5-2017

Opioid Use in Rhode Island - Review and Suggestions

Vanessa S. Kolb
University of Rhode Island, vkolb01@gmail.com

Opioid Use in Rhode Island – Review and Suggestions

By: Vanessa Kolb[1] Advisor: Dr. Bryan Dewsbury[2]

[1]Psychology [2]Biological Sciences

Background

- ~80% of heroin users report beginning use with prescription pain medications[1]
- Since 2011, RI has reduced the number of prescription-related overdose deaths by 40%, but illegal drug overdose deaths have increased by 250%[2]
- Fentanyl is an inexpensive synthetic opioid said to be 80 times more powerful than heroin. In 2011, Fentanyl had almost no presence in RI, but by 2015 it was implicated in 50% of overdose deaths[2]
- In 2015, ~250 Rhode Islanders died due to opioid overdoses[3]

Currently in Rhode Island

- RI requires all prescribers to consult the Prescription Drug Monitoring Program before any new opioid prescriptions, and once per year for long-term patients
- In 2015, Governor Raimondo's Overdose Prevention and Intervention Task Force established a goal to reduce opioid-related deaths 33% by 2018. Their Strategic Action Plan includes:
  - Improving prescribing practices
  - Expanding the availability of Naloxone for overdoses
  - Enhancing the quality and availability of Medication-assisted treatment (MAT)
  - Increasing available support for those in recovery
  - Launching a public education campaign[2]
- Additional programs include a 24/7 counselor hotline, making funding available for alternative chronic pain treatments, brochures with information about using Naloxone, seeking treatment and the dangers of Fentanyl, and the Anchor Recovery Community Center's peer support services

Funding Available for Opioid-Related Programs	
State Budget	$4 million
To DOC for MAT programs	$2.5 million
To DHHS for PDMP, Naloxone, Peer Recovery	$740,000
Matching Federal Medicaid	$760,000
Federal Grant: 21st Century Cures Act	$2.1 million
Federal Grant: Medication-Assisted Treatment Prescription Drug Opioid Addiction Grant	$1.9 million
Total	$8 million

Extended-Release Injectable Naltrexone

- Opioid antagonist: blocks opioid receptors and prevents their effects – no potential for abuse
- Requires that patient has abstained from opioid use for 7-10 days before beginning treatment
- May be prescribed by anyone licensed to prescribe medications
- More expensive and more effective than methadone or buprenorphine, but when other healthcare costs are factored in, injectable Naltrexone is 49% less costly than methadone and comparable to buprenorphine treatment
- RI Department of Corrections is currently running a pilot program with the cooperation of the Office of Medicaid to determine the efficacy of monthly Naltrexone injections, started before release, in preventing relapse and reincarceration. Results are forthcoming[4]

Supervised Injection Sites

- Controversial due to questionable legality, impression of condoning drug use, and refusal of neighborhoods to host the site
- Positive outcomes include reduced needle sharing, increased referral to treatment programs, and near zero rates of fatal overdoses for site users
- 63% of young adults in RI at risk for injecting opioids reported that they would be willing to use a supervised injection site; those who were at higher risk for overdosing had higher rates of willingness to utilize the site
- Cost-Benefit analyses of supervised injection sites generally focus on healthcare costs saved by preventing new cases of HIV and Hepatitis C
- Important variables: proportion of intravenous drug users (IDU) who are negative and positive for each health condition, rate of needle sharing, typical number of needle sharing partners, and the chances of infection from each shared needle use
- Not all of this data is currently available in RI. Additionally, the state's only needle exchange program was defunded in 2016, making it difficult to accurately predict outcomes of a supervised injection site vs. multiple needle exchange sites

Considerations

- While strict monitoring of prescriptions is important, tapering or 'cutting off' a patient without an agreed-upon plan can lead to illicit drug use, increasing the likelihood of overdose[5]
- Because of its small population, RI is well-suited for programs that require strong communication and collaboration between agencies[4]
- The greatest number of resources are located in the Providence area, but this does not reflect the needs of many RI residents. Programs that require excessive daily travel may prove ineffective.

Reduce patient burden to remain in MAT programs

Create multiple needle exchange sites

Make use of RI's ability to easily collaborate

Suggestions

- Making injectable Naltrexone widely available for suitable candidates should be a priority. It is easily prescribed, has no abuse potential, and eliminates the need for daily visits to a clinic for MAT, which decreases the number of people who quit treatment
- Supervised injection sites may be helpful for reducing overdose deaths, but needle exchange programs should be made widely available first. The necessary data about IDUs and HIV/Hepatitis C rates can then be collected.

References

[1]National Institute on Drug Abuse (2015). *Prescription Opioids and Heroin.* Retrieved from https://www.drugabuse.gov/publications/research-reports/relationship-between-prescription-drug-heroin-abuse/prescription-opioid-use-risk-factor-heroin-use

[2]Raimondo, G.M. (2016). *Governor's Overdose Prevention and Intervention Task Force* [PowerPoint slides]. Retrieved from http://www.governor.ri.gov/documents/press/051116.pdf

[3]Kaiser Family Foundation (2017). *Opioid Overdose Death Rate and All Drug Overdose Death Rates per 100,000 Population (age-adjusted).* Retrieved from http://kff.org/other/state-indicator/opioid-overdose-death-rates/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

[4]Cleman-Cope, L., Kotonias, C., & Marks, J. (2017). *Providing Medications at Release: Connecticut and Rhode Island.* Urban Insitute Health Policy Center and Justice Policy Center. Retrieved from http://www.urban.org/sites/default/files/publication/88041/meds_at_release_1.pdf

[5]Kertesz, S. (2016). Turning the tide or riptide? The changing opioid epidemic. Substance Abuse. Doi:10.1080/08897077.2016.1261070