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# Fighting Opioid Addiction in the United States: Legislative Policy Review, and How Peer Supports are Suited for Battle

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**T**he prevalence of opioid misuse and addiction is rapidly increasing. In 2017, a record-breaking 72,000 people died from opioid overdoses (National Institute of Drug Abuse, 2018a). Massachusetts is one of the top states in the nation for opioid-related overdose deaths. In 2016, there were 29.7 opioid-related deaths per 100,000 people, more than double the national average of 13.3 deaths per 100,000 (National Institute of Drug Abuse, 2018b). As of November, there were more

than 1,200 confirmed opioid overdose deaths in 2018 in the commonwealth (Massachusetts Department of Public Health, 2018a). Those who die from opioid overdoses in Massachusetts are predominately White and male. Thus far in 2018, 73% of all confirmed opioid overdose deaths were male, and 81% were White (Massachusetts Department of Public Health, 2018a). However, it is important to note that the percentage of Blacks who died from an opioid overdose increased by 4% in 2018 (Massachusetts Department of Public Health, 2018a).

Since 2013, there has been an overall increase in Emergency Medical Services incidents that are opioid related (Massachusetts Department of Public Health, 2018b). In 2017, there were 22,215 opioid-related overdoses (fatal and non-fatal) reported in Massachusetts (Massachusetts Department of Public Health, 2018b). Compared to the general population, adults who survive a non-fatal opioid overdose are 24 times more likely to die in the year following the overdose (Olfson, Crystal, Wall, Wang, Liu, & Blanco, 2018). Olfson et al. (2018) found that these deaths are attributed to a range of factors, including suicide, circulatory diseases, and cancer. However, the researchers found that the most common immediate cause of death within this population were substance-use associated diseases, including a subsequent overdose

(Olfson et al., 2018). Previous research has found that rates of relapse with opioid-use disorder (OUD) were higher than with any other substance (Kadam, Sinha, Nimkar, Matcheswalla, & De Sousa, 2017; Tkacz, Severt, Cacciola, & Ruetsch, 2012).

One promising solution has been the use of peer supports in treatment. Peer supports have been positively associated with treatment compliance in a variety of mental and physical health fields. A meta-analysis of peer supports for addiction treatment concluded that they were beneficial for patient outcomes (Bassuk, Hanson, Greene, Richard, & Laudet, 2016). The Substance Abuse and Mental Health Services Administration (SAMHSA) (2017a) and the U.S. Department of Veterans Affairs (2011) found that peer supports were associated with reduced hospitalizations, reduced relapse rates, reduced substance use, and improved access to social supports. This article will discuss the history of policy and treatment of opioid-use disorder and illustrate why peer support is an emerging solution.

### **A Historical Review of Policy**

Regulation is the primary response by the U.S. government when addressing drug addiction and illicit substances. Until recently, treatment for substance abuse has been and still is punitive. Regulatory measures have strongly focused on controlling substances and the legal application of this

treatment (Sacco, 2014). In 1914, the United States first federally regulated the prescribing of opioids with the Harrison Narcotic Act. The Harrison Narcotic Act did not prohibit the prescribing of opioids for addiction treatment by physicians in medical settings (Jaffe & O’Keeffe, 2003). Officials designated to implement the act opposed the ambiguity and privilege of physicians to determine how they administered and treated in their medical practice (Jaffe & O’Keeffe, 2003). This led to legal action against physicians prescribing opioids as a maintenance program for addiction (Jaffe & O’Keeffe, 2003).

In 1919, the Supreme Court ruled against the use of opioid maintenance as a legitimate medical practice. The U.S. government’s first attempts at dealing with drug addiction were not to improve clinical services, research, and delivery methods. Rather, it targeted physicians and used threats of punishment by fines and imprisonment (McCarty, Priest, & Korthuis, 2018). The American Medical Association (AMA) strongly opposed prescribing opioids to addicts and in 1920, pushed to prosecute physicians who continued this practice. The actions by the AMA were not strongly supported, and no significant changes occurred until after the end of 1964 (Jaffe & O’Keeffe, 2003).

The use of public health hospitals between 1938 and 1974 were set up by authorization of Congress and were named U.S. public health

hospitals under the management of both the US Public Health Service and the Bureau of Prisons. It started off as a volunteer service for individuals who were convicted of federal drug crimes. Treatment was minimal but included management of withdrawal, a drug-free environment, psychotherapy, and education; in this atmosphere, success rates were low. When these medical facilities were closed, they were repurposed and became federal correctional institutions (McCarty et al., 2018).

The 1960s saw a resurgence of addiction and included a heroin epidemic. With the rise in use, positive American attitudes towards treatment of addiction evolved. This development peaked, and political opinions ushered in the Narcotic Addict Rehabilitation Act (NARA) of 1966. This Act was more than a response to public opinion. It legitimized the use of oral methadone as a scientifically sound medical practice to treat addicts (Jaffe & O’Keeffe, 2003).

Additionally, the NARA started the use of community-based outpatient services. This legislation implemented the authorization of civil commitments for two groups. First, people convicted of federal drug offenses. Second, to civilians and individuals who were not charged with a crime but were petitioned by the community or family members to mandate a hospital commitment and supervision after treatment. This attempt was plagued by slow implementation, the severe need for

training, and a shortage of clinically trained professionals (McCarty et al., 2018).

Public and political response to substance misuse has been heavily influenced by racial politics. In 1971, President Nixon launched the “War on Drugs”. Instead of supporting treatment options for individuals with substance-use disorders, drug use was criminalized, and mass incarceration ensued, increasing the country’s prison population 350% (Pearl & Perez, 2018). The Anti-Drug Abuse Act of 1986 established mandatory minimum sentences for possession and use of illegal substances (Cohen, 2015). These sentences were far harsher on crack, typically used within inner-city communities of color, than on powder cocaine, a more expensive version of the drug, typically used within white suburban communities (Cohen, 2015). The federal government’s response to opioid use within communities of color has historically focused on criminalization and punishment (Cohen, 2015). The current opioid epidemic has largely impacted White communities. Thus, today’s focus on harm reduction versus criminalization is important to frame within the larger historical narrative of responses to substance misuse.

### **Uses of Medication-Assisted Opioid Treatments**

Research on the use of methadone for the treatment of OUD ensued. This prompted Congress, and subsequently the Food and Drug

Administration (FDA) and the Drug Enforcement Administration (DEA), to implement regulations and oversights on the use of methadone in programs and clinics. These programs multiplied and became widely used during the 1970s and 1980s. There were attempts by the FDA and the DEA to adhere strictly to the guidelines but with the expansion and wide use, oversight became difficult (Jaffe & O’Keeffe, 2003; McCarty et al., 2018).

The period of increased regulation starting in 1966 was followed by 30 years of effort to liberalize the FDA’s regulations. Abstinence was the primary focus of all treatment during this time. The Controlled Substances Act of 1970 created a classification system for drugs based on their alleged likelihood of being abused. These schedules continue to impact the ability of physicians to prescribe medication-assisted opioid treatments today (Jaffe & O’Keeffe, 2003). During this time, buprenorphine was developed and found to be an efficacious treatment option for opioid addiction. Due to its nature as a partial opioid agonist and its limited toxicity when ingested, legislation was developed and was submitted to Congress and signed into law. This was known as the Drug Addiction Treatment Act of 2000 (Jaffe & O’Keeffe, 2003). Therapeutic communities emerged in the mid-1950s and 1960s. These settings were set up as long-term residential care. These were prototypes of our current residential treatment system. As

they emerged, they had difficulties being accepted by the community because of the association with a long history of the criminalization of drug use and incarceration (McCarty et al., 2018). These residential settings were also used for people with dysfunctional behavior and other deviant behaviors or thinking. They were heavily criticized for being dehumanizing and confrontational. Estimated dropout rates were between 70% and 75%, and outpatient-programs dropout rates were not significantly different. These institutionalized, community-based residential are now identified as an ineffective and inhumane way of treating persons with substance abuse or mental health issues (McCarty et al., 2018).

### **The Current Legislative Landscape**

Improvement in treatment is imperative, and the policy is ever evolving in response to current social needs. In the last 20 years, the incidents of overdose deaths related to opioids have dramatically increased. This increase, often referred to as the “opioid epidemic”, is having significant social, political, and economic impacts on communities across the country, including within the Commonwealth of Massachusetts. The federal government has made many attempts in recent years to develop policies addressing this epidemic.

## Federal

On a federal level, there is a long legislative history of attempted regulation and prohibition of certain substances. Rates of drug overdoses slowly increased under these policies (Coyne & Hall, 2018). In 1971, the death rate due to drug overdose was 1 in every 100,000 people. By 2014, it had risen nearly 1500% to 14.7 overdose deaths in every 100,000 people (Coyne & Hall, 2018; McCarty et al., 2018). According to Coyne and Hall (2018), prohibitive drug policies have increased rates of drug use and drug abuse. Additionally, these policies have led to increases in use of more potent drugs, such as opioids. In 2014, 61% of drug-related overdose deaths were due to opioids (Coyne & Hall, 2018).

Federal policies providing options for drug treatment are much more limited. The use of opioid-agonist treatment - the treatment of opioid dependence with medications, such as morphine, methadone, or buprenorphine - has been proven one of the most effective treatments for OUD (Nadelmann & LaSalle, 2017). As previously mentioned, the Drug Treatment Act of 2000 expanded options for medication-assisted treatment of opioid addiction, allowing physicians to prescribe schedule III, IV, and V drugs for opioid-agonist treatment (Jaffe & O’Keeffe, 2003). In 2002, the Federal Drug Administration (FDA) approved buprenorphine and buprenorphine/naloxone for use with opioid

addiction (Jones, Viswanath, Peck, Kaye, Gill, & Simpoulos, 2015). The 2006 Reauthorization Act increased the number of patients a physician could administer buprenorphine to from 30 to 100 (Jones, et al., 2016)

Opioid overdose deaths continued to rise despite increased treatment options. In 2016, the number of drug overdose deaths related to opioids rose by 20% (Jones, et al., 2016). Of the 42,000 people who died from an opioid overdose in 2016, 20,000 of them were due to use of fentanyl, 15,000 were connected with heroin use, and the remainder were overdoses of prescription opioids (Jones et al., 2016).

Federal support for opioid-agonist treatments grew under the Obama Administration. In 2015, President Obama issued a Presidential Memorandum directing states to analyze barriers to opioid-agonist treatment and develop action plans to address these (Nadelmann & LaSalle, 2017). Major barriers remain, however, to patients enrolling in such treatment. Methadone clinics face extremely restrictive policies, while access to buprenorphine is limited by many insurances, as well as policies on how many patients to which a single physician can prescribe (Nadelmann & LaSalle, 2017).

In 2016, the Comprehensive Addiction and Recovery Act (CARA) was signed into law. This was the first major legislation in more than 40 years to comprehensively address drug addiction

(Community Anti-Drug Coalitions of America [CADCA], 2016). This legislation changed a variety of policies relating to treatment for OUD. CARA increased the number of patients a physician could administer buprenorphine to from 100 to 275 (Substance Abuse & Mental Health Services Administration [SAMHSA], 2017b). Additionally, it launched a variety of evidence-based practices for heroin and opioid addiction aimed to expand these treatment options nationally. Some of the best practices recommended were medication-assisted treatment and expansion of diversion services to connect individuals to treatment rather than bring criminal prosecution (CADCA, 2016). CARA also expanded partnerships with law enforcement agencies and prisons to develop best practices for identifying and treating incarcerated individuals with substance use disorders (CADCA, 2016).

In October 2018, Congress passed the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act. The SUPPORT Act includes a variety of provisions impacting treatment. It gave nurse practitioners and physicians prescribing authority and allowed for the development of new addiction recovery centers, especially in communities which have been hit hardest by the opioid epidemic (Garvin, 2018; National Council of State Boards of Nursing, 2018).

Peer support is not a new concept on a

federal level. In 2005, the Department of Veterans Affairs (VA) instituted and funded positions for Peer Supports (PS) staff. The VA recognized that the use of peer-support technicians is an effective research-based intervention that can significantly improve outcomes in treating substance abuse disorders, including opioid addiction (Chinman, Shoi, & Cohen, 2010; Thomas, 2017; U.S. Department of Veterans Affairs, 2011).

### **Massachusetts**

Massachusetts has been one of the states hardest hit by the opioid epidemic and thus has enacted a variety of policies in response. In 2016, Massachusetts passed an act relative to Substance Use, Treatment, Education, and Prevention (STEP). This legislation was developed collaboratively through conversations with medical professionals, policy makers, and community members (Mass. Gen. Laws, Chapter 52 & Section 32, 2016; Rudder, Tsao, & Jack, 2016). The STEP Act included changes to opioid prescribing policies, education guidance for K-12 schools, and liability protections for civilians who administer naloxone to someone who has overdosed (Rudder et al., 2016).

Additionally, the STEP Act recognized the important role that hospital emergency rooms played in responding to survivors of non-fatal, opioid overdoses. When originally introduced, this legislation included an amendment calling for a

72-hour hold in which survivors of non-fatal opioid overdoses could be held in the hospital against their will and forced to enter treatment involuntarily (Beletsky, Parmet, & Sarpatwari, 2016). The 72-hour hold amendment was deeply contested and ultimately struck from the final legislation (Beletsky et al., 2016). In its place, the legislation required that a licensed mental health professional provide a substance abuse evaluation within 24 hours after a patient is admitted to the hospital for an opioid overdose (Mass. Gen. Laws, Chapter 52 & Section 32, 2016).

In 2018, Massachusetts passed additional legislation to strengthen its response to the opioid crisis. The Combating Addiction, Accessing Treatment, Reducing Prescriptions, and Enhancing Prevention (CARE) Act improved access to treatment, expanded school-based education programs, and broadened insurance coverage for alternative treatments (Cyr, 2018). The CARE Act also strengthened emergency rooms' responses to opioid overdose. Under the CARE Act, individuals admitted for an opioid overdose must be provided with the option to begin treatment while in the hospital (Cyr, 2018). This bill required all emergency departments to have the capacity to begin voluntary opioid-agonist treatment if requested by the patient (Governor's Press Office, 2018). The CARE Act for the first time acknowledged the important role of peer supports in the treatment process. The bill

established a commission to recommend standards for developing a professional credential for peer supports as a way to standardize their role in the treatment and recovery process (Cyr, 2018).

Since the implementation of these policies, Massachusetts has seen a slight decline in rates of opioid-overdose deaths. In 2016, the Commonwealth reached a historic high of 31.6 overdose deaths per 100,000 people. Preliminary 2017 numbers suggest those rates are down two percentage points to 29.6 overdoses per 100,000 people (Massachusetts Department of Public Health, 2018b). Massachusetts is a national leader in implementing effective legislative responses to the opioid epidemic (Sanger-Katz, 2018). Continuing to invest in alternative treatments that further reduce rates of opioid overdose is an important legislative priority.

### **Need for Further Legislative Action**

As research has shown, OUD can be effectively treated with opioid-agonist treatments that help relieve opioid cravings and improve functioning in everyday life (Canadian Agency for Drugs and Technologies in Health, 2016). However, for these treatments to be effective, patients must complete them. Previous research has found that rates of relapse with opioid use is higher than any other substance (Kadam et al., 2017; Tkacz et al., 2012). Research on treatment compliance and overdoses has found that OUD patients who are

non-compliant with treatment are ten times more likely to relapse than those who were compliant (Tkacz et al., 2012). Increased treatment compliance leads to increased positive recovery outcomes for individuals with OUD. Peer supports (PS) are a potentially promising response to support increased treatment compliance (U.S. Department of Veterans Affairs, 2011; Wakeman, Jack, Magidson, & Regan, 2018).

### **Peer Supports as a Solution**

The Substance Abuse and Mental Health Services Administration (SAMHSA) (2018) defined peer-support services as those administered by individuals with a history of addiction and successful recovery. Peer supports are found in both mental health and substance abuse fields. They may have a variety of job titles including recovery coaches, recovery support specialists, whole health and resiliency peer specialists, and certified peer specialists (National Association of State Mental Health Program Directors, 2014). In this article, the term peer supports will be used.

Literature on peer supports agrees that the ability to bring one's lived experience to their work with a client is a unique and important component of the treatment and can help strengthen the therapeutic alliance. Additionally, research has found that peer supports can reduce incidents of relapse and increase treatment completion rates (Reif et al.,

2014; U.S. Department of Veterans Affairs, 2011). Peer supports are an evidence-based practice that the VA is implementing department-wide. It is described as a fundamental building block that is oriented towards all recovery services within the framework of mental health (MH) services and multimodal treatment delivery. The objective is to provide treatment modalities that meet the veterans' needs and improve the experience of treatment for all veterans who utilize the services delivered by Veterans Health Administration (U.S. Department of Veterans Affairs, 2011).

### **Supporting Treatment Compliance**

Peer supports have been linked to increased treatment compliance for individuals with OUD. A study at Massachusetts General Hospital paired 643 patients who were admitted to the hospital for a substance use-related incident with a peer support. The research found that patients with a peer support were less likely to be readmitted to the hospital and more likely to utilize outpatient treatment facilities (Wakeman et al., 2018). Additionally, patients who voluntarily began buprenorphine for OUD were significantly more likely to be abstinent in the 6 months following their hospital admittance than patients who did not work with a peer supports (Wakeman et al., 2018). This study offers promising insight on the role that peer supports can play in supporting treatment compliance for

patients with substance-use disorders, especially OUD. Connecting OUD patients to a peer support may increase compliance with medication-assisted treatment, reduce rates of relapse, and reduce opioid-related overdose deaths (Governor's Press Office, 2018; SAMHSA, 2018; U.S. Department of Veteran's Affairs, 2011).

### **Concerns About Utilizing Peer Supports**

Peer supports need a standard level of professionalism and a clear scope of practice. There is concern that peer supports will replace clinical workers without clinical training. For this reason, peer supports need to be identified as unique members of a treatment team but not as a replacement for a clinician. In addition, organizations implementing peer supports need to develop policies that safeguard against peer supports being left to do less desirable or menial tasks (U.S. Department of Veterans Affairs, 2011).

Concerns around dual relationships, or relationships between peers who are concurrently participating in two or more roles, have emerged in response to the use of peer supports in addiction treatment. For example, in the VA, one example of dual roles may be both being veteran consumers. This dual relationship may be benign. Other dual relationships may be exploitive, for instance a sexual relationship. Care must be taken to inhibit dual relationships that violate the necessary boundaries

between the peer support and consumer (U.S. Department of Veterans Affairs, 2011).

Finally, the potential of relapse is an additional concern that has been voiced. There is a need to ensure that identified peer supports have reached an assessed level in their process of recovery that would allow them to assume the role of providing support (Myrick & Vecchio, 2016; U.S. Department of Veterans Affairs, 2011).

### **Recommendations for Future Policy**

As previously discussed, federal and state level policies have recently been passed to strengthen treatment options for individuals with OUD. As these policies are merely months old, these authors cannot yet analyze the outcomes, impacts, and unintended consequences of this legislation. As history has shown, policies have complex ramifications on political, social, and economic systems. It remains to be seen how recent legislation will impact the opioid epidemic.

Based on previously reviewed research, these authors have a series of recommendations for how to continue to strengthen legislative outcomes and improve treatment for OUD. Emergency departments are at the frontlines of responding to opioid overdoses. Massachusetts' new legislative guidelines mandate that hospitals begin voluntary opioid-agonist treatment if requested by a patient before they leave the hospital (Governor's Press

Office, 2018). Under this new legislation, emergency departments must work with patients to connect them to appropriate outpatient resources in the community to continue their treatment upon release from the hospital.

Peer supports have a critical role to play in ensuring treatment compliance for these individuals. These authors recommend that Massachusetts add legislation that requires peer supports to be assigned to any patient who accesses treatment through an emergency department following a non-fatal overdose. A pilot program in two Rhode Island hospitals found increases in treatment completion when patients worked with a peer support following an emergency room visit (Samuels, Mello, Baird, & Yang, 2018). This Rhode Island-based program- the Lifespan Opioid Overdose Prevention (LOOP) program- partnered with a community-based, peer recovery organization to provide additional addiction treatment support (Samuels et al., 2018). These authors recommend that Massachusetts implement measures, like SAMHSA has recommended, and that the VA has implemented agency-wide, to build out peer supports as positions that are state-funded, trained, and supervised. The CARE Act, passed in August, developed a commission to make recommendations for standardizing the peer support specialist credentialing process (Governor's Press Office, 2018). A credentialing process will help to clarify the peer

support role on a treatment team, develop a standard set of performance measures, define their scope of practice, develop a core curriculum to ensure consistent training, as well as standardize pay scales and compensation (National Association of State Mental Health Program Directors, 2014). These authors recommend that, in addition to the credentialing commission, Massachusetts establish a Peer Support Advisory Board, comprised of partners from community agencies to make recommendations and be involved in process improvements. This advisory board would be established as a permanent structure within Massachusetts' peer support system to ensure that those on the frontline of treatment have a direct line to communicate and address process improvements. This would create a concerted effort of governmental and community agencies, working collaboratively to effectively implement peer supports to end the opioid epidemic.

### **Final Thoughts**

The prevalence of opioid misuse and addiction is rapidly increasing. In 2017, a record breaking 72,000 people died from opioid overdoses (National U.S. Library of Medicine, 2018). Studies have shown higher rates of relapse for individuals seeking treatment for opioid addiction than other substance-use disorders. Finding effective solutions to support the continued recovery and treatment

compliance of individuals struggling with opioid addiction is of the utmost importance (Kadam et al., 2017). Mental health agencies are increasingly utilizing peer support specialists to support recovery and treatment compliance for individuals with substance misuse. Literature on peer-support specialists agree that the ability to bring one's lived experience to their work with a client is a unique and important component of the treatment and can help strengthen the therapeutic alliance. Additionally, research has found that peer-support specialists can reduce incidents of relapse and increase treatment completion rates (Reif, et al., 2014). These authors argue that expanded use of peer support specialists amongst individuals suffering from opioid addiction is an answer to continued treatment and recovery.

### References

- Bassuk, E. L., Hanson, J., Greene, R. N., Richard, M., & Laudet, A. (2016). Peer-delivered recovery support services for addictions in the United States: A systematic review. *Journal of Substance Abuse Treatment*, 1-9. doi:10.1016/j.jsat.2016.01.003
- Beletsky, L., Parmet, W., & Sarpatwari, A. (2016). Expanding coercive treatment is the wrong solution for the opioid crisis. *Bill of Health*. Retrieved from <http://blog.petrieflom.law.harvard.edu/2016/02/12/expanding-coercive-treatment-is-the-wrong-solution-for-the-opioid-crisis/>
- Canadian Agency for Drugs and Technologies in Health. (2016). *Buprenorphine/naloxone versus methadone for the treatment of opioid dependence: A Review of comparative clinical effectiveness, cost-effectiveness and guidelines* [Internet]. Available from: <https://www.ncbi.nlm.nih.gov/books/NBK385163> Canadian Agency for Drugs and Technologies in Health (2016).
- Chinman, M., Shoai, R., & Cohen, A. N. (2010). Using organizational change strategies to guide peer support technician implementation in the Veterans Administration. *Psychiatric Rehabilitation Journal*, 33, 269-277.
- Cohen, A. (2015, August 12). How White users made heroin a public-health problem. *The Atlantic*. Retrieved from <https://www.theatlantic.com/politics/archive/2015/08/crackheroin-and-race/401015/>
- Community Anti-Drug Coalitions of America (CADCA). (2016). *Comprehensive Addiction and Recovery Act (CARA)*. Retrieved from <http://www.cadca.org/comprehensive-addictionand-recovery-act-cara>

- Coyne, C., & Hall, A. (2018). POLICY ANALYSIS NO. 811: Four decades and counting: The continued failure of the war on drugs. *The Cato Institute*. Retrieved from <https://www.cato.org/publications/policy-analysis/four-decades-counting-continuedfailure-war-drugs#full>
- Cyr, J. (2018, July 23). *Massachusetts senate passes major legislation aimed at addressing opioid crisis*. Retrieved from [https://www.senatorcyr.com/opioid\\_crisis](https://www.senatorcyr.com/opioid_crisis)
- Garvin, J. (2018, October 4). Congress passes bipartisan opioid legislation. *American Dental Association News*. Retrieved from <https://www.ada.org/en/publications/ada-news/2018archive/october/congress-passes-bipartisan-opioid-legislation>
- Governor's Press Office. (2018, August 14) *Governor Baker signs second major piece of legislation to address opioid epidemic in Massachusetts* [Press release] Retrieved from <https://www.mass.gov/news/governor-baker-signs-second-major-piece-of-legislation-toaddress-opioid-epidemic-in>
- Jaffe, J., & O'Keeffe, C. (2003). From morphine clinics to buprenorphine: Regulating opioid agonist treatment of addiction in the United States. *Drug and Alcohol Dependence*, 3-11.
- Jones, M. R., Viswanath O., Peck J., Kaye, A. D., Gill, J. S., & Simopoulos, T. T. (2018). A brief history of the opioid epidemic and strategies for pain medicine. *Pain Theory*, 7(1), 13-21.
- Kadam, M., Sinha, A., Nimkar, S., Matcheswalla, Y., & De Sousa, A. (2017). A comparative study of factors associated with relapse in alcohol dependence and opioid dependence. *Indian Journal of Psychological Medicine*, 39(5), 627-633.
- Mass. Gen. Laws, Chapter 52 § Section 32 (2106). Massachusetts Department of Public Health. (2018a). *Opioid-related overdose deaths, all intents, MA residents – demographic data highlights*. Retrieved December 1, 2018 from <https://www.mass.gov/files/documents/2018/11/16/Opioid-Demographic-November-2018.pdf>
- Massachusetts Department of Public Health. (2018a). *MA opioid-related EMS incidents 2013-June 2018*. Retrieved December 1, 2018 from <https://www.mass.gov/files/documents/2018/11/16/Emergency-Medical-Services-Data-November-2018.pdf>
- Massachusetts Department of Public Health. (2018b). *Data brief: Opioid-related overdose deaths among Massachusetts residents*.

- Retrieved from <https://www.mass.gov/files/documents/2018/05/22/Opioid-related%20Overdose%20Deaths%20among%20MA%20Residents%20-%20May%202018.pdf>
- McCarty, D., Priest, K., & Korthuis, T. (2018). Treatment and prevention of opioid use disorder: Challenges and opportunities. *Annual Review of Public Health, 525-541*.
- Myrick, K., & Vecchio, P. (2016). Peer support services in the behavioral healthcare workforce: State of the field. *Psychiatric Rehabilitation Journal, 197-203*.
- Naddleman, E., & LaSalle, L. (2017). Two steps forward, one step back: Current harm reduction policy and politics in the United States. *Harm Reduction Journal*. doi: 10.1186/s12954-017-0157-y
- National Association of State Mental Health Program Directors. (2014). *Enhancing the peer provider workforce: Recruitment, supervision and retention*. NASMHPD's Technical Assistance Coalition, Alexandria, VA. Retrieved from [https://www.mentalhealthamerica.net/sites/default/files/Enhancing%20the%20Peer%20Provider%20Workforce\\_9-15-14%20final.pdf](https://www.mentalhealthamerica.net/sites/default/files/Enhancing%20the%20Peer%20Provider%20Workforce_9-15-14%20final.pdf)
- National Council of State Boards of Nursing. (2018). *Legislation addressing opioid epidemic Becomes Law (policy brief)*. Retrieved from <https://www.ncsbn.org/13104.htm>
- National Institute of Drug Abuse. (2018a). *Overdose death rates*. Retrieved December 1, 2018 from <https://www.drugabuse.gov/related-topics/trends-statistics/overdose-death-rates>
- National Institute of Drug Abuse. (2018b). *Massachusetts opioid summary*. Retrieved December 1, 2018 from <https://www.drugabuse.gov/drugs-abuse/opioids/opioid-summaries-by-state/massachusetts-opioid-summary>
- Olfson M., Crystal, S., Wall, M., Wang, S., Liu, S. M., & Blanco, C. (2018). Causes of death after nonfatal opioid overdose. *JAMA Psychiatry*. doi:10.1001/jamapsychiatry.2018.1471
- Pearl, B., & Perez, M. (2018). *Ending the war on drugs*. The Center for American Progress. Retrieved from <https://cdn.americanprogress.org/content/uploads/2018/06/26112055/EndingTheWarOnDurgs-brief.pdf>
- Reif, S., Braude, L., Lyman, R., Dougherty, R., Daniels, A., Shoma Ghose, S., Salim, O., & Delphin-Rittmon, M. (2014.) Peer recovery support

- for individuals with substance use disorders: Assessing the evidence. *Psychiatric Services*, 853-861
- Rudder, M., Tsao, L., & Jack, H. (2016). Shared responsibility: Massachusetts legislators, physicians, and an act relative to substance use treatment, education, and prevention. *AMA Journal of Ethics*. Retrieved from <https://journalofethics.ama-assn.org/sites/journalofethics.ama-assn.org/files/2018-07/pfor2-1609.pdf>
- Sacco, L. (2014). *Drug enforcement in the United States: History, policy, and trends*. Washington: Congressional Research Service.
- Samuels, E. A., Mello, M. J., Baird, E., & Yang, E. (2015). EMF preliminary evaluation of the lifespan opioid overdose prevention program. *Annals of Emergency Medicine*, 120-121.
- Sanger-Katz, M. (2018, August 15). Bleak new estimates in drug epidemic: A record 72,000 overdose deaths in 2017. *The New York Times*. Retrieved from <https://www.nytimes.com/2018/08/15/upshot/opioids-overdose-deaths-rising-fentanyl.html>
- Substance Abuse & Mental Health Services Administration. (2017a). *Peers supporting recovery from substance use disorders*. Retrieved from [https://www.samhsa.gov/sites/default/files/programs\\_campaigns/brss\\_tac/peerssupporting-recovery-substance-use-disorders-2017.pdf](https://www.samhsa.gov/sites/default/files/programs_campaigns/brss_tac/peerssupporting-recovery-substance-use-disorders-2017.pdf)
- Substance Abuse & Mental Health Services Administration. (2018). *Peers*. Retrieved from <https://www.samhsa.gov/brss-tacs/recovery-support-tools/peers>
- Tkacz, J., Severt, J., Cacciola, J., & Ruetsch, C. (2012). Compliance with buprenorphine medication-assisted treatment and relapse to opioid use. *American Journal on Addictions*, 21(1), 55-62. <https://doi-org.libserv-prd.bridgew.edu/10.1111/j.1521-0391.2011.00186.x>
- Thomas, P. (2017, April 19). *National rx drug abuse and heroin summit*. Retrieved from <https://www.hhs.gov/about/leadership/secretary/speeches/2017-speeches/secretary-priceannounces-hhs-strategy-for-fighting-opioid-crisis/index.html>
- U.S. Department of Veterans Affairs. Veterans' Health Administration Washington, D.C. (2011). *20420 VHA HANDBOOK 1163.05 Transmittal Sheet July 1, 2011*.
- U.S. National Library of Medicine Website. (2018).

Retrieved from <https://www.nlm.nih.gov/>

and to interrupt the school-to-prison pipeline.

Wakeman, S., Magidson, J., Regan, S., & Jack, H. (2018). *Reduced hospitalizations and increased abstinence six months after recovery coach contact*. Poster session presented at the Annual Conference of Innovations in Addiction Medicine & Science. San Diego, CA. Retrieved from <http://www.eventscribe.com/2018/posters/ASAM//SplitViewer.asp?PID=MTU2NzYwN-DE2MTY#>

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