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A Local Approach to the Opioid Epidemic

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Context

In 2017, the Trump administration's Commission on Combating Drug Addiction and the Opioid Crisis published its final report. It included two notable conclusions: federal funding must be streamlined and organized to make it accessible to states,¹ and addiction is heavily influenced by environmental factors.² This has resulted in an opioid crisis that mimics cancer—in that it's really a myriad of different societal failures that end with a common symptom and diagnosis. My research has shown that states with similar opioid overdose rates achieve these dismal figures in different ways. Massachusetts's overdoses occur largely in a window of wealthy communities with median incomes of \$100,000 to \$125,000.³ This starkly contrasts with what many assume to be the typical epidemic community profile,⁴ even though Massachusetts has the seventh highest number of opioid overdoses per state.⁵ So how do wealthy communities in New England and poorer communities in the Midwest come to have similar overdose statistics? It's clear that we researchers do not currently have enough data to reliably determine the root of the issue in each community, and thus cannot craft conventional mandate-based policy to address this crisis.

The majority of policy makers do not recognize that each community is arriving at the epidemic stage due to different environmental causes. Even the aforementioned final report focused much of its recommendation on promoting Prescription Drug Monitoring Programs (PDMPs), which have not been shown to statistically improve overdose or opioid consumption rates.⁶ While they do improve Schedule II drug use rates (such as fentanyl and oxycodone),⁷ they do not affect Schedule I drugs like heroin. Some studies have suggested that PDMPs are simply forcing users away from medical opiates to street drugs with the same fatal results.⁸

These state-run programs receive a substantial portion of the \$28 million in funds from the Center for Disease Control's Overdose Protection in States branch.⁹ The branch is formed of three programs: Prescription Drug Overdose: Prevention for States (PfS); the Data-Driven Prevention Initiative (DDPI); and the Enhanced State Opioid Overdose Surveillance (ESOOS). The first, PfS, specifically seeks to maximize PDMPs and funds such programs in twenty-nine states. The ESOOS provides financial support for states to produce frequently updated data on the epidemic, and support in sharing this data across state lines. The Center for Disease Control has also recently announced that over the next three years it will be providing over \$900 million to state and local governments to track opioid overdose data.¹⁰ While this provides more local government support than ESOOS does, it does not provide a policy solution to solving the opioid epidemic, it merely monitors it.

The Policy

I propose that all funds currently used by PFS to promote PDMPs be redirected into block grants for innovative local governments, under the condition that they report community statistics to their states and show improvement over time. State-level politicians and university professors were usually surprised by that my research found wealthier communities to have a higher overdose rate than neighboring poorer communities. But, a quick dive into local community websites showed that higher academia was among the last to identify communities struggling with the opioid epidemic. Locals noticed it first, for obvious reasons.

For example, the small Massachusetts town of Billerica was identified as a hot spot for high per-capita opioid overdoses in the state. Billerica town officials didn't need to be told they were a hot spot—they knew it from living there. In 2017 (a year before I began my research), they held raffle events to educate seniors on how to keep their prescription medications safe. The first item on the agenda? “Hear from an Addict on how he ripped off his grandparents.”¹¹ Billerica already knew they had a higher-than-usual population of elderly resident, without checking census statistics or setting up a meeting with local politicians. They pulled in an “enterprise bank manager” to speak with those in attendance on how to close and check their bank accounts. Most important, like any local event, there was a stronger degree of trust in learning this advice from community leaders rather than from researchers, state officials, or pamphlets. Unlike larger federal programs, this influential event cost a total of \$50, simply as a raffle prize to entice attendees. With far less in resources, a local event was able to provide community-specific education before quarterly state statistics identified the issue.

Locality also matters when determining how to stop drugs from entering a community. Areas near the Mexican border face different supply-chain challenges than a wealthy New England town does. In one place it might be more effective to combat gang presence, which facilitates heroin access. In another it might be worthwhile to focus more heavily on doctor shopping and pain-management protocols. In most states, communities within one hundred miles of one another will have these differences in supply chains, to varying degrees. While it is useful to facilitate data exchange at the state level to help communities understand these supply chains, giving local governments the power to enact and craft addiction prevention and education policies puts money where the most knowledge is.

With regard to solutions targeting opioid supply and opioid abuse, locals have the most useful ideas for how to help their own communities. By providing grants through their state governments, citizens and local nonprofits can focus their efforts on improving a single community hit hardest by the opioid crisis. If conventional, large-scale (state and federal) programs were effective, then we would have seen drastic improvement over the last two decades. Since we haven't, we now need to allow communities to recognize their own needs and provide their own solutions.

Oversight

Strong state oversight should be used to protect these federal funds from abuse. Rather than offering a blank check, these block grants would be re-approved annually by state governments under the condition of total data transparency and success within a year and a half. Such programs will need to electronically deliver biannual reports containing the number of attendees to local programs, dates of program activities, and invoices for any program costs. These reports will be made immediately viewable by the public via an online portal. Programs may only be started in communities that have per-capita opioid overdoses above the state average, and they must show a reduction in that overdose rate within the first year and a half to maintain funding. After their initial success period, further reductions must be shown every two years afterward, and transparency reports must continue. States should individually determine what improvement to the per-capita overdose rate can be considered a success.

Any states receiving these grants must then summarize these transparency reports by success rates, program descriptions, and community statistics. Furthermore, any state accepting these grants must maintain overdose statistics by city, and they must be made available to the public digitally. Without them states cannot accurately determine whether a community is above the state average for opioid overdoses per capita, and thus whether or not they are eligible for funding. These numbers must be made publicly accessible so that local community leaders can independently determine a proper course of action. Citizens and nonprofits who wish to help should not have to work through the bureaucratic process simply to ascertain which areas are suffering.

The ESOOS program already provides funding to thirty-three states so that they can provide prompt, up-to-date data on the opioid crisis.¹² This application is competitive, and my proposal should be tied to this existent policy. If states are already receiving funding to develop their fact-finding systems on this issue, then it makes most sense to allow those states to apply for block grants that function off of that data.

Possible Results

My research also found that, at least in Massachusetts, wealthy communities with overdose hot spots were surrounded by lower-income communities with slightly lower per-capita overdose rates.¹³ This suggests that certain communities may serve as hubs of opioid abuse, leaking into surrounding areas. If states provide funds to spot-treat these communities with innovative approaches, we may see surrounding communities benefit without additional concerted efforts.

Over time and if successful, this program could be expanded by increasing the number of grants available to ESOOS-participating states. Successful programs

could become models in their states, and suggested to counties that have similar community profiles. A small town in western Massachusetts has far more in common with a small town in the Midwest than it does with the Boston metropolitan area. By encouraging creative solutions in communities with willing leaders and documenting how they built their successes, they could be artificially replicated in less organically supported communities. Communities would no longer have to wonder whether mental health support, methadone clinics, or drug busts would be most effective. The federal government would have a register of situations in which each solution was or was not successful.

If enacted, this policy would take the guess work out of the opioid crisis. It would effectively outsource research to civilians willing to help, without requiring that other communities wait for their state government to figure out an effective solution to the problem. It also would allow success to be defined as reduction in harm (fewer overdose deaths) rather than a reduction in medical prescriptions (less Schedule II drug use). Doctors currently describe their narcotic prescription process with words like “blame” or “guilt,” due in no small part to its regulation in an effort to reduce opioid addiction.¹⁴ By seating future addiction prevention programs in voluntary, community-based approaches, we absolve doctors to some degree of this guilt. If a group chooses to install Narcan kits in common overdose locations,¹⁵ it prevents overdoses before addicts enter the hospital. If communities successfully increase mental health support for those at risk of addiction, it prevents doctor shopping from ever occurring.

Current federal and state regulations that attempt to combat the opioid crisis take a top-down approach. Criminalizing drugs made people turn to illegal supply chains. Requiring a prescription for Naloxone makes the drug difficult to acquire during a life-threatening event. Regulation is a choke hold on innovation, and all standard, homogeneous approaches to the opioid crisis have failed. Given the chance, local governments can and do care for their citizens. Giving them more autonomy on such a critical issue at worst does nothing. At best, it saves lives.

¹ “The Commission urges Congress . . . to block grant federal funding for opioid-related and SUD-related activities to the states, where the battle is happening every day. . . . The Commission believes that ONDCP [Office of National Drug Control Policy] must establish a coordinated system for tracking federally-funded initiatives.” Chris Christie, Charlie Baker, Roy Cooper, Patrick J. Kennedy, Bertha Madras, and Pam Bondi, report of the President’s Commission on Combating Drug Addiction and the Opioid Crisis, 2017, https://www.whitehouse.gov/sites/whitehouse.gov/files/images/Final_Report_Draft_11-1-2017.pdf.

² “Powerful environmental factors can shape the course of heroin addiction... these results illustrate that powerful environmental factors may influence the course of heroin addiction.” Chris Christie et al., Combating Drug Addiction.

³ Kaila Webb, “The Opioid Crisis’ Wealth Window: There’s a Network of Overdoses on the East Coast,” *Pioneer Institute*, August 17, 2018. <https://pioneerinstitute.org/blog/the-opioid-crisis-wealth-window-theres-a-network-of-overdoses-on-the-east-coast>.

⁴ Katherine M. Keyes, Magdalena Cerdá, Joanne E. Brady, Jennifer R. Havens, and Sandro Galea, “Understanding the Rural–Urban Differences in Nonmedical Prescription Opioid Use and Abuse in the United States,” *American Journal of Public Health* 104, no. 2 (February 2014):e52–59.

⁵ National Institute on Drug Abuse, “Opioid Summaries by State,” revised May 2019, <https://www.drugabuse.gov/drugs-abuse/opioids/opioid-summaries-by-state>.

⁶ Gil Kerlikowske, Christopher M. Jones, Regina M. Labelle, and Timothy P. Condon, “Prescription Drug Monitoring Programs—Lack of Effectiveness or a Call to Action?,” *Pain Medicine* 12, no. 5 (May 2011):687–89.

⁷ Kerlikowske et al, “Prescription Drug Monitoring Programs.”

⁸ Richard C. Dart, Hilary L. Surratt, Theodore J. Cicero, Mark W. Parrino, S. Geoff Severson, Becki Bucher-Bartelson, and Jody L. Green, “Trends in Opioid Analgesic Abuse and Mortality in the United States,” *New England Journal of Medicine* 372, no. 3 (January 15, 2015):241–48; Theodore J. Cicero, Matthew S. Ellis, and Hilary L. Surratt, “Effect of Abuse-Deterrent Formulation of OxyContin,” *New England Journal of Medicine* 367, no. 2 (July 12, 2012):187–89.

⁹ Mark R. Jones, Matthew B. Novitch, Syena Sarrafpour, Ken P. Ehrhardt, Benjamin B. Scott, Vwaire Orhurhu, Omar Viswanath, Alan D. Kaye, Jatinder Gill, and Thomas T. Simopoulos, “Government Legislation in Response to the Opioid Epidemic,” *Current Pain and Headache Reports* 23, no. 6 (May 1, 2019):40.

¹⁰ “Trump Administration Announcing Nearly \$2B in Opioid Grants.” Associated Press, September 9, 2019, <https://apnews.com/aff5fa628c6146dab958f21ad868ca7a>.

¹¹ “Opioids & How NOT to Be a Victim,” Town of Billerica event listing, May 20, 2017, <https://www.town.billerica.ma.us/Calendar.aspx?EID=515>.

¹² “Enhanced State Opioid Overdose Surveillance,” Centers for Disease Control and Prevention, page last reviewed July 16, 2019, <https://www.cdc.gov/drugoverdose/foa/state-opioid-mm.html>.

¹³ Kaila Webb, “A Wealth of Data: A Map of the Massachusetts Opioid Epidemic,” *Pioneer Institute*, August 17, 2018. <https://pioneerinstitute.org/blog/a-wealth-of-data-a-map-of-the-massachusetts-opioid-epidemic>.

¹⁴ Angela Y. Esquibel, and Jeffrey Borkan, “Doctors and Patients in Pain: Conflict and Collaboration in Opioid Prescription in Primary Care,” *PAIN* 155, no. 12 (December 2014): 2575–82.

¹⁵ Glenn Forbes, “City of Green To Install NARCAN Kits In Hotels,” *Ideastream*, May 28, 2019, <https://www.ideastream.org/news/city-of-green-to-install-narcan-kits-in-hotels>.