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Preface

The Guarini Institute for Government and Leadership White Paper Series (GWPS) is designed to stimulate timely and relevant discussion around key public policy topics germane to New Jersey. The series will provide contributors a unique opportunity to share their opinions related to critical public policy issues. This is the sixth paper in a series of white papers sponsored by the Guarini Institute. On behalf of the institute, we thank Dr. Edgar Colon for his contribution.

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Heroin in New Jersey: Historical Legislation and the Path Forward

Abstract: *This article provides an overview of the heroin epidemic in the US broadly, but also provides a summary of the specific concerns in New Jersey. This paper also discusses the legislative history in New Jersey aimed at combatting heroin addiction and overdose prevention. This paper then examines public policy suggestions in harm reduction, prevention, recovery, and criminal justice handling of heroin users. If enacted, these policy proposals would afford a greater quality of life and higher levels of dignity and respect to heroin dependent residents of New Jersey and would contribute to stronger, healthier communities.*

Introduction

Heroin, a highly addictive opiate found throughout the US, leads to the deaths of tens of thousands of people each year. Heroin is found in a variety of different forms, including brown heroin, white heroin, and white tar heroin. Brown heroin, a powder, is often ingested by smoking, but may also be used intravenously with the addition of an acid. White heroin, also a powder, is the most refined heroin on the market and is usually injected intravenously. Finally, black tar heroin is a resinous substance that is usually intravenously injected. Because the most common way of ingesting heroin is intravenously, heroin is associated with the standard adverse effects of intravenous drug use including HIV, hepatitis C, as well as other viral infections and bacterial infections of the skin, bloodstream, and heart [16]. Absent the risks of injection, heroin carries a high risk of overdose. The CDC found that of the heroin overdose deaths in 2013, 81% were unintentional [5, 6]. Though innovations are becoming more effective at treating acute overdoses, the underlying, highly addictive properties of heroin make it an elusive target for public policy initiatives.

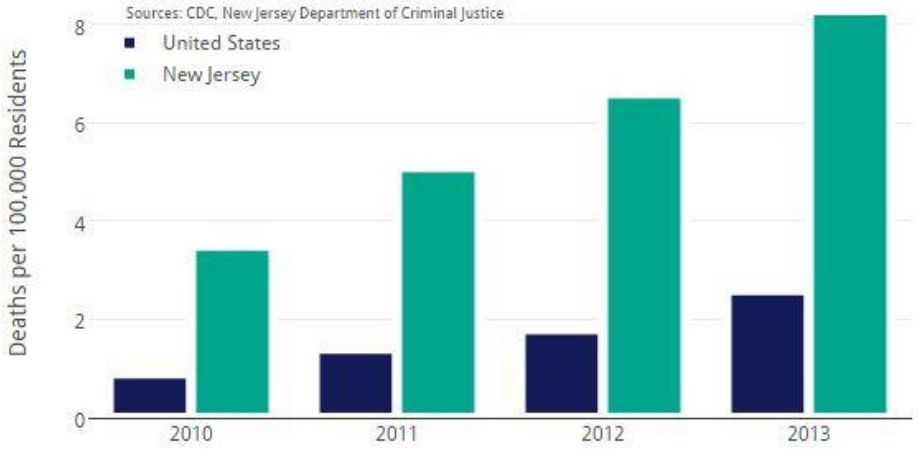
Heroin in the United States:

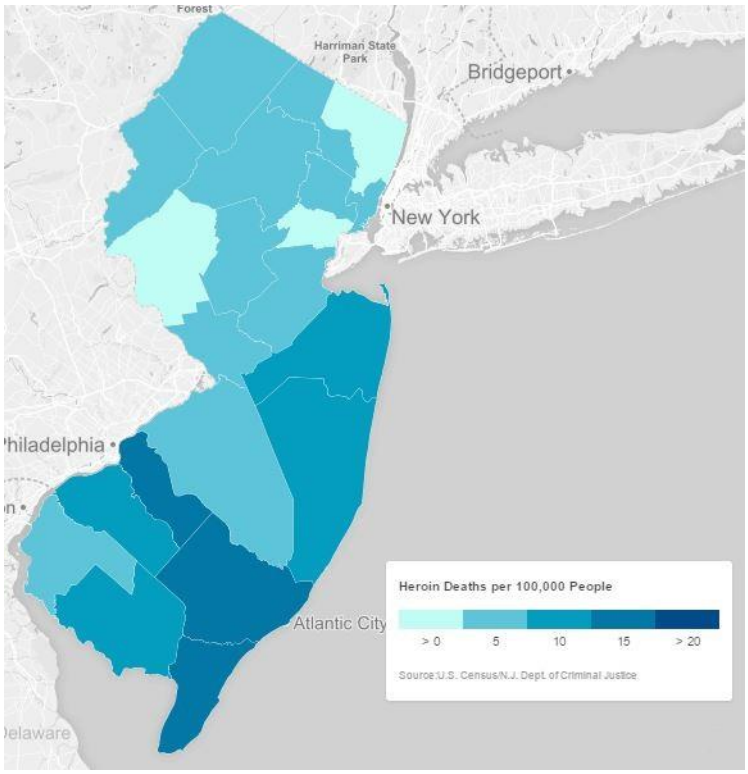
The United States is facing an extreme heroin epidemic. Between 2002 and 2014, the rate of heroin-related overdose deaths in the US more than quadrupled, with more than 10,500 deaths in 2014 alone [6, 31]. One concern is the transition of individuals who use opioid pain relievers, like morphine, to more readily available forms of opioids: heroin. This is especially true for younger patients who are usually prescribed opioids for acute conditions like sports injuries, dental procedures, or broken bones. They often have a much more limited supply of doctor provided opiates than older adults with more chronic pain conditions. Many young users develop a dependency on these opiates: when their supply is suddenly cut off, the literature suggests they are more likely to revert to heroin [18, 22, 31]. In fact, 75% of heroin addicts used prescription opioids before turning to heroin [18].

Heroin in New Jersey:

Though an issue of national concern, heroin has particularly strong impact on the state of New Jersey. Despite powerful new tools like the overdose antidote, naloxone, there were 781 heroin-related overdose deaths in New Jersey, more than twice as many as 2010 [5, 7, 8]. and more than

three times the national average (Figure 1) [9, 16]. This has been a long-standing pattern, and despite technological and medical breakthroughs, the overdose rate continues to rise in New Jersey. In fact, it eclipses deaths from homicide, suicide, and car accidents in the state [5, 7]. These deaths are unequally distributed within the state, affecting already underserved communities and counties at a significantly higher rate (Figure 2). The conversion from legal opioids to heroin may be part of the cause: while New Jersey ranks only 45th in the country for its opioid prescription rate, it still amounts to 63 painkiller prescriptions per 100 people [22]. However, the prevalence of heroin cannot only be explained by a prescription drug conversion. Some users may start as early as high school. The 2013 New Jersey Student Health Survey found that 2 percent of high school students had used heroin at some point in their lifetimes. That is about half as many as in 2001, though the figure has held steady for several years [10].





In 2015, New Jersey admitted 27,621 people into substance abuse programs who listed heroin as their primary drug; this amounted to 40% of the overall admitted population [29]. Though Ocean County only accounts for 6.5% of the total state population, 12% of those admitted to drug abuse treatment programs throughout the state were residents of Ocean County. This is more than 3% higher than Monmouth and Essex Counties who each admitted the second highest number of primary heroin users (9%) [29]. However, when these numbers are broken down per 100,000 people, Cape May County leads the state with 1,138 per 100,000 residents entering drug abuse treatment programs with heroin as their primary drug [28].

But these statistics only capture those who are able to access treatment. There are not enough beds to handle the tens of thousands more who are seeking treatment in New Jersey [25]. Despite having the highest rate of residents seeking treatment and the third highest overdose rate, Cape May County has no treatment beds and residents must seek facilities outside of their county to receive services. Costs for treatment are often prohibitive as well. Many insurance companies do not cover treatment for those who are admitted. Private insurance was used to cover just 10 percent of all admissions in 2014, down from 22 percent the year before [25]. Substance abuse experts have said very few users ultimately have the means or insurance to pay for treatment, and this likely shows those that do are seeking help in other states.

For heroin users unable to leave the state or afford treatment, the clearest path to long-term treatment for anyone in New Jersey is to be arrested since you can then be referred to different social services through the drug courts [25]. Currently, 17.42% of the New Jersey inmate population is facing a primary charge related to drug use or possession and many more are facing a secondary drug charge related to a separate primary charge [30]. These users are able access recovery resources and rehabilitation center beds through the drug courts program. This program has been invaluable for heroin users who are unable to access services and yet are in dire need. However, this has increased the strain on these public facilities. For example, the CEO of the largest heroin treatment facility, said only 100 to 150 beds of its 400 are available for people who are outside of the criminal justice system – the majority are reserved for those in drug court [19, 24].

Current Legislation in New Jersey

New Jersey lawmakers have addressed the high rates of heroin use and overdose through a four-prong approach including legislation around syringe access, prescription opioid abuse prevention, overdose prevention, and criminal justice reform.

Syringe Access

In December of 2006, Governor Jon S. Corzine signed the Blood Borne Disease Harm Reduction Act [14]. This law provided the regulatory structure for sterile needle access programs that have since been implemented in five New Jersey municipalities. Additionally, it decriminalized the possession of hypodermic syringes and needles (even those containing trace amounts of controlled substances like heroin) for participants in sterile syringe access programs [14, 27]. Though these programs do not seem to directly address the heroin epidemic, they are designed to prevent the spread of HIV, hepatitis C and other blood borne pathogens. Needle exchange and access programs also often serve as a bridge to drug abuse treatment and other social services for drug users by facilitating trust and respect for healthcare and social service providers [26].

Prescription Opioid Abuse Prevention

Prescription monitoring programs have been identified as an important way for medical service providers to share information regarding patients who are at risk of abuse of controlled substances. These databases allow providers to share patient information to supplement and verify evaluations, confirm drug history, or document therapeutic regimen compliance. These systems also help identifying patients potentially having an issue of concern regarding drug use and can flag high-risk patients. These systems have the potential to be invaluable in developing early intervention programs to prevent patients from transitioning from prescription opioids to more easily available opioids like heroin [24].

The New Jersey Prescription Monitoring Program (NJPMP) was signed into law in 2008 and has been operational since 2011. The NJPMP is a statewide database that collects data on Controlled Dangerous Substances (CDS) and Human Growth Hormone (HGH) dispensed in outpatient settings in New Jersey, and by out-of-state pharmacies dispensing into New Jersey [20]. In April of 2016, New York joined Delaware, Connecticut, Rhode Island, Virginia, Minnesota, and South Carolina in expanding the interstate data-sharing capabilities of NJPMP [12, 20, 24]. Since its inception in 2011, the database has captured information on more than 59 million written prescriptions and conducted more than 6 million user requests [20, 24].

In March of 2015, it became mandatory for pharmacists to report information on dispensement of CDS and HGH within one business day of dispensement [20]. Though physicians are able to voluntarily register to use the database, prescribing physicians are not required to check the database before prescribing substances with the potential for abuse (including opioids) [20, 24]. However, efforts to increase NJPMP enrollment by doctors and other healthcare practitioners has led to a more than 400 percent increase in the number of physicians registered for NJPMP access, and a more than 250 percent increase in the number of all prescribers and pharmacists registered for access.

Overdose Prevention

In high risk situations, many people witnessing overdose deaths are wary of alerting authorities due to --- often justified --- fears of being arrested for related drug crimes or fears related to escalation of force by police and first responders [21]. In response, many states and localities have signed “Good Samaritan” laws to provide legal protection to overdose victims and those seeking assistance in emergency situations.

In May of 2013, The Overdose Prevention Act was signed into law. In addition to providing Good Samaritan legal protection to witnesses and overdose victims that called 911, it also eliminated the potential for negative legal action against bystanders or healthcare professionals who administered overdose antidotes in emergency situations [21, 26]. In February 2015, this legislation was expanded to provide legal immunity to first responders who dispensed naloxone, the opioid overdose antidote. Though naloxone does not take the place of emergency medical

assistance, it can be used to provide life-saving interventions. The most common current form is a nasal spray that requires no additional training to assemble or administer [33]. This nasal spray replaces an injection option that required professionaltraining and special care [33]. The Overdose Prevention Act aimed to increase the services and emergency responses available to victims and witnesses of opioid overdose and lead to fewer lives lost. Additionally, the Department of Human Services in New Jersey has established a statewide Opioid Overdose Prevention program that provides education to people who are at risk of overdose as well as their friend and family. Since its inception, this program has trained over 1,700 people in recognizing the signs of opioid overdose and equipped them with naloxone kits [12]. As of May of 2016, there had been more than 11,000 deployments of naloxone in New Jersey. However, the Ocean County Prosecutor has noted that naloxone is only a temporary save and does not address the underlying addiction.

Criminal Justice Reform

In December of 2000, New Jersey began the process of phasing in drug courts across the state. These courts aim to combat the abuse of alcohol and other drugs and related criminal activity though a holistic, collaborative program. These court programs are seen as an alternative to traditional incarceration models by emphasizing the importance of drug rehabilitation in the criminal restitution process. These programs seek to address the root of drug related criminal activity by encouraging recovery goals through a network between courts, prosecutors, public defenders, law enforcement, treatment providers, social service agencies and community-based non-profit organizations [12, 19]. These programs seek to help individuals dealing with drug addiction reclaim their lives, rather than warehousing them in prison [2, 12, 19]. In August 2015, legislation was signed expanding this program and allowing for the completion of a special probation drug court program with use of medication-assisted treatment (MAT). Through this bill, the treatment provider, rather than a judge, can now decide whether narcotic-based treatment should be permitted for convicted offenders who have been admitted to the Drug Court program for drug abuse.

For heroin and other drug users who are incarcerated, the state of New Jersey is currently in the process of developing a dedicated and licensed state correctional drug treatment facility. This institution is slated to open in January of 2017 and will be based at Fort Dix in Burlington County. It seeks to provide drug treatment and substance use disorder programs for State sentenced prison inmates [2]. This program aims to change the way that inmates who are struggling with substance use disorders can receive treatment while incarcerated.

New Jersey is also seeking to expand reentry services available to those reentering communities after incarceration through the New Jersey Reentry Corporation. This corporation is part of a reintegration system designed to streamline services available to ex-offenders to ensure a network of support post-incarceration. The New Jersey Reentry Corporation was formed initially through the New Jersey Department of Community Affairs and then was provided funding to

continue operation through individual cities. It is currently operational in Jersey City, Newark, and Paterson [2, 12]. This program works to provide or refer reentry residents to services such as substance disorder treatment, employment services, ID acquisition assistance, sober housing assistance, limited access to pro bono legal representation and assistance accessing existing programs such as Medicaid and SNAP benefits.

Recommendations

In New Jersey, there is a dire need for continuing a holistic strategy of not only targeting and reducing the harm associated with heroin use, but also preventing the transition to heroin and facilitating heroin recovery. Though many strides have been made in recent policy changes, there are areas where policy could be improved, especially in treating heroin users with increased dignity and respect.

Harm Reduction Strategies

Increasing access to sterile hypodermic needles has been shown to have a large effect on the comorbid conditions with heroin addiction, especially HIV and Hepatitis C rates [26]. Expanding these programs across New Jersey would have a direct impact on the wellbeing and daily lives of residents struggling with heroin use. Additionally, these positive experiences with social service providers can provide a much-needed bridge to further interactions between service providers and users by facilitating reputation building and signaling mutual respect. Expanding needle access is also recommended to go hand-in-hand with other initiatives that seek to restore dignity and safety to the daily lives of those facing substance use disorders.

One such initiative is the provision of "safe injecting rooms." Also known as safe injection facilities (SIFs), these facilities can play a large role in harm reduction approaches to substance use disorders. SIFs are legally sanctioned, indoor facilities where injection drug use occurs under the supervision of medically trained personnel and in safe and sterile conditions. SIFs have seen success in European cities in the Netherlands, Switzerland, and Germany starting in the 1980s and are typically integrated with centers that provide additional services such as counselling, primary medical care, and referrals for drug treatment or advocacy [3, 4, 11, 14]. Since their beginning in Europe, many have opened in Vancouver, offering good models for other North American communities. Insite, a Vancouver SIF, served 9,259 individuals in 2012 with only a $2.8 million budget [3, 4]. Compared to costs of incarceration and medical emergency response, these facilities represent about 98% savings [3]. Since those who voluntarily visit SIFs are 25% less likely to be arrested and SIFs are often a viable alternative to incarceration, these facilities represent an opportunity to substantial budget savings while diverting resources away from less successful drug law enforcement strategies like over-criminalization and lengthy incarcerations [3, 4, 11]. Additionally, these facilities add dignity and respect into harm reduction strategies aimed at intravenous drug users and are often popular amongst heroin users [3, 4, 11]. Like the needle exchanges, these programs also offer the opportunity for positive, respectful interactions

between social service providers and heroin users, increasing the likelihood of enrollment in rehabilitation programs [4, 28].

Another important part of harm reduction for heroin users is the increasing the availability and provision of naloxone, especially the newly available nasal spray form. New Jersey has many facilities available to provide these kits along with training in their use. Legislative action should be taken to provide naloxone in pharmacies without a prescription. Though access has been marginally increased through the community programs, increasing access to any resident who can access a pharmacy would ensure that more people are prepared to help in overdose emergencies and ultimately, save lives.

Prevention

While these harm reduction strategies have an important life-saving function, they do little to address the addiction itself. Other strategies are needed to prevent conversion from prescription opioids to heroin and to provide services to address heroin addiction in treatment and recovery capacities. In order to better monitor prescription opioid users and flag users who are likely to transition to heroin, New Jersey should expand the NJPMP to require prescribing physicians to check the database before prescribing opioid pain relievers. This would increase the oversight and network of care for opioid users and allow primary physicians to confirm their patients are maintaining a therapeutic regimen and are not seeking overlapping prescriptions from multiple sources. Additionally, expanding the cross-state data sharing would make programs like the NJPMP more comprehensive. One way to skirt identification by the system currently is to fill overlapping prescriptions in states that do not currently share data with New Jersey. Expanding the data-sharing network would help provide medical interventions to opioid users before the transition to heroin occurs.

Legal Alternatives

The current expansion of drug courts in New Jersey is laudable; however, more than 17% of the New Jersey inmate population is primarily facing a drug related charge [29]. The specifications governing when cases may be transferred to drug courts should be loosened to allow more accused access to alternative forms of restitution that may lead to actual decreases in criminalized behavior. In cases that require individuals to be held in traditional prisons, every effort must be taken to ensure that rehabilitation and recovery services are available while incarcerated. Medically assisted therapy should also be available to the incarcerated population, especially since detox is often completed while entering prison facilities. Allowing users to begin a MAT program in a supervised setting would reduce recidivism and could even have an impact on drug-related prison violence [15, 23, 27, 32]. An expansion of the facilities like those planned for Fort Dix would combat the root of drug-related criminal activity instead of warehouse drug offenders in prison without addressing the root of the problem. By avoiding prison time for drug offenders, New Jersey can instead focus on rebuilding communities by maintaining the human capital of indigenous residents and can preserve users' access to social services.

Recovery

Another top priority for the state of New Jersey should be expanding access to treatment facilities and emerging methods of therapy. Though many state employees have opposed the expansion of public funds for residential facilities, the private sector is not filling the gap as quickly as is needed to address the ballooning problem in New Jersey and in other states. One option is to require insurance companies to fund residential treatment for heroin users. This would ensure that more insured patients would have access to residential treatment and, if necessary, have the option to seek treatment out-of-state to reduce the burden on New Jersey treatment facilities. However, many of the heroin and opioid users have little to no insurance at all. Increasing funding for construction and expansion of existing residential treatment programs would have a more direct impact on this population, especially since many experts say that most heroin users require residential treatment to see full recovery [28, 31].

Another promising alternative to residential treatment is Medication Assisted Therapy (MAT). Currently, only 18% of heroin or opioid users have MAT planned in their treatment plan (13% Methadone and 5% Suboxone) [29]. Though some heroin users will not require this sort of intervention, much of the emerging research points to the efficacy of medication assisted therapy for almost all heroin users [15, 23, 28, 32]. One medication that is not currently in use is an injectable, suspended-release form of naltrexone. This medication requires a once a month visit to a physician trained to inject this medication, and blocks the effects of opioid-based drugs and heroin, including pain relief or feelings of well-being that can lead to abuse [17]. This medication is a post-detox option that can be used to maintain sobriety for users without relying on daily pills or injections. Because it is time released, it can reduce the burden on care providers who do not have the capacity to administer a traditional methadone clinic. Additionally, it could be used by drug courts as a condition of avoiding incarceration, or in addition to enrollment in other forms of therapeutic treatment. In conjunction with other recovery expansions, suspended-release naltrexone has the potential to dramatically reduce the rates of drug-related recidivism, relapse, and improve their quality of life [1, 17].

Conclusion:

More needs to be done to combat the heroin epidemic in New Jersey. With an overdose rate more than three times the national average, New Jersey needs to expand their heroin policies to holistically combat the epidemic by preventing the transition to heroin from opiates, reducing the harm to current users, reforming the sentencing and legal action taken against users, and increasing the access to recovery services. However, all of these policies must start by affording heroin users increased respect and dignity. Combating a growing heroin mortality rate must be a community endeavor with community leaders, teachers, and families joining together to learn, educate, and support heroin users both within the community and in the public sphere.

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