



**Grand** Challenge  
Responding to the Addictions Crisis

# Innovations in Opioid Law and Policy Interventions Workshop

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## **Summary of Proceedings**

*August 2018*

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## EXECUTIVE SUMMARY

In 2017, Indiana University, in cooperation with Indiana Governor Eric Holcomb and community partners, launched the Grand Challenge: Responding to the Addictions Crisis initiative, a university-wide effort to advance interdisciplinary research and interventions in response to the substance abuse crisis affecting Indiana and the nation. The “Legal and Policy Best Practices in Response to the Substance Abuse Crisis” project is one of sixteen funded under Phase 1 of the Grand Challenge.

In July 2018, and as part of this project, the research team convened a group of national experts to discuss legal and policy innovations to respond to the opioid use disorder (OUD) crisis. This report summarizes the proceedings of this workshop and updates some of the recommendations made by the team in their March 2018 Preliminary Report.

During the workshop, experts answered targeted questions relating to the challenges in implementing law and policy recommendations to respond to the addiction crisis, as well as identified gaps in the current research. Participants provided examples of innovative interventions to respond to this crisis across four primary topic categories: (1) Criminalization; (2) Public Health; (3) Treatment; and (4) Effectuating Change. The research team utilized this information to identify opportunities to improve the response to this crisis:

### **Criminalization:**

1. Reevaluate and redraft criminal laws to reduce society’s reliance upon the criminal justice system to address behaviors related to substance use.
2. Reduce the costs related to the investigation, prosecution, and enforcement of the criminal code as it pertains to the actions of people who use drugs and reinvest these funds into treatment and public health interventions.
3. Encourage those engaged in current response efforts to rebuild trust and reconcile with communities that were disproportionately affected by the largely criminal justice-focused response to past drug crises.

### **Public Health:**

1. Strengthen public health surveillance laws and systems to improve reporting and data quality. Ensure that data reported is housed in health departments and not shared with child protective services or law enforcement.
2. Improve data collection and data analysis across the OUD timeline, addiction, overdoses, impact on families, neonatal abstinence syndrome (NAS), treatment outcomes, recovery, and overdose deaths.
3. Establish syringe exchange programs and safe consumption sites. Emergency departments have an existing infrastructure that support these services.
4. Increase access to naloxone, safe injection kits, and drug testing kits.

**Treatment:**

1. Adopt MAT as the standard of care for the treatment of OUD across all healthcare settings.
2. Adopt five-year recovery as standard measure of effectiveness for SUD treatment to incentivize treatment programs to look beyond episodic care models.
3. Expand access to agonist treatment, particularly methadone.
4. Increase access to treatment by leveraging emergency departments as access points to treatment.
5. Improve outcome measures and outcome reporting for substance use disorder (SUD) treatments and the promotion of resilience.
6. Build education models in nursing and medical schools that go beyond medicalization of SUD by incorporating public health models.

**Effectuating Change:**

1. Avoid burnout by remembering that change *is* possible.
2. Identify hurdles successfully overcome in other, peer states.
3. Increase funding across federal, state, and local governments for public health interventions and improved access to treatment. Federal funds should be provided with a longer spending horizon and increased promise of sustainability.
4. Invest in coalition-building by increasing the range of people “at the table,” mirroring the scope of the problem within the community. Where possible, identify institutions’ “internal” champions.
5. In some cases, find: (1) consensus across the various stakeholder groups; (2) efforts needed to coalesce around; and/or (3) outreach limited to a narrow area of focus; for example, improving access to MAT or naloxone.
6. Persuade stakeholders of their value in this response as a means of dealing with “one-drug-substituting-for another” and diversion counter-arguments.
7. Ensure that individuals actively using drugs have a voice in how interventions are crafted in addition to but separately from the interests of those in recovery or the interests of family members.

## INTRODUCTION

### Indiana University Grand Challenge Initiative

In 2017, Indiana University (IU), in cooperation with Indiana Governor Eric Holcomb and community partners, launched the Grand Challenge: Responding to the Addictions Crisis initiative, a university-wide effort to advance interdisciplinary research and interventions in response to the substance abuse crisis affecting Indiana and the nation.<sup>1</sup>

The three overarching goals of the Addictions Crisis Grand Challenge initiative are to:

- Reduce the incidence of substance use disorders (SUD);
- Decrease opioid deaths; and,
- Decrease the number of babies born with NAS.

The Grand Challenge seeks to leverage the strengths of IU in the following domains: (1) data sciences and analytics; (2) education, training, and certification; (3) policy analysis, economics, and law; (4) basic, applied, and translational research; and (5) community and workforce development.

### This Project

The “Legal and Policy Best Practices in Response to the Substance Abuse Crisis” project is one of sixteen funded under Phase 1 of the Grand Challenge: Responding to the Addictions Crisis initiative and focuses on law and policy. The project team consists of researchers at the IU Robert H. McKinney School of Law (McKinney Law) and IU Richard M. Fairbanks School of Public Health (FSPH) at Indiana University-Purdue University Indianapolis (IUPUI; see Appendix A: Research Team Biographies).

The causes of the current crisis are multifactorial. Research has identified effective policies and programs, implemented at an array of intervention points, which may reduce substance abuse and/or the adverse effects of substance abuse on health and society. However, how lawmakers, and those who interpret and implement laws, define and identify problems, set priorities, and invest in legal and policy responses, often deviate from the research evidence. Their actions tend to be mediated by divergent political, professional, and personal philosophies and language.

To better identify and understand legal and policy barriers to effective implementation of opioids addiction interventions, the research team split the project into two parts:

Part 1 (January-April 2018) used a qualitative research model to discover expert stakeholders’ views of legal and policy barriers to effective interventions. Part 2 (May-August 2018) centered on a workshop featuring innovative policymakers and implementers from across the country who could advise us on “next steps.”

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<sup>1</sup> Grand Challenges: Addictions. Indiana University. <https://grandchallenges.iu.edu/addiction/index.html>. Accessed July 30, 2018.

Part 1 of our project concentrated on the identification of immediate legal and policy barriers to effective interventions. We conducted interviews with key stakeholders with expertise related to these law and policy concerns. Informed by the evidence collected, the project's primary goals were to identify and assess opportunities to improve the effectiveness of Indiana law and policy implicated in the State's response to the substance abuse crisis. Interviewees were identified in a variety of domains and with various subject-matter expertise. The team conducted qualitative research by holding semi-structured interviews with a goal of enhancing insights found during independent research and identifying near-term, medium-term, and long-term opportunities for—and obstacles to—law and policy reform that would better align current response efforts with evidence-based and evidence-informed best practices. Informed by the evidence collected from the interviews, this Part 1 project identified and assessed opportunities to improve the effectiveness of Indiana law and policy implicated in the State's response to the substance abuse crisis. We published our findings as "Legal and Policy Best Practices in Response to the Substance Abuse Crisis: A Preliminary Report."<sup>2</sup>

While Part 1 primarily focused on the insights and experience within Indiana, this Part 2 workshop explicitly sought out expertise from outside our state (and in most cases our region) to better inform our research into possible law and policy innovations. The workshop discussions were geared to not only understand the potential of these innovations, but also to understand the barriers they might face in Indiana and exploring how those barriers might be overcome.

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<sup>2</sup> "Legal and Policy Best Practices in Response to the Substance Abuse Crisis," Grand Challenges: Addictions. Indiana University. <https://grandchallenges.iu.edu/doc/iu-grand-challenges-legal-and-policy-best-practices.pdf>. Accessed July 30, 2018.



## INNOVATIONS IN OPIOID LAW AND POLICY INTERVENTIONS WORKSHOP

On July 16, 2018 the research team hosted a workshop at IU McKinney titled “Innovations in Opioid Interventions.” A diverse group of national experts were invited to participate in sharing and discussing their innovations with local stakeholders in Indiana. This part of our project was designed to capture emerging and innovative approaches in addressing the opioid and addictions crises. The goals of the workshop were to:

- Capture emerging or innovative approaches to addressing the opioid and other addictions crises;
- Learn about the strategies that have been successful in practice;
- Collect lessons learned and identify legal barriers; and
- Where appropriate, make recommendations.

### Attendees





The national experts who attended the Innovations in Opioid Interventions Workshop were chosen on the basis of both their domain expertise (e.g., bioethics or Medicaid) and their experience either in implementing or studying innovative policy initiatives.

- Lindsey Browning, Program Director for Medicaid Operations, National Association of Medicaid Directors
- Corey Davis, Senior Attorney, National Health Law Program
- David Jefferson, Public Health Analyst, Skagit County Public Health
- Lindsay LaSalle, Senior Staff Attorney, Drug Policy Alliance
- Ross MacDonald, Chief Med. Officer/Assistant VP, Correctional Health Services, NYC Health + Hospitals
- Jamila Michener, Assistant Professor, The Department of Government, Cornell University
- Eric Miller, Professor of Law, Loyola Law School Los Angeles
- Dawn Pepin, Public Health Analyst, Cherokee Nation Assurance, Public Health Law Program, Centers for Disease Control and Prevention
- Beth Tanzman, Executive Director, Vermont Blueprint for Health, Vermont Dept. of Health Access
- Steve Wood, Fellow in Bioethics, Center for Bioethics, Harvard Medical School

These national experts were joined at the workshop by local leadership and stakeholders.

- Joan Duwve, Associate Dean of Public Health Practice & Assistant Professor at the Indiana University Richard M. Fairbanks School of Public Health, Chief Medical Officer at the Indiana State Department of Health
- Claire Fiddian-Green, President & CEO, Richard M. Fairbanks Foundation
- Faith Kirkham Hawkins, Associate Vice President, Research Development and Strategic Initiatives, Indiana University
- Seema Mohapatra, Associate Professor at the Indiana University Robert H. McKinney School of Law
- Ellen Quigley, Vice President of Programs, Richard M. Fairbanks Foundation

### **Confidentiality, Publication, and Attribution**

In order to maximize open and productive discussion, the workshop participants were guaranteed non-attribution of any statements made during the meeting.

- The workshop proceedings were not recorded, although, members of the research team took notes.
- The participants were told in advance:
  - The research team would be preparing this summary report to be shared with IU Grand Challenge leadership, and that the information and analysis gleaned from the workshop might be used as a basis for future publications.
  - In the report the participants would be identified by name as attendees unless they opted out.
- It follows that in this report we will not attribute any opinions or other information expressed during the workshop to any named individual.

## Structure and Agenda

The workshop was highly structured. In advance, each national expert was asked to supply five bullet points that they considered key to the innovation they would discuss, and to offer suggested readings for the participants. These readings were distributed to all participants in advance of the workshop (See Appendix B). The workshop agenda was organized into four sessions:

1. **Session 1:** During the first two hours of the workshop, the national experts made micro-presentations on their topics. The other workshop participants were asked to react in writing to each presentation across four metrics:
  - Benefits
  - Potentials
  - Concerns
  - Overcomes
2. **Session 2:** This session allowed all participants the opportunity to react to and further question the national experts in an effort to refine the workshop's focus on key issues and policy choices.
3. **Session 3:** The third session was a working lunch. The participants were placed at four tables, each of which was provided with one of four discussion questions:
  - What is the best way to frame recommendations for policymakers and stakeholders who may not share social or political goals or beliefs?
  - What interventions in response to the opioid use disorder crisis would help build more resilient responses to future addictions crises?
  - In designing interventions with small, under-resourced communities, how do we go about aligning evidence-based practices with varied stakeholder interests?
  - What would success look like in response to the opioid crisis?

Each "table" reported back to the group with written responses.

4. **Session 4:** The final session was a facilitated discussion where participants were invited to respond to the "lunch answers," address what additional data or research would be useful, and what priorities should be assigned to additional needs for evidence-based practices. Additionally, the discussants attempted to identify barriers to effective intervention implementation, the steps necessary for effective program implementation, and assess the benefits and contents of potential model state and national legislation.

## Findings

The workshop participants proved to be expert presenters and highly informed discussants. With their help we have been able to move closer to addressing some of the questions we encountered during our research on legal and policy barriers. Our findings are organized into three sections: (1) Answering Challenging Questions, which outlines how participants responded to specific questions asked by the research team; (2) Unearthing Themes, which provides a narrative of the major topics discussed during the meeting; and (3) Suggestions for Future Research and Analysis, which lists the gaps in the current evidence-base as described by participants.

Before detailing these in the sections below, we acknowledge some self-evident truths that we also discussed. First, the group we assembled coalesced around evidence-based interventions; overall, it rejected criminalization, embraced treatment mainstreaming of OUD, and embraced public health harm reduction models. We recognize, however, that an evidence-base or even a basic cost-benefit analysis will not sway those who view OUD as a moral or criminal deficiency or who see spending public money on these public health crises as “welfare” that creates dependency. Second, some of our participants were selected because of their role in or knowledge of the implementation of innovative interventions to respond to the OUD crisis. Our participants were quick to admit that some innovations they brought to the table may have been products of local environments (e.g., strong social capital or a largely ideologically homogeneous population). Neither they nor the research team regard all the innovations we discussed to be automatically transferable or scalable.

### Answering Challenging Questions

#### ***(1) What interventions in response to the opioid use disorder crisis would help build more resilient responses to future addictions crises?***

- (a) *Public Health lessons from prior crises.* Participants noted there were clear lessons to be learned from prior public health crises, particularly from the HIV/AIDS epidemic. There was a strong lesson to be taken away from most prior crises—that the solution was to be found in public health solutions and not criminalization. We need to commit today to determine exactly what level of criminalization is necessary and effective to try and reduce the recycling of failed models in this and future crises. Now is the time to engage health systems and payers and add new resources and programs designed to tackle addictions generally or at least SUD.
- (b) *Decriminalization.* The recognition that addiction is not itself a crime and that decriminalizing most low-level drug-connected activity will help reduce stigma and remove barriers to harm reduction, treatment, and recovery. Going forward, a decriminalized frame should lessen unproductive, “knee-jerk” punitive responses.
- (c) *Community Building.* The building (or rebuilding) and strengthening of communities is key. They provide a foundation for resilience and offer choice and hope. Community activation also makes it more likely that necessary institutions (for example, justice, health, housing, and education) will be provided and improve social determinants of health. Strengthened communities can support safe spaces, increase mental health care, and improve resilience. Additional community-based services, such as early home visiting and other services designed to build family and community safety, can help in the reengagement of those who have become alienated or marginalized and connect them to resources. Some participants thought there were opportunities for community amplification through apps and online portals.

- (d) *Improved Treatment Models.* Steps that increase access are vital. Treatment should be modeled on the needs of patients rather than on any particular addiction or addictive drug. Responses should not be tailored to the latest “flavor of the month” addiction “scare” but own crises that are on the horizon. Thus, treatment-related responses that are tailored only to opioids (for example, opioid prescription guidelines, prescription drug monitoring programs (PDMPs), and even SEPs) that fail to engage users of cocaine or stimulants likely will fail to address underlying issues. Effective treatments for SUD exist and can be routinely implemented, while recovery coaching and special services for pregnant women need to be built into health and SUD treatment systems. The standard of care for SUD should evolve and adopt, say, a five-year recovery as a standard measure of effectiveness for SUD treatment; this will encourage treatment programs to look beyond episodic care.

**(2) What is the best way to frame recommendations for policymakers and stakeholders who may not share social or political goals or beliefs?**

- (a) *Carefully select stakeholders.* Find people who are willing to be changed and to create change from both inside and outside the system or institution you are seeking to influence. Find and cultivate allies within the institution. Address stakeholders’ institutional interests and frame recommendations to institutional agents empowering them and improving their institutional status. Attempt to replace cynicism felt by those within systems with the instinct to do good. Recognize that good policies may run counter to institutional or self-interest; for example, corrections facilities may be large local employers, rendering decriminalization less popular. On the other hand, healthcare is a massive employer, so increasing the medicalization of addictions with more and improved treatment could work in an opposite, positive direction.
- (b) *Actionable Items.* If recommendations require legislative action, frame them with specificity and demonstrate how they are actionable. Emphasize the right stories that are not politically charged and that resonate with the values of policymakers.
- (c) *Be cognizant of all costs, and who will bear them.* Community members and political stakeholders generally will prefer that private payers would pay to reduce the consequences of a crisis or build new capacity, rather than seeing tax dollars spent on those with OUD. Also, some policymakers may associate payments for services to disproportionately poor populations as inappropriate “welfare” expenditures.
- (d) *Stress Value.* Demonstrate how your recommendations net out with a cost benefit.

**(3) In designing interventions with small, under-resourced communities, how should we go about aligning evidence-based practices with varied stakeholder interests?**

- (a) *Community support.* Make sure that the proposed interventions have public/community support and use community leaders to present the ideas to the impacted community.
- (b) *Good communication.* Use consistent vocabulary and terminology. Promote the intervention using evaluation and marketing. Use terminology and rhetoric that resonates with those you seek to influence. Stay away from “bad” rhetoric; for example, supporting syringe exchanges.
- (c) *Implementation.* Identify stakeholders who have implementation authority. Assess and understand bias and carefully deliver your evidence-based practices. Fight against the natural policymaker impulse to delay action because “everyone wants to be second.”

***(4) What would success look like in response to the opioid crisis?***

- (a) Reduction of the number of deaths by opioid overdose/suicide. Reduction of comorbid and chronic conditions.
- (b) Re-integration of those who have been marginalized, particularly minority and immigrant communities.
- (c) Acknowledgement that the treatment of OUD in this crisis is different from what occurred during other drug-related crises (for example, crack cocaine) for some communities of color.
- (d) Mitigation of some “war on drugs” custodial sentences.
- (e) Improved public schools and job programs.
- (f) The development of a metric of success that looks not just to equality, but also to equity.

## Unearthing Themes

While the discussions ranged across a variety of topics, the innovators' presentations and the discussion that followed centered around four primary themes: (1) criminalization; (2) public health; (3) treatment; and (4) effectuating change.

### Criminalization

The current addictions crisis, like every prior substance use-related crisis of the past century, too-often is viewed as a problem that demands primarily substantive criminal law responses. While criminal law continues to have an important role in controlling the supply of illegal drugs, many attendees argued that the effective *criminalization of addiction* exacerbated the crisis. Multiple attendees attested to a need to realign society's response to the crisis away from punishment for what should be seen primarily as a healthcare concern. Thus, reducing the role of the criminal justice system in addressing substance use disorder would facilitate a reframing of society's approach from punishment to public health, and from criminal justice to social justice.

Millions of Americans, as they struggle with substance use disorder, will end up using illicit substances, and may engage in criminal behavior in their effort to address their drug cravings or stave off withdrawal. This has resulted in a substantial share of people who use drugs entering into our criminal justice system, and our criminal justice system becoming among our most prominent sites for substance use disorder-related needs and treatment. As many attendees noted, jail- and prison-based access to comprehensive and evidence-based substance use disorder treatment is widely variable, and often unavailable. Furthermore, substance use disorder care provided while incarcerated does not frequently continue into the community setting, making the population of individuals who are immediately post-release among the most at risk for overdose death.

Attendees resisted narratives that would justify the use of the criminal justice system as an acceptable pathway or cost for people who use drugs to get into treatment programs. In addition to concerns related to the scope and quality of the care available within the carceral system, attendees pointed to the many additional harms that came to individuals as a result of having a criminal record. Criminalization results in a loss of many social supports for people with opioid use disorder. This may include loss of employment and significant reduction in the number of employers who would be willing to hire them, disqualification from housing and other public benefits, and loss of custody of their children. The separation of parents from their children due to criminal prosecutions arising out of substance use-related behavior creates multi-generational problems, as both the stigmatized SUD-related behavior and the placement of a family member in jail or prison are both considered to be Adverse Childhood Experiences (ACEs) that raise the relative risk of the child engaging in future health-harming behaviors.

Efforts by policymakers and healthcare providers to restrict access to prescription opioids, without concomitant improvements in the accessibility and affordability of substance use disorder treatment services, were seen by many attendees as significant contributors to the current accelerating substance use overdose mortality rate. Those seeking affordable, accessible drugs increasingly look in the unregulated street market, where risks have increased substantially due to the introduction of synthetic opioids, such as fentanyl, into the illicit drug market.



Criminalization hinders the effectiveness of harm reduction strategies. As noted in our preliminary report, individuals who witness an overdose may be reluctant to call 911 out of fear that they, or the person suffering the overdose, may be subject to arrest. Many states, including Indiana, consider possession of a syringe that was used (or is intended for use) for illicit drug use as a criminal act (it is currently a felony under Indiana law). This also contributes to: (a) stigma against Syringe Services Programs (SSP) and Safe Consumption Sites, as communities and neighborhoods often oppose their presence in the community generally, and in their neighborhoods specifically; (b) decreased likelihood that an individual receiving syringes from an SSP will return them to the SSP or dispose of the syringes safely, as syringe possession itself may be considered a criminal activity subject to prosecution; and (c) lowers the likelihood of local healthcare providers' willingness to participate in area SUD treatment efforts. The introduction of synthetic opioids into the drug market makes the testing of those drugs critically important. However, in many states, possession of fentanyl testing strips may be considered drug paraphernalia possession.

Criminalization also inhibits access to evidence-based treatments that could support people who use drugs. Attendees noted that many criminal justice settings are reluctant to authorize the use of Opioid Agonist Therapies (OAT), such as buprenorphine, in their facilities as these drugs may themselves be subject to the risk of diversion and misuse. While this is a legitimate concern that must be acknowledged by OAT advocates, attendees felt the diversion risks could be minimized, and that diversion risks were outweighed by the benefits of widespread access to evidence-based treatments. Furthermore, one attendee noted that diversion of buprenorphine might help to decrease demand for other illicit substances within incarceration settings. As OATs are themselves controlled substances, criminalization and stigma mean that those using such medications as part of their recovery may run into problems with drug testing at work, driving restrictions, and disqualification from housing (such as recovery housing).

Criminalization is also extremely costly. The costs related to the investigation, prosecution, and enforcement of the criminal code as it pertains to the actions of people who use drugs far outstrip the costs related to substance use disorder treatment. One Midwestern county, an attendee noted, has spent over a million dollars on prosecutions of drug overdose homicide cases, public funds that might otherwise have been spent elsewhere in the community. Attendees pointed to California's Proposition 47, passed in 2014, which reduced most nonserious and nonviolent drug crimes from felony to misdemeanor charges, reduced state jail and prison populations, and redirected the state's resulting cost savings (estimated at between \$150-250 million annually) into a state Safe Neighborhoods and Schools Fund.

If decriminalization is not pursued by policymakers, attendees noted that it becomes even more important that comprehensive evidence-based treatments be made available throughout the criminal justice system (jails, prisons, as well as within the probation system). Finally, attendees noted that any decriminalization efforts must take into account the disparate treatment suffered by urban, largely non-white populations in earlier drug crisis as a result of aggressive criminal prosecutions, severe drug related sentences, and the lack of sympathetic consideration of those crises as health concerns. Attendees advise that decriminalization efforts be accompanied by undertaking reconciliation efforts with those minority communities targeted in prior drug wars.

## Public Health

The OUD crisis has been referred to as a public health epidemic by the media, experts, and policymakers. While our attendees agreed that there is a public health crisis, in their experience, the response to this crisis has been piecemeal and focused on criminalization and supply-side controls rather than a comprehensive public health response. Workshop attendees discussed a variety of public health interventions to respond to the OUD crisis, focused on reporting and harm reduction strategies as well as strengthening public health systems.

Public health promotes the health and wellbeing of populations and communities by preventing, detecting, and responding to health threats. Effective, tailored, and responsive interventions hinge on understanding the scope of the public health crisis. This is achieved through comprehensive public health surveillance. Effective surveillance hinges on both reporting and tracking of health conditions. However, our attendees indicated that in the context of OUD and related conditions, there are many gaps in our data. SUD, overdose, and NAS are not universally considered reportable conditions across state law. Additionally, there is much variability in the definitions of these conditions and how data are collected, thus impacting the quality of data through mischaracterization or underreporting. It was noted that one qualitative study found that making NAS a reportable disease improved provider reporting, produced better quality data, and made data available more quickly. Additionally, state law and policies vary in terms of agencies that might have access to this information. Our attendees agree that health departments should be the only agencies that have access to this data. Sharing this data with law enforcement or child protective services can lead to criminalization of addiction and deter people from seeking healthcare.

Harm reduction refers to public health interventions that seek to minimize illness and injuries associated with drug use rather than merely trying to end drug use. Numerous attendees noted the importance of promoting harm reduction strategies to respond to the opioid crisis. For example, naloxone access was noted as an effective strategy that has been underutilized. Although many states have passed naloxone access laws, naloxone remains a prescription drug and is not widely available to those needing it. Most emergency departments cannot give out naloxone to patients because these departments do not function as pharmacies or because naloxone remains cost prohibitive.

Other interventions highlighted during the workshop include establishing syringe exchange programs and safe consumption sites. Evidence indicates these services reduce incidence of infectious disease and overdose, can reduce overall incidence of drug use, and link individuals to treatment. Attendees also highlighted that these services also make financial sense, for example, by reducing the need and cost of emergency services for the government as well as for businesses concerned about public consumption in or near their establishments. One attendee noted that the infrastructure for these services already exists at emergency departments.

The workshop attendees suggested other harm reduction interventions that may be less politically polarizing but still reduce overdose and infectious disease transmission. These include distributing drug testing strips, safe injection kits, and offering overdose prevention, naloxone, and CPR training more widely. Additionally, making a “buddy system” a best practice for consumers of drugs can also reduce overdose rates.

Some attendees discussed the role of limiting access to prescription opioids as important interventions to respond to the OUD crisis. These include requiring pharmaceutical companies to be responsible for collecting and disposing of unwanted medications via a secure medicine return program and using PDMPs to better monitor and track prescription rates. One attendee suggested that PDMPs should be used not to penalize but to connect folks to treatment and other services. One attendee reminded us that PDMPs have led to more heroin overdoses.

Attendees also made general observations regarding the role of public health in the opioid crisis. One attendee said that not only should representatives from public health be at the table to determine the best response to this crisis, but that they should be at the head of the table, steering the response. Another attendee highlighted the need to strengthen collaborations across agencies and sectors including the public health and criminal justice systems.

One attendee noted that the systems established to respond to public health threats are too singular, specifically structured to respond a single crisis rather than laying the foundation to respond to future crises. The attendee noted that much investment was made to respond to the threat of Ebola in healthcare settings yet these facilities are wholly unprepared to address behavioral health issues. Finally, one attendee observed that the public health community was always having to prove itself and justify its interventions as compared to criminalization, which does not. Policies that promote health, as one attendee framed, should be the default outcome.

One of the primary goals of public health is to prevent adverse health outcomes before they occur. Prevention of SUD is often missing from discussions relating to the addiction crisis. But, there are known predictors of SUDs including ACEs, incarceration of parents, and homelessness as a child. We also know that adult stressors, such as housing, job, or food insecurity can also lead to the development of SUD. Thus, investing in social and economic determinants of health are an essential public health strategy to reduce SUD.

## Treatment

Many of our participants' comments about OUD treatment reiterated what we learned and, in several cases, recommended in our Preliminary Report. This is itself a worrying commentary; what we know to be evidence-based, effective (indeed, cost-effective) interventions are still viewed as "innovative" by experts from all across the country.

There was broad agreement among the participants that we are dealing with a humanitarian crisis that requires us to prioritize the most vulnerable and institute evidence-informed treatment focused on recovery. Similarly, there was unanimous agreement that sustainable progress depended on addressing social and structural determinants of health.

Participants agreed that treatment offered should reflect an individualized process of recovery, rather than channeling groups into treatment programs based on risk assessments. Participants were clear that medication assisted treatment (MAT) was the standard of care for opioid use disorder and that all three FDA-approved MAT drugs should be available. In particular, participants expressed support for agonists, particularly methadone as producing positive long-term results. Less enthusiasm was shown for naltrexone (including Vivitrol). Concern was voiced about placing too much reliance on medications alone; the psychosocial support that goes with the MAT is what makes it so successful. There was also discussion about using timely data to support appropriate prescribing and linkage to treatment. There was also positive discussion of emerging hub-and-spoke treatment systems.

Access and cost issues continue to frustrate treatment interventions. There was some discussion of creating better incentives for physicians to provide MAT. There were well-received suggestions that the role and scope of practice of emergency departments (ED) should be increased; for example, by allowing ED doctors to initiate treatment, increasing mental health services within EDs, and discharging overdose patients with MAT information and a "safe injection" kit.

For large swathes of the OUD population, Medicaid coverage remains the key to unlocking treatment. Participants urged the elimination of work requirements and other restrictive policies that make it more difficult for otherwise eligible Medicaid cohorts to enroll or continue to benefit from Medicaid services. It is also imperative that there should be continued Medicaid eligibility for persons in jails and prisons. Participants also noted the need to scrutinize the pricing practices of pharmaceutical companies as they increase the cost of life saving treatments such as naloxone and buprenorphine.

Wraparound services, whether or not financed through Medicaid waiver approvals, are required to cover supportive recovery housing and wrap around services including employment, education and related needs. The continuum of care should be extended to track individuals throughout the 2-5 years of recovery. Priorities include care coordination and integration; the key to successful treatment is continuous rather than episodic care. There should be expanded use of community health workers and health navigators, especially those that specialize in helping people with substance abuse disorders. There are also opportunities to leverage telehealth to deal with lack of access to substance abuse services such as MAT in areas with high opioid use.

One OUD sub-cohort attracted specific recommendations. It was noted that methadone and buprenorphine medications remain widely unavailable in criminal justice settings and that a particularly urgent need was to make MAT available in jails. We were told of huge numbers of persons with OUD are "churning" through jails often in acute withdrawal on admission and with a greater risk of overdose upon discharge. In both jails and prisons, there need to be concerted efforts to promote MAT (particularly agonists) by addressing fears of diversion and other philosophical objections.

## Effectuating Change

Many communities have implemented promising interventions that address significant health-harming aspects of the addictions crisis. Vermont's hub-and-spoke response was seen by attendees as a breakthrough system structure improving the availability and accessibility of comprehensive substance use disorder services throughout the state. The New York City health department has implemented a robust MAT program in the city's jail system, significantly improving the treatment and health outcomes for one of the most vulnerable drug-using populations. Rhode Island has made available a broad spectrum of MAT-related treatments in the state's correctional facilities. Skagit County, Washington has developed a collaborative system of care offering wrap around services. Telehealth services are seen by some as a way that can help improve access to specialty care in underserved areas. However, the scalability of these programs and policies is compounded by a number of systems-level concerns.

As a wicked problem, this crisis defies simple implementation solutions. Response efforts are confounded by lack of consistency in response roles, language, and terminology. How participants in the response define problems, how they prioritize response to those problems, and what they define as success varies. Response efforts are hindered by data problems, which may include inadequate quality, comprehensiveness, and/or consistency. One attendee noted, for example, that it is unclear how many non-fatal overdoses are occurring in the United States, let alone fatal overdoses. Another attendee observed that it is unclear where current federal funds are being allocated, and there is insufficient reporting on the impact of such investments. Data systems are also incomplete and fragmented.

In addition to the structural barriers and lack of comprehensive systems, the adequacy of funding was seen by many attendees as a critical challenge. The lack of comprehensive health insurance coverage sufficient to cover the true range of costs, services, and length of care is seen as a perpetual challenge for programs aimed at populations with complex and stigmatized mental health and substance use disorder care needs. Costs of providing care, and the resources available, are not seen holistically, nor are they treated as fungible; costs incurred or funds available to the criminal justice system are seen as completely distinct from costs and funds in, say, the Medicaid system.

Healthcare alone offers an example of the barriers created by siloed provider systems; mental health services often are treated by different providers than those offering substance use disorder services, which are offered in different environments than treatment for chronic pain. Consequently, any changes to the reimbursement or service delivery process runs the risk of sparking a turf war.

Furthermore, attendees noted that improvements in funding streams, as seen for example with expanded Medicaid waiver programs, often are accompanied by policies that likely will depress access to coverage and services, such as work requirements or burdensome proof of eligibility and enrollment processes. Expanded services may require a commitment to expanding resources; however, attendees noted that, in many communities, raising funds through expanding local taxes was seen as a politically insurmountable obstacle.

Despite these challenges, attendees offered a number of suggestions as to how to implement effective solutions. Coalition-building is critical, as the range of people “at the table” must mirror the scope of the problem within the community. To ensure representation from within the affected communities, this may require significant time and effort spent in outreach, trust- and capacity-building within disaffected and disenfranchised populations. This process can take a great deal of time before paying dividends with improvements in local services or program alignment. Programs should be built to address upstream contributors to community health as much as possible, building resilience within families and communities, stabilizing housing, improving workforce conditions, assuring quality education, investing in community safety and social structures that support mental health needs. The systems also should be built to be flexible, responding to the needs of the affected populations, rather than the particular drug of the moment.

As the old saying goes, “politics makes strange bedfellows.” Workshop attendees frequently cited to the nontraditional collaborations that needed to be fostered to bring about successful policies and programs. In some cases, to find consensus across the various stakeholder groups, efforts needed to coalesce around, and outreach limited to, a narrow area of focus, such as improving access to MAT or naloxone. That said, attendees also discussed how coalition building often did not demand that everyone agree on a common goal, but rather relied upon demonstrating how a particular intervention might allow multiple goals to be satisfied (for example, how a syringe service program might mean “harm reduction” for a public health advocate, and “less needles in the local park” to the business community). To some policymakers, support might hinge on showing how investment in an effective response might bring about a net fiscal benefit to the community, or strengthen the situation for a large local employer (such as a correctional facility).

In picking voices to advocate for change, several attendees promoted cultivation of “internal” champions who mirror the stakeholders and people in the room. For example, identifying correctional officers as leaders who came to believe in the changed approach to caring for the incarcerated population, recognizing their institutional contributions and new status as therapeutic experts.

Finally, workshop participants discussed how individuals with SUD and individuals actively using drugs are often further marginalized by being excluded from the policymaking process. Often, their interests are conflated with the interests of those in recovery or the interests of family members of those with SUD. Instead, individuals actively using drugs need to have a leading voice in how interventions are crafted and implemented.



## SUGGESTIONS FOR FUTURE RESEARCH AND ANALYSIS

In addition to providing recommendations for law and policy interventions, workshop participants identified gaps in currently available research. These gaps are outlined here.

- General
  - Adopt standardized terminology and improve definitions of issues and states
  - Increase the use of narratives; for example, tell the story of recovery
  - Ethnographic studies on the addiction crisis
  - Mapping of Policy-Politics: What does the policy landscape look like? What are the politics that make it work? How can policy and politics be better synchronized?
  - Impact on families and family units
  - What promotes resilience and/or recovery?
  - Associational studies evaluating law and policy interventions
  - Linking costs across state i.e. cost of incarceration to healthcare, single cost to society verses just a county or hospital
  
- Data Gaps
  - Improve analysis of federal spending on the opioids crisis to create an improved picture of allocation of funds and effectiveness of resulting interventions
  - Better assessment of interventions implemented and their impact on the crisis.
  - Number of fatal or non-fatal overdoses
  - Data that explores discharge from jails or emergency departments and overdose frequency.
  - Prevalence of OUD; there are few longitudinal studies
  - Better NAS data--are increasing NAS numbers a positive sign that mothers are getting help or are there other explanations?
  - Impact of OUD on families and not just individuals
  - Collect qualitative not just quantitative data
  - Recovery numbers
  - Stop measuring the wrong things; we need to see more data and analysis about the role of housing and jobs
  
- Treatment
  - Promote treatment heterogeneity. There is not one treatment type of model for all but the need for a broad menu of options for individuals seeking recovery.
  - Monitor medical and nursing school curricula. We need to build an education model that will succeed in its search for understanding why people turn to substances. But, simply medicalizing it is insufficient because it neglects public health.

- Improve outcomes measures for treatment generally and also for different treatment models. One issue to be addressed would be the identification of the correct outcome; for example, recovery or maintenance?
- More and better research on cannabis, including the likelihood and advisability of exit drug or substitution for opioids.
- Criminalization and Decriminalization
  - What is the impact of decriminalization on the criminal justice system?
    - Drug Courts. Do they now do less?
    - Law enforcement. Are there fewer arrests?
  - Discharge to jail and rates of overdose from local level data
  - Analyze return on investment in treatment versus incarceration

## OPPORTUNITIES

In “Legal and Policy Best Practices in Response to the Substance Abuse Crisis,” our March 2018 Preliminary Report, we identified 8 areas where there were legal barriers to effective interventions or where state actors could make better policy decisions based either on evidence or best practices. Those areas were:

1. Harm Reduction
2. Healthcare Interventions
3. Care Coordination and Wrap-Around Services
4. Drug Take Back Programs
5. Patient Privacy Protections
6. Patient Privacy Protections
7. Courts
8. Stigma

In that preliminary report we made 33 specific recommendations divided across those 8 subject areas.

In the intervening six months, the Indiana legislature has only briefly been in session while the branches of the federal government have been working on broad study, funding and other provisions. At the federal level H.R. 6 (115) contains several provisions that could positively impact the addiction crisis in Indiana.<sup>3</sup> For example, it calls for an enhanced Medicaid matching rate related to expanded state SUD treatment and recovery services, additional incentives for Medicaid health homes for patients with SUD, improvements in Medicare availability of MAT, and increased numbers of providers authorized to administer buprenorphine. Meanwhile, the Senate has advanced several bills, arguably the most important being S.2680 (115) that includes provisions furthering prescribing restrictions, PDMPs, drug take-back and disposal programs, providing federal relief grants based on the severity of the crisis in particular states and with no end dates, the funding of comprehensive recovery centers, recovery housing, and training programs related to federal privacy laws.<sup>4</sup> Unfortunately, there are considerable reconciliation hurdles ahead, together with a packed Senate agenda that makes passage of any meaningful legislation before Labor Day highly unlikely and potentially consigning it to a “lame-duck” session.<sup>5</sup> Separately, HHS has announced a forthcoming Request for Information (RFI) on the misalignment between HIPAA and 42 CFR Part 2.

In Indiana, there has been some progress. For example, the recent Statewide Opioid Summit organized by Chief Justice Rush has begun an immensely important discussion among justice professionals about the appropriate level of criminalization and the imperative of providing persons in the custody of the criminal justice system with MAT. As for legislation, several key pieces of legislation are likely to be introduced in the Fall 2018 session.

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<sup>3</sup> [SUPPORT for Patients and Communities Act 2018.](#)

<sup>4</sup> [Opioid Crisis Response Act of 2018.](#)

<sup>5</sup> Haberkorn J, Ehley B, Graff GM, et al. Timetable for Senate opioid bill may slip. About Us. <https://www.politico.com/story/2018/07/23/senate-opioid-legislation-could-slip-into-the-fall-702466>. Published July 23, 2018. Accessed July 31, 2018.

The research team has also received reports of innovative policing, treatment programs, and community outreach in some parts of the State, for example the P.A.A.R.I. initiative launched by the LaPorte City Police Department.<sup>6</sup> FSSA continues to expand reimbursement while some of the concerns voiced in our preliminary report have been somewhat assuaged by a recent federal court decision casting doubt on the validity of Kentucky's Medicaid "work requirement."<sup>7</sup> Unfortunately, both Lawrence County and Madison County closed their SEPs, although the latter then reinstated its program that will be run by Aspire Indiana. Crucially, Marion County has voted to open a SEP and notwithstanding some controversy, a new treatment center has opened in Bloomington. Overall, however, there is little evidence of any abatement of the opioid crisis in Indiana and it remains clear that there is much more work to done.

Overall, we believe the Workshop participants reinforced several of the issues and recommendations in our Preliminary Report (although this was not an explicit goal of the event). Additionally, the participants focused our attention on several important opportunities to strengthen our response to the crisis.

- **Criminalization:** Our original report discussed the limitations of the criminal justice system to respond to the addiction crisis and emphasized how criminal law impedes the effectiveness of harm reduction strategies. Additionally, the way many laws and policies characterize the actions of people who use drugs as criminal is a primary contributor to the stigma affecting this vulnerable population. However, the report did not discuss the lopsided funding funneled into law enforcement, the harmful impacts of entanglements with the criminal justice system on health and families, and the disproportionate amount of funding that is directed towards criminal justice and away from (or in lieu of) treatment, recovery, and prevention.

In terms of criminalization, we found opportunities to:

1. Reevaluate and redraft criminal laws to reduce society's reliance upon the criminal justice system to address behaviors related to substance use.
2. Reduce the costs related to the investigation, prosecution, and enforcement of the criminal code as it pertains to the actions of people who use drugs and reinvest these funds into treatment and public health interventions.
3. Encourage those engaged in current response efforts to rebuild trust and reconcile with communities that were disproportionately affected by the largely criminal justice-focused response to past drug crises.

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<sup>6</sup> La Porte City, Ind. Police Department Joins P.A.A.R.I. To Launch Addiction Recovery Initiative, <https://paariusa.org/2016/05/10/la-porte-city-ind-police-department-joins-p-r-launch-addiction-recovery-initiative/>. Published May 10, 2016. Accessed July 31, 2018.

<sup>7</sup> Scott D. Federal judge blocks Kentucky's Medicaid work requirements. Vox. <https://www.vox.com/policy-and-politics/2018/6/29/17517862/medicaid-work-requirements-kentucky-lawsuit-decision>. Published June 29, 2018. Accessed July 31, 2018.

- **Public Health:** The workshop reinforced the need for public health interventions to respond to the crisis. However, the workshop discussion highlighted some deficiencies in our public health surveillance systems and the need for improved data collection and reporting laws. Additionally, our original report discussed the role of syringe exchange programs and safe consumption sites as harm reduction interventions. Yet, it failed to specially recommend these programs. Our original report discussed Indiana’s naloxone access law, but failed to describe the limitations of this law to ensure that the most vulnerable individuals have access to naloxone and that it can be available at an affordable price for individuals and organizations. Our original report also fails to consider other types of harm reduction tools that can be distributed.

Thus, we identified opportunities to:

1. Strengthen public health surveillance laws and systems to improve reporting and data quality. Ensure that data reported is housed in health departments and not shared with child protective services or law enforcement.
  2. Improve data collection and data analysis across the OUD timeline, addiction, overdoses, impact on families, neonatal abstinence syndrome (NAS), treatment outcomes, recovery, and overdose deaths.
  3. Establish syringe exchange programs and safe consumption sites. Emergency departments have an existing infrastructure that support these services.
  4. Increase access to naloxone, safe injection kits, and drug testing kits.
- **Treatment:** In the context of treatment, the workshop reinforced several important points from our preliminary report. There was strong agreement that all three FDA-approved MAT drugs should be available in every healthcare setting. Yet, MAT remains widely unavailable in criminal justice settings. Additionally, SUD treatment provided during incarceration seldom continues immediately into the community setting, making the population of individuals who are immediately post-release among the most at risk for overdose death. The workshop also reminded us that the risk of “losing” otherwise Medicaid-eligible persons because of paperwork, lock-out, and work requirement provisions should not be underestimated. Despite these acknowledgments, the report failed to explicitly refer to and cite MAT as the standard of care, discuss the particular importance of agonist treatment, or describe how certain healthcare settings such as emergency departments can improve access to treatment. Finally, the report did not discuss the measures to track and evaluate the effectiveness of SUD treatment or developing education models for SUD treatment in medical schools.

In the context of treatment, we found opportunities to:

1. Adopt MAT as the standard of care for the treatment of OUD across all healthcare settings.
2. Adopt five-year recovery as standard measure of effectiveness for SUD treatment to incentivize treatment programs to look beyond episodic care.
3. Expand access to agonist treatment, particularly methadone.
4. Increase access to treatment by leveraging emergency departments as access points to treatment.
5. Improve outcome measures and outcome reporting for substance use disorder (SUD) treatments and the promotion of resilience.
6. Build education models in nursing and medical schools that go beyond medicalization of SUD by incorporating public health models.

- **Effectuating Change:** The preliminary report did not discuss the processes needed to implement the recommendations made. The workshop highlighted various ideas and processes for passing and implementing public policy measures to respond to the addictions crisis.

Based on the workshop discussion, we identified opportunities to:

1. Avoid burnout by remembering that change *is* possible.
2. Identify hurdles successfully overcome in other, peer states.
3. Increase funding across federal, state, and local governments for public health interventions and improved access to treatment. Federal funds should be provided with a longer spending horizon and increased promise of sustainability.
4. Invest in coalition-building by increasing the range of people “at the table,” mirroring the scope of the problem within the community. Where possible, identify institutions’ “internal” champions.
5. In some cases, find: (1) consensus across the various stakeholder groups; (2) efforts needed to coalesce around; and/or (3) outreach limited to a narrow area of focus; for example, improving access to MAT or naloxone.
6. Persuade stakeholders of their value in this response as a means of dealing with “one-drug-substituting-for another” and diversion counter-arguments.
7. Ensure that individuals actively using drugs have a voice in how interventions are crafted in addition to but separately from the interests of those in recovery or the interests of family members.



## APPENDICES

### APPENDIX A: RESEARCH TEAM BIOGRAPHIES

**Nicolas P. Terry (Co-PI)**, Hall Render Professor of Law & Executive Director of the Hall Center for Health Law at Indiana University Robert H. McKinney School of Law. There, he teaches “Introduction to Health Care Law & Policy,” “Healthcare Quality & Safety,” and “Health Information Technology & Privacy.” His recent scholarship has dealt with health privacy, mobile health, the Internet of Things, Big Data, and AI. Terry has served on the Board of Advisors for the non-profit Patient Privacy Rights and was a member of the US Department of Health and Human Services Health IT Policy Committee’s Consumer Workgroup. In 2016, he testified before Congress on the regulation of mobile health apps. Currently, he is serving on Indiana University’s Grand Challenges Scientific Leadership Team, working on the addictions crisis and is the PI on addictions law and policy Grand Challenge grants. In that capacity he recently testified on opioids policy before the Senate Committee on Aging. He is one of the permanent bloggers at Harvard Law School’s Bill of Health. His recent publications are at <http://ssrn.com/author=183691>, you can find the Terry-Pasquale “The Week in Health Law” podcast at TWIHL.com, and he is @nicolasterry on twitter.

**Ross D. Silverman (Co-PI)**, Professor of Health Policy and Management at the Indiana University Richard M. Fairbanks School of Public Health at IUPUI, and Professor of Public Health and Law at the Indiana University Robert H. McKinney School of Law. He is a member of the Indiana University Center for Health Policy and the Indiana University Center for Bioethics. Prior to 2013, Professor Silverman served 15 years as faculty at Southern Illinois University Schools of Medicine and Law, including five years as chair of the medical school’s Department of Medical Humanities. His research addresses a wide array of subjects at the intersection of public and population health, healthcare, law, policy and policy surveillance, and ethics, with publications appearing in major journals in these fields, including the *New England Journal of Medicine*, *JAMA*, *Health Affairs*, *Science*, *Annals of Surgery*, and the *Journal of Law, Medicine, and Ethics*. He has had two recent publications in peer-reviewed journals related to Indiana opioid policy, law, and ethics, in *Pain Medicine* (doi: 10.1111/pme.12580) and *JAMA* (doi: 10.1001/jama.2015.12672). He is an investigator conducting community-engaged research and law and policy analysis for the Indiana State Department of Health *Prescription Drug Overdose Prevention for States* contract with the Fairbanks School of Public Health (D. Watson, PI). Professor Silverman is the Associate Editor on Legal Epidemiology for the journal *Public Health Reports*, the official journal of the Office of the U.S. Surgeon General and the U.S. Public Health Service.

**Aila Hoss**, Visiting Assistant Professor and IU Grand Challenge Fellow at Indiana University Robert H. McKinney School of Law. Her research explores topics in public health law, health policy development, and the impact of federal Indian law and Tribal law on health outcomes. Prior to joining the faculty at IU, Aila served as a staff attorney for the Centers for Disease Control and Prevention’s Public Health Law Program (PHLP), where she worked to improve public health through the development of legal tools and the provision of legal technical assistance to state, Tribal, local, and territorial governments. This included supporting the agency’s Ebola Emergency Operations Center and responding to legal research requests related to the Zika virus. Aila has published on a variety of health law topics in the *Journal of Law, Medicine and Ethics*, the *Journal of Public Health Management and Practice*, and the CDC’s *Morbidity and Mortality Weekly Report*, among others, and has presented at national conferences including the Public Health Law Conference and the National Indian Health Board Public Health Summit. Aila serves as a faculty member for CDC University’s Working Effectively with Tribal Governments course and has previously served as a member of the Expert Review Workgroup for the CDC’s Legal Epidemiology Competency Model Project.

**Emily Beukema**, JD/MPH candidate Indiana University Robert H. McKinney School of Law, Indiana University Richard M. Fairbanks School of Public Health. Her research interests lie in health law and policy, specifically, access and affordability of care. She earned her Bachelor of Science in Biomedical Sciences from Western Michigan University and was first introduced to health law while working in a clinical setting as a medical scribe.

**APPENDIX B: DISTRIBUTED READINGS RECOMMENDED BY WORKSHOP PARTICIPANTS**

1. Nicolas P. Terry, Ross D. Silverman, Aila Hoss, Rebecca Critser, Emily Beukema, Catherine Sterling. Legal and Policy Best Practices in Response to the Substance Abuse Crisis, A Preliminary Report, Indiana University Addictions Grand Challenge. March 30, 2018.
2. The Opioid Workgroup Leadership Team (OWLT). OPIOID WORKGROUP LEADERSHIP TEAM, Community-wide Action Plan and Call to Action. Skagit County, Washington. December 13, 2016.
3. Josh Katz. How a Police Chief, a Governor and a Sociologist Would Spend \$100 Billion to Solve the Opioid Crisis. The New York Times. February 14, 2018.
4. Veeral N. Tolia, Stephen W. Patrick, Monica M. Bennett, Karna Murthy, John Sousa, Brian Smith, Reese H. Clark, Alan R. Spitzer. Increasing Incidence of the Neonatal Abstinence Syndrome in U.S. Neonatal ICUs. The New England Journal of Medicine. May 28, 2015.
5. Nabarun Dasgupta, Leo Beletsky, Daniel Ciccarone. Opioid Crisis: No Easy Fix to Its Social and Economic Determinants, American Journal of Public Health. February 2018.
6. Drug Policy Alliance. A Public Health and Safety Approach to Problematic Opioid Use and Overdose. November 2017.
7. Traci C. Green, Jennifer Clarke, Lauren Brinkley-Rubinstein L, Brandon Marshall, Nicole Alexander-Scott, Rebecca Boss, Josiah Rich. Postincarceration Fatal Overdoses After Implementing Medications for Addiction Treatment in a Statewide Correctional System. JAMA Psychiatry. April 2018.
8. CMS. Strategies to Address the Opioid Epidemic. Department of Health and Human Services: Centers for Medicare & Medicaid Services. November 1, 2017.
9. Jonathon C. Lee. The Opioid Crisis Is a Wicked Problem. The American Journal on Addictions. December 28, 2017.
10. Dayna Bowen Matthew. Un-burying the lead: Public health tools are the key to beating the opioid epidemic. Brookings Institution. January 23, 2018.
11. John R. Brooklyn & Stacey C. Sigmon. Vermont Hub-and-Spoke Model of Care For Opioid Use Disorder: Development, Implementation, and Impact. Journal of Addiction Medicine. July 31, 2018.
12. Fergus McNeill. What Works and What's Just? European Journal of Probation, University of Bucharest. 2009.