



FOCUS *report*

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Texas considers policy responses to opioid crisis

Opioid abuse and addiction have increased dramatically in the United States in the past 20 years, with far-reaching consequences for communities, governmental agencies, and health care providers. In addition to the personal toll on individuals and families, the problem has imposed significant costs on first responders and emergency rooms dealing with overdose victims, led to reduced productivity and more people dropping out of the workforce, and contributed to driving down life expectancy. In October 2017, the opioid crisis was declared a national public health emergency in the United States.

According to the Centers for Disease Control and Prevention (CDC), preliminary estimates for 2017 show that 72,000 people died from a drug overdose and 49,000 of those deaths involved an opioid, up from 64,000 deaths and 42,000 opioid-related deaths in 2016. The number of opioid overdose deaths increased fivefold from 1999 to 2016, with more than 350,000 deaths. About 40 percent of opioid overdose deaths in 2016 involved a prescription opioid.

While Texas currently has the third-lowest opioid-related overdose death rate of any state, the number of overdose deaths involving a prescription opioid increased by nearly 300 percent from 1999 to 2016. In Texas, 1,375 opioid-related overdose deaths occurred in 2016, according to the CDC, a rate of 4.9 deaths per 100,000 people, compared to the national rate of 13.3 per 100,000. Texas House and Senate committees recently have been reviewing the opioid problem in the state.

The CDC describes the increase in opioid overdose deaths in three stages, beginning with increased prescribing of opioids in the 1990s and an increase in prescription opioid overdose deaths since at least 1999. Heroin-related overdose deaths began increasing around 2010, and 2013 brought the start of a substantial rise in synthetic opioid overdose deaths, especially those involving illicitly manufactured fentanyl.

Definitions

Opioid. An opioid is a substance that activates one or more of the body's three opioid receptors (mu, kappa, and delta) to inhibit pain. This includes prescription medication, such as oxycodone (*e.g.*, OxyContin) and hydrocodone (*e.g.*, Vicodin), synthetic opioids (*e.g.*, fentanyl), and illicit drugs (*e.g.*, heroin). Fentanyl, which is legally manufactured as a prescription drug to treat pain in clinical settings or illegally manufactured as a non-prescription drug, is 50 to 100 times more potent than morphine and is often mixed with heroin to intensify heroin's euphoric effect.

Dependence. Physical dependence is an adaptation to a drug that produces symptoms of withdrawal when a person stops taking the drug. It is a physiological response to a drug and, alone, does not indicate addiction.

Addiction. Addiction is a chronic, neurobiological disease characterized by craving and compulsive use of drugs despite harm to oneself or others.

State and federal policymakers are examining the opioid problem, with Congress holding hearings and introducing dozens of bills on the issue in recent years. Proposals include commissioning studies on the opioid epidemic, educating prescribers and pharmacists about opioid abuse, addressing the way prescription opioids are tracked, and increasing access to addiction treatment, among other approaches.

Both the Texas House of Representatives and the Texas Senate have been charged this interim with studying the impact of opioids on Texans. The House Select Committee on Opioids and Substance Abuse has been directed to:

- study trends in deaths and overdoses in Texas compared to other states;
- examine how opioid abuse has affected certain groups, such as pregnant women, foster youth, veterans, and homeless individuals;
- review current policies on preventing prescription drug abuse; and
- identify how opioid abuse has impacted the work of law enforcement, emergency responders, and hospitals, among other issues.

This report examines how Texas and other states are responding to the opioid crisis through prevention,

intervention, and treatment and reviews policies the 86th Legislature may consider in 2019 to help reduce opioid-related misuse, overdoses, and deaths.

Prevention

Federal and state policymakers are tackling the opioid problem with a broad range of measures aimed at preventing addiction and abuse. This can include educating health professionals and the public about the risks of opioid misuse, including encouraging the safe storage and disposal of medication, identifying symptoms of misuse before addiction and overdoses occur, preventing or limiting access to prescription opioids, and stemming the flow of illegal forms of the drug into the country.

Texas and other states are acting to improve the prescribing of opioids and to mitigate misuse. People who experience acute or chronic pain from a condition, disease, injury, or surgery often are prescribed opioids to alleviate it. If they become physically dependent, they may seek more and stronger doses to achieve the desired effect and to manage pain and withdrawal symptoms. According to the CDC, individuals addicted to prescription opioids are 40 times more likely to become addicted to heroin than people not addicted to prescription opioids. According to the federal Substance Abuse and Mental Health Services Administration (SAMHSA), 80 percent of heroin users started out misusing prescription opioids.

Prevention strategies being employed in Texas include limiting the dosage and duration of prescriptions and requiring doctors and pharmacists to check a statewide prescription monitoring database before prescribing or dispensing certain controlled substances. Some states have implemented per-pill taxes on opioids to help fund addiction prevention, law enforcement, and substance abuse treatment expenses incurred as a result of overdoses.

Prescription limits. To address a perceived undertreatment of pain, the Joint Commission, a national nonprofit medical accrediting organization, in 2001 [issued](#) hospital pain management protocols that encouraged doctors to treat pain as a "fifth vital sign" akin to clinical measurements such as pulse rate, temperature, respiration rate, and blood pressure and to prescribe treatment accordingly. Around the same time, according to the National Institute on Drug Abuse, pharmaceutical companies began advertising prescription opioids as a safe and effective way

to treat pain. For most hospitals, Medicare payments were tied to a patient satisfaction survey required by the Centers for Medicare and Medicaid Services (CMS) that included questions about pain management.

In 2016, the CDC released new guidelines on opioid prescribing intended to curtail high dosages and long-term use. In October 2017, the CMS issued a federal [rule](#) to remove hospital pain management survey results from the scoring formula used to calculate Medicare payments. In January 2018, the Joint Commission [released](#) revised pain assessment and management standards for hospitals. Hospitals are now required to actively engage medical staff and hospital leadership in developing strategies to decrease opioid use, facilitate access to prescription drug monitoring programs, provide at least one non-pharmacological pain treatment modality, educate patients on the safe storage and disposal of opioids, and help refer patients addicted to opioids to treatment programs.

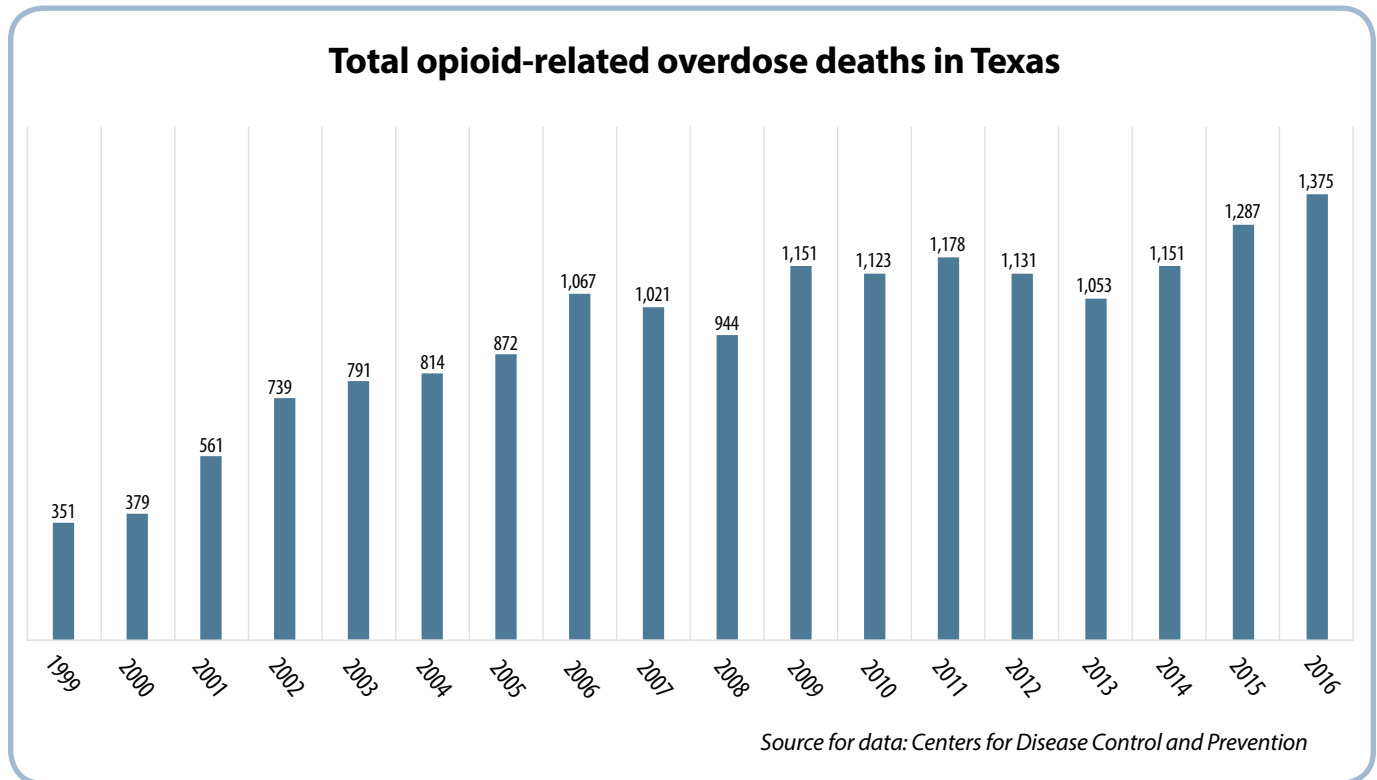
Many state agencies, health plans, and hospitals are amending their policies for prescribing and dispensing opioids to reflect the CDC's new opioid prescription guidelines for chronic pain. In January 2018, the Texas Health and Human Services Commission (HHSC) limited the daily morphine equivalent dose (MED) to 300 milligrams for clients enrolled in Medicaid fee-for-service. The limit exempts cancer patients

and those receiving palliative or hospice care. Before this, no MED limits were in place.

HHSC also released a tentative schedule with a decrease of the maximum allowable MED from 300 milligrams to 90 milligrams by January 2019. This decline of the maximum allowable MED limit is intended to give prescribers time to taper a person's opioid prescriptions to the lower doses recommended by CDC guidelines.

Although Medicaid managed care organizations (MCOs) are not required to implement the same MED limits as the Medicaid fee-for-service model, they may implement similar measures. Beginning March 2018, the MCO Superior HealthPlan limited the daily MED to 300 milligrams for Medicaid and Children's Health Insurance Program clients. The limit provides the same exemptions for certain patients and decreases the maximum allowable MED to 90 milligrams by November 2018.

Several states have enacted or are considering legislation to restrict the duration of first-time opioid prescriptions. Texas currently has no such statutory limit, according to the Texas State Board of Pharmacy. In 2016, Massachusetts became the first state to enact a [law](#) that limits opioid prescriptions to a seven-day supply for first-time prescriptions, with certain exceptions. In March 2018, the Florida Legislature enacted



a [law](#) that limits a prescription for a Schedule II opioid (e.g., Vicodin, OxyContin, and fentanyl) to a maximum of three days if prescribed to treat acute pain. The law, which took effect July 1, 2018, includes an exception to allow a prescriber who believes that more than a three-day supply is medically necessary to prescribe a seven-day supply.

Some have called for Texas to consider applying dosage limits to first-time opioid prescriptions for acute pain similar to proposals enacted in other states.

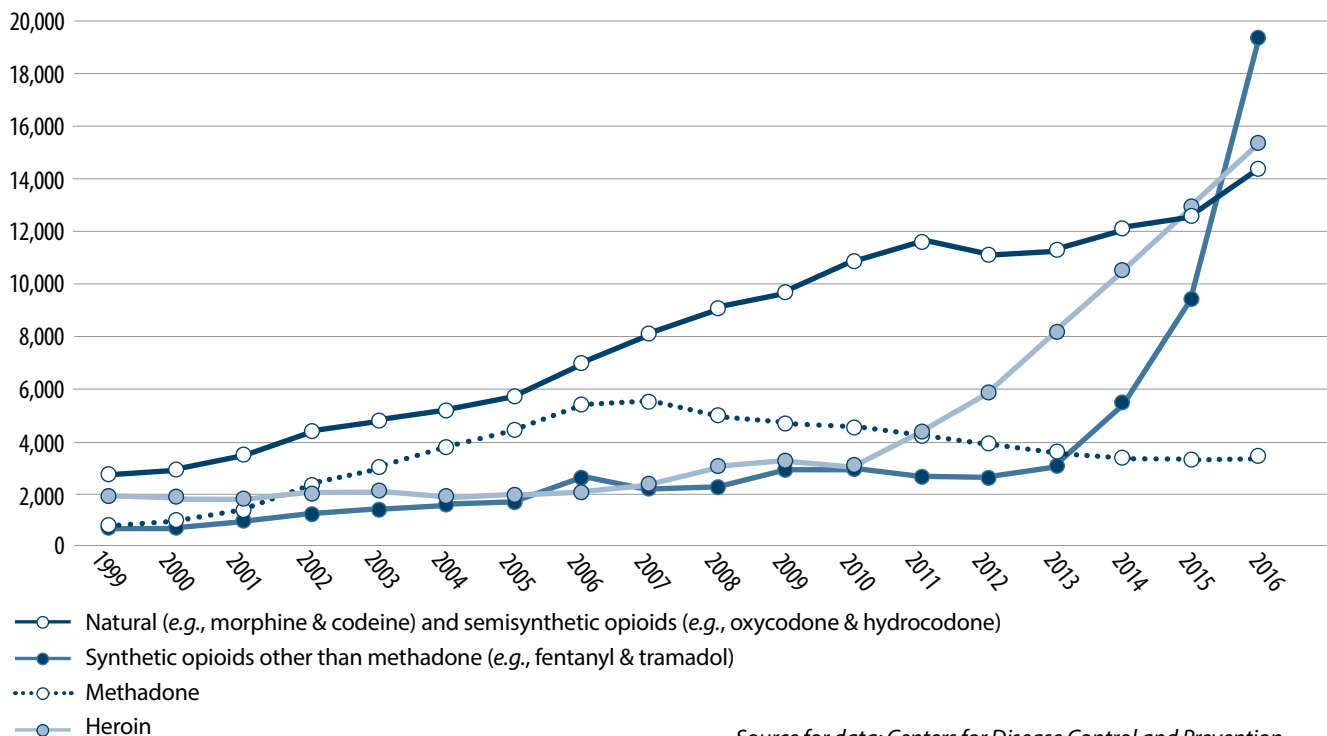
Supporters of limiting the dosage and duration of opioid prescriptions say it decreases the risk of patients and others becoming addicted. They say the opioid crisis developed partly because doctors overprescribed pills to patients with common pain complaints and post-surgical pain. The CDC indicates that patients who receive larger quantities of pills to treat acute pain are more likely to become long-time users of opioids, with some becoming addicted, than those prescribed a smaller number of pills. Relatives and friends of the intended patient also can access unused pills if the prescription is not properly stored or disposed of, putting them at risk of overdose and addiction. Many opioid prescription limits provide reasonable exceptions for patients who need pain relief for longer periods due to chronic issues.

Critics of limiting opioid prescriptions say it could incentivize patients to use cheaper and more accessible drug alternatives (i.e., heroin and illicitly made fentanyl). They say opioid prescribing thresholds hinder access to drugs for patients with chronic pain who are accustomed to high doses and could increase suicidal ideation among patients whose opioid dosages are reduced or discontinued.

Prescription Monitoring Program. Texas monitors the dispensing of certain controlled substances through the Prescription Monitoring Program (PMP), which was developed in 1982 under the Department of Public Safety. The 84th Legislature in 2015 transferred responsibility for the PMP to the Texas State Board of Pharmacy effective September 1, 2016 ([SB 195](#) by Schwertner). Under the program, pharmacists may search a database and review a patient’s prescription history before dispensing certain medication to monitor, prevent, and detect the diversion and abuse of prescription controlled substances. All 50 states and the District of Columbia have their own versions of the program, and the Texas PMP shares its data with programs in 21 other states.

In 2017, the 85th Legislature enacted [HB 2561](#) by S. Thompson, which beginning September 1, 2019, requires

Overdose deaths in the United States by opioid type



Source for data: Centers for Disease Control and Prevention

all prescribers and pharmacists, except veterinarians, to review a patient’s prescription history in the PMP database before prescribing or dispensing opioids, benzodiazepines, barbiturates, or carisoprodol. Prescribers and pharmacists are not required to check the PMP for patients diagnosed with cancer or receiving hospice care. Since 2017, the law also has required pharmacists to enter a patient’s prescription information into the database no later than the next business day, rather than within seven days as previously allowed.

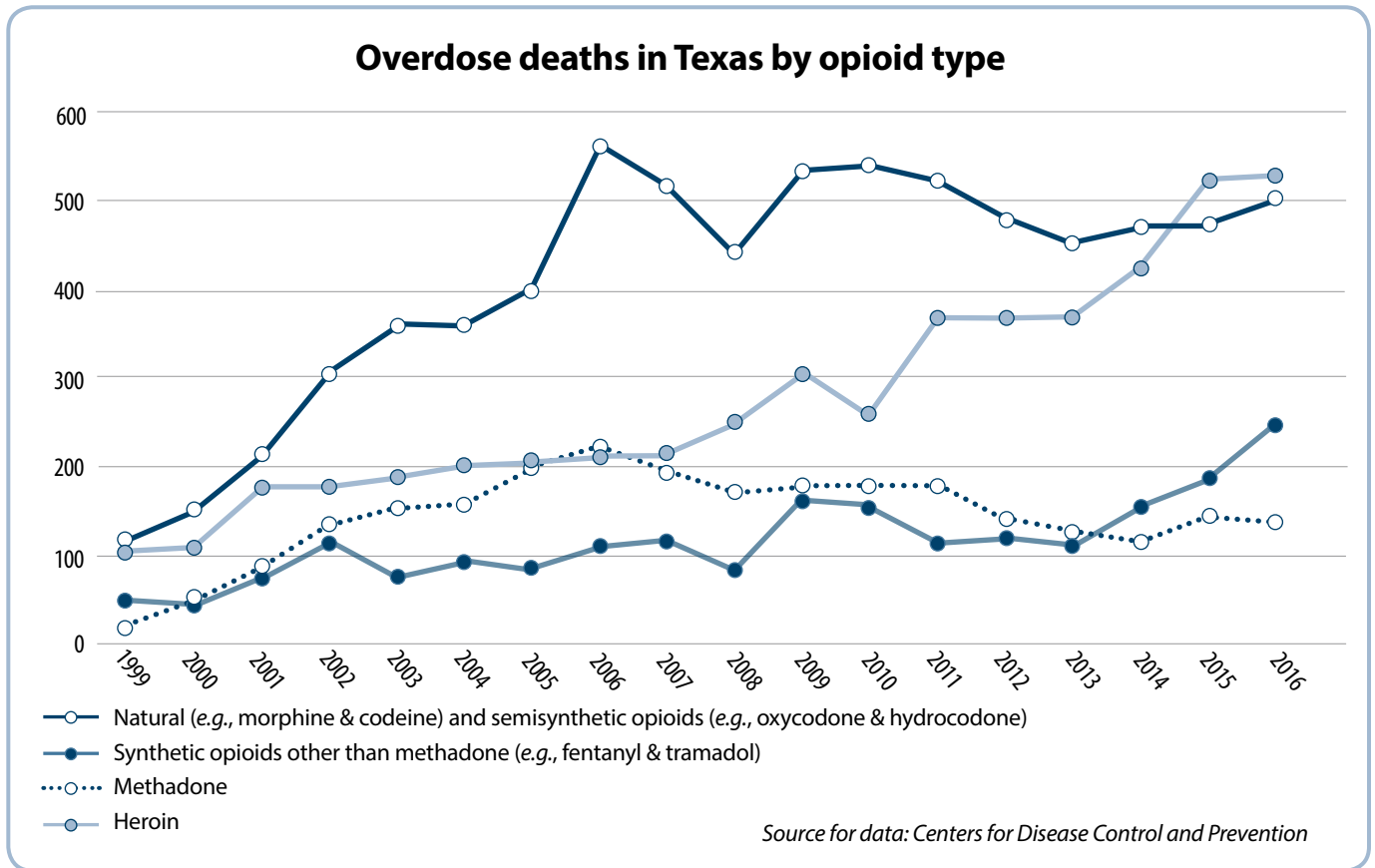
The revised PMP requirements are intended to better equip doctors and pharmacists to combat prescription drug abuse by narrowing the time frame to check the PMP before providing more controlled substances to patients. Some have raised concerns that requiring all prescribers to check the PMP could interrupt the workflow of medical professionals, particularly those in emergency room settings, and have called for the law to exempt ER physicians in order to decrease a patient’s wait time to receive medically necessary drugs in urgent situations.

Some also have suggested integrating the PMP’s database into electronic health record systems, especially those used in emergency departments. They say integrating the PMP data with a patient’s medical record would increase program use,

minimize workflow interruptions, and improve patient care. The Texas State Board of Pharmacy is expected to request about \$4.5 million from the 86th Legislature for the 2020-21 biennium to integrate the PMP database into electronic health record systems.

Pill taxes. Some states have introduced legislation to tax opioid manufacturers or importers and use the revenue to fund opioid addiction prevention, treatment, and law enforcement efforts. Lawmakers in [California](#) and [Massachusetts](#) have proposed a tax rate of 1 cent per one milligram dose sold. New York enacted a [law](#) in July 2018 directing its state health department to impose an annual \$100 million surcharge on opioid manufacturers and distributors through June 2024.

At the federal level, Congress introduced [H.R. 2038](#), the Budgeting for Opioid Addiction Treatment Act, which has been referred to the U.S. House’s Energy and Commerce Subcommittee on Health. A companion bill, [S. 523](#), has been referred to the U.S. Senate Committee on Finance. Both bills would impose a 1-cent-per-milligram fee on the sale of active opioids by the manufacturer, producer, or importer. The fee would exclude prescription drugs used exclusively in medication-assisted treatment for opioid addiction.



Supporters of taxing manufacturers and distributors for opioid sales say the opioid crisis was fueled in part by the marketing techniques of pharmaceutical companies. The national opioid prescribing rate of 81.3 prescriptions per 100 persons peaked in 2012, with roughly 255 million dispensed prescriptions. While the overall number of opioid prescriptions has gone down, the opioid epidemic caused in part by prescription medication continues to worsen. Instituting a tax-per-milligram of active opioid would be an appropriate way to ensure that pharmaceutical companies were contributing to fund addiction prevention and treatment for consequences stemming from their product.

Critics of opioid taxes say such taxes would cause manufacturers to pass the increased costs from opioid taxes onto consumers via higher prices for the medication, which would unfairly penalize vulnerable patients who rely on opioids to treat serious, debilitating, and sometimes terminal

Lawsuit against manufacturers

The Texas attorney general's office on May 15 filed a lawsuit against Purdue Pharma, the pharmaceutical company that makes OxyContin and other prescription opioids. The suit, filed in a state district court in Travis County, alleges that Purdue violated the Texas Deceptive Trade Practices Act ([DTPA](#)) by misrepresenting the risk of addiction to opioids. Texas is one of several states and local governments across the country that have sued pharmaceutical manufacturers for alleged conduct related to the opioid crisis. The [suit](#) seeks civil penalties and injunctive relief against Purdue to halt the alleged deceptive marketing of prescription opioids.

The alleged violations of DTPA include misrepresenting the effectiveness of opioids, failing to disclose the risks of addiction, falsely representing that doctors and patients could increase opioid dosages indefinitely without added risk, falsely instructing doctors that certain signs of addiction in patients are in fact signs that the patient's opioid dose should be increased, and falsely representing that the abuse-deterrent formulation of OxyContin reduces the risk of addiction, among other claims. Purdue has denied the claims. In addition to the injunction, the suit asks the court to order Purdue to pay civil penalties to the state for each violation of the DTPA up to a total of \$20,000 per violation, in addition to court costs and attorneys' fees and disgorgement of all ill-gotten gains.

conditions. Raising costs on needed medications also could incentivize some people to switch to illicit opioids, critics say, which would increase the risk of overdoses. Critics also say it is unfair to single out one industry and ignore other factors contributing to the current crisis, including heroin and counterfeit fentanyl being brought into the United States by drug traffickers.

Intervention

While prevention seeks to avoid conditions that can lead to addiction, intervention focuses on mitigating the effects of opioid abuse and addiction that have already occurred. This could involve acting to stop or reverse an overdose or addressing secondary effects, such as the spread of disease from intravenous drug use.

Texas has implemented certain intervention strategies to combat the opioid crisis, including equipping first responders with naloxone. The state has considered but not implemented a needle exchange pilot program or a defense to prosecution for a person seeking medical assistance after a suspected drug overdose.

Naloxone. Texas and other states are using federal grant money to provide emergency personnel and law enforcement with naloxone, referred to as an opioid antagonist, which is a drug that blocks the effects of opioids and reverses an overdose. An attorney general [opinion](#) issued last year addressed [SB 1462](#) by West, a law enacted in 2015 that allows certain individuals to be prescribed an opioid antagonist. The law permits a doctor to prescribe, directly or by standing order, and a pharmacist to dispense an opioid antagonist to a person at risk of experiencing an opioid-related drug overdose or a family member, friend, or other person in a position to assist a person at risk of overdosing. The attorney general opinion stated that law enforcement agencies are among those in a position to assist an individual at risk of experiencing an opioid-related drug overdose and thus are authorized to receive an opioid antagonist (*i.e.*, naloxone, known by the brand name Narcan).

In Texas, some pharmacies have obtained a physician-signed standing order that allows pharmacists to dispense naloxone to eligible persons as described in SB 1462; other pharmacies have not. Some advocates have said that the current arrangement has led to a patchwork of naloxone availability and confusion on the part of the public and some pharmacists about who is eligible to receive the medication.

They have called for the Texas Department of State Health Services to establish a statewide standing order similar to proposals enacted in other states, such as Pennsylvania and Maryland. A statewide standing order would enable all pharmacies in the state to provide naloxone to eligible persons without the pharmacy obtaining a physician's order.

Supporters of expanding naloxone access say it can help first responders, law enforcement, and other third parties prevent many overdoses in Texas. While intervention efforts alone will not end addiction, they say, first responders or others who administer naloxone are well positioned to provide information on resources to people addicted to opioids. They say that while naloxone is a prescription drug, it is not a controlled substance and has no abuse potential. It also can be administered by a minimally trained layperson and in most cases has no significant negative side effects.

Critics of expanding naloxone access say it could encourage more drug abuse when individuals have a safeguard in place. One frequently cited white paper suggests that broadening naloxone access leads to more opioid-related ER visits with no reduction in opioid-related mortality. The study found that in the Midwest, after naloxone-access laws took effect, there was a 14 percent increase in opioid-related deaths.

Good Samaritan laws. Some states have implemented a good Samaritan law, which generally provides immunity from arrest, charge, or prosecution for people who may be in possession of drugs or drug paraphernalia and seek medical assistance when they experience or observe an overdose. As of July 2017, 40 states and the District of Columbia had enacted some form of a good Samaritan law that provides some protection from arrest or prosecution for those who report an overdose in good faith.

The Texas Legislature in 2015 and 2017 considered [HB 225](#) and [HB 73](#) by Guillen, legislation that would have created a good Samaritan defense to prosecution for certain drug offenses for individuals seeking medical assistance for themselves and others under some circumstances. HB 225 was vetoed by the governor in 2015, and HB 73 died in the House Calendars Committee in 2017.

For a person possessing specified amounts of certain illicit substances or drug paraphernalia, the bills would have created a defense to prosecution if that person was the first to request emergency medical assistance in response to a possible drug overdose, remained on the scene until medical assistance arrived, and cooperated with medical assistance

and law enforcement personnel. The defense also would have applied if the person was the victim of a possible overdose that prompted a request for emergency medical assistance. The defense to prosecution proposed by the bills would not have been available if, at the time of the request for emergency medical assistance, a peace officer was in the process of arresting the actor or executing a search warrant describing the actor or the place from which the request for medical assistance was made.

Supporters of legislation to establish a defense to prosecution say many overdose-related deaths in Texas could be prevented with quick, appropriate medical treatment but that fear of arrest and prosecution often prevent people from calling 911. They say a defense to prosecution would save lives by encouraging people best positioned to seek emergency care to help those in danger of an overdose. To prevent its misuse, the defense to prosecution could be valid only in emergency situations, not apply to calls made during an arrest or execution of a search warrant, and not preclude admissions of evidence for other crimes.

Critics of legislation to establish a defense to prosecution say the bills considered in the Texas Legislature did not provide adequate protections to prevent habitual drug abusers and drug dealers from misusing the defense. Allowing individuals to avoid prosecution or at least the possibility of prosecution could result in them not interacting with the criminal justice system, which sometimes is the only way they gain access to treatment or other help to stop using dangerous and illegal drugs.

Needle exchange programs. Needle exchange programs provide a site for drug users to exchange used needles for clean ones. Rather than addressing overdoses, they address secondary health concerns, such as the spread of infectious diseases. Since 2003, the Texas Legislature has considered but not enacted various proposals for a needle exchange program. The 80th Legislature in 2007 authorized a pilot program in Bexar County ([SB 10](#) by Nelson), but it was not implemented. The Texas attorney general issued an [opinion](#) in May 2008 that the legislation could subject participants to prosecution under state drug paraphernalia laws. Currently, a person in Texas may be charged with a misdemeanor for possessing drug paraphernalia, which is defined in Health and Safety Code, [sec. 481.002\(17\)](#) to include a hypodermic syringe, needle, or other object used or intended to inject a controlled substance into the human body.

Supporters of needle exchange programs say they reduce transmission of HIV, AIDS, hepatitis C, and other blood-borne diseases among intravenous drug users and those they could infect, while lowering medical costs to the state and providing a chance to connect drug users with treatment. Supporters say legalizing needle exchange programs in New York was associated with a significant decline in newly diagnosed AIDS cases among intravenous drug users from 1992 to 2012. A study of a New York City program cited by the CDC estimated the government would save \$1,300 to \$3,000 per client each year.

Critics of needle exchange programs say they only serve to enable habitual drug use and addiction. They say such programs fail to send a clear message to adolescents about the dangers of drug abuse when they see the state distributing an instrument for drug use to an addict. Opponents also say needle exchange programs can lead to an increase of discarded needles and crime in neighborhoods where they operate. Instead of supplying addicted individuals with equipment used for substance abuse, they say, the state should focus its efforts on supporting programs that help people recover from addiction and abstain from drug use altogether.

Treatment

People addicted to prescription or illicit opioids may receive treatment in several ways, such as individual or group counseling, including 12-step programs such as Narcotics Anonymous, or at rehabilitation facilities. Some may first encounter treatment options as a result of an interaction with the criminal justice system. Some individuals experiencing addiction to opioids may take certain medications to ease withdrawal symptoms, including through medication-assisted treatment (MAT).

Many states, including Texas, provide MAT and other treatment options through Medicaid, federal grant programs, and other systems. HHSC received a \$27.4 million federal grant from SAMHSA in 2017 for its Texas Targeted Opioid Response (TTOR) program, which focuses on individuals who live in major metropolitan areas, pregnant or postpartum women, and individuals with a history of prescription opioid misuse or at risk for developing an addiction. HHSC is using the TTOR grant to expand access to MAT services, establish priority admission counselors to help individuals receive the right services, implement 24/7 mobile crisis services, provide re-entry support for people released from prison, and increase recovery housing, among other initiatives.

Medication-assisted treatment (MAT). Federal law requires MAT to combine counseling, which could include behavioral therapy, with approved U.S. Food and Drug Administration (FDA) medication to treat opioid use disorder. The FDA has approved three medications to treat opioid dependence and addiction: methadone, buprenorphine, and naltrexone. These medications interact with the brain's opioid receptors in different ways and are restricted to certain clinical settings.

Methadone, which is taken daily and available in pill, liquid, and wafer forms, lessens the painful symptoms of withdrawal and blocks the euphoric effects of other opioid drugs by fully occupying the opioid receptors. In doing so, methadone deceives the brain into thinking it is still experiencing the euphoric effect a person would otherwise get from pain pills or heroin. Patients seeking treatment for opioid addiction may access methadone only through a licensed narcotic treatment center.

Buprenorphine binds partially to the brain's opioid receptors to reduce cravings and withdrawal symptoms. It is taken daily in pill or cheek film form or implanted under the skin every six months. To prescribe buprenorphine, physicians must apply for the appropriate waiver through SAMHSA. Access to buprenorphine is limited to a physician's office but may be self-administered by the patient at home if the patient meets specific criteria.

Naltrexone works to suppress cravings by binding and blocking the opioid receptors, rather than stimulating them. If a person using naltrexone relapses and starts using an abused drug, naltrexone prevents the person from experiencing the abused drug's euphoric and sedative effects. Naltrexone is taken daily in pill form (brand name ReVia or Depade) or monthly in an injectable extended-release form (Vivitrol). Any health care provider who is licensed to prescribe medications may prescribe naltrexone.

Some treatment centers report that long wait lists and a lack of MAT-certified physicians limit access to MAT. Some advocates have called for improving accessibility by increasing funding for treatment, leveraging telehealth to provide addiction counseling at primary care sites in underserved areas, educating providers on addiction medicine, screening and identifying patients addicted to opioids in all emergency rooms and primary care clinics, and enabling health prescribers to receive MAT training.

Advocates for MAT say patients who use medication combined with counseling show significant improvement in addiction-related behaviors and psychosocial functioning compared to patients who take the medications or attend counseling separately. Studies show MAT can reduce the all-cause mortality rate among addiction patients by roughly 50 percent, and although individuals may develop a dependence on the replacement drug, MAT can eliminate opioid use, reduce criminal activity driven by addiction, and cut transmission of many infectious diseases, including HIV and hepatitis B and C, advocates say. Others raise concerns that MAT substitutes one drug (*e.g.*, heroin) with another (*e.g.*, methadone) and could cause a person to become addicted to the replacement drug. They say that patients should instead seek mental health treatment, such as individual or group counseling, to deal with their addiction, with the ultimate goal of abstaining from misuse of opioids altogether.

Hub-and-spoke model. One treatment model that states such as California, Vermont, and Washington are using to reduce wait lists and increase access to MAT is an integrated, “hub-and-spoke” system. Specialists in regional “hubs” assess patients for appropriate treatment (*e.g.*, methadone or buprenorphine provided in an office-based setting) and provide access to addiction counseling and medicine consultation via “spokes,” which are primary care practices and outpatient addiction programs where physicians, nurse practitioners, and physician’s assistants have a federal waiver permitting them to prescribe buprenorphine. The system was designed to ease patient transfers between the hub and spokes to provide the most appropriate level of care. In January 2013, Vermont was the first state to launch a hub-and-spoke model after the legislature authorized it in 2012. The model is funded by state and federal dollars (Vermont expanded Medicaid under the Affordable Care Act) and applies to clients with any type of health insurance.

Buprenorphine treatment waiver. Another way MAT is delivered is through a federal waiver for physicians and some other health professionals to prescribe buprenorphine. The Drug Addiction Treatment Act of 2000 (DATA) waiver administered by SAMHSA, allows qualified physicians to provide buprenorphine treatment to patients in various settings, such as an office, community hospital, health department, or correctional facility. To treat patients with buprenorphine, a licensed physician must be registered with the Drug Enforcement Administration (DEA) to prescribe controlled substances, be able to refer patients for counseling and ancillary services, and have completed eight hours of training. With a DATA waiver, physicians may treat up to

Federal legislation

The U.S. House of Representatives on June 22 passed H.R. 6, the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act. The omnibus bill, which passed by a vote of 396 to 14, includes several Medicaid, Medicare, and public health reforms to address the opioid crisis. H.R. 6 would:

- require the Centers for Medicare and Medicaid Services (CMS) to increase substance use provider capacity under state Medicaid programs;
- direct the secretary of Health and Human Services to issue guidance on developing non-addictive treatments and improving care for infants with neonatal abstinence syndrome and their families;
- authorize grants to state and local agencies to operate public health laboratories to detect fentanyl, its analogues, and other synthetic opioids;
- make the buprenorphine prescribing authority for physician assistants and nurse practitioners permanent; and
- allow a waived practitioner to bypass the initial 30-patient cap and start treating 100 patients with buprenorphine if the practitioner meets certain criteria, among other provisions.

H.R. 6 included several individual bills that previously passed the House that would improve data to identify and help at-risk patients and families, increase access to federal resources for local communities, establish comprehensive opioid recovery centers, and expand access to treatment and recovery services.

The U.S. Senate on October 3 passed the final amended version of H.R. 6 by a vote of 98 to 1. The bill is pending signature from the president.

30 patients in the first year, after which they may apply to SAMHSA to increase their patient limit to 100. According to a federal [rule](#) issued in July 2016 by the U.S. Department of Health and Human Services, physicians with a patient limit of 100 may apply to increase their patient limit to 275.

Many doctors do not seek the DATA waiver because of concerns about training, liability, DEA oversight, and financial reimbursement. SAMHSA reported in 2017 that

286 certified physicians in Texas were authorized to prescribe buprenorphine to a maximum of 30 patients each, and 48 could prescribe to no more than 100 patients. Although SAMHSA offers eight-hour buprenorphine waiver training courses on pharmacology, safety, and patient assessment, some doctors say the training lacks sufficient, hands-on knowledge and experience. To address the shortage of doctors in Texas willing to prescribe buprenorphine, some have expressed the need for more courses in opioid addiction treatment during and after medical school.

Telehealth education. To better equip doctors to treat patients with opioid addiction, some states are using telehealth to provide additional training, education, and

support. New Mexico and Oklahoma are using the Project Extension for Community Healthcare Outcomes (ECHO) model, which is a collaborative model of medical education and care management using videoconferencing technology designed to help clinicians in rural and underserved communities to provide specialty care. Teams of medical experts at academic institutions facilitate discussions among community health providers to educate them on evidence-based practices for treating patients with opioid addiction and other health conditions.

— *Alison Hern*

Treatment in the criminal justice system

More than 70 percent of Texas judges responding to a 2018 survey by the Office of Court Administration reported viewing opioids as a moderate or major problem. People addicted to opioids may come in contact with the criminal justice system at several points, but few of the system's substance abuse treatment programs are specific to opioid addiction.

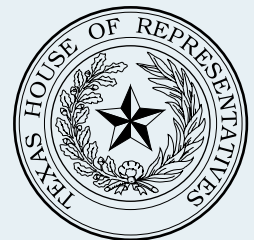
Treatment programs can exist in courts, local jails, and state prisons and for those who are on probation or parole but not incarcerated. Those arrested for, charged with, or convicted of drug offenses or other non-violent offenses in which drugs contributed to the crime could be handled by one of 75 drug courts in the state, which provide intensive supervision and treatment. Other courts also may have pre-trial or other programs to address substance abuse issues. Local jails, which can hold individuals before trial or after conviction for a misdemeanor offense, may operate substance abuse programs run by the local entity. These programs generally are not drug-specific, but in late 2017 the Harris County jail began a pilot program offering monthly shots of injectable naltrexone (*i.e.* Vivitrol) to inmates leaving the jail.

The Texas Department of Criminal Justice assesses offenders entering the state system and has found about half need some type of treatment for substance abuse, including drugs and alcohol. The agency has about 10,000 beds for offenders in substance abuse treatment programs, which include in-prison therapeutic communities and pre-release programs as well as six- and nine-month programs in substance abuse felony punishment facilities for offenders on probation or parole. Local probation departments also offer substance abuse programs, including residential facilities and outpatient programs.

In June 2018, the Criminal Justice Committee of the Texas Judicial Council made two [recommendations](#) relating to the impact of opioid drug use on Texas courts. It recommended that the Legislature create a statewide Opioid Task Force involving state and local leaders, experts, and advocates to communicate and collaborate on issues created by the opioid epidemic. The committee also recommended that the Judicial Council collect case level data from all levels of courts in Texas and that the Legislature fund the collection of data. Data could provide information on the volume and outcome of cases that involve opioids and help with policy and budget decisions, according to the recommendations.

— *Kellie A. Dworaczyk*

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