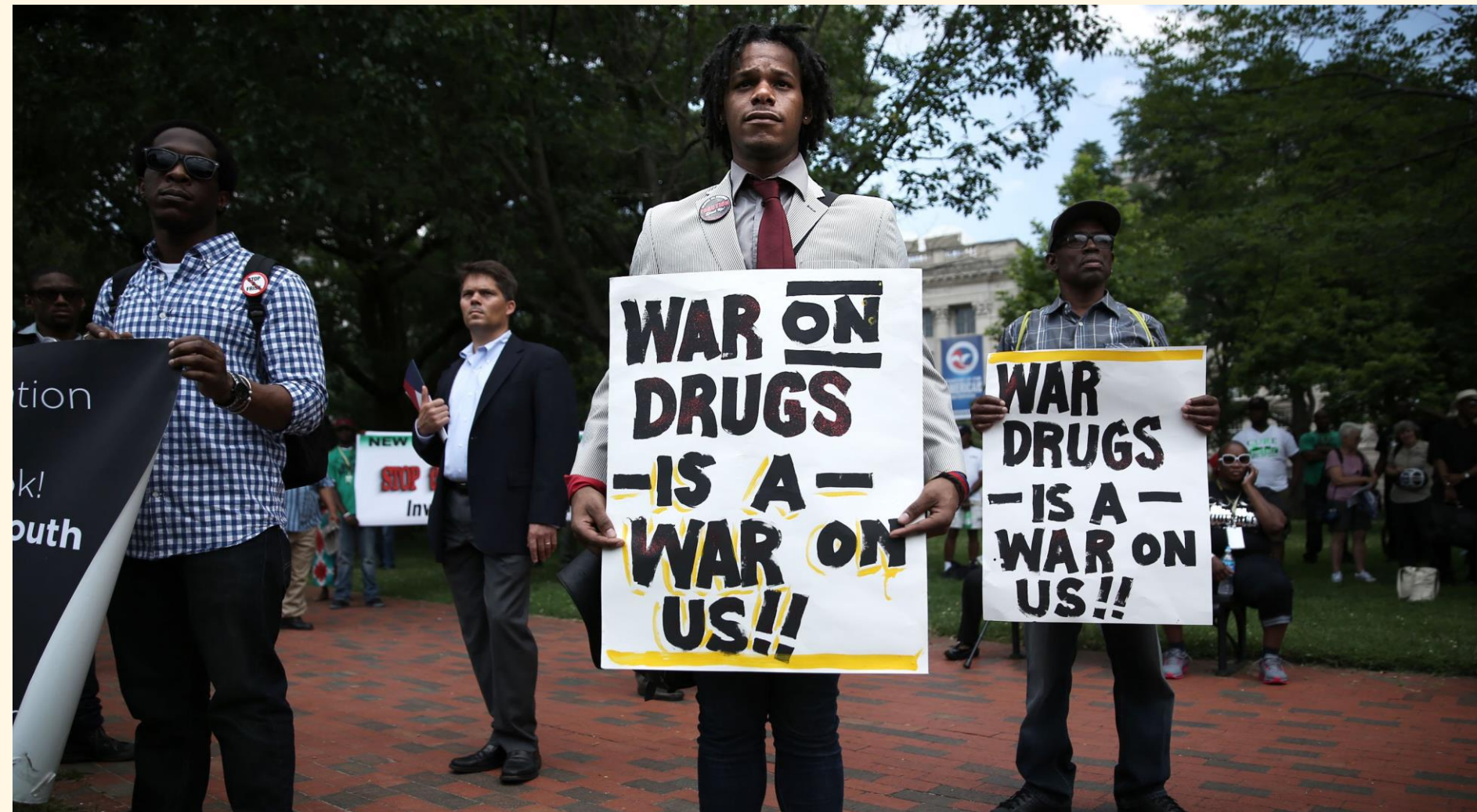
Jeff Sessions wants a new war on drugs. It won't work.

By David Cole and Marc Mauer June 22

David Cole is national legal director of the American Civil Liberties Union's Sentencing Project.

We cannot incarcerate our way out of drug use and the opioid epidemic.

Attorney General Jeff Sessions is right to be concerned about recent increases in violent crime in some of our nation's largest cities, as well as a tragic rise in drug overdoses nationwide [["Lax drug enforcement means more violence,"](#) op-ed, June 18]. But there is little reason to believe that his response — reviving the failed ["war on drugs"](#) and imposing more mandatory minimums on nonviolent drug offenders — will do anything to solve the problem. His prescription contravenes a growing bipartisan consensus that the war on drugs has not worked. And it would exacerbate [mass incarceration](#), the most pressing civil rights problem of the day.

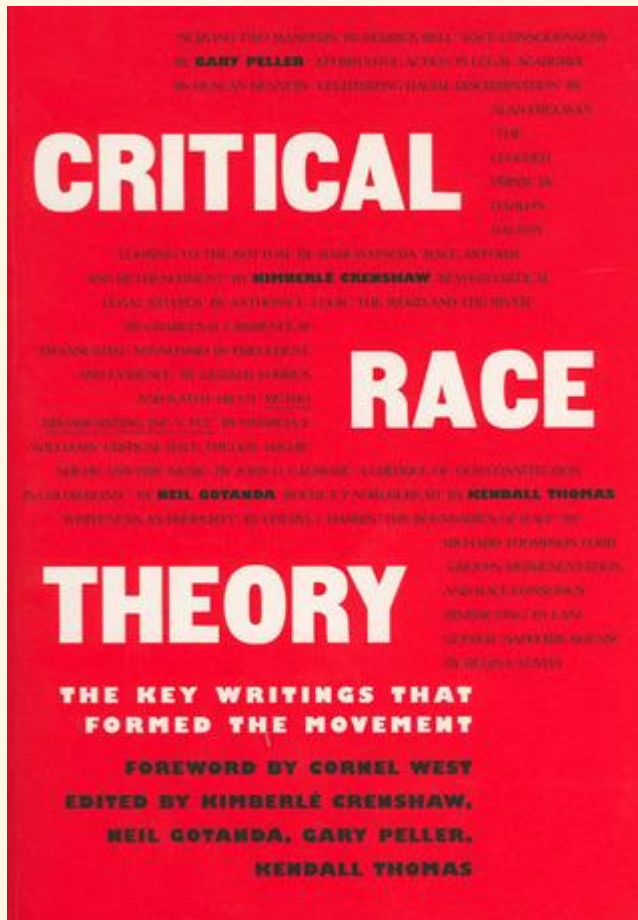


A WAR ON OUR OWN PEOPLE

Three Pillars of the War on Drugs

- The School-to-Prison Pipeline**
- Racialized Mass Incarceration**
- The For-Profit Prison System**





**CRITICAL RACE THEORY (CRT):
Racism & Progressive Race Consciousness**

2 STEPS BACK



SCHOOL-TO-PRISON PIPELINE

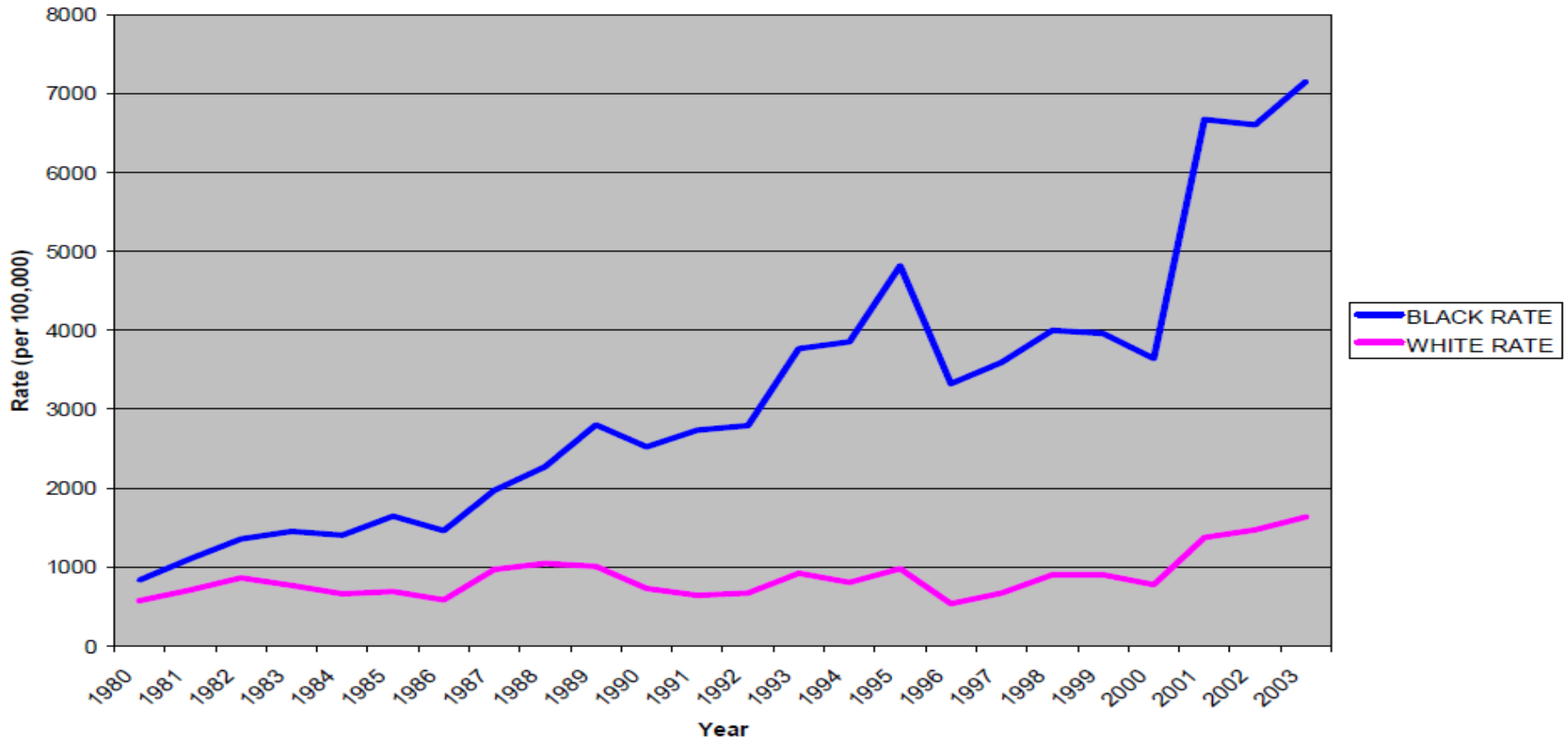
The Criminalization of School Discipline



2 STEPS BACK

RACIALIZED MASS INCARCERATION
Inequality and African-American Men

BALTIMORE



Inequality and African-American Men in Baltimore, MD

MASS INCARCERATION OF AFRICAN-AMERICAN MEN

A photograph showing a group of people, mostly Black men, wearing orange jumpsuits, walking in a prison courtyard. They are walking in a line, some looking towards the camera. The background shows a building with a doorway and a fence.

2 STEPS BACK

#MassIncarceration #FreeAmerica #BlackLivesMatter

Prison-For-Profit Is Wrong.
It creates demand for prisoners.

WE *the* PEOPLE YOU + YOU

THE FOR-PROFIT PRISON SYSTEM

Privatization Incentivizing Mass Incarceration

MILLION DOLLAR BLOCKS

Million Dollar Blocks



On the surface, this is just a map showing the neighborhood where prisoners came from. But in fact, it's a blueprint of where to invest in community empowerment and development programs: after-school programs, drug prevention clinics, midnight basketball leagues, job placement programs, street beautification, etc.

DISPROPORTIONATE IMPACT: A Vicious Multi-Directional, Multi-Generational Cycle

**Race,
Education
& Poverty**



**Access &
Other Health
Disparities**



**Criminal
Justice
Involvement**

“The Critical Link Between Health Care and Jails”

James Marks & Nicholas Turner, *Health Affairs*, March 10, 2014

- ***“Jail involved individuals (people with a history of arrest and jail admission), carry a heavy illness burden, with high rates of infectious and chronic disease, mental illness, and substance abuse. Because these people tend to also be uninsured, jail frequently has been their only regular source of health care”***
- 30% of local corrections budget allocated for inmate health care costs → ***“This investment is largely lost when people are released back into the community, where they typically do not get treatment”***

“The Critical Link Between Health Care and Jails”

James Marks & Nicholas Turner, *Health Affairs*, March 10, 2014

- “People with untreated substance use or mental illness are at heightened risk of cycling in and out of jail for low-level, non-violent offenses”
- “The expansion of Medicaid eligibility under the Affordable Care Act is a critical opportunity to bring the jail-involved population into the mainstream healthcare system”



In Closing: We are morally and ethically bound to address this drug addiction crisis, and the time is now.

- ***“We do not have a crisis of pills needing management, although pills are part of a picture we must address.***
- ***We do have a crisis of people who need care responsive to who they are and the communities where they live.”***



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"Knowing is not enough, we must apply. Willing is not enough, we must do." Goethe