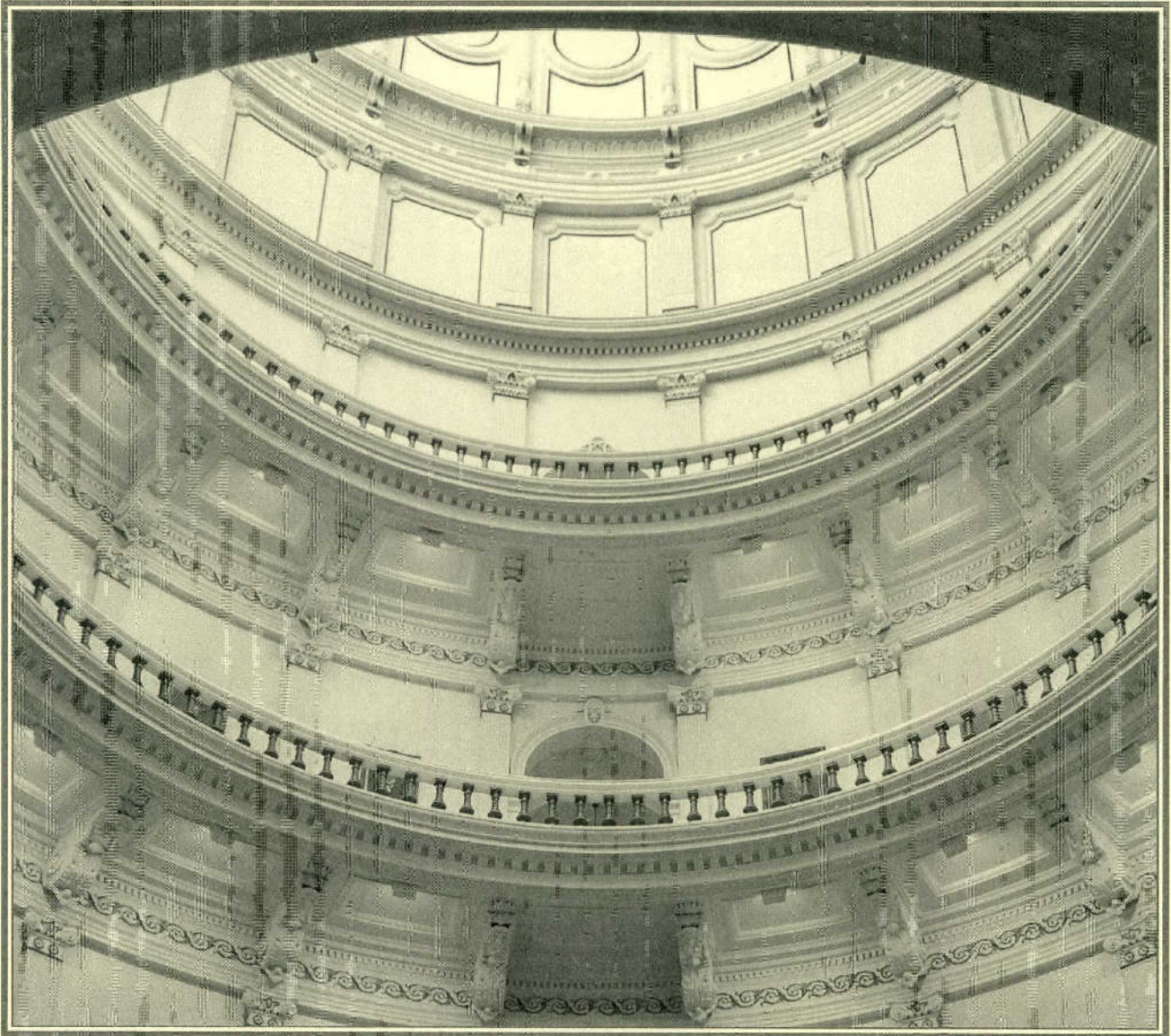


INTERIM REPORT  
*to the 86<sup>th</sup> Texas Legislature*



**HOUSE SELECT COMMITTEE ON  
OPIOIDS AND SUBSTANCE ABUSE**

*November 2018*



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**HOUSE SELECT COMMITTEE ON OPIOIDS AND SUBSTANCE ABUSE  
TEXAS HOUSE OF REPRESENTATIVES  
INTERIM REPORT 2018**

**A REPORT TO THE  
HOUSE OF REPRESENTATIVES  
86TH TEXAS LEGISLATURE**

**FOUR PRICE  
CHAIRMAN**

**COMMITTEE CLERK  
SANDRA TALTON**

**ASSISTANT COMMITTEE CLERKS  
ELIZABETH FARLEY  
AUDREY RHYNERSON**

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Select Committee On  
Opioids and Substance Abuse

November 12, 2018

Four Price  
Chairman

P.O. Box 2910  
Austin, Texas 78768-2910

The Honorable Joe Straus  
Speaker, Texas House of Representatives  
Members of the Texas House of Representatives  
Texas State Capitol, Rm. 2W.13  
Austin, Texas 78701

Dear Mr. Speaker and Fellow Members:

The Select Committee on Opioids and Substance Abuse of the Eighty-fifth Legislature hereby submits its interim report including recommendations for consideration by the Eighty-sixth Legislature.

Respectfully submitted,

Four Price, Chairman

Joe Moody, Vice Chairman

Representative Garnet Coleman

Representative Ina Minjarez

Representative Poncho Nevarez

Representative Toni Rose

Representative Gary VanDeaver

Representative Carol Alvarado

Representative Jay Dean

Representative Andrew Murr

Representative Kevin Roberts

Representative J.D. Sheffield

Representative James White



## ACKNOWLEDGEMENTS

The Chairman, the Vice-Chairman, and the Members of the House Select Committee on Opioids and Substance Abuse would like to acknowledge and thank Ms. Sandra Talton, Committee Director, for her dedication throughout the entire committee process and for preparation of this report.

The Chairman, the Vice-Chairman, and the Members of the House Select Committee on Opioids and Substance Abuse also express gratitude to Ms. Elizabeth Farley and Ms. Audrey Rhynerson, Assistant Committee Clerks, for their assistance during the committee process and throughout the writing of the report and to each Member's respective office staff for their efforts on the success of the House Select Committee on Opioids and Substance Abuse.





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# SELECT COMMITTEE ON OPIOIDS AND SUBSTANCE ABUSE

## EXECUTIVE SUMMARY

Every day, on average, 115 Americans die from an opioid overdose.<sup>1</sup> Americans with an opioid addiction equaled 2.4 million in 2016,<sup>2</sup> and approximately 20.1 million Americans aged 12 or older were reported to have a substance use disorder, with 11.5 million misusing pain reliever opioids.<sup>3</sup>

In Texas, in 2016, 2,831 persons died due to a drug overdose.<sup>4</sup> In 2017, 90 out of 172 child fatalities, of families involved with the Texas Department of Protective Services, were caused by abuse or neglect and involved a parent or caregiver actively using a substance and/or under the influence.<sup>5</sup> Of the more than 145,000 offenders incarcerated in the state's prison system, 23,670 are serving because of drug offenses; this number does not include those involved in pre-trial diversion programs.<sup>6</sup>

With a rating of 10.1 by the Centers for Disease Control and Prevention (CDC) in 2016, Texas' overdose deaths per capita are low when compared to other states with ratings as high as 52.0, 39.1 and 37.9 and the overall United States rating at 19.8.<sup>7\*</sup> However, with an actual recorded number of 2,831 overdose deaths in Texas<sup>8</sup> in 2016 and a report by *Castlight Health* showing four Texas cities in the top twenty-five United States cities for opioid abuse, Longview, Texarkana, Odessa, and Amarillo,<sup>9</sup> the issue is alarming.

This substance abuse crisis in our nation and state prompted the Texas House of Representatives' Speaker Joe Straus to appoint the Select Committee on Opioids and Substance Abuse (Committee). The Committee was charged to study the effects of the opioids and substance abuse epidemic in Texas and to provide recommendations to address the findings for consideration in the upcoming 86th Legislative Session, in order to combat the abuse of drugs, both legal and illicit, including methamphetamines and synthetic marijuana.

The issue is complex and broad, and to address the force of this continued endangerment to our society, much attention and coordination of efforts will be required.

The committee held six hearings to delve into the eight charges which covered a broad gamut of topics, including, specific populations; the impact on the criminal justice system and on the Child Protective Services system; regulations and procedures for healthcare professionals who prescribe or dispense opioids and other addictive drugs; the prescription monitoring program; state-funded / state-administered prescription drug plans; law enforcement, first responders, and emergency departments; and laws and programs currently in place. Public testimony was taken from stakeholders from across the state and the nation. Also, varied organizations, services providers, manufacturers of medications, persons in recovery, and many others have contacted the committee members' offices to share their stories and experiences.

Topics discussed repeatedly by the various stakeholders include data accuracy and timeliness; prescription dosage limits; implementation of the prescription monitoring program; drug take back

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programs and safe drug disposal; availability and utilization of medication assisted treatment (MAT) programs; lack of immediate bed availability for persons ready for treatment; the potential for a rise in use of illicit drugs; the current abuse of opioids and alcohol and use of illegal substances such as methamphetamines and marijuana; the danger of fentanyl; and the potential affect on patients who rely on opioids to function on a daily basis.

The national attention to the epidemic has produced actions and results: nationally, federal funds have been provided to states, of which Texas is a recipient; overprescribing is being recognized; and practices are changing with the CDC adopting new guidelines for a limited number of dosages/days for the prescribing of opioids. PhRMA comments that only a comprehensive approach can solve this complex problem and that all stakeholders, pharmaceutical companies, wholesale distributors, payers, local communities and government, pharmacists, prescribers, and patients, must contribute to a solution.<sup>10</sup>

Prevention, intervention, and treatment and recovery programs are currently being utilized to address the epidemic throughout the nation and state. In Texas, the Health and Human Services Commission has oversight of the Statewide Behavioral Health Coordinating Council which endeavors to ensure that programs in the various state agencies are complementary and non-overlapping in efforts for realizing the most efficient use of funds and best outcomes.

Texas lawmakers have addressed drug use during past sessions and will continue to do so. However, as all are aware, an increase in services and programs typically requires increased funding, and funds are limited, whether federal, state, or local. A constant review of services and programs in-place is required to ensure efficient utilization of monies. Also, innovation through technology such as telemedicine, and capitalizing on best practices help the available funds stretch further.

Disclaimer - This report is, in large part, generated from information obtained in meetings with various stakeholders and in the public hearings. Progress on programs and services continues as additional federal funds are awarded, organizations announce new partnerships, and new ideas are adopted by local communities. Additionally, data and information continue to be reviewed and produced. This report is based on data as presented at the time of the hearing date and may not reflect the latest data or findings.

\* The referenced CDC statistics can be found at [https://www.cdc.gov/nchs/pressroom/sosmap/drug\\_poisoning\\_mortality/drug\\_poisoning.htm](https://www.cdc.gov/nchs/pressroom/sosmap/drug_poisoning_mortality/drug_poisoning.htm) and is in Appendix B.



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## INTRODUCTION

Recognizing that the epidemic related to opioids and substance abuse is directly affecting many people throughout the United States and Texas, the Honorable Joe Straus, Speaker of the Texas House of Representatives, on October 23, 2017 appointed thirteen members from across the state to the Select Committee on Opioids and Substance Abuse (Committee) for the 2017/2018 interim. The Committee membership consisted of Four Price (Chairman), Joe Moody (Vice Chairman), Carol Alvarado, Garnet Coleman, Jay Dean, Ina Minjarez, Andrew Murr, Poncho Nevárez, Kevin Roberts, Toni Rose, J.D. Sheffield, Gary VanDeaver, and James White.

The Proclamation of the Select Committee on Opioids and Substance Abuse can be found at <https://house.texas.gov/media/pdf/PROCLAMATION-Select-Committee-Opioids-and-Substance-Abuse.pdf> and is also included in this report as Appendix A. Generally, the charges instructed the Committee to review the prevalence and impact of this epidemic in Texas and to provide recommendations to address the issue.

The charges were:

1. Study the prevalence and impact of substance use and substance use disorders in Texas, including co-occurring mental illness. Study the prevalence and impact of opioids and synthetic drugs in Texas. Review the history of overdoses and deaths due to overdoses. Also review other health-related impacts due to substance abuse. Identify substances that are contributing to overdoses, related deaths and health impacts, and compare the data to other states. During the review, identify effective and efficient prevention and treatment responses by health care systems, including hospital districts and coordination across state and local governments. Recommend solutions to prevent overdoses and related health impacts and deaths in Texas.
2. Review the prevalence of substance abuse and substance use disorders in pregnant women, veterans, homeless individuals, and people with co-occurring mental illness. In the review, study the impact of opioids and identify available programs specifically targeted to these populations and the number of people served. Consider whether the programs have the capacity to meet the needs of Texans. In addition, research innovative programs from other states that have reduced substance abuse and substance use disorders, and determine if these programs would meet the needs of Texans. Recommend strategies to increase the capacity to provide effective services.
3. Review policies and guidelines used by state agencies to monitor for and prevent abuse of prescription drugs in state-funded or state-administered programs. Include in this review policies implemented by the Texas Medicaid Program, the Division of Workers' Compensation of the Texas Department of Insurance, the Teacher Retirement System, and the Employee Retirement System. Make recommendations regarding best practices.

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4. Monitor and evaluate the implementation of legislation passed by the 85th Legislature regarding the Prescription Monitoring Program. In addition, review the prescribing of addictive drugs by physicians and other health care providers within various geographic regions of this state. Determine the role of health care professionals in preventing overutilization and diversion of addictive prescriptions. Provide recommendations that will improve efforts to prevent overutilization and diversion of addictive prescriptions.
  5. Identify how opioids have impacted the normal scope of work for law enforcement, first responders, and hospital emergency department personnel.
  6. Examine the impact of substance abuse and substance use disorders on Texans who are involved in the adult or juvenile criminal justice system and/or the Child Protective Services system. Identify barriers to treatment and the availability of treatment in various areas of the state. Recommend solutions to improve state and local policy, including alternatives to justice system involvement, and ways to increase access to effective treatment and recovery options.
  7. Examine the impact of overdose reporting defense laws known as "Good Samaritan" laws.
  8. Identify the specialty courts in Texas that specialize in substance use disorders. Determine the effectiveness of these courts and consider solutions to increase the number of courts in Texas.

The Committee has completed its hearings and has issued the following final report with its findings and recommendations. The committee members were provided information on these charges from diverse witnesses from around the state; however, the information shared is not exhaustive due to time limitations, witness availability, and the broadness of the topic.

The recommendations included in this report were submitted by the Committee's members. Each one does not necessarily reflect the opinion of every member, but the lists reflect suggestions, based on information presented throughout the interim hearing process, for consideration to improve upon the opioids and substance abuse challenges through prevention, intervention, and treatment and recovery efforts.

The recommendations are set forth to provide a representative set of considerations for potential study, analysis, or future legislative evaluation. Many of the recommendations included in this report could serve as a catalyst for future study or action, both during the 86th Legislative Session and beyond.

Additional state appropriations for current and potentially new programs would be required for many of the recommendations herein. The Committee realizes that measures need to be considered for the most effective use of funds throughout the state.

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For consideration regarding funding:

- The state cannot fund every project; however, matching fund programs can potentially be utilized to ensure communities are invested in programs and are not dependent entirely on state funding to address local needs;
- If programs are moved or new programs are implemented, the recognition that funds may need to follow a different path is imperative for efficiency;
- Every community cannot duplicate all programs in other communities, but many best practice community programs already in place may be scalable and implemented in other geographic areas of the state;
- Some of the suggestions may be eligible to utilize funds already available, such as through the Texas Targeted Opioid Response (TTOR) grant and other grant programs; and
- Some of the recommendations may be able to be adopted and implemented by local entities with no legislative intervention. Local initiative is encouraged.

The Committee wishes to express appreciation to the state agencies, local government entities, organizations, and concerned citizens who testified at the public hearings.

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## INTERIM STUDY CHARGES

The proclamation for the appointment of the Select Committee on Opioids and Substance Abuse is comprehensive in scope. The charges were addressed in six hearings (five hearings with invited testimony plus one hearing for public testimony). The invited testimony included state agencies, local government representatives, community organizations, community advocates, and professional providers of care. Emphasis was placed on ensuring that all population areas - urban, suburban, and rural - were represented.

Public Hearing 1 related to Interim Charge 1 - Study the prevalence and impact of substance use and substance use disorders in Texas, including co-occurring mental illness. Study the prevalence and impact of opioids and synthetic drugs in Texas. Review the history of overdoses and deaths due to overdoses. Also review other health-related impacts due to substance abuse. Identify substances that are contributing to overdoses, related deaths and health impacts, and compare the data to other states. During the review, identify effective and efficient prevention and treatment responses by health care systems, including hospital districts and coordination across state and local governments. Recommend solutions to prevent overdoses and related health impacts and deaths in Texas.

Public Hearing 2 related to Interim Charges 1, 2, 3, and 6.

Related to Interim Charge 6 - Testimony was provided from one witness in regards to foster care and substance abuse. Additional testimony regarding Charge 6 was provided during Hearing 5; all testimony provided on Charge 6 is covered in the section for Hearing 5 of this document;

Related to Interim Charge 1 - Representatives of two Texas recovery centers provided further testimony related to Interim Charge 1;

Related to Interim Charge 2 - Review the prevalence of substance abuse and substance use disorders in pregnant women, veterans, homeless individuals, and people with co-occurring mental illness. In the review, study the impact of opioids and identify available programs specifically targeted to these populations and the number of people served. Consider whether the programs have the capacity to meet the needs of Texans. In addition, research innovative programs from other states that have reduced substance abuse and substance use disorders, and determine if these programs would meet the needs of Texans. Recommend strategies to increase the capacity to provide effective services; and

Related to Interim Charge 3 - Review policies and guidelines used by state agencies to monitor for and prevent abuse of prescription drugs in state-funded or state-administered programs. Include in this review policies implemented by the Texas Medicaid Program, the Division of Workers' Compensation of the Texas Department of Insurance, the Teacher Retirement System, and the Employee Retirement System. Make recommendations regarding best practices.

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Public Hearing 3 related to Interim Charge 4 - Monitor and evaluate the implementation of legislation passed by the 85th Legislature regarding the Prescription Monitoring Program. In addition, review the prescribing of addictive drugs by physicians and other health care providers within various geographic regions of this state. Determine the role of health care professionals in preventing overutilization and diversion of addictive prescriptions. Provide recommendations that will improve efforts to prevent overutilization and diversion of addictive prescriptions.

Public Hearing 4 related to Interim Charges 5 and 7.

Related to Interim Charge 7 - Examine the impact of overdose reporting defense laws known as "Good Samaritan" laws; and

Related to Interim Charge 5 - Identify how opioids have impacted the normal scope of work for law enforcement, first responders, and hospital emergency department personnel.

Public Hearing 5 related to Interim Charges 6 and 8.

Related to Interim Charge 6 - Examine the impact of substance abuse and substance use disorders on Texans who are involved in the adult or juvenile criminal justice system and/or the Child Protective Services system. Identify barriers to treatment and the availability of treatment in various areas of the state. Recommend solutions to improve state and local policy, including alternatives to justice system involvement, and ways to increase access to effective treatment and recovery options.

Related to Interim Charge 8 - Identify the specialty courts in Texas that specialize in substance use disorders. Determine the effectiveness of these courts and consider solutions to increase the number of courts in Texas.

Public Hearing 6 related to all charges - Public testimony.

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## **PUBLIC HEARING 1: CHARGE 1 - OPIOIDS AND SUBSTANCE ABUSE**

To acquire a comprehensive overview of opioids and substance abuse, the Committee held its first public hearing on March 27, 2018 at 10:00am in Austin, Texas in the Capitol Extension, Room E2.012.

*Charge 1 - Study the prevalence and impact of substance use and substance use disorders in Texas, including co-occurring mental illness. Study the prevalence and impact of opioids and synthetic drugs in Texas. Review the history of overdoses and deaths due to overdoses. Also review other health-related impacts due to substance abuse. Identify substances that are contributing to overdoses, related deaths and health impacts, and compare the data to other states. During the review, identify effective and efficient prevention and treatment responses by health care systems, including hospital districts and coordination across state and local governments. Recommend solutions to prevent overdoses and related health impacts and deaths in Texas.*

The following organizations/individuals were invited to testify:

Kristene Blackstone, Department of Family and Protective Services  
Sharon Brigner, MS, RN, PhRMA  
Bryan Collier, Texas Department of Criminal Justice  
Jamie Dudensing, Texas Association of Health Plans  
Sonja Gaines, Texas Health and Human Services Commission  
John Hawkins, Texas Hospital Association  
Karen Hearod, MSW, LCSW, Substance Abuse and Mental Health Services Administration (SAMHSA)  
John Hellerstedt, MD, Texas Department of State Health Services  
Cynthia Humphrey, Association of Substance Abuse Programs  
Lee Johnson, Texas Council of Community Centers  
Andy Keller, PhD, Meadows Mental Health Policy Institute  
Lisa Ramirez, Texas Health and Human Services Commission  
Samantha Schaffer, Legislative Budget Board  
Laurie Vanhooose, Texas Association of Health Plans  
Reilly Webb, Office of the Governor Criminal Justice Division

The following section of this report related to opioids and substance abuse is produced in large part from the oral and written testimony of the individuals above.

### *Brief History*

Although the most widespread and deadly drug crisis in the nation's history, the current opioid crisis is not the first involving addiction and government response.

A brief history of opiate drugs in America entails high levels of addiction and withdrawal post-civil war with veterans developing addictions to morphine to relieve pain from war injuries. Also, medical tonics that contained cocaine and opioids had widespread sales and use.

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To combat the crisis, alternative pain medications were developed, stricter prescription laws were enacted, professional literature was written and published to train physicians on morphine prescribing, the Pure Food and Drug Act passed in 1906 requiring better product labeling, taxes were placed on narcotics, importation bans were implemented on opium, and ultimately heroin was made illegal in 1924. In 1914, Congress passed the Harrison Narcotics Act which regulated and taxed opiates and coca products; this Act is often cited as the beginning of the criminal justice response to addiction.

In the 1960s, heroin use surged, driven in part by the Vietnam War, and the counter culture movement's acceptance of drug use. The prescribing of amphetamine tablets surged for psychiatric conditions and for weight-loss. To address, President Nixon declared a "war on drugs"; the Comprehensive Drug Abuse Prevention and Control Act passed in the 1970s which established the modern set of controlled substance "schedules"; and the DEA was established.

In the 1970s, powder cocaine emerged and in the 1980s "crack." The 1980s also produced numerous unsubstantiated claims that opioid addiction is rare.

The current epidemic is fueled by two primary factors, the unsubstantiated claims that were made in the 1980s about opioid addiction being rare and the increased prescription rates for opiates seen between the 1990s and the 2010s. Opioids also became easier and cheaper to obtain illegally. In 2000, "Pain as the Fifth Vital Sign" was introduced by the Joint Commission as a standard to measure the performance of healthcare providers. This was reinforced by patient satisfaction surveys and accreditation standards and may have contributed to the increased prescribing of opioids. In the early 2000s, states began to implement prescription drug monitoring programs.

The federal government declared a Public Health Emergency specific to opioids on October 26, 2017. In May, 2017, prior to the emergency declaration, the Substance Abuse and Mental Health Services Administration (SAMSHA) awarded Texas \$27 million for the Texas Targeted Opioid Response (TTOR) program.<sup>11 12</sup>

### *Statistics*

#### National Statistics:

- On average, 115 Americans die every day from an opioid overdose;<sup>13</sup>
- The number of opioid prescriptions in this country quadrupled between 1999 and 2010, largely due to an increase in the use of opioids to treat chronic pain;<sup>14</sup>
- Total drug-related emergency department visits increased 99 percent and the rate of opioid related inpatient stays increased 64 percent from 2005 to 2014;<sup>15</sup>
- Opioid related deaths increased from 28,647 to 42,249 between 2014-2016; drug overdose deaths grew from 47,055 to 63,632;<sup>16</sup>
- In 2016, an estimated 2.4 million Americans had an opioid addiction;
  - Only one in five individuals with opioid use disorders received specialty treatment for illicit drugs,
  - Only 37.5 percent of people with heroin use disorders received treatment, and



- 
- Only 17.5 percent of people with prescription pain reliever use disorders received treatment;<sup>17</sup>
  - Each day, 1,000 people are treated in emergency departments for not using prescription opioids as directed;<sup>18 19</sup>
  - Seventy percent of abused medicines are taken from household medicine cabinets;<sup>20</sup> and
  - The national economic toll of opioid abuse is \$78.5 billion per year in lost productivity, prescription drug abuse, hospitalizations, and emergency room utilization.<sup>21</sup>

Texas Statistics:

- In 2017, nearly 3,000 Texans died due to drug overdose; (A graph detailing opioid-related deaths at the county level can be found in Appendix C.)<sup>22</sup>
- 464,000 Texans abused illicit drugs in 2017;<sup>23</sup>
  - Gateway drugs correlate to abuse; in 2017 an estimated 24,000 adults (18+) reported past-year heroin use;<sup>24</sup>
- In 2017, over 30,000 drug exposure calls were made to the Texas Poison Control Center Network, including 5,265 for opioid exposure;<sup>25</sup>
- Nearly eight of every 100 Texans have a substance use disorder,<sup>26</sup> equating to an estimated 1.6 million adults and 1.1 million children and adolescents who need substance abuse services in Texas;<sup>27</sup>
- Drug overdose is a leading cause of maternal deaths;<sup>28</sup>
- Of Texas high school students, one in five has taken prescription drugs without a doctor's prescription;<sup>29</sup>
- Among Texas students in grades 7-12, nine percent misused codeine cough syrup and four percent misused other opioids in 2017;<sup>30</sup>
- About five percent of Texas college students reported misusing opioids in 2017;<sup>31</sup> and
- 8.6 percent of people aged 12+ who used illicit drugs received treatment; the national average is 14.1 percent.<sup>32</sup>

Statistics Related to Co-Occurring Substance Use and Mental Illness:

- Texas has a higher rate of dual diagnoses – about 29 percent of adults treated in Texas by a state mental health agency had a co-occurring mental health and substance use disorder (SUD) compared to the national average of 22.7 percent;<sup>33</sup>
- Estimates for people with serious mental illness (SMI) and co-occurring SUD range from 23 percent to over 50 percent;<sup>34</sup>
- For adults trapped in the cycle of super-utilization of jails and emergency departments, rates of co-occurring SUD range from 50 percent to 85 percent with an estimate of 25,000 individuals;<sup>35</sup> and
- Research conservatively estimates that at least one-third of adults and one-fourth of youth with substance use disorders (SUDs) in Texas have comorbid psychiatric conditions.<sup>36</sup>

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Statistics Related to Individuals Involved in the Criminal Justice System:

- 19,000 (14 percent) of the state prison population are incarcerated because of a drug related offense;
- Comparatively, in state jails, 41 percent of the population are serving because of a drug related offense; and
- About 54 percent of offenders within the system are identified as needing some level of substance abuse treatment; of these, 70 percent need intensive treatment.<sup>37</sup>

Statistics Related to Families Involved with the Department of Family Protective Services (DFPS) in Fiscal Year 2017:

- 90 out of 172 child fatalities were caused by abuse or neglect and involved a parent or caregiver actively using a substance and/or under the influence of at least one substance that affected their ability to care for the child:
  - 20 child fatalities involved methamphetamine and amphetamine actively used by caregiver; and
  - Six child fatalities involved caregiver actively using heroin or opioids;
- 46,750 families (about 28.6 percent) served in the investigation stage had substance use identified; and
- Caregiver substance abuse contributed to 68 percent of removals of children.<sup>38</sup>

Statistics Related to Social and Economic Costs Related to Substance Abuse:

- Overdoses and other consequences of drug use cost the U.S. \$500 billion in 2015 due to increased healthcare and SUD treatment costs, lost productivity, and costs to the criminal justice system;<sup>39</sup>
- The opioid crisis costs Texas \$20 billion annually;<sup>40</sup>
- For U.S. hospitals, the cost of treating an opioid overdose victim in intensive care units rose 60 percent between 2009 and 2015;<sup>41</sup>
- In 2015, the average cost among 162 academic hospitals was nearly \$93,000 per patient in intensive care;<sup>42</sup> and
- Unmet SUD needs result in an estimated \$350 million per year in emergency room charges, excluding costs for comorbid medical conditions, intoxication-caused accidents, and co-occurring psychiatric conditions.<sup>43</sup>

*Overview of Substances*

Opioids are natural or synthetic. The substances are used medically for pain relief and recreationally for a euphoric feeling. Common opioids include morphine, heroin, codeine, oxycodone, and fentanyl.<sup>44</sup>

Controlled Substance Scheduling

Controlled substances are regulated at the federal level by the Controlled Substances Act. The federal and state systems of scheduling controlled substances are determined based on accepted medical use, a substance's potential for abuse, physical dependence, and psychological dependence. Scheduling regulates which drugs should be grouped with penalties for law

enforcement purposes and which drugs should be logged into prescription monitoring programs. Of the five drug schedules, schedule one substances have high abuse potential and no currently accepted medical use according to the Drug Enforcement Administration (DEA).<sup>45 46</sup>

**Schedule I**

Fentanyl,  
Heroin,  
Marijuana

- Opiates
- Opium Derivatives
- Hallucinogenic Substances
- Stimulants
- Depressants
- Cannabimimetic Agents

**Schedule II**

Cocaine,  
Fentanyl

- Substances, vegetable origin or chemical synthesis
- Stimulants
- Depressants
- Hallucinogenic Substances
- Precursors

**Schedule III**

Benzodiazepines

- Depressants
- Narcotics
- Stimulants
- Anabolic steroids and hormones
- Hallucinogenic substances

**Schedule IV**

Benzodiazepines

- Depressants
- Stimulants
- Narcotics and other substances

**Schedule V**

- Narcotics containing non-narcotic active medicinal ingredients
- Stimulants
- Depressants

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The commissioner of DSHS is statutorily required to establish and modify the Schedule of Controlled Substances (Schedule) for the state of Texas. The Schedule supports law enforcement, pharmacies, and the Texas Legislature in their respective roles in addressing emerging controlled substance threats.

Scheduling entails the regular scheduling process which involves a state annual update to the schedule and responses to federal action, and an emergency scheduling process that streamlines scheduling of certain drugs. The emergency scheduling process is important because variations of synthetic drugs are developed at a rapid pace. Emergency scheduling allows the state to keep up with scheduling new controlled substances as they appear on the market as opposed to waiting for the FDA or the annual state update.<sup>48</sup>

A more detailed description of prescription opioids, illicit substances, and opioid overdoses can be found in Appendix D.

*The State of the Crisis*

With a rating of 10.1 by the Centers for Disease Control and Prevention (CDC) in 2016, Texas' overdose deaths per capita are low when compared to other states with ratings as high as 52.0, 39.1 and 37.9 and the overall United States rating at 19.8.<sup>49</sup> However, with an actual recorded number of 2,831 overdose deaths in Texas<sup>50</sup> in 2016 and a report by *Castlight Health* showing four Texas

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cities in the top twenty-five United States cities for opioid abuse, Longview, Texarkana, Odessa, and Amarillo,<sup>51</sup> the issue is alarming. (The referenced CDC statistics can be found at [https://www.cdc.gov/nchs/pressroom/sosmap/drug\\_poisoning\\_mortality/drug\\_poisoning.htm](https://www.cdc.gov/nchs/pressroom/sosmap/drug_poisoning_mortality/drug_poisoning.htm) and in Appendix B.)

Numerous programs with an emphasis on prevention, intervention, and treatment and recovery are currently in-place throughout the state to address drug abuse. The stakeholders have the same basic goal but to determine the extent of the programs, to learn where gaps exist, to hear discussion on expanding best practices, and to gain perspectives on new ideas for programs, stakeholders presented information on their programs and their areas of concern. Stakeholders explained how we got here and their ideas for countering.

#### Prevention

Regarding prevention, emphasis by varied stakeholders is on education targeted at school-aged youth, public awareness campaigns regarding drugs, the importance and effectiveness of drug take back events and safe disposal of unused drugs.

#### Intervention

Regarding intervention, stakeholder emphasis is on naloxone availability for overdose reversal and on pre-trial diversion programs.<sup>52</sup>

Opioid overdoses slow down bodily functions, including the impulse to breathe. Physical characterizations are non-responsiveness, and blueness around fingertips and eyelids. Brain damage and death are possible results of an overdose. Opioid antagonists reverse/reduce the effects of an opioid overdose or opioid use disorder. A number of drugs are available to combat short-term and long-term opioid use, the most common being naloxone. Naloxone is a pure antagonist of opioids and provides an immediate overdose reversal effect. The drug is injected into the body and blocks the receptors that the opioid targets, thereby blocking the effects of the opioid on the body. Naloxone is administered by an auto-injector or nasal spray. The drug is, however, only effective for 30 minutes to an hour during which the individual experiencing the overdose should be transported to a medical facility for more definitive care.<sup>53</sup>

#### Treatment and Recovery

Regarding treatment and recovery, emphasis is on medication assisted treatment (MAT) availability and support after treatment.

Methadone, naltrexone, and buprenorphine are Food and Drug Administration (FDA) approved medications used in MAT programs. All three medications are prescribed as part of a comprehensive treatment plan that includes counseling and participation in social support programs.

Methadone helps people reduce or quit their use of heroin or other opiates. Methadone has been used for decades to treat people who are addicted to heroin and narcotic pain medicines and works by changing how the brain and nervous system respond to pain. It lessens the painful symptoms of opiate withdrawal and blocks the euphoric effects of opiate drugs such as heroin, morphine, and codeine, as well as semi-synthetic opioids like oxycodone and hydrocodone.

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Methadone is offered in pill, liquid, and wafer forms and is taken once a day. Patients taking methadone to treat opioid addiction must receive the medication under the supervision of a physician.

Naltrexone is a medication to treat opioid use disorders and alcohol use disorders. It comes in a pill form or as an injectable and can be prescribed by any health care provider who is licensed to prescribe medications; special training is not required. Naltrexone blocks the euphoric and sedative effects of drugs such as heroin, morphine, and codeine. It works differently in the body than buprenorphine and methadone, which activate opioid receptors in the body that suppress cravings. Naltrexone binds and blocks opioid receptors, and is reported to reduce opioid cravings. There is no abuse and diversion potential with naltrexone.

Buprenorphine is used to help people reduce or quit their use of heroin or other opiates, such as pain relievers like morphine. Approved for clinical use in October 2002 by the FDA, buprenorphine represents the latest advance in MAT. Medications such as buprenorphine, in combination with counseling and behavioral therapies, provide a whole-patient approach to the treatment of opioid dependency. When taken as prescribed, buprenorphine is safe and effective. Unlike methadone treatment, which must be performed in a highly structured clinic, buprenorphine is the first medication to treat opioid dependency that is permitted to be prescribed or dispensed in physician offices, significantly increasing treatment access. Under the Drug Addiction Treatment Act of 2000 (DATA 2000), qualified U.S. physicians can offer buprenorphine for opioid dependency in various settings, including in an office, community hospital, health department, or correctional facility.<sup>54</sup>

Treatment for co-occurring mental health and substance use disorders need to be simultaneous.

#### *Recent Legislative Actions and Funding Measures*

##### Legislative Actions:

- The federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) 2008 requires group health plans that offer mental health or substance use benefits to offer them at parity with medical and surgical benefits;<sup>55</sup>
- The 2009 Texas legislature added substance use disorder (SUD) treatment services to the Medicaid program;
- Senate Bill 1325 (81R) established the Mental Health Program for Veterans to provide peer-to-peer counseling for veterans;
- Senate Bill 55 (84R) directed HHSC to establish a grant to support community mental health programs providing and coordinating mental health services for Texas veterans and their families;
- House Bill 1212 (84R) amended law related to the designation and regulation of abusable synthetic substances, the emergency scheduling of certain controlled substances, the prosecution and punishment of certain offenses involving a controlled substance or controlled substance analogue, and the offense of falsification of drug test results;

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- Senate Bill 1462 (84R) established a standing order for the prescribing of opioid antagonists;
  - House Bill 10 (85R) provided the Texas Department of Insurance (TDI) with parity enforcement authority related to physical health care and mental health care, including substance use treatment services;
  - House Bill 13 (85R) created a matching grant behavioral health program to support community mental health programs for individuals experiencing mental illness and the coordination of certain behavioral health programs;
  - Senate Bill 292 (85R) created a matching grant program to support programs aimed at reducing recidivism, arrest, and incarceration of individuals with mental illness;
  - Senate Bill 315 (85R) contains provisions that permit the Texas Medical Board (TMB) to inspect uncertified pain management clinics or facilities and gives TMB greater authority to investigate and crackdown on pain clinics that are dispensing unsound prescriptions;
  - Under SB 315 and SB 584 (85R), TMB is to adopt guidelines for the prescribing of opioid antagonists: guidelines are to address prescribing an opioid antagonist to a patient to whom an opioid medication also is prescribed and identifying patients at risk of an opioid-related drug overdose and prescribing an opioid antagonist to that patient or to a person in a position to administer the opioid antagonist to that patient;
  - House Bill 1486 (85R) adds certification requirements for peer specialists in Texas and adds peer support services to the Medicaid program;
  - House Bill 2561 (85R) requires the Texas State Board of Pharmacy to work with other agencies to identify potentially harmful prescribing practices and patient prescription patterns that suggest drug diversion or drug abuse. Effective September 1, 2019, all prescribers and dispensers, other than a veterinarian, shall consult the Prescription Monitoring Program prior to dispensing or prescribing opioids, benzodiazepines, barbiturates, or carisoprodol, with an exemption for cancer patients or hospice care;
  - House Bill 2671 (85R) amended law relating to the placement of certain substances in Penalty Groups 1 and 3 of the Texas Controlled Substances Act for the purposes of prosecution of criminal offenses involving those substances;
  - House Bill 2804 (85R) removed the requirement that the commissioner consider certain additional factors provided by the Texas Controlled Substances Act in determining whether a substance poses an imminent hazard to the public safety and authorizes the commissioner to extend the emergency scheduling of a substance by up to one year by publishing the extension in the Texas Register; and
  - On October 26, 2017, President Trump declared a Public Health Emergency nationwide as the result of the Opioid Crisis. This 90-day declaration was renewed on January 19th, 2018 and on April 20th, 2018.

**Funding:**

- Of the initial 1115 waiver projects, 56 included substance abuse services such as: integrated physical and behavioral health treatment, increased access to substance use treatment, improved interventions to justice-involved individuals who also need substance use

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services, and coordinated care among health systems. 1115 waiver projects collectively received more than \$432 million in the first six years of the Delivery System Reform Incentive Payment (DSRIP) program. In December of 2017, Centers for Medicare and Medicaid Services (CMS) approved a five-year extension of the 1115 waiver through September 30, 2022.<sup>56</sup>

- The federal 21st Century Cures Act (Act), enacted in December 2016, created the National Mental Health and Substance Use Policy Lab to coordinate policy changes related to mental health, recovery, and the prevention and treatment of substance use disorders. The Act made one billion dollars available to states and territories in grants over two years to fight the opioid crisis. Through the Texas Targeted Opioid Response (TTOR) program, the Texas Health and Human Services Commission (HHSC) was awarded \$27.4 million in FY 2017 to further evidence-based treatment programs, improve data collection, and encourage innovation in programs and practices. HHSC will receive an additional \$27.4 million for FY 2018.<sup>57 58</sup>
- The federal 2017 Family First Prevention Services Act brought sweeping changes to the child welfare system allowing states to use federal foster care entitlement dollars on evidence-based drug treatment for families at imminent risk of losing their children to the foster care system.<sup>59</sup>
- As established by Article IX, Sec 10.04, of the Texas Legislature Senate Bill 1 (85R), the total funds appropriated for the 2018-2019 biennium for non-Medicaid/CHIP-related behavioral health and substance abuse services total \$4.0 billion in All Funds (\$2.9 billion in General Revenue-Related Funds). Of these funds, an estimated \$741 million All Funds (\$440 million GR-R), based on what the agencies reported for the 2018-19 biennium, is to be used for substance abuse services. The funding amounts do not include the receipt of new federal funding, including Texas Targeted Opioids Response (TTOR), newly identified behavioral health funding by the Statewide Behavioral Health Coordinating Council, nor any additional services identified after the publication of the expenditure proposal. Estimated Medicaid and CHIP expenditures for substance abuse services totals \$190.0 million in All Funds for the 2018-19 biennium. Overall, estimated funding for substance abuse services totals \$931.1 million for the 2018-19 biennium.
  - For the Office of the Governor Trusteed Programs in Article I, the funds appropriated during the 85th Legislative Session were \$7,000,000 in General Revenue-Related Funds (\$8,800,000 in All Funds);
  - To the Department of Family and Protective Services in Article II, the funds appropriated during the 85th Legislative Session were \$5,224,862 in General Revenue-Related Funds (\$5,933,822 in All Funds);
  - To the Health and Human Services Commission in Article II, the funds appropriated during the 85th Legislative Session were \$88,121,981 in General Revenue-Related Funds (\$380,160,933 in All Funds);
  - To the Texas Department of Criminal Justice in Article V, the funds appropriated during the 85th Legislative Session were \$337,024,622 in General Revenue-Related Funds (\$341,961,659 in All Funds);

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- To the Texas Juvenile Justice Division in Article V, the funds appropriated during the 85th Legislative Session were \$1,321,644 in All Funds;
  - To the Texas State Board of Dental Examiners in Article VIII, the funds appropriated during the 85th Legislative Session were \$263,856 in General Revenue-Related Funds (\$263,856 in All Funds);
  - To the Texas State Board of Pharmacy in Article VIII, the funds appropriated during the 85th Legislative Session were \$486,009 in General Revenue-Related Funds (\$486,009 in All Funds);
  - To the Texas State Board of Veterinary Medical Examiners in Article VIII, the funds appropriated during the 85th Legislative Session were \$90,000 in General Revenue-Related Funds (90,000 in All Funds);
  - To the Texas Optometry Board in Article VIII, the funds appropriated during the 85th Legislative Session were \$72,000 in General Revenue-Related Funds (\$72,000 in All Funds); and
  - To the Texas Board of Nursing in Article VIII, the funds appropriated during the 85th Legislative Session were \$2,010,916 in General Revenue-Related Funds (\$2,010,916 in All Funds).<sup>60</sup>

#### *National and State Overviews*

#### *Substance Abuse and Mental Health Services Administration (SAMHSA) and Association of Substance Abuse Programs (ASAP)*

The Substance Abuse and Mental Health Services Administration (SAMHSA), within the U.S. Department of Health and Human Services (HHS), leads public health efforts to advance the behavioral health of the nation. Their mission is to reduce the impact of substance abuse and mental illness on America's communities. SAMHSA was established by Congress in 1992 to make substance use and mental health disorder information, services, and research more accessible.<sup>61</sup>

HHS's opioid strategy encompasses improving access to prevention, treatment, and recovery support systems; targeting availability of distribution of overdose-reversing drugs; strengthening timely public health data and reporting; supporting cutting-edge research, and advancing the practice of pain management. The strategy is comprehensive, evidence-based, targets drivers of the epidemic and is flexible to emerging threats. SAMHSA's role in the strategy includes various grant programs for prevention, treatment, and recovery, response to the crisis, medication assisted treatment (MAT) programs, training programs, and addiction technology transfer centers.

Commander Hearod of SAMHSA testified that the opioid epidemic in America is tied to the rise in prescriptions in the late 1990s, associated with higher prescription doses for longer periods of time, and combination prescriptions of multiple drugs, including a benzodiazepine, which increases a risk of overdose. Commander Hearod also discussed the dangers and potency of fentanyl.



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Also, with the increased prevalence of opioid addiction and abuse of other substances, many experts are concerned about a coming crisis related to communicable diseases, such as diseases spread via needle use. Because of this concern, some cities have considered opening clean injection sites where healthcare professionals provide drug users with sterile instruments.

Commander Hearod reports seeing emerging signs of progress. The signs include: a decline in youth prescription opioid misuse, which may be attributed to a decline in opioid prescribing and to heroin use stabilizing; a decline in prescription opioid misuse; an exponential increase in naloxone dispensing; significant increases in people receiving MAT; and a leveling off of overdose deaths in some states.<sup>62</sup>

According to Ms. Humphrey of the Association of Substance Abuse Programs (ASAP), “The opioid crisis has especially impacted women in Texas, and the state has seen an increase in maternal mortality and an increase of women in prisons.” Findings show a leading cause of maternal mortality is drug overdose. Additionally, the number of diagnosed cases of Neonatal Abstinence Syndrome (NAS) in Medicaid-funded deliveries increased 75 percent from 2010 to 2015. Ms. Humphrey further emphasized the importance and need for gender specific treatments as some SUD treatment programs do not admit pregnant women.

Experts, such as Ms. Humphrey, believe the U.S. is experiencing an addiction epidemic not only regarding opioids but one that spans across opioids, alcohol, stimulants, muscle depressants, and sedatives. Individuals with addictive tendencies are more likely to be abusing multiple prescriptions or illicit substances. Ms. Humphrey also testified that opioid use disorder is much more frequently diagnosed in combination with other mental health issues such as alcoholism, suicidal ideation, bipolar disorder, PTSD, and other issues.

She reports that alcohol use and abuse has also increased: alcohol use increased 11 percent from 2002 to 2013; alcohol use disorder increased by almost 50 percent. Alcohol use increased especially within minorities, women, and senior populations.<sup>63</sup>

To treat patients in rural and medically underserved areas, Commander Hearod and Ms. Humphrey recommend the expansion of telemedicine and telehealth networks.

They reference Project ECHO, based out of the University of New Mexico Health Sciences Center, as an academic network that connects primary care physicians to specialists of various health fields via telemedicine. By training and educating primary care physicians, the Project ECHO system provides support for specialty cases to primary care physicians.<sup>64</sup> Currently 119 “hub” centers provide support to primary care clinicians about various diseases, conditions, mental illnesses, and substance use disorders across the U.S.<sup>65</sup> Commander Hearod comments that because the certification to prescribe buprenorphine is only eight hours, some physicians are wary about their preparedness and may be apprehensive about treating patients with addiction and prescribing this treatment of MAT. However, by linking healthcare providers to specialists via telehealth networks like Project ECHO, primary care clinicians may feel more at ease in providing MAT.<sup>66</sup>

The Hub-and-Spoke Model of Care for Opioid Use Disorder system developed in the state of Vermont was also introduced.<sup>67 68</sup> The hubs are opioid treatment programs that provide intensive

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treatment services and all elements of MAT, and the spokes are office-based opioid treatment in community settings that provide maintenance of care and continued support for patients going through MAT. The Hub and Spoke services are provided through Medicaid by the state of Vermont, and over 6,000 people are now participating.<sup>69</sup>

### *PhRMA*

Ms. Brigner acknowledged PhRMA's role in contributing to the crisis solution, but highlighted the importance of all stakeholders being involved in addressing the opioid epidemic. Stakeholders include:

- Pharmaceutical companies that develop the products and their being transparent about what is in their drugs;
- Prescribers and Patients understanding how to use the medications appropriately and having a plan on how to get off of the medication when appropriate;
- Distributors looking for odd prescribing and shipping patterns that deviate from normal activity;
- Pharmacists informing the patient of the benefits and the risks of the prescribed medication when the patient picks it up; and
- Payers with a responsibility to consider equal coverage for non-opioid pain management treatments.

She advises that PhRMA supports the various national efforts to help combat the epidemic. National level activities include the President's Commission on Combatting Drug Addiction and Opioid Abuse. Other work by national associations and agencies includes: the National Governors Association developing recommendations for how states can specifically address their own needs; Centers for Medicaid Services hosting roundtables with stakeholder groups requesting input to implement the first ever CDC rules and regulations regarding pain management, including comments on implementing seven day prescription limits and point of pharmacy restriction; and the FDA opioid steering committee implemented the FDA Opioid Action Plan to reduce addiction behaviors.

Regarding states' actions, she reports that since January 1, 2018, 499 legislative bills have been introduced across state legislatures to address opioid abuse. These pieces of legislation include Prescription Drug Monitoring Program (PDMP) interoperability, dosage limits, naloxone distribution, Good Samaritan laws, and abuse deterrent formulations (ADFs).

Successes realized in other states include:

- Ohio and Kentucky mandated PDMP reviews by prescribers and implemented pain clinic regulations and saw a decrease of abuse from 85 percent to 62 percent between 2010, when the regulations were put in place, and 2015;
- Florida implemented pain clinic regulations and mandated PDMP reporting and saw an 80 percent decrease in prescribing and a 50 percent decrease in overdose deaths;
- New York required PDMP prescriber checks and saw a 75 percent reduction of multiple prescriptions for the same drugs across different providers;

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- Tennessee required PDMP prescriber checks and saw a 36 percent decline in doctor shopping; and
  - Oregon required PDMP prescriber checks, implemented prior authorization for medication assisted therapies, Narcan education for family members of abusers, and other patient education initiatives and saw a 38 percent reduction in overdose deaths.

PhRMA's proactive policy agenda for combatting the opioid crisis includes:

- No more than seven day opioid prescriptions for acute pain with appropriate exceptions / support for the CDC guidelines for pain management treatment;
- Expanding prescriber training requirements, including mental health screening tools;
- Expanding tools to inform prescribing, for example guidelines for treatment of chronic pain and the PDMP interoperability;
- Enforcing mental health parity;
- Improving coverage and access to full range of treatment and recovery options, non-opioid analgesics, and ADFs;
- Advocating for an independent review on DEA's manufacturing quota system for controlled substances;
- Advancing new treatments to address the opioid crisis through public-private partnerships; and
- Supporting the CDC guidelines for pain management treatment.<sup>70</sup>

### *Programs and Services in Texas*

#### *Department of State Health Services (DSHS)*

Dr. Hellerstedt with the Texas Department of State Health Services (DSHS) agrees that the national statistics are staggering, but the Texas numbers highlight the fact that the opioid and drug overdose epidemic has not hit the state quite as hard as other areas of the country. However, DSHS data shows that drug exposure cases resulting in inpatient stays and deaths are rising in Texas. Opioid use plays a significant role in the increase. Other drugs are also increasingly present in inpatient stays, overdose deaths, and drug exposure calls made to the Texas Poison Control Center. Antidepressants have, and continue to be, the most frequently seen in drug exposures, and benzodiazepines are increasingly present in data collected by the Poison Control Center.

The number of opioid-related exposure calls to the Texas Poison Center rose in the early 2000s, mimicking the drug overdose data provided by the state, but have decreased since 2010. Calls related to commonly prescribed opioids follow the same trend; however, calls related to synthetic opioids, or opioids obtained illegally, other than heroin have steadily risen since 2011.

Death certificate data shows that overall, accidental drug overdose deaths in Texas have been rising since 1999, and opioid related deaths contributed to almost half of the total accidental overdose deaths in 2015.

Accidental poisoning, or overdose, death data available to the state is based on death certificate information maintained by the Center for Health Statistics at DSHS. However, when reading the state data, not all medical certifiers currently use the same system or method, and therefore, data

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is not collected in a uniform way across the state. DSHS is addressing this issue through the implementation of a new electronic records vital events system called TexEver set to go live in 2019. Also important to understand is that in the case of accidental overdose deaths, often more than one substance is present in the body, therefore determining what substance contributed the most to a death is difficult.

Regarding drug-related inpatient admissions to emergency departments, DSHS data for 2016 shows that opioid-related admissions account for almost 40 percent of the total number of drug-related admissions and benzodiazepines for 30 percent.

Texas' county data shows higher numbers of opioid-related inpatient admissions in the Dallas/Fort Worth (DFW) metroplex, the Houston area, and along the I-35 corridor. Also, county data shows that accidental opioid-related overdose deaths are more prevalent in east Texas, and the DFW and Houston metro areas.

DSHS also has oversight of the TexasAIM Program and the Texas Health Data Opioid Dashboard to address substance abuse in Texas.

#### The TexasAIM Program

The TexasAIM Program, or the Texas Alliance for Innovation in Maternal Health, is the DSHS initiative tasked with driving down the incidence of maternal mortality in Texas. Specific to opioid use, TexasAIM is developing and implementing the Obstetric Care for Women with Opioid Use Disorder Bundle. The program is voluntary for doctors and hospitals who want to participate. The Bundle will provide participating doctors and hospitals with evidence-based practices and data-driven quality improvement strategies to improve substance use disorder screening, treatment, and education for pregnant women and mothers.

#### The Texas Health Data Opioid Dashboard

The Texas Health Data Opioid Dashboard is operated and updated by DSHS to improve transparency and provide public data-driven information regarding the opioid crisis in Texas. Current datasets used in the Dashboard include death certificate data, the Texas Poison Center Network, and Texas administrative claims data. DSHS is currently working to expand the Dashboard to include data from Texas school health surveys, emergency medical services (EMS) run data, and other data partnerships as they develop. DSHS is working to improve the Dashboard by adding visualization of data by Public Health Region and including other demographic indicators as allowed by bringing on additional data sets. The data displayed on the dashboard is not up to date, but shows the most recent data from 2015.<sup>71</sup>

#### *Health and Human Services Commission (HHSC)*

For cohesion of programs and elimination of redundancy of efforts in providing services for behavioral health, House Bill 1 (84R) created the Statewide Behavioral Health Coordinating Council (Council). The Council's membership encompasses 23 state agencies and 29 SUD programs that directly provide services across the state. The Texas Health and Human Services Commission (HHSC) has oversight of the Council. HHSC estimates that the Council member agencies have over \$540 million (approximately \$230 million in general revenue, and \$312 million

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in federal funds for each FY 2018 and 2019) for funding substance abuse and SUD programs statewide.

Programs administered through HHSC emphasize prevention, intervention, treatment and recovery, and include programs for individuals on Medicaid as well as programs for the indigent care population.

HHSC reports that in Texas, the first point of entry for people accessing services is frequently through Outreach Screening Assessment Referral (OSAR) sites. Fourteen OSAR programs are located at Local Mental Health / Behavioral Health Authorities (LMHAs/LBHAs) throughout the state. At least one OSAR is located in each of the 11 HHSC Health and Human Service Regions. A map of the location of all fourteen OSARs can be found in Appendix E. OSARs serve approximately 30,000 people annually, operate 24 hours per day, seven days per week, and receive about \$7 million in annual funding.

Prevention programs focus on grades 1-12, best practices curriculum, and identifying early signs of substance abuse. Prevention resource centers throughout HHSC regions provide data and community resources.

Intervention efforts include comprehensive behavioral health models; promotion of culturally sensitive prevention, intervention, and treatment in rural border communities; and HIV programs with outreach and early intervention initiatives.

Treatment includes an array of substance abuse programs for adults, ages 18 plus, and youth. Adult services include detox, residential, outpatient, specialized services for women, MAT contracted services, services for co-occurring mental health and SUD, and HIV residential services. Intensive residential, supportive residential, and outpatient services are available for youth. Recovery initiatives include recovery support services, peer support, and peer recovery services.

Regarding the non-Medicaid, indigent care population served by HHSC, SUD care totals \$177 million between federal and state dollars. Approximately 76 percent of that total is federal funding.

Commissioner Gaines reported that almost 90 percent of adults who complete non-Medicaid treatment through an HHSC program report abstinence at the end of treatment. Approximately 35,000 adults are served annually through HHSC SUD treatment services. Over 90 percent of youth who complete treatment services through HHSC report positive outcomes and abstinence, and 80 percent report they are attending school. Approximately 4,500 youth are served annually through HHSC SUD treatment services.

Regarding the Medicaid population served by HHSC, treatment costs for the SUD Medicaid benefit totaled \$9.7 million in FY 2015 and 5,967 unique individuals received SUD treatment.

#### Texas Targeted Opioid Response (TTOR)

The Texas Targeted Opioid Response (TTOR) grant of \$27 million is focused on prevention, treatment, and recovery. As required by the grant, five to 10 percent of the funds are concentrated on prevention goals and initiatives which include, distributing federal guidelines and related

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materials to all prescribers in Texas, developing a marketing campaign to increase Texas' Prescription Monitoring Program (PMP) registration and utilization, supporting safe prescription drug disposal, and expanding universal prevention programs for youth and communities.

Eighty percent of the funds are for treatment and recovery programs. Goals and initiatives include greater recovery support services, job training and peer reentry, expansion of access to MAT programs, and expanding outreach and engagement.

Ms. Ramirez reported that since May 2017, the state has been involved with collection of over 8,000 pounds of medication through safe drug take back initiatives.

Training projects for the general public, workforce, and professionals include comprehensive overdose prevention training, "Opioid 101" trainings, an opioid misuse prevention summit, MAT advocacy, and suicide and overdose prevention.

Intervention and treatment projects include OSAR expansion, mobile crisis outreach teams responding to opioid-related crisis events to ensure families have access to naloxone, expanding MAT, expanding office-based opioid treatment, and adding treatment for comorbid conditions such as Hepatitis C. Communicable disease transmission rates are rising nationally for people under 30 because of the opioid crisis.

Recovery projects include support for populations vulnerable to overdose such as those recently released from jail, hiring additional recovery coaches, expanding sober living facilities, expanding peer re-entry programs, and adding supported employment programs to partner with MAT providers.

The term for TTOR funding is two years, 2017 and 2018, with \$27.4 million per fiscal year. HHSC estimates that 14,710 individuals will be served during the two-year period.<sup>72</sup>

*Department of Family and Protective Services (DFPS)*

The Department of Family and Protective Services (DFPS) reported an increased strain on its services because of the opioid and addiction epidemic. Commissioner Blackstone reports that although substance abuse alone is not usually grounds for removal, it can be a contributing factor to issues that affect a child's safety and wellbeing; some states' number of children removed has tripled in response to the opioid crisis. Texas' increases have not been as dramatic because of opioids, but the state has seen methamphetamine and marijuana use related to cases of child removal according to DFPS.

DFPS families who require in-patient or out-patient treatment usually receive treatment through HHSC providers. In FY 2017, DFPS utilized OSARs screenings for 9,220 clients and of those, 6,511 received treatment.

DFPS was appropriated approximately \$3 million per fiscal year for the 2018/2019 biennium for substance abuse prevention and treatment services outside of HHSC services. These funds are

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utilized for services delivered primarily to families who have a child in foster care or are receiving family-based safety services due to high potential for child removal.

The bulk of DFPS appropriations for substance abuse prevention and treatment, \$5.28 million per year for the 2018/2019 biennium, goes to drug testing services. In situations of suspected substance/alcohol abuse, access to drug testing is necessary to determine the ongoing risk to the child.<sup>73</sup>

#### *Texas Department of Criminal Justice (TDCJ)*

The Texas Department of Criminal Justice (TDCJ) populations include offenders incarcerated in correctional facilities, offenders on parole or mandatory supervision, and offenders on probation.

Director Collier advises that of the \$170 million allocated within the TDCJ budget for substance abuse-related services, \$82 million is budgeted for institution-based programs within the TDCJ system; \$7 million is budgeted to parole-based services; and \$81 million is budgeted to probation.

Upon intake an Individualized Treatment Plan (ITP) is prepared for each offender. The results from assessments are added to an offender's ITP to establish the offender's priority need for treatment. Individuals receive information regarding the ITP process during offender orientation, assignment, and reviews related to their program placement.

Assessment-Driven Treatment Strategies are:

- The Texas Risk Assessment System (TRAS);
- The Texas Christian University Drug Scale (TCUDS); and
- The Addiction Severity Index (ASI) Assessment.

TDCJ has 10,047 incarceration beds dedicated to substance abuse treatment programs.

Programs include:

- Substance Abuse Felony Punishment Facilities (SAFPF) – 3,956 beds. Primarily used by judges that directly sentence people to treatment, these facilities provide intensive substance abuse treatment to those on probation or parole. Operated in a therapeutic community setting, the program generally lasts six to nine months depending on an individual's needs. After completing the incarceration period of the SAFPF program, community-based treatment centers continue to provide residential and outpatient counseling to those who need it.
- In-Prison Therapeutic Community (IPTC) – 2,141 beds. An intensive six-month substance abuse therapeutic community program for prison offenders who receive a program placement vote from the Board of Pardons and Paroles (BPP). After completing the incarceration period of the IPTC program, community-based treatment centers continue to provide residential and outpatient counseling to those who need it.
- Pre-Release Substance Abuse Program – 1,150 beds. An intensive six-month substance abuse treatment program for individuals approved for parole upon successful completion

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of the program. The pre-release substance abuse program operates in a substance abuse treatment environment similar to the IPTC program. FY 2017 saw 1,836 successful completions.

- Pre-Release Therapeutic Community (PRTC) – 600 beds. A six-month intensive therapeutic community program for individuals approved for parole upon successful completion of the program. The three components of PRTC are educational and vocational training, substance abuse treatment, and cognitive restructuring. FY 2017 had 843 completions.
- In-Prison Driving While Intoxicated (DWI) Recovery Program – 1,000 beds. A six-month program designed for DWI offenders, and especially individuals with diverse anti-social behavior issues and those at high risk for re-offending. FY 2017 had 1,447 completions.
- State Jail Substance Abuse Program (SJSAP) – 1,200 beds. A care program integrated within the state jail system designed for individuals in state jail convicted of a broad range of offenses. Six different facilities in Texas have 200 beds each.

Recidivism for the SAFPF program after three years is about 45 percent and for the IPTC program, recidivism is about 22 percent. However, these two programs encompass the most intense populations. All programs combined have about a 21 percent recidivism rate.

Parole Substance Abuse Programs are contracted out-patient services through vendors in communities with licensed counselors on staff.

- Specialized Substance Abuse Parole Caseloads encompass 7,592 offenders: TDCJ has parole officers on staff who are trained specifically to work with substance abusers.
- Outpatient Substance Abuse Counseling: TDCJ contracts with providers and licensed parole counselors throughout the state to provide outpatient services. If an individual on parole fails a drug test, he/she is sent to schedule an outpatient abuse counselling appointment and is usually engaged 60-90 days.
- Intermediate Sanction Facility (ISF): Substance abuse treatment services are provided with an ISF placement decision by the Board of Pardons & Paroles. Focused on substance abuse treatment and cognitive intervention, this is a short-term alternative to parole revocation for those who have failed parole and need treatment. 2,965 ISF beds are available.

Substance Abuse Programs within probation are for individuals on probation and offered via services through various community corrections facilities. TDCJ has 11 substance abuse treatment facilities, seven court residential treatment facilities, six intermediate sanction facilities, and three dually diagnosed residential facilities, with a total of 27 facilities and 2,897 beds available. Over 9,000 people received services in FY 2017.

The programs had 16,556 individuals successfully complete treatment programs in FY 2017.<sup>74</sup>



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*Office of the Governor - Criminal Justice Division (CJD)*

Texas has 176 registered specialty courts; 71 of the specialty courts are funded by the Office of the Governor, Criminal Justice Division (CJD) with \$8.6 million for specialty courts. Adult drug courts receive about \$4.4 million. The CJD oversees registration of all specialty courts.

A specialty court provides specialized direct services, usually drug treatment, to high-risk offenders with high needs, as an alternative to incarceration. High-risk individuals have a high likelihood of re-offending in a standard supervised setting; high needs refers to a clinical disorder or functional impairment, such as substance abuse.

Pre-adjudication, courts may divert cases into the specialty courts before they enter a plea. Post-adjudication, sentences may be waived or suspended, pending successful completion of program.

Texas defines a specialty court as either a drug, family, veterans, mental health, commercially sexually exploited persons, or public safety employees treatment court. Program results for 2017 include: 6,284 participants, 1,794 successful graduates, 805 individuals who failed the program or were rearrested. Upon enrollment, 32 percent of participants were unemployed; at graduation, 93 percent were employed or supported; 95 percent were housed. Eighty-two percent of the participants scored "high" or "moderate" risk; 36 percent had mental health issues. The average graduation time was 16 months.<sup>75</sup>

*Advocates*

*Texas Council of Community Centers*

The Texas Council of Community Centers, represents the state's community centers (local mental health authorities/local behavioral health authorities - LMHAs/LBHAs), through which most substance use services via OSARs are provided. Mr. Johnson expands on HHSC's comments:

- Through *outreach*: OSARs strive to ensure the community, clinical providers, and justice systems are informed on how to access available resources;
- Through *screening*, financial eligibility for state-supported assistance in accessing substance use treatment is determined;
- Through *assessment*, an individual's needs for treatment is determined; and
- Through *referral*, specific needs of individuals are recognized for connection to available treatment services in their communities. Community centers can connect individuals to detoxification services, short-term residential and supportive residential services, intensive outpatient programs, supportive outpatient services and counseling, as well as, linkage to recovery communities, recovery coaches, and support services.

In FY 2017, community centers served over 520,000 Texans through local contracts, HHSC services, and X-waivers through DSRIP-funded projects. Nine percent of the services provided to 45,000 individuals were for early childhood interventions (ECI); 16 percent of services were provided to 85,000 individuals with intellectual/developmental disabilities (IDD); 10 percent of services were provided to 53,000 individuals with substance use disorders; and 65 percent of services were provided to 337,000 individuals with mental health needs.<sup>76</sup>

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*Texas Hospital Association (THA)*

Mr. Hawkins with the Texas Hospital Association (THA) testifies, "Despite emergency departments prescribing a fraction of the prescriptions written nationally, emergency department prescriptions for opioids are reported to account for approximately 45 percent of those opioids diverted for non-medical use."

In an effort to curb opioid addiction and overdose deaths as well as overprescribing, the THA Board of Trustees approved the use of Voluntary Emergency Department Prescribing Guidelines To Curb Opioid Misuse And Abuse.

The voluntary prescribing guidelines are:

- Encourage hospitals to develop a process for identifying patients, including pregnant and postpartum women, at risk for developing a substance use disorder and for those with a substance use disorder.
- Discourage ED providers, who are not the initial prescribers, primary care providers or pain specialists, from writing prescriptions for controlled substances that are lost, destroyed or stolen, or doses of methadone for patients in methadone treatment programs.
- Emphasize use of short-acting opioids, if opioids are prescribed in the ED.
- Endorse adoption of a multi-modal non-opioid medication model for acute pain management treatment.
- Recommend that when any opioid prescriptions for patients leaving the ED be written for the shortest duration possible, usually no more than five days, unless the diagnosing physician determines more are necessary.
- Recommend that, when opioids are prescribed, hospitals have a system in place to notify the patient's primary opioid prescriber or primary care provider of the ED visit and the medications prescribed.
- Encourage ED prescribers, or their designees, to consult the state's Prescription Monitoring Program (PMP AWARe) before writing opioid prescriptions to check patients' prescribing history.<sup>77</sup>

Hospital associations in 18 other states have developed similar guidelines.<sup>78</sup>

*Meadows Mental Health Policy Institute (MMHPI)*

Dr. Keller with the Meadows Mental Health Policy Institute (MMHPI) states that a substance use disorder (SUD) is a medical illness involving repeated misuse and functional impairment; a pattern of harmful, continued use, not occasional misuse.

He reports that nearly eight of every 100 Texans have a SUD:

- Among youth in Texas ages 12-17, an estimated 75,000 have an alcohol-related SUD and an estimated 85,000 have an illicit drug SUD; and
- An estimated 1.4 million adults in Texas have an alcohol related SUD and an estimated 410,000 have an illicit drug-related SUD.

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Treatment admissions from 2012 to 2016 showed abuse of alcohol, cocaine/crack, heroin, prescription opioids, and methamphetamine. Alcohol continues to show the largest admission numbers; methamphetamine numbers show continued growth over the years; and cocaine/crack and prescription opioids show to be decreasing. (A graph depicting treatment admissions broken down by substance use between 2012 and 2016 can be found in Appendix F.)

MMHPI reports that in 2016, state monies provided services for just under 35,000 of approximately 680,000 adults in poverty and just under 5,000 youth with SUD needs in Texas. Through Medicaid in 2015, just under 6,000 adults received Medicaid-funded SUD treatment and an unknown number of youth with SUD needs received care. In review of appropriated monies, Dr. Keller states that data shows more money for the provision of additional state services is needed to address substance use in Texas.

Dr. Keller reports that barriers to SUD care in the private sector are also prevalent in Texas but data nor statistics are available on private care. MMHPI estimates one in three persons in need receives care through the private system and that coverage is typically for only a short-term episode and a subset of all needed services – inpatient, outpatient, brief residential, and some medications. Also, SUD coverage may require prior authorization or entail other barriers to care. SUD services are usually managed as a separate cost center, requiring two separate insurance contracts for mental health and physical health.

MMHPI emphasizes that unmet SUD needs impact Texas as a whole. SUDs are a leading contributor to children entering the child protective services (CPS) system; drug overdose is a leading cause of maternal deaths in Texas, most of which are attributed to abuse of prescription opioids. Unmet SUD needs result in an estimated \$350 million per year in emergency room costs.

Recognizing the prevalence and impact of co-occurring mental illness and substance use disorders when examining the opioid crisis is important. Dr. Keller informed that research conservatively estimates that at least one-third of adults and one-fourth of youth with a SUD in Texas also have co-morbid psychiatric conditions. He also says the number is, in reality, much higher as studies of individuals in SUD treatment programs report that up to two-thirds of people with SUDs also have mental illnesses. Co-occurring disorders can lead to higher chances of relapse, experiencing homelessness, incarceration, medical illnesses, suicide, and early death. These individuals are best served by an integrated care model where both disorders are addressed at the same time with appropriate interventions for each.

Regarding MAT programs, Dr. Keller expresses support for these as effective medication and supportive counseling programs. He comments about the limitation of access for methadone with only 85 providers licensed in Texas and references that any physician can prescribe naltrexone and with training to qualify for a waiver can prescribe buprenorphine.

Dr. Keller expresses concern that MAT is only being provided to 14 percent of people with opioid use disorders by non-Medicaid HHSC-funded providers, and says this creates a huge gap in services.

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MMHPI recommendations include obtaining better data on how much the state is spending on substance use; designating the opioid crisis as a public health emergency; promoting MAT as a necessary treatment option and prioritizing expanded access to MAT for publicly-funded care; removing barriers to accessing MAT; and embracing the use of long-acting injectable MAT for key populations including for justice involved individuals.<sup>79</sup>

*Texas Association of Health Plans (TAHP)*

Ms. Dudensing of the Texas Association of Health Plans (TAHP) advises, "Both commercial health plans and Medicaid Managed Care Organizations (MCOs) are on the front lines helping patients and providers."

Health plans have access to the data and the tools necessary for early identification, education/care management tools to help shift patients to more appropriate treatment, and relationships with providers to collaborate on efforts. The organizations' strategies to address opioid abuse include prevention, early intervention, and treatment.

Examples of actions already taken include:

- Setting a goal to reduce inappropriate opioid prescribing to members by 50 percent by 2022;
- Using an innovative retrospective narcotic overutilization program which has decreased the number of opioid prescriptions written by 41 percent; has decreased the number of physicians prescribing opioids by 45 percent; and has decreased the number of pharmacies dispensing opioids by 41 percent;
- Aiming to reduce customers' Rx opioid use from 2015 levels by 25 percent before 2019;
- Built a data mining program to identify members on the "Houston Cocktail;" and
- Automated a program to identify poly-pharmacy, high dose prescribing, and overutilization of opiates.

TAHP identifies barriers being a significant shortage of MAT providers, especially for pregnant women, and a lack of flexibility in the Medicaid program to implement safety prior authorizations.

The association agrees that lock-in programs are a best practice to address doctor shopping and intervention with high risk clients but discusses that the limitations on the current Medicaid Lock-In Program need to be lifted and that MCOs need the ability to lock-in high risk clients to a single prescriber and/or single pharmacy for frequently abused drugs.

TAHP comments regarding the need for improved data sharing and coordination of access to data and client information to better provide services for clients and to identify trends and implement targeted programs. Additionally, the association wants client education to include, at the point of sale, a notice indicating the potential and likely dangers of opioid use and the legal consequences for inappropriate diversions of opioid products; access to naloxone; and "Good Samaritan" legislation to provide basic legal protection to those who assist a person who is injured or in danger.<sup>80</sup>

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## *Challenges*

- Data, concern about accuracy and the lack of real-time information.
- Too few OSARs.
- Lack of infrastructure available; the need for services regularly exceeds capacity, creating the need to maintain a waiting list.
- Access to treatment, especially in rural/underserved areas, for women, and for individuals with co-occurring mental health and substance use disorders.
- Lack of screening and appropriate referrals to treatment in healthcare systems.
- Access to medication assisted treatment (MAT).
- Cost of opioid antagonists.
- Low number of licensed providers of methadone.
- Low number of prescribers and dispensers obtaining the waiver for buprenorphine.
- Siloed care and lack of ability to charge for varied services provided in a single visit to a facility on the same date, as opposed to integrated care.
- Lack of parity in insurance coverage for mental health and substance use disorders.
- Overprescribing.
- Concern about persons who may turn to illicit drugs when cut off from prescription opioids.
- Concern regarding persons with chronic pain and their ability to obtain medication.
- Funding.
- Lack of education of drug take back programs and the dangers of left-over medication.

## *Recommendations*

- Reverse "Pain as the Fifth Vital Sign" by formal declaration (resolution).
- Continue the emphasis on integrated care to provide care for the whole person and not separate physical health from mental health.
- Continue the effort to ensure parity laws are enforced.
- Require following the Centers for Disease Control (CDC) guidelines for days or dosages of an opioid prescription, with applicable exceptions.
- In continued review of methods to reduce the abuse of opioids and other drugs, recognize and fully consider medically appropriate and legitimate uses of opioids.
- Consider the potential unintended consequence of increased use, abuse and overdose of heroin and fentanyl due to opioids no longer being available to some patients because prescriptions are harder to obtain, and/or prescription medication is more expensive.
- As emergency departments write a large number of prescriptions, encourage following the emergency department guidelines generated by the Texas Hospital Association.
- Identify methamphetamines as a Texas crisis, due to some parts of the state having more prevalence of methamphetamine use and abuse than opioids - give weight to extreme ease of use, addictiveness, and social, criminal and health-related costs associated with this powerful substance.

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- Treat substance use disorder (SUD) as a chronic illness.
  - Increase availability of and access to opioid antagonists.
  - Encourage MAT treatment centers to include on-site mental health providers, for a "one-stop shop," for co-occurring conditions.
  - Expand the state's definition of MAT, to include more treatments and more opioid antagonist options on the Preferred Drug List (via the Vendor Drug Program and Drug Utilization Review Board).
  - Encourage an increase in the number of prescribers of MAT medications.
  - People suffering from opioid use and/or SUD need access to MAT options available in all counties of the state - expand treatment options in medically underserved areas to ensure an adequate network of prescribers and providers to reduce geographic gaps in treatment availability.
  - Encourage development of new non-addictive medications that will work on the brain's opioid receptors.
  - Review funding rates to substance abuse service facilities as capacity to provide treatment is impacted by rates and the current rates do not support growth. Perform a comprehensive rate study based on best practices for each level of care to determine the best rates for recommendation.
  - Evaluate scope of recovery support services including recovery housing and recovery coaching, including possible enhancements.
  - Consider the need for continuum of services that are flexible to individuals and communities to improve service delivery and reduce recidivism based on evidenced-based best practices.
  - Encourage prescribers to advocate for other pain management methods; make opioids a last resort.
  - Determine how to obtain data in a more real-time manner to better address progress and gaps of programs.
  - Improve data content and accuracy by standardizing reporting across all agencies related to opioid and substance abuse, for better data, analysis, and communication.
  - For accuracy in correct cause of death declarations, require training programs to anyone who has the authority to issue a death certificate's cause of death but is not a medical professional to ensure the person knows what the symptoms and conditions are in an overdose fatality.
  - Consider methods for improved data sharing with various stakeholders, including insurance companies, prescribers, dispensers, and others as appropriate, for coordination of access to data and client information to identify trends.
  - Prevention is key to reducing first incidence and recurrence of substance use disorders and should be available across one's lifespan; provide education in school and community environments.

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- Strengthen schools' curriculum with specific regard to substance abuse in Health classes in middle and high schools across the state.
  - Generate awareness campaigns similar to "Drinking and Driving" campaigns, to include public service announcements regarding not only risk of opioid and drug addiction, but also risk of over-sedation, respiratory depression, mixing medications, etc.
  - Consider the employment of prevention specialists in public schools.
  - Require a list of local, evidence-based drug education and prevention programs be provided to TEA for distribution to all school districts.
  - Promote education regarding safe storage and safe disposal of unused medications.
  - Expand drug take back programs and encourage that every pharmacy and hospital have a secure, consistent, and anonymous collection point for unused medications.
  - Encourage pharmacy follow-up where a pharmacist calls to check on a patient regarding use of a prescription and if all was taken; if not, what happened to the medication, as in, was it thrown out, left in a cabinet, or other?
  - Require providers to educate patients regarding the risks associated with highly addictive substances and how to safely dispose of their medication prior to prescribing opioids.
  - Review access to telemedicine services in rural communities and other medically underserved areas to address coverage gaps and limited access to transportation to urban communities with treatment services and facilities.
  - Ensure the Statewide Behavioral Health Coordinating Council remains intact and continues to coordinate and financially align the programs among the various state agencies and entities to address substance use disorders and abuse.
  - Address the state's lack of facilities and capacity for treatment options by creating matching grant programs, and promoting partnerships between state agencies and treatment facilities; allow for local flexibility over funds granted to treatment providers with state contracts.
  - Promote regional accountability for public sector SUD outcomes.
  - Continue review of federal and other states' programs and initiatives regarding the opioids and substance abuse crisis to help develop plans of action to assist Texans in avoiding use of these drugs or getting treatment to break the cycle of addiction, and to fulfill one's potential to live, work, and support a family. Ensure the state is applying for available funds from the various federal programs. Formulate a plan for the infusion of federal dollars, aligned with state priorities.

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**PUBLIC HEARING 2: CHARGE 6 - REVIEW OF OPIOIDS AND SUBSTANCE ABUSE IMPACT ON THE CHILD PROTECTIVE SERVICES SYSTEM, CHARGE 1 - OPIOIDS AND SUBSTANCE ABUSE (OVERVIEW CONTINUED), CHARGE 2 - REVIEW OF PREVALENCE OF SUBSTANCE ABUSE AND SUBSTANCE USE DISORDERS IN SPECIFIED POPULATIONS, AND CHARGE 3 - REVIEW OF POLICIES/GUIDELINES OF STATE AGENCIES TO MONITOR FOR AND PREVENT ABUSE OF PRESCRIPTION DRUGS IN STATE-FUNDED/ADMINISTERED PROGRAMS**

The Committee held its second public hearing related to opioids and substance abuse on April 17, 2018 at 10:00am in Austin, Texas in the Capitol Extension, Room E2.012. The following organizations/individuals were invited to testify:

**Charge 6 - *Review of Opioids and Substance Abuse Impact on the Child Protective Services System.***

Sherry Lachman, Foster Care

**Charge 1 - *Opioids and Substance Abuse (Overview Continued).***

Matthew Feehery, Memorial Herman Prevention and Recovery Center  
Amy Granberry, Charlie's Place Recovery Center; Association of Substance Abuse Programs

**Charge 2 - *Review the prevalence of substance abuse and substance use disorders in pregnant women, veterans, homeless individuals, and people with co-occurring mental illness. In the review, study the impact of opioids and identify available programs specifically targeted to these populations and the number of people served. Consider whether the programs have the capacity to meet the needs of Texans. In addition, research innovative programs from other states that have reduced substance abuse and substance use disorders, and determine if these programs would meet the needs of Texans. Recommend strategies to increase the capacity to provide effective services.***

Brooke Boston, Texas Department of Housing and Community Affairs  
Manda Hall, MD, Texas Department of State Health Services  
Lisa Hollier, MD, Texas Department of State Health Services; Maternal Mortality and Morbidity Task Force  
Tim Keesling, Texas Veterans Commission  
Kevin Langehennig, Haven for Hope  
Ikenna Mogbo, Dallas Metrocare Services  
Lisa Ramirez, Texas Health and Human Services Commission  
Ivonne Tapia, Aliviane  
Kenneth Wilson, Haven for Hope

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**Charge 3 - Review policies and guidelines used by state agencies to monitor for and prevent abuse of prescription drugs in state-funded or state-administered programs. Include in this review policies implemented by the Texas Medicaid Program, the Division of Workers' Compensation of the Texas Department of Insurance, the Teacher Retirement System, and the Employee Retirement System. Make recommendations regarding best practices.**

Ryan Brannan, Texas Department of Insurance; Division of Workers' Compensation  
D.C. Campbell, Texas Department of Insurance  
Laura Chambers, University of Texas System  
Katrina Daniel, Texas Retirement System  
Diana Kongevick, Employee Retirement System  
Sheri Meyer, Texas A&M University System  
Stephanie Muth, Health and Human Services Commission  
Chris Voegele, Texas Department of Insurance; Division of Workers' Compensation

The following section of this report related to opioids and substance abuse is produced in large part from the oral and written testimony of the individuals above.

*Charge 6: Review of Opioids and Substance Abuse Impact on the Child Protective Services System*

The public hearing for Charge 6 was held on August 7, 2018. Sherry Lachman with Foster America was in Texas for a symposium and was permitted by the Chairman to testify on this charge during the committee's April 17, 2018 public hearing. Her comments regarding Charge 6 are included under Public Hearing 5.

*Charge 1: Opioids and Substance Abuse (Overview Continued)*

To gain a perspective regarding day to day providers of services, the Committee heard testimony from representatives from Charlie's Place Recovery Center in Corpus Christi and from Memorial Hermann PaRC (Prevention & Recovery Center) in Houston.

*Statistics*

Additional statistics regarding Charge 1:

- One out of sixteen people prescribed opioids will become addicted;<sup>81</sup>
- Seven days, the number of days needed to become dependent on or addicted to prescription opioids;<sup>82</sup>
- Nationally, 80 percent of all heroin users first started with prescription opioids;<sup>83</sup>
- In the U.S., opioid misuse contributes to over 420,000 emergency department visits each year;<sup>84</sup>
- In Texas, an overnight opioid overdose admission costs over \$36,000 dollars;<sup>85</sup>
- Nationally, in 2017, approximately 47,000 people died due to heroin, fentanyl, and prescription opioid overdoses (out of 67,000 accidental drug deaths);<sup>86</sup>

- In Texas, deaths from opioid overdose have been increasing approximately ten percent per year since 2014, primarily fueled by heroin and fentanyl overdoses;<sup>87</sup>
- About 6.5 percent of Texans have a substance use disorder;<sup>88</sup>
- Relapse rates for substance use disorders (40-60 percent) are comparable to those for other chronic diseases such as diabetes (20-50 percent), hypertension (50-70 percent), and asthma (50-70 percent);<sup>89</sup> and
- As a chronic, progressive, relapsing disease, the risk of relapse does not drop below 15 percent for at least the first four to five (or more years) following remission of use.<sup>90</sup>

### *Providers of Substance Abuse Services*

#### *Charlie's Place Recovery Center (Charlie's Place)*

Charlie's Place Recovery Center (Charlie's Place) is a substance abuse treatment center located in Corpus Christi that provides inpatient and ambulatory detoxification services, residential services for adults, specialized female residential services, outpatient treatment, recovery support services, and co-occurring substance use disorder case management services.

In 2017, Charlie's Place treated 2,079 patients of which 1,466 required detoxification. Of the patients treated, 1,616, or 78 percent, had no insurance. The number of children under 18 impacted by a parent receiving treatment was 831.

The primary substances identified as being used by patients in treatment were heroin and alcohol. Other substances for services included opiates/synthetics, methamphetamine, and cocaine/crack.

Charlie's Place has 155 licensed beds of which it currently contracts with the state to provide 20 detox beds and 36 residential/inpatient beds for HHSC's Region 11.

The number of patients in Charlie's Place with co-occurring substance use disorder and mental health disorders is generally in the 55-60 percent range.

Ms. Granberry testified, "Due to a lack of infrastructure available, and the funding to support it, treatment is difficult to access." She expressed specific concern regarding per day rates that have not kept up with costs and the waiting list that averages 25-30 patients per day (or six to nine weeks for residential services). If someone ready to receive services is turned away, they may never return.

Regarding funding, further concern is expressed that substance use disorders (SUDs) and mental health services are handled differently although block grants are received for both from SAMHSA. On the substance abuse side, the funds are primarily federal block grants with some general revenue. SUD treatment services are bid competitively every five years which creates a barrier to growth and lacks flexibility to address changing needs within communities.

Ms. Granberry elaborates that the substance use disorder system is very dependent on services available in the community and continued relationships are needed for referrals sources and

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providers of other services. Charlie's Place works with the local Recovery Oriented System of Care (ROSC), local veteran's coalitions, local homeless coalitions, drug court team in family court, and other community service providers.

She expresses that a continuum of services with recovery supports is also integral to the "long term recovery puzzle." Charlie's Place provides certified recovery coaches working in various service needs areas – homelessness, opiates, and veterans.

Testimony by Charlie's Place advises that prevention is vital to reducing substance use. Relevant prevention initiatives and education should be available in the Texas Essential Knowledge and Skills (TEKS) education guidelines in public schools and age-specific material for adults and young people. Ms. Granberry testified that prevention should be expanded to all areas and age-groups within a community to truly be effective.

Intervention is also incredibly important to the state's response to the opioid crisis and risk reduction. The state's provision of funds and grants allows local entities to equip first-responders, law enforcement, hospitals, treatment providers, and individuals with access to opioid antagonists. Intervention best practices such as early treatment referral via healthcare providers and access to opioid antagonists like naloxone in the event of overdose, present opportunities to actively intervene and address substance abuse in communities.<sup>91</sup>

*Memorial Hermann Prevention and Recovery Center (PaRC)*

Memorial Hermann Prevention and Recovery Center (PaRC) provides services including inpatient detoxification, residential treatment, a chronic addiction treatment program (the first of its kind in Texas), adolescent and adult services, and a treatment program for licensed professionals such as physicians, lawyers, and nurses. PaRC services address both substance use and co-occurring mental health disorders, and includes wrap-around support services.

Mr. Feehery states that SUDs are very treatable and that treatment should include all options and medications that can effectively allow someone to live a healthy, productive life without continued use of mood-altering substances. He informs that medication assisted treatment (MAT) has become the most recommended approach for treating individuals with an addiction to opioids, which may conflict with abstinence-based treatment approaches offered in the same treatment setting. Medications containing the partial agonist buprenorphine are the most used medications to address opioid dependence because the drug allows many people to feel normal and function without the cravings that drive use. However, buprenorphine is itself an opioid and is addictive.

He explains that antagonist opioid blocking medications, such as naltrexone, should be included in MAT treatments, but for many people with polysubstance dependence (alcohol, benzodiazepines and opioids, or opioids and stimulants, or other drug combinations), the partial agonist buprenorphine may not be the most suitable. Additionally, methadone, a full agonist opioid medication has been in use for over 40 years but is highly regulated and primarily available in structured clinic settings.

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Mr. Feehery emphasizes that MAT, by definition, combines medications with therapy, counseling and mutual support, not in place of or instead of other therapeutic treatment components.

He comments that in rural Texas, program access is limited for receiving medication and wrap-around counseling and other treatment services. Additionally, for buprenorphine, the withdrawal process is uncomfortable and should be managed by a physician or treatment program. Also, buprenorphine has a street value and is subject to misuse. If a patient finds himself/herself discharged for some reason with no further access to the medication, many will return to the use of other opioids.

Mr. Feehery states that PaRC and the majority of private residential treatment programs in Texas prefer the opioid blocking medication due to its non-narcotic make-up. Naltrexone is available in a long-acting monthly dosage, but the medication's cost presents a challenge.

Regarding opioids and pain relief, Mr. Feehery testifies that new data has reported that opioid pain relievers are no more effective at managing pain than non-opioid pain relievers. He highlights a November 2017 Journal of the American Medical Association (JAMA) study wherein for patients presenting to the emergency department (ED) with acute extremity pain, at two hours there were no statistically significant differences in pain reduction among single-dose treatment with ibuprofen and acetaminophen than with three different opioid and acetaminophen combination analgesics.<sup>92 93</sup>

Additionally, a JAMA study released in March of 2018 reported that treatment with opioids was not superior to treatment with non-opioid medications for improving pain-related function over 12 months.<sup>94</sup> These two recent studies highlight that in many cases a potentially addictive prescription opioid may not be necessary to manage one's pain and that other treatment options are just as viable.

PaRC has observed that primary care and chronic pain physicians are offering effective medication and procedural alternatives to patients when appropriate. Also, patient awareness about the potential dangers of prescription opioids is increasing, and they are actively seeking alternatives from their physicians.<sup>95</sup>

## *Charge 2: Review of Prevalence of Substance Abuse and Substance Use Disorders in Specified Populations*

### *Pregnant Women*

#### *Background*

Neonatal abstinence syndrome (NAS) is a set of symptoms that can occur in a newborn that has been prenatally exposed to opioids while in the mother's womb. Upon birth, exposure to opioids is abruptly stopped, and the baby will experience symptoms of withdrawal such as gastrointestinal problems, crying, feeding issues, and sensitivity to stimuli in the environment. Substance use among pregnant women impacts the health of the mother and child and is affected by access to and availability of services specific to pregnant women.<sup>96</sup>

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### Statistics Related to Pregnant Women:

- Rates of NAS diagnoses in Texas are increasing: Texas Medicaid saw 1,150 diagnoses in 2011 and over 1,300 diagnoses in 2015;<sup>97</sup>
- Texas has a higher NAS average hospital length of stay than national average; the average hospital length of stay for NAS in Texas is 21 days while the national average is about two weeks;<sup>98</sup>
- One maternal death represents 50 to 100 women suffering from severe maternal morbidity in Texas;<sup>99</sup>
- From 2012 to 2015, drug overdose was found to be the leading cause of maternal death in Texas;<sup>100</sup>
- From 2012 to 2015, 382 maternal deaths in Texas occurring within 365 deaths of pregnancy were confirmed;
  - Maternal drug overdose was the cause of 64 maternal deaths, with 42 (66 percent) involving a combination of drugs; and
  - Opioids were involved in 37 (58 percent) of maternal drug overdose deaths, with benzodiazepines involved in at least 13 opioid-involved maternal drug overdose deaths.<sup>101</sup>
  - Overdose drugs included the following:
    - Opioids;
    - Sedatives;
    - Heroin;
    - Cocaine;
    - Methamphetamine, and
    - Fentanyl.<sup>102</sup>

### *Programs and Providers of Services*

#### *Health and Human Services Commission (HHSC) - Neonatal Abstinence Syndrome*

State and national strategies in-place to address maternal opioid use and neonatal abstinence syndrome (NAS) are based on prevention of NAS, intervention with pregnant and mothering women, and supported recovery.

#### National Strategies

National strategies are multi-faceted and prioritize the prevention and treatment of NAS and maternal substance abuse. Primary prevention strategies focus on reducing prenatal exposure to opioids during pregnancy through safe prescribing practices and disseminating safe guidelines across prescribers. Secondary prevention involves treating NAS and maternal opioid use disorder with evidence-based interventions.

In treating NAS, two lines of treatment are typically utilized. The first involves the mother providing care for her newborn and emphasizes keeping the mother and child together which avoids negative repercussions in the newborn's attachment and development. Interventions

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supporting the first line of treatment increase attachment and bonding with the newborn and mother, increase family preservation, and reduce hospital costs and length of stay.

Pharmacologic interventions and medications for the newborn are used in the second line of treatment if the first line of treatments are unsuccessful.

Tertiary prevention seeks to improve long-term health outcomes and include overdose prevention strategies and low threshold support services (in home, home visitation programs, support programs, recovery coaches, etc.).

#### Texas' Strategies

Texas' strategies to address NAS and maternal substance abuse align with nationally recommended strategies.

The Texas Neonatal Abstinence Syndrome Initiative encompasses overdose prevention training, media campaigns, specialized treatment, Mommies programs, targeted outreach and engagement, the MOM Study, Kangaroo Mother Care, and statewide stabilization center. The Texas NAS Initiative was appropriated \$11.2 million to fund special programs. Examples of primary intervention in Texas include emphasis on safe prescribing and reducing exposure to opioids during pregnancy. Some initiatives are also funded through the Texas Targeted Opioid Response (TTOR) grant program.

Medical providers in hospital systems report that women with opioid use disorders often show up very late or at labor and delivery instead of engaging in prenatal care earlier on, demonstrating Texas' need for prevention initiatives.

The Maternal Opioid Morbidity Study (MOMS) by UT Health Science Center in San Antonio examines mothers who have relapsed and family members of women who have experienced relapse and overdosed. The goal of the study is to learn how to better intervene and prevent opioid relapse and overdose deaths. The next steps are to develop a brief screening instrument to identify women at risk for maternal opioid relapse.<sup>103</sup>

#### *Department of State Health Services (DSHS) - Maternal Mortality and Morbidity*

Maternal mortality became a focus because of a 2016 research article that showed a sharp increase in maternal mortality in Texas. The study reported that maternal mortality deaths in Texas peaked in 2012 with 147 maternal deaths within 42 days post partum.

In response, the Department of State Health Services (DSHS) and the Texas Maternal Mortality and Morbidity Task Force (Task Force), led by Chairperson Dr. Hollier, performed a review of all maternal deaths in 2012 using a DSHS developed enhanced method of identifying maternal deaths in Texas. Fifty-six maternal deaths within 42 days post partum in 2012 were confirmed. Although the number of maternal deaths was not as high as initially determined, DSHS emphasizes that one maternal death should not be viewed in isolation. DSHS reports that the enhanced method will be used in all future analyses to assure current and future investigators address major factors concerning maternal mortality and severe maternal morbidity.

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Using steps from the enhanced method, the DSHS Task Force has been able to confirm maternal death data in Texas and examine the role of drug overdose in maternal mortality. Through investigation, the Task Force seeks to identify where the greatest opportunities exist for prevention by determining the specific drugs involved, demographics of those more at risk, geographic region, and timing of death of the maternal deaths studied.

The maternal drug overdose death investigation yielded the following demographic information – the demographic risk profiles for maternal drug overdose deaths do not vary significantly from the risk profiles for all maternal deaths aside from ethnicity and region. The demographic risk profiles show that those at greatest risk for maternal death are black women, aged 40+, living in urban counties and/or HHSC Region One (Panhandle) and Region Eight (includes San Antonio), and are covered by Medicaid at delivery. The demographic risk profiles show that those at greatest risk for drug overdose maternal deaths are white women, aged 40+, living in urban counties and/or Region Two/Three (Dallas/Ft. Worth) and Region One (Panhandle), and are covered by Medicaid at delivery.

#### TexasAIM Initiative

The TexasAIM Initiative is a part of the National Alliance for Innovation on Maternal Health (AIM). The AIM program was created in hopes of reducing severe maternal morbidities using evidence-based systems to enhance maternal care. TexasAIM currently implements maternal safety bundles for obstetric hemorrhaging and severe hypertension in pregnancy. A bundle currently in development is for obstetric care for women with opioid use disorders. Implementation of these bundles ultimately seeks to change practitioner behavior to reduce maternal mortality and severe morbidities.

The Obstetric Care for Women with Opioid Use Disorder Bundle will provide the tools necessary to assess and treat opioid use disorders among pregnant women and to prevent opioid-related overdose among pregnant and post-partum women. Texas is working towards statewide implementation of the opioids bundle for summer of 2019.<sup>104</sup>

#### *Homeless Individuals*

##### Statistics Related to Homeless Individuals:

- On a single night in 2016, an estimated 549,000 plus individuals in the U.S. experienced homelessness, including 120,819 children;<sup>105</sup>
- In January 2016, one in five people experiencing homelessness had a serious mental illness, and a similar percentage had a chronic substance use disorder;<sup>106</sup> and
- In FY 2017, approximately 14.2 percent of adults receiving HHSC-funded treatment for a substance use disorder reported being homeless.<sup>107</sup>



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## *Programs and Providers of Services*

### *Health and Human Services Commission (HHSC) Referenced Programs*

#### Recovery Oriented Systems of Care

Recovery Oriented Systems of Care (ROSC) is a framework for coordinating multiple systems, services, and supports throughout the state of Texas. The framework is individual-centered, self-directed, and designed to be adjustable to meet each person's needs and chosen path to recovery. ROSC communities represent a need to shift away from acute care models of brief, repeated sessions of care, to a sustainable, long-term support model that emphasizes whole health, and physical and mental wellbeing. Houston established the first ROSC community in 2010; the number and breadth of ROSC communities has increased across the state.

#### Recovery Support Services

Recovery Support Services (RSS) are nonclinical services to assist individuals and families as they recover from alcohol, drugs (illicit and legal), or co-occurring SUDs. Services are provided via community-based organizations, recovery community organizations, and treatment organizations. HHSC referenced a study on recovery support services by The University of Texas which found that recovery support services greatly aid individuals in regaining stability to successfully reenter their communities. The study showed that only 32 percent of individuals had stable housing at admission and 54 percent had housing 12 months into long-term peer services. Employment increased from 24 percent at admission to 58 percent, and average wages increased from \$252/month at admission to \$879/month.<sup>108</sup>

#### Oxford Houses

The Oxford House program is a peer-run recovery residence program that is democratically run, self-supporting, and substance free. Houses are self-run with residents of each house electing officers to serve six-month terms. The houses are self-supporting with each resident paying an equal share of rent and household expenses. Oxford Houses typically have six to fifteen residents at a time.<sup>109</sup>

Oxford House, Inc. is a publicly supported, non-profit 501(c)3 corporation which provides the network connecting all Oxford Houses and makes resources available to create new Oxford Houses.<sup>110</sup>

HHSC funded 200 Oxford Houses in FY 2017 and plans to fund 61 new houses in FY 2018. Homelessness prior to living in an Oxford House was reported by 62 percent of residents. Individuals are frequently referred to Oxford Houses by SUD treatment providers, as well as drug courts and non-profit organizations.

HHSC reported improvements in employment, decreased rates of substance use and incarceration, and a cost savings of \$29,000 per person over a two-year time period for individuals involved in this program.<sup>111</sup>

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*Texas Department of Housing and Community Affairs (TDHCA) Programs*

The Texas Department of Housing and Community Affairs (TDHCA) currently has no programs designed specifically to serve people with opioid and other substance use disorders. However, Ms. Boston explains that the agency does have housing programs in place that serve the homeless and people with disabilities, which are populations known to struggle with substance use.

**Emergency Solutions Grants Program**

The Emergency Solutions Grants Program is a competitive federal grant from the Department of Housing and Urban Development (HUD) which TDHCA awards to private non-profit organizations, cities, or counties within Texas. TDHCA oversees \$8 million to \$9 million annually for this program. The program is designed to help people at risk of homelessness or who are homeless to regain stability and permanent housing through outreach, emergency sheltering, homelessness prevention, and short and long-term housing assistance.

**Section 811 Program**

The Section 811 Program through HUD provides project-based rental assistance for extremely low-income people with disabilities. This program is made possible through partnerships with TDHCA, HHSC, DFPS, and participating multi-family properties. Eligible persons include people with disabilities who are exiting institutions and are eligible for Medicaid waiver services; people who receive behavioral health services through local mental health authorities (LMHAs), and youth/young adults with disabilities who are exiting foster care. The Section 811 Program is currently a pilot operating in eight metropolitan areas in the state. TDHCA has been awarded \$24 million for the Section 811 Program. Although not specifically designed for individuals with substance use disorders, those served by the Section 811 Program include individuals with co-occurring diagnoses that may include substance or opioid abuse.

**Homeless Housing and Services Program (HHSP)**

The Homeless Housing and Services Program (HHSP) is the only state-funded program that specifically serves homeless people. Through HHSP, TDHCA provides about \$5 million dollars annually to the state's eight largest cities: Arlington, Austin, Corpus Christi, Dallas, El Paso, Fort Worth, Houston, and San Antonio. From FY 2010 to 2016, HHSP has served over 45,000 people.

**Community Services Block Grant**

Through the Community Services Block Grant program, funds flow statewide to community action agencies to provide relatively flexible funding to address the most critical issues that perpetuate poverty in the specific communities. Some community action agencies may choose to use these funds for initiatives that address substance use.<sup>112</sup>

*A Best Practice Community Based Services Provider - Haven for Hope*

Haven for Hope is a housing, treatment, and recovery facility, located in San Antonio, providing services for individuals experiencing homelessness in Bexar County. About 1,700 previously homeless individuals are served daily including about 200 children and about 120 veterans. Comprehensive "transformational" services are available throughout the 22-acre campus. Haven

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for Hope has a partnership with the state's Healthy Community Collaborative (HCC) funding and also leverages public funding through private partnerships.

Mr. Wilson explains that Haven for Hope has 140 nonprofit agency partners, with 63 on campus, and 77 community referral partners. The comprehensive services aim to address root issues related to homelessness through a transformation process. Upon intake, an initial assessment is used to gauge the needs of an individual, then recovery services are focused on individual transformation. Haven for Hope's services are trauma-informed and are tailored to recognize the debilitating effects of trauma to assist persons experiencing homelessness.

Haven to Home teams transition individuals to permanent housing via clinical case managers and peer support staff. This model reduces relapse because of its individual-centered planning approach. The integrated treatment programs available on campus include detox and sobering units, with a program specifically for pregnant mothers detoxing from substance use.

A recently implemented program allows law enforcement officers to drop off homeless individuals in need of services immediately, rather than taking arrested persons to their office or jail. This saves law enforcement and homeless individuals in need of services time and saves the city money.

The Center for Health Care Services (CHCS) Restoration Center, the area's LMHA, provides integrated, residential treatment for persons seeking assistance with addiction, mental health, and co-occurring disorders.

From September 2016 to August 2017, 7,509 people were assisted on the campus. Of those individuals, 231 people were enrolled in permanent supportive housing (PSH) for mental illness, substance use, or co-occurring disorders. Ninety-four percent retained housing for six months; 90 percent retained housing for 12 months; and 71 individuals graduated from PSH program services. Within this time, 1,142 persons were enrolled in mental health crisis services, and 770 were enrolled in detox services at CHCS.

As an integral part of their program, Haven for Hope emphasizes the importance of peer integration in their hiring of persons with shared life experiences. Mr. Langehennig, a peer support specialist and employee of Haven for Hope, provided testimony on the merit of peer support services. He states that with their common life experiences, peer support specialists are able to connect with individuals and work towards recovery in a personal way.<sup>113</sup>

### *Veterans*

#### Statistics Related to Veterans:

- The Substance Abuse and Mental Health Services Administration reports 21 percent of veterans suffering with SUD are homeless;<sup>114</sup>
- In 2016, approximately 39,500 veterans experienced homelessness on any given night;<sup>115</sup> and
- According to the Veterans Affairs Department (VA), approximately one-third of veterans seeking treatment for a SUD also have a PTSD diagnosis.<sup>116</sup>

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## *Programs and Providers of Services*

### *Texas Veterans Commission (TVC) and Health and Human Services Commission (HHSC)*

The Texas Veterans Commission (TVC) and the Health and Human Services Commission (HHSC), express that the stigma surrounding substance use and mental health is very high among veterans and affects service members and veterans in accessing care. Persons within the population may have benefits from their employer to receive treatment but will not utilize them in order to hide their SUD. In 2017, HHSC screened over 2,000 veterans through a state-funded system and admitted one-half to treatment services.<sup>117 118</sup>

Also, service members who have been discharged related to substance use likely did not receive an honorable discharge which impacts their ability to receive care through the VA.<sup>119</sup>

Senate Bill 55 (84R) created the Texas Veterans + Family Alliance (TV + FA) Grant Program. Through this bill, HHSC created a grant program to support community mental health programs providing and coordinating mental health services for Texas veterans and their families. TV + FA grants support a wide range of clinical mental health and non-clinical supportive services for veterans and family members, including substance use disorders. Based on local needs, the partners of each TV + FA collaborative provide, coordinate, or make referrals for substance use disorder services.<sup>120</sup>

Senate Bill 1325 (81R) created the Mental Health Program for Veterans to provide peer-to-peer counseling for veterans, which is known as the Veterans Mental Health Program (VMHP) by TVC. HHSC and TVC coordinate to administer this program through local contracts to provide services. The program provides direct peer-to-peer services to engage veterans and family members who have experienced military trauma, are at risk for isolation from support services, and do not seek services through traditional channels. The program provides training and technical assistance to the LMHA based Military Veteran Peer Network (MVPN), licensed mental health professionals, community- and faith-based organizations, the criminal justice system, and state agencies on the impacts of military-related trauma and the individuals who have been military trauma-affected. The program also provides outreach activities to assist women and rural veterans and coordinates services for justice system involved veterans.

The providers are imbedded within the community to be a resource and referral entity to target veteran populations. Many who are trauma-affected may be unaware of their trauma and may isolate themselves.

In FY 2017:

- 667 new peers registered and 3,536 total peers registered on the VMHP platform;
- 3,836 service members, veterans, and family members were educated on military-related trauma, and 4,728 individuals were referred to community-based services;
- 330 law enforcement officers were trained in how to de-escalate trauma-affected veterans; and 80 parole officers and 30 reentry personnel were trained in military-related traumas and cultural competency;

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- 119 licensed mental health providers were trained by VMHP;
  - 156 mental health providers are registered on the VMHP platform; and
  - 236 community- and faith-based organizations reached out to VMHP on how to better serve veterans.<sup>121 122</sup>

TVC also reports that the Veterans Administration (VA) has found that substance use and mental illness are highly prevalent among veterans and often untreated. The VA was the first hospital system in the nation to release its opioid prescription rates and has seen a 41 percent reduction in opioid prescription rates since the launch of its 2012 Opioid Safety Initiative. Since 2012, 99 percent of all VA facilities have reduced their opioid prescription rates. The VA emphasizes that not just a change in prescribing practices is needed but also educating doctors within the VA system on alternatives to opioid prescription, alternative therapies, means of pain reduction, and integrated medicine.<sup>123</sup>

### *Metrocare Services*

Metrocare Services (Metrocare) serves Dallas, Texas and the surrounding areas. Mr. Mogbo explains that traditionally, Metrocare has not provided specific services for the veteran population, but two years ago they received a generous donation to fund a military specific clinic, called the Stephen A. Cohen Military Family Clinic, to serve post 9/11 veterans. In opening that clinic, Metrocare began to understand the great need of the veterans community and to look for ways to serve them.

Metrocare applied for funds through Senate Bill 55 (84R), a statewide veterans mental health grant program administered by HHSC. One program Metrocare developed with funds from SB 55 is traumatic brain injury treatment which is housed at the Stephen A. Cohen Clinic. Metrocare also works with the MVPN to provide peer services and has partnered with a company called E Quest to create another program that provides the evidence-based practice of equine therapy for veterans.

Additionally, Metrocare is focusing on filling the service gaps for veterans in the community. This holistic approach provides supported housing, has a financial assistance component, provides primary care including medication, and provides treatment for mental illness and substance use disorders for both the veterans and their families.

Through the resources available at the Stephen A. Cohen Clinic, Metrocare is also able to use telemedicine to provide outreach and care for veterans throughout 38 counties in North Texas. The expanded program sends "outreach navigators" to those areas to identify veterans and communities in need, then through telemedicine technology, employs Metrocare evidence-based treatments to address those needs. The outreach component is essential to reaching the more rural areas. Therefore Metrocare has partnered with an organization called Institute for Veterans and Military Families (IVMF) to develop an electronic database that can connect veterans to the services they need; this database is called Texas Serves North Texas.

Metrocare is also actively pursuing communications and partnership with the area VA office so that referrals can flow easily between the VA and Metrocare and for the VA's awareness of the

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resources available to veterans at Metrocare. This program provides treatment regardless of a veteran's ability to pay.

Metrocare expressed a need for the development of an integrated referral network between the VA and itself, as individuals with a less than honorable discharge are typically ineligible for VA services. With this proposed system, the VA could refer individuals to Metrocare if the person is ineligible for VA services or if the VA is unable to provide services.<sup>124</sup>

### *Aliviane*

Aliviane is a nonprofit behavioral health organization based in El Paso, Texas that has served counties in west Texas for the past 48 years. The mission of Aliviane is to help people recover from addiction through a holistic behavioral health approach that includes prevention, intervention, treatment, and recovery support services. Services include outreach, education, prevention, intervention, treatment for substance use and co-occurring disorders, medication assisted treatment, pregnant/postpartum intervention, testing for infectious diseases, HIV services, recovery support services, parenting classes, youth counseling, case management, and community awareness projects.

Ms. Tapia testified regarding the unique challenges faced in west Texas and border communities. She also advises that while much of the drug use discussion centers on opioids, methamphetamine use is rising in west Texas.

She expresses that substance use treatment providers must take into account that 29.7 percent of the total population of El Paso County are uninsured and that 50-80 percent of residents in border towns do not have health insurance. West Texas residents also typically travel long distances to receive care, therefore Aliviane provides direct services to both Hudspeth and Culberson counties to reach those in need who do not have the ability to travel to El Paso for treatment.

Provider service capacity is an ongoing challenge. Due to high operating costs and low reimbursement rates, Aliviane was forced to close the only residential service treatment center for men in El Paso County after operating the center for 25 years, and El Paso's Trinity Recovery Center is only funded for eight detox beds to serve the entire city.

To help combat the lack of treatment services, Aliviane created the Pregnant/Postpartum Intervention Program that serves pregnant teens and women. The program focuses on early intervention to provide services to women and children before they reach the point of needing treatment for substance use disorders. In March of 2018 alone, Aliviane enrolled 24 new 18 and 19 year old women who are at risk for substance use disorders into the program, a 20 percent increase from the entire year of 2017.<sup>125</sup>

### *Challenges Related to Charge 2*

- The lack of data, especially regarding the homeless and their needs and access to services.
- The need for supportive housing after an individual transitions out of residential services, as they are vulnerable to relapse.

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- Service members who have been discharged because of substance use likely did not receive honorable discharge status and may not be eligible for substance use services from the VA.

*Charge 3: Review of Policies/Guidelines of State Agencies to Monitor For and Prevent Abuse Of Prescription Drugs in State-Funded/Administered Programs*

*Texas Medicaid Program (administered by Health and Human Services Commission)*

The Texas Medicaid Program (Medicaid) manages prescription drugs through oversight of the Medicaid benefit, covers SUD treatment services, and partners with managed care organizations (MCOs) to meet community needs. In 2009, the 81st Texas Legislature added substance use disorder treatment, including MAT, as a Medicaid benefit.

HHSC reports that due to successful prevention and intervention strategies, opioid prescriptions within Medicaid have decreased from 42 prescriptions per 100 individuals per year in 2014 to 31 prescriptions per 100 individuals per year in 2016.

One tool used by HHSC to ensure safe and appropriate drug utilization is the Drug Utilization Review Program (DUR). The DUR is federally required for fee-for-service (FFS) and managed care services and is also used for Medicaid and CHIP services. The DUR includes prospective clinical prior authorizations (PA), retrospective drug utilization reviews, and various utilization management tools. A clinical PA is required based on a client's history or specific prescriptions and can help prevent inappropriate utilizations.

Examples of criteria that would require a PA for opioids include: use of multiple opioids, excessive prescriptions from multiple prescribers or pharmacies, higher-strength opioids without chronic or malignant pain, and opioids prescribed concurrently with other potentially harmful drug regimens.

Retrospective drug utilization reviews of suspicious prescription drug claims help identify prescribing patterns and outliers to clinically accepted prescribing practices or guidelines.

Medicaid uses utilization management (UM) tools such as quantity, days' supply, and refill-too-soon limits to manage drug utilization, ensure patient safety, and control costs. In January 2018, HHSC implemented morphine equivalent dose (MED) limitations, which can be used to measure a patient's total use of opioids across all prescriptions.

Additionally, HHSC can use the Texas Medicaid Preferred Drug List (PDL) to deter use of opioids associated with harm or misuse by listing them as non-preferred, and by encouraging use of drugs such as naloxone for opioid overdose.

Medicaid MCOs have implemented strategies to address prevention, early intervention, treatment, and recovery. MCOs have begun using DUR programs that include PA, retrospective drug utilization reviews, and other utilization management tools, including CDC opioid prescribing guidelines.

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MCOs also implement strategies to provide access to Medicaid SUD treatment and care coordination for members, as well as collaboration with community non-profits, criminal justice organizations, law enforcement, and maternity care centers to provide social services for clients.

The Office of Inspector General Medicaid Lock-In Program restricts a member to a designated provider or pharmacy if their actions contradict Medicaid best practices.

The Medicaid Program Integrity (MPI) Division conducts Medicaid investigations, evaluates complaints and referrals, and works collaboratively with HHSC to conduct quarterly fraud detection operations.

HHSC non-Medicaid indigent care SUD services primarily emphasize prevention. Youth prevention education for grades 1-12 use evidence-based curriculum to serve target populations. A universal curriculum was designed to reach the general population ages 6-18, with selective materials directed at subgroups determined to be at-risk for a SUD. An indicated curriculum was designed for individuals identified as experiencing early signs of SUD and related behavioral issues for ages 11-21.

Prevention Resource Centers provide substance use and behavioral health information and other community resources within each HHSC Health Regions. Community Coalition Partnerships implement evidence-based preventative strategies for youth and adult populations in communities.

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### *Texas Department of Insurance Division of Workers' Compensation (DWC)*

The Texas Department of Insurance Division of Workers' Compensation (DWC) is a state regulated insurance program intended to pay medical bills and cover some lost wages to injured employees. The program is not mandatory in Texas; however, government entities and employers that want to contract with government entities are required to provide workers' compensation. Approximately 10 million Texas employees in the public and private sector are covered by the workers' compensation program. The DWC acts as a regulatory body and manages dispute resolution, compliance and investigations, and via the office of the medical advisor reviews the quality of healthcare provided in the worker's compensation system to take appropriate action as needed.

House Bill 7 (79R) in 2005 required the commissioner of workers' compensation to adopt evidence-based treatment guidelines intended to reduce excessive or inappropriate medical care while protecting necessary care. DWC selected the Official Disability Guidelines (ODG) published by MCG Health, which provides evidence-based treatment guidelines and return-to-work guidelines for conditions typically associated with the workplace.

Additionally, HB 7 (79R) required the DWC to adopt a closed formulary because drug costs had become a significant portion of total workers' compensation medical costs, accounting for 13-14 percent of total costs. DWC became increasingly aware that many injured employees were receiving prescriptions that may not have been best suited in aiding recovery. The closed formulary includes all FDA-approved drugs prescribed and dispensed for outpatient use but excludes drugs



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with "N" (not-recommended drugs) status as identified by the current edition of the Official Disability Guideline (ODG). Excluded drugs are available to injured employees following submission of a prior authorization request by the prescribing physician and certified review by TDI. The closed formulary took effect for new claims on September 1, 2011 and for older claims on September 13, 2013.

Since the 2007 reforms and enrollment of the closed formulary, DWC has seen a decrease in return-to-work time, in claims receiving N-drugs, in opioids costs, in total pharmacy costs, and in medication dosages. Return-to-work numbers have decreased to an average of 19 days off work for injured workers, primarily due to the effective regulation of opioids.

The number of claims receiving N-Drugs decreased by 67 percent from 2011-2012, with 24,286 claims in 2011 to 8,120 claims in 2012. Opioid costs for the DWC were \$43 million in 2009 and decreased to \$18 million in 2015. Total pharmacy costs decreased from \$162 million in 2009 to \$106 million in 2015.

The average daily dosage of fatal opioid overdose cases is 98 morphine milligram equivalents (MMEs) per day, and DWC had 15,000 claims receiving 90+ MMEs per day in 2009. Less than 500 claims in 2015 reported such dangerously high dosages of prescriptions, signaling a decrease in opioid prescriptions across the board, not a shift from higher to lower doses.

Current projects include an opioids plan-based audit to evaluate prescription appropriateness, as well as a 2018 Workers' Compensation Research Evaluation Group (REG) to further study the impact of the DWC's closed formulary.<sup>127</sup>

#### *Texas Employee Retirement System (ERS)*

The Texas Employee Retirement System (ERS) is the administrator for the Group Benefits Program (GBP) for state of Texas employees and retirees. A large shared risk pool, the plan is kept affordable by averaging costs among the 534,000 active employees, retirees, and dependents covered by the plan.

In examining GBP participants, evidence shows that substance abuse is a serious issue. Mental health/substance abuse is an ERS top five chronic condition and a top five medical expense. Of HealthSelect prescription drug claims, about four percent are for opioids. Of the 33,844 HealthSelect participants with an opioid prescription between September and December of 2017, one in four participants with a prescription were "high utilizers," filling three or more scripts within 120 days.

Currently, the OptumRx pharmacy network fills the prescriptions for HealthSelect of Texas and has developed risk management strategies to reduce opioid abuse. OptumRx reports that short-acting opioids, which present the greatest risk of abuse make-up 61 percent of opioid prescriptions. To combat short-acting opioid abuse, OptumRx developed their Risk Management Program to educate patients and providers, minimize early exposure, reduce inappropriate supply, and monitor safe and appropriate dosage.

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OptumRx risk management strategies include quantity and refill limits consistent with CDC guidelines. The program requires prior authorization for all "first refills" for long-acting opioids and for opioid-based cough medicines for patients 17 and younger, and point of sale safety edits prompts pharmacists to intervene around certain opioid regimens before allowing a claim, such as opioid prescriptions for pregnant women. Additionally, the program aims to prevent early refills that could lead to stockpiling by narrowing the refill window for prescriptions.

As of April 1, 2018, members with an opioid prescription received an educational letter detailing the risk management strategies and the risks of opioids, safe practices, alternative pain management options, appropriate storage, and safe disposal.

Data from the third quarter of 2017 to the fourth quarter of 2017 reflects a decrease in the percentage of opioid users by 22 percent. Total claims increased seven percent, but total opioid claims decreased by four percent.<sup>128</sup>

#### *Texas Teacher Retirement System (TRS)*

Teacher Retirement System (TRS)-Care provides health coverage for 237,000 retired Texas public school employees, and Teacher Retirement System (TRS)-ActiveCare provides medical benefits for 492,000 active Texas public school employees.

In response to the opioid crisis, TRS has implemented strategies to balance legitimate and at-risk opioid use. To enhance opioid utilization management, TRS has aligned itself with CDC guidelines. TRS has begun limiting first fill prescriptions to seven days, when appropriate, with additional days' supply available with prior authorization. TRS is limiting the quantity of opioid products prescribed up to 90 morphine milligram equivalent (MMEs)/day based on a 30-day supply.

In requiring step therapy, members may be required to try a prerequisite or "first-line" drug before a step therapy drug may be prescribed in hopes of meeting medical needs without inappropriate or unnecessary opioid prescriptions. Step therapy drugs are FDA approved and used to treat the same conditions.

TRS aims to maintain clinical access and supports limits on duration and dosage of prescriptions when appropriate. Quantity limits are based on MMEs.

Since implementation, TRS-ActiveCare overall expenditures have declined steadily.<sup>129</sup>

#### *Texas A&M University System (TAMUS)*

The Texas A&M University System (TAMUS) health plan is Blue Cross Blue Shield of Texas (BCBSTX), and the pharmacy plan is Express Scripts. The system covers 23,756 employees and retirees from eleven universities and seven state agencies.

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TAMUS provides coverage for professional and facility, inpatient and outpatient services. Of its 9,439 members and dependents with opioid prescriptions, Express Scripts estimates that 590 are becoming addicted; 118 are seeking treatment; and 29 could potentially overdose.

Express Scripts implemented a new opioid program April 1, 2018 that targets the pharmacy, home, and physician. For the pharmacy, the program includes a seven-day supply limit, additional long-acting prior authorizations, concurrent utilization reviews between doctors and facilities, and prescriptions at an appropriate morphine equivalent dose (MED). For the home, the program includes an educational safety letter with their prescription and a safe disposal bag, if needed. For physicians, Express Scripts also sends point of care alerts to opioid-prescribing physicians in the case of duplicate prescriptions, treatments, use of multiple prescribers/pharmacies, and when their patient is approaching their MME.<sup>130</sup>

*University of Texas System (UT System)*

The University of Texas System (UT System) health plan has BCBS as its administrator and Express Scripts as the administrator of the prescription plan. The system covers 15 institutions and 212,000 members.

The system advises that opioids represent less than three percent of all prescriptions filled under their plan with fewer than 28,000 patients filling an opioid prescription in FY 2017. Of the members who filled opioid prescriptions, one doctor and one pharmacy were utilized.

The system advises that about 80 participants received treatment for opioid dependence during 2017.

The UT System's Opioid Management program features alerts to pharmacists at point of sale, dispensing limits, prior authorization limits, medical and pharmacy data alerts, and sharing pharmacy claims data with nurse care managers for additional oversight and coordination with medical plan.

The New Advanced Opioid Management Program in 2018 involves the pharmacy, home, and physician. For the pharmacy, the plan provides an initial seven days' supply, enhanced long acting opioid PA, concurrent DUR, MED, enhanced fraud, waste, and abuse (FWA), auto lock, and fentanyl quantity limits and tighter criteria. For the home, the plan provides an educational letter, proactive specialized neuroscience, use of a therapeutic research center, pharmacist outreach, and provision of disposal bags. For the physician, the plan provides point of care alerts, enhanced FWA auto lock, physician care alert to add naloxone, prescriber education, and peer comparison.

With these policies, the UT system hopes to see an increase in overall use of electronic medical records and sharing of patient data among treating physicians.<sup>131</sup>

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*Recommendations*

- Increase awareness of the dangers of opioid use during pregnancy and distribute educational materials to women in the Medicaid for Pregnant Women Program.
- Review housing programs and consider a funding mechanism to improve substance abuse treatment capacity and recovery housing initiatives for mothers and their children, veterans, the homeless, and those with mental illnesses.
- Encourage programs through the Texas Veterans + Family Alliance (TV + FA) grant program.
- Consider request that HHSC study and advise numbers served, costs impact, and potential benefits regarding Medicaid reimbursements to recovery community organizations (RCOs).
- Require Medicaid MCOs to report to HHSC on the success of programs they have implemented and report on barriers encountered and how the barriers are being addressed.
- Consider allowance of Medicaid MCOs to implement safety edits when prescribing opioids and other highly addictive substances to patients and require a report to HHSC.
- Consider requiring high risk Medicaid patients be locked into one pharmacy and doctor.
- Consider flexibility in the Medicaid program to implement safety prior authorizations.
- Require an automatic manual review by MCOs of patients receiving more than a seven day, or CDC guidelines, script of opioids and other highly addictive substances.
- Continue tight management programs within employer plans.
- Encourage continued meetings between the state-administered insurance plans for discussion of trends and sharing of ideas on efficiencies of programs.
- Increase overall use of electronic medical records and sharing of patient data among treating physicians.

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## **PUBLIC HEARING 3: CHARGE 4 - REVIEW OF PRESCRIBING PRACTICES AND IMPLEMENTATION OF THE PRESCRIPTION MONITORING PROGRAM IN TEXAS**

The Committee held its third public hearing related to opioids and substance abuse on May 15, 2018 at 10:00am in Austin, Texas in the Capitol Extension, Room E2.012. The following organizations/individuals were invited to testify:

Jeremy Ashley, Brookshire Grocery Company, National Association of Chain Drug Stores, Texas Federation of Drug Stores  
Allison Benz, Texas State Board of Pharmacy  
W. Boyd Bush, Texas State Board of Dental Examiners  
Stephen Carlton, Texas Medical Board  
Audra Conwell, Alliance of Independent Pharmacists of Texas  
Troy Fiesinger, MD, Texas Medical Association  
Scott Freshour, Texas Medical Board  
Stacey Hail, MD, UT Southwestern Medicine  
John Hawkins, Texas Hospital Association  
Bryan Henderson II, Texas State Board of Dental Examiners  
Justin Hudman, Texas Pharmacy Association  
James (Dusty) Johnston, Texas Board of Nursing  
Chris Kloeris, Texas Optometry Board  
Carlos Nichols Lee, MD, Texas Society of Anesthesiologists  
Jeff Loesch, National Association of Chain Drug Stores, Texas Federation of Drug Stores, The Kroger Co.  
Hemant Makan, Texas Department of Licensing and Regulation  
Bree Watzak, Texas A&M University Health Science Center  
Michael Wright, Texas Pharmacy Business Council

The following section of this report related to opioids and substance abuse is produced in large part from the oral and written testimony of the individuals above.

*Charge 4 - Monitor and evaluate the implementation of legislation passed by the 85th Legislature regarding the Prescription Monitoring Program. In addition, review the prescribing of addictive drugs by physicians and other health care providers within various geographic regions of this state. Determine the role of health care professionals in preventing overutilization and diversion of addictive prescriptions. Provide recommendations that will improve efforts to prevent overutilization and diversion of addictive prescriptions.*

### *Background*

Effective September 1, 2016, Senate Bill 195 (84R) transferred the Prescription Monitoring Program (PMP) from the Department of Public Safety (DPS) to the Texas State Board of Pharmacy (TSBP) and eliminated the Texas Controlled Substance Registration Program.

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House Bill 2561 (85R), effective September 1, 2017, amended the Texas Controlled Substances Act and mandated greater usage of the Texas PMP by requiring pharmacies to send all required information for Schedule II-V prescriptions to the PMP not later than the business day after the prescription is completely filled.

On or after September 1, 2019, a prescriber or pharmacist authorized to access the PMP, other than a veterinarian, shall access the PMP for the patient before prescribing or dispensing opioids, benzodiazepines, barbiturates, or carisoprodol.

Also, wholesalers must report the sale of controlled substances by the distributor to a person in the state.

### *State Agencies and Professional Associations*

#### *Texas State Board of Pharmacy (TSBP)*

The Texas Prescription Monitoring Program (PMP), also called prescription drug monitoring program (PDMP), is an online system that stores a patient's controlled substance prescription history and is referenced by certain healthcare providers regarding prescribing or dispensing a controlled substance.

In Texas, the list of medical professionals who have access to the PMP and the authority to prescribe or dispense controlled substances include: physicians, pharmacists, dentists, podiatrists, optometrists, veterinarians, advanced practice registered nurses, physician assistants, medical residents with prescriptive authority, and prescriber or pharmacist delegate (some prescribers have limitations).<sup>132</sup>

Currently participation in the Texas PMP is voluntary with 40.8 percent of prescribers registered as of March 2018.

According to the TSBP, the Texas PMP is connected with 20 other states, including all border states, for review of a patient's controlled substance history. The connected states are: Alabama, Arizona, Arkansas, Connecticut, Idaho, Kansas, Louisiana, Maine, Massachusetts, Minnesota, Mississippi, Montana, New Mexico, New York, North Dakota, Oklahoma, Pennsylvania, South Carolina, Tennessee, and Virginia.

Information gathered from PMP data shows that between 2015 and 2017:

- Risky opioid prescribing may be declining;
- Benzodiazepine prescribing shows a little decline;
- Stimulant prescribing may be increasing; and
- Significant differences in prescribing across age groups and geographic areas of Texas.

Although the rate of opioid prescription in Texas has decreased, the average strength of Texas prescriptions remains higher than the U.S. average.

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The PMP provides for notifications to be sent to prescribers and pharmacists when a patient has exceeded a prescription threshold. "Push" or "threshold" notifications are generated when a patient shows to have a minimum of five prescriptions from five prescribers from five pharmacies (5-5-5).

The PMP can be accessed online or can be integrated into an electronic medical record (EMR) system. Integrated access of PMP has associated costs; access to the program via a web browser does not have a cost, but this method takes additional time, approximately one to two minutes longer per review. According to TSBP, the cost for the integrated system is about \$2.25 million per year and provides access to all prescribers and pharmacists in Texas. If each user pays, the cost is about \$50 per year per user.

TSBP recommends EMR system integration of the PMP. Additional recommendations are e-prescribing and to enhance the PMP system to include clinical alerts and Narxcare.

Regarding e-prescribing, TSBP advises various benefits of adding safety and security, improving patient care and outcomes and reducing error. Data from self-reported drug abusers suggest that between three and nine percent of diverted opioid prescriptions are tied to forged prescriptions.<sup>133</sup>

#### *Texas Medical Board (TMB)*

In the agency's regulatory framework, the Texas Medical Board (TMB) provides oversight of physician and physician assistant prescribing practices, pain management clinics (PMCs), the prescription monitoring program, delegation of prescribing authority, and the use of opioid antagonists and enforcement actions.

According to TMB, illicit PMCs have been a significant contribution to the opioid crisis and rise of addiction in America. PMCs are a publicly or privately-owned facilities at which many patients have a recurring prescription of opioids, benzodiazepines, barbiturates, or carisoprodol. However, via Senate Bill 911 (81R) and Senate Bill 315 (85R), the state and TMB have increased regulation and management of pain clinics by allowing inspection of PMCs with suspicious prescriber licensing, inappropriate prescriptions, or complaints. Since 2014, 221 pain clinics have been inspected.

In accordance with House Bill 2561 (85R), TMB works with the Texas State Board of Pharmacy to identify potentially harmful prescribing practices and patient prescription patterns that may suggest drug diversion or abuse. TMB investigators have access to the PMP, from which 5-5-5 PMP alerts are received and run data on the 50 top prescribers throughout the year. TMB strongly encourages PMP registration to all physicians and physicians' assistants (PA) who are prescribing controlled substances. Utilization of the PMP will be required as of September 1, 2019.

TMB also regulates physicians' delegation of prescribing authority. A physician may delegate prescribing authority to a PA or to an advanced practice registered nurse (APRN); however, physicians must register with the TMB if they choose to delegate prescriptive authority. PAs and APRNs with prescriptive authority must have DEA numbers in order to prescribe controlled

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substances and must have the name of their current delegating physician prescriptive authority on file with the DEA.

TMB, as required by SB 315 (85R) and SB 584 (85R), has developed safe and clear prescribing guidelines for the use of opioid antagonists.

Emergency actions and final actions may be taken by TMB against prescribers or PMCs in response to inappropriate or illegal activity. From January 2016 to May 2018, TMB enforced 13 temporary suspensions related to "pill mill" activity and other nontherapeutic prescribing activity. Currently, TMB is considering four to six more cases for temporary suspension.

Between 2012 and 2014, TMB took over 200 disciplinary actions addressing prescribing behavior and PMC violations. In 2017, 22 physicians had their prescribing authority restricted and four had their licenses revoked.<sup>134</sup>

*Texas Society of Anesthesiologists (Society)*

Dr. Lee, representing the Texas Society of Anesthesiologists (Society), expresses concern regarding the Centers for Disease Control (CDC) statistic that one in fifteen patients will become chronically dependent on opioids after having anesthesia in the operating room.

Since the 1990's, use of opioids has tripled in the U.S. Interestingly the U.S. makes up about five percent of the world's population but uses 80 percent of the narcotics. Dr. Lee says that numbers have not caught up but the way opioids are prescribed and viewed is changing. Over the past five to 10 years narcotics use has been cut by one-half.

Dr. Lee reported that the recent shortage of opioids led prescribers to review alternatives to narcotics use by "pushing" the use of non-opioid pain control, and taught physicians that narcotics are not always needed to manage pain.

The Society recognizes the crisis and supports education for physicians and patients with an emphasis on substance abuse and mental health. Dr. Lee discussed the importance of gauging for physical pain and considering the complexity of each individual patients' needs or procedure when prescribing opioids. In some cases a seven-day prescription of opioids may not be functional, but the prescription in addition to physical and/or cognitive therapy could aid recovery and help avoid overprescribing.<sup>135</sup>

*Texas Medical Association (TMA)*

Dr. Fiesinger, a family practitioner, representing the Texas Medical Association (TMA) discussed that in the 1990s medical students were told that pain was not being treated adequately and that opiates were not addictive. He discusses that physicians understand they have a role to play in today's crisis and that they need to be proactive in prescription management. Based on a personal experience, he relays that prescribing and use should be customized.



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Dr. Fiesinger is a strong proponent of the PMP and is interested in enhancements to the system. He reports that the EMR system in his group is not integrated to the state's system.

Regarding education on opioids, Dr. Fiesinger advises that continuing medical education (CME) and resources are available, and that the CDC has a website with guidelines regarding chronic pain.

In response to questions concerning MAT programs, Dr. Fiesinger comments that access to the programs is critical, as addiction is a chronic illness, as is hypertension or diabetes. However, a physician cannot just prescribe medication; counseling is needed as well. Support in funding, ensuring payers cover expenses, and incentives for physicians to become registered/licensed for MAT are important to increase the numbers of providers. TMA reports that those receiving MAT as part of their treatment plans are 75 percent less likely to die due to substance use disorders than those not receiving medications.

Regarding genetics and medications, Dr. Fiesinger comments that the likelihood of addiction in a patient is much higher if they have a parent or other family members with a drug addiction or alcoholism. Additionally, 30 percent of children cannot metabolize codeine or morphine, which means that the medication will have little-to-no effect on managing their pain. This once again places an emphasis on intentional prescribing and exploring alternatives to opioid prescriptions.

Dr. Fiesinger and TMA emphasize the importance of providing and encouraging means to safely dispose of unwanted and unused medications in order to prevent potential misuse and abuse. Incorrect disposal can affect water supply, safety in the home, and landfills.<sup>136</sup>

#### *UT Southwestern Medical Center (UTSW)*

As an Associate Professor for UT Southwestern Medical Center (UTSW), an emergency department (ED) physician at Parkland Health and Hospital System (Parkland), one of the busiest EDs in the country, and one of less than 300 board certified medical toxicologists in the country, Dr. Hail provides a unique perspective into the opioid crisis. Dr. Hail testified that one single cause did not create the opioid epidemic, and therefore, one single solution will not resolve the crisis.

Dr. Hail informed that she regularly uses the PMP while working in the ED at Parkland and appreciates the important information that can be garnered. However, she informed that taking one to two minutes per patient to check the PMP is not always feasible over the course of an eight-hour ED shift where a single physician may see up to 40 patients.

She advises that EDs present different challenges compared to other physician specialties. Emergency physicians do not know their patients, they have not seen their patients before, and they will likely not see them again. For this reason, the PMP can be specifically helpful because it can provide information that the physician would otherwise have never known, but she expresses there is an increased burden on physicians who choose to check the PMP. Additionally, emergency physicians primarily treat acute pain and if a patient comes in with a blatant physical trauma, the physician will be less likely to check the PMP to see if that patient also has a drug addiction problem because of focusing on treatment.

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As a medical toxicologist, Dr. Hail informed that there are opiate receptors in places other than in the brain. "Peripheral opiate receptors" are present in the back of the throat and in joints, for example. So if a patient presents with extreme knee pain, morphine can be injected directly into the knee, avoiding the opiate receptors in the brain all together.

Dr. Hail also addressed pain being named the "Fifth Vital Sign." She informed that this addition tied patient satisfaction to prescribing by giving patients the ability to report a physician if they do not feel their pain was managed effectively. She believes this led to a rise in opioid prescriptions.

Dr. Hail also testified that feeling some amount of pain can be productive in the healing process for the patient and provides, both the patient and the treating physician, insight into where the patient is in the healing process.

Dr. Hail recommends integration of the PMP into the EMR to reduce the time needed to check the PMP and support of alternative pain management treatment plans in EDs.<sup>137</sup>

#### *Texas A&M University Rural and Community Health Institute (ARCHI)*

The Texas A&M Rural and Community Health Institute's (ARCHI) mission is to improve access to healthcare and reduce disparities in health status and outcomes by improving the quality and safety of healthcare. Since the opioid epidemic concerns all healthcare providers, ARCHI strategies to reduce opioid overprescribing are educational.

The two strategies are:

##### Continuing Medical Education (CME):

- Pharmacology and Prescribing course - designed for prescribers desiring to increase their knowledge of pharmacology and optimal prescribing practices;
- Risk Management course - addresses medical documentation especially regarding chronic pain treatment with opioids; and
- Grand Rounds webinars - one-hour courses on varying topics open to any hospital, clinic, or individual without cost.

##### Assessment-Training-Monitoring (ATM) program:

- A comprehensive collection of educational offerings and tools aimed at identifying educational needs, providing education, and performing follow-up monitoring on opioid prescribing; and
- A collaborative effort with LifeGuard services in Pennsylvania to provide frameworks and guidance for physicians and prescribers to identify opportunities, enhance clinical performance, improve patient safety, and ensure compliance with national guidelines and state/federal regulatory requirements.<sup>138</sup>

#### *Pharmacy Associations*

Five of the eight pharmacy associations in Texas had representation for testimony regarding opioids and substance abuse and PMP: Texas Pharmacy Association, National Association of

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Chain Drug Stores, Texas Federation of Drug Stores, Alliance of Independent Pharmacists of Texas, and Texas Pharmacy Business Council.

The Texas Pharmacy Association (TPA) emphasized a strong commitment of pharmacy organizations to partnering with law makers, law enforcement, and other stakeholders to find viable solutions to prevent prescription opioid diversion and abuse. Pharmacy groups can support: seven-day supply limit for initial opioid prescriptions for acute pain; pharmacists' ability to provide a partial fill for an initial opioid prescription for acute pain consistent with federal law and regulations; electronic prescribing of controlled substances, with limited exceptions; pharmacists' ability to furnish opioid antagonists, such as naloxone, directly to individuals who may have a need; pharmacists' identification of individuals with a substance use disorder, such as participation in SBIRT, including recognition by payers as a provider; and controlled substance take back programs.

Mr. Hudman also discussed SB 1462 (84R) in relation to naloxone and prescribing and dispensing to certain third parties. TPA reports that naloxone access has increased widely, but that more can be done to increase access and asks that DSHS establish a standing order to make naloxone available to all pharmacists.<sup>139</sup>

The Texas Pharmacy Business Council representative, Mr. Wright, expressed that this epidemic is a shared responsibility between dispensers, manufacturing, distribution, prescribers, and patients. The group provided their recommendations to improve the Texas PMP which include: require out-of-state pharmacies to report to Texas PMP program if they dispense controlled substances to patients in Texas; allow Medicare, Texas Medicaid, state health insurance programs, health payers and insurers to request access to PMP data to assist in fraud investigations; specify in statute that PMP data is not available to the public or subject to open-record laws; and allow receipt of PMP data by patient, parent or guardian on behalf of minor child and health-care agent, attorney, or third party with consent.<sup>140</sup>

From a perspective of chain pharmacies located in numerous states, Mr. Loesch, a representative of the National Association of Chain Drug Stores and Texas Federation of Drug Stores advised, that through utilization of PMP (or PDMP) a reduction in patient look-up errors and a reduction in controlled substances dispensed have been realized. He emphasized the benefits of the specific features of NarxCheck to allow a quick review of a patient's information which includes a Narx score for higher risk assessment.<sup>141</sup>

Mr. Ashley, also a representative of the National Association of Chain Drug Stores and Texas Federation of Drug Stores, advised that only 14 percent of controlled substance prescriptions are issued electronically and referenced the report about drug users that suggests that three to nine percent of diverted opioid prescriptions are tied to forged prescriptions. He expressed that e-prescribing enhances safety and security of the prescribing process, improves patient care with elimination of handwriting errors or missing information, and track the filling and refilling of a prescription.<sup>142</sup>

Ms. Conwell of the Alliance of Independent Pharmacies of Texas mentions that the pharmacist's role is to fill and dispense prescriptions, but he/she is sometimes caught in the middle of what is

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prescribed and what a pharmacy benefit manager (PBM) will pay. She also spoke about dependence versus addiction and how some people are dependent on medication to function; she asks that burdens be eased on the legitimate patient.

Additionally, regarding drug take back programs, Ms. Conwell advises that not many independent pharmacists participate due to the requirements of an approved DEA receptacle that must be bolted down and DEA must retrieve the drugs; this increases the risk of robberies and crimes at these establishments. She stresses that pharmacists want to help and suggests that pharmacists could counsel patients and also utilize a four question risk assessment tool, the CAGE Questionnaire out of the state of Washington, but payment models would have to allow for these tasks.<sup>143</sup>

#### *Texas State Board of Dental Examiners (TSBDE)*

The Texas State Board of Dental Examiners' (TSBDE) wants dentists to be accountable and has adopted rules related to opioids and prescribing of controlled substances. The rules are:

- Additional Continuing Medical Education Required (adopted December 25, 2016);
- Self-query of Prescription Monitoring Program (PMP) (adopted December 25, 2016);
- Prescription Monitoring by the Dentist (adopted March 18, 2018; effective September 1, 2019); and
- Prescription Monitoring by the Board (adopted March 18, 2018; effective September 1, 2019).

Within the past two years, TSBDE has suspended and revoked licenses specifically for overprescribing opioids. TSBDE is currently developing specific guidelines for bringing a complaint against a dentist the agency finds through a PMP check is engaging in conduct that violates laws or rules related to the practice of dentistry.

TSBDE comments that the 5-5-5 report from the TSBP is helpful, but at this time, TSBDE informs that they are limited in their research. TSBDE is unable to search for specific data needed to monitor the prescription writing activities of dentists and no process is available for the agency to conduct a search based on the number of prescriptions written, types of prescriptions written, or on refills prescribed. TSBDE is able to review one record at a time but with almost 18,000 dentists, this takes time. Additionally, some dentists have multiple DEA numbers making record review more difficult.

The American Dental Association (ADA) has three new policies items regarding opioids, of which two have been addressed by TSBDE. The third is statutory limits on opioid dosage and duration of not more than seven days for treatment of acute pain, consistent with the federal CDC evidence-based guidelines. TSBDE advises they have received feedback in favor and against this third item.

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#### *Texas Board of Nursing (BON)*

The Nurse Practice Act provides the Texas Board of Nursing (BON) the authority to license APRNs based on their completion of advanced education, and to regulate APRNs' practice to include prescriptive authority with appropriate education. Under the Occupations Code APRNs

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receive delegated authority under a physician or in a facility practice with proper protocols and written authorizations.

Of approximately 28,000 APRNs, 22,000 have Texas APRN prescriptive authority with 7,800 currently registered with the PMP. To prescribe controlled substances the APRN must also comply with DEA registration.

The BON has drafted and sent a newsletter to nurses and APRNs in Texas with details on the opioid crisis in Texas.

One important need the BON recognized is the prevalence of nurses with SUDs. The BON referenced a higher prevalence of controlled substance abuse among nurses and other healthcare professionals because of their access to medication. The Texas Peer Assistance Program for Nurses is a partnership that supports rehabilitation of nurses with substance use disorders.<sup>145</sup>

#### *Texas Optometry Board (Board)*

According to the Texas Optometry Board (Board), the opioid prescribing authority of the 3,100 optometrists in Texas is limited to Schedule III-V drugs. Optometrists are also limited in the length of time for which they are allowed to prescribe opioids. The Board has recently taken many steps to continue to work towards educating Texas optometrists on opioids and safe prescribing practices. The Board will be discussing requiring a CME course for all licensed optometrists. The Board is also taking steps to comply with requirements of HB 2561 (85R) and is discussing rule amendments to comply thereto. Through licensing renewal fees, optometrists contribute to funding of the Texas PMP.<sup>146</sup>

#### *Texas Department of Licensing and Registration – Podiatry Board (TDLR)*

The podiatry program was transferred from the Texas State Board of Podiatric Medical Examiners (TSBPME) to the Texas Department of Licensing and Registration (TDLR) on September 1, 2017 pursuant to HB 3078 (85R). TDLR actively participates in the Texas PMP.

As of March 2018, out of approximately 1100 podiatrists, nearly 33 percent were registered with PMP. As of April 2018, TDLR requires all podiatrists who renew their license online to provide an email address, which allows TDLR to perform outreach and increase the number of podiatrists participating in PMP.

TDLR is working on guidelines for responsible prescribing by podiatrists, and a webpage with information and resources to ensure podiatrists' compliance with the PMP. TDLR requires 50 hours of continuing medical education every two years, and two hours must be ethics courses. The opioids abuse continuing medical education fulfills the ethics continuing medical education requirement, which will potentially increase the number of podiatrists taking this course.<sup>147</sup>

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*Texas Hospital Association (THA)*

The Texas Hospital Association Board approved in February 2018 voluntary guidelines for use in Texas hospitals' EDs; these guidelines are listed in the THA testimony section in Hearing 1.

THA stresses the importance of the ultimate reliability and interoperability of the hospital EMRs and the PMP. A key element is that prescribers check PMP; a separate log-in is problematic.

Other states have reduced the misuse of opioids through a regimen of this nature and improved overall patient safety and quality of care.

Mr. Hawkins comments that cost is a concern regarding interface with electronic health/medical records. THA fully supports TSBP in its request for the state to appropriate monies to integrate system and to pay the users' fees. Otherwise each interface in the hospital gets charged and each user gets charged.<sup>148</sup>

*Challenges*

- The PMP program does not allow for the specific data searches by the various Boards needed to monitor their licensed professionals.
- Emergency physicians primarily treat acute pain and if a patient comes in with a blatant physical trauma, the physician will be less likely to check the PMP to determine if that patient also has a drug addiction problem, because of focus on treatment.
- Emergency department physicians are not an employee of the hospital.
- Access to naloxone, although the state has a standing order.
- Pharmacists are in the middle of what the physician prescribes and what the PBM will pay.
- Payment for integrated PMP system software for prescribers and dispensers to implement the PMP check requirement.

*Recommendations*

- Ensure the requirement for prescribers and dispensers to check the Prescription Monitoring Program (PMP) prior to prescribing or dispensing is implemented September 1, 2019 (as passed in House Bill 2561 (85R)).
- Review the cost of integration of PMP for the various prescribers and dispensers and determine if the state should pay for the integrated user fees or if individual users should be responsible for the fee.
- Require out-of-state pharmacies to report to the Texas PMP program if they dispense controlled substances to patients living in Texas.
- Establish legal penalties for wrongful use of PMP data.
- Allow receipt of PMP data by patient, parent, or guardian on behalf of minor child and health-care agent, attorney or third party with consent.

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- Require enhancement of prescriber education regarding opioids and evidence-based pain management; include collaboration with institutions of higher education and hospitals for maximum patient safety and prevention of addiction and to examine the full range of therapeutic options for the treatment of pain.
  - Require education regarding the addiction potential of opioids during CME and student education for all medical professions.
  - Review creating a program to proactively contact patients who have been identified via the prescription monitoring program (PMP) or otherwise, as a "doctor shopper," and make an attempt of placement in a treatment facility or initial MAT evaluation. Additionally, when a physician is arrested for inappropriate prescribing, provide outreach to the physicians' patients with options for drug treatment.
  - Ensure prescribers have the necessary training and tools to know how to respond when they find evidence that their patients are "doctor shopping."
  - Require e-prescribing.
  - At point of sale, require that clients receive a notice indicating the potential and likely dangers of opioid use and the legal consequences for inappropriate diversion of opioid products.
  - Continue efforts authorized in Senate Bill 1462 (84R) to ensure that people who need access to an opioid antagonist are identified and properly trained in how to use these life-saving drugs; consider establishing a standing order for naloxone through DSHS.
  - Encourage businesses/agencies to keep overdose prevention drugs on hand in the case of an emergency.
  - Continue to promote compatibility of Health Information Exchange (HIE) systems for data sharing among the varied care providers.
  - If an opioid is dispensed, consider including an overdose prevention drug with the original prescription as a safety measure.
  - When prescribing/dispensing addictive drugs, implement an education resource that more actively involves the consumer who receives the prescription (like an interactive video link).
  - Consider including overdose prevention drugs in first aid kits.

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**PUBLIC HEARING 4: CHARGE 7 - REVIEW OF "GOOD SAMARITAN" LAWS IN TEXAS, AND CHARGE 5 - REVIEW OF THE IMPACT OF OPIOIDS AND OTHER SUBSTANCES ON THE SCOPE OF WORK FOR LAW ENFORCEMENT, FIRST RESPONDERS, AND HOSPITAL EMERGENCY DEPARTMENT PERSONNEL**

The Committee held its fourth public hearing related to opioids and substance abuse on June 26, 2018 at 10:00am in Austin, Texas in the Capitol Extension, Room E2.012.

*Charge 7 - Examine the impact of overdose reporting defense laws known as "Good Samaritan" laws.*

The following organizations/individuals were invited to testify:

Mark Davis, Hardin County Sheriff's Office  
Lara Lamprecht, DrPH, Department of State Health Services  
Thomas Mayes, Bexar County Joint Opioid Overdose Prevention Task Force, Office of Judge Nelson Wolff

*Charge 5 - Identify how opioids have impacted the normal scope of work for law enforcement, first responders, and hospital emergency department personnel.*

The following organizations/individuals were invited to testify:

John Bateman, Department of Public Safety, Criminal Investigations Division  
Kathleen Berg, MD, Texas Hospital Association  
Colleen Bridger, MPH, PhD, Bexar County Joint Opioid Overdose Prevention Task Force, San Antonio Metropolitan Health District  
Mark Davis, Hardin County Police Department  
Doug Jeffrey, MD, Texas College of Emergency Physicians Leadership and Advocacy Fellowship  
Celeste Johnson, DNP, APRN, PMH, CNS, Parkland Health and Hospital System, Texas Hospital Association  
John Jones, Department of Public Safety, Intelligence and Counter-terrorism Division  
Davis Knight, City of Kerrville Police Department  
Kevin Luzius, Bexar County Joint Opioid Overdose Prevention Task Force, City of San Antonio Police Department  
Joe Frank Martinez, Val Verde County Sheriff's Office  
Thomas Mayes, Bexar County Joint Opioid Overdose Prevention Task Force, Office of Judge Nelson Wolff  
Kenneth Mitchell, MD, St. David's Health Care, Texas Hospital Association  
David Persse, MD, City of Houston  
Ernesto Rodriguez, Texas EMS Alliance  
Jim Sevey, City of Nacogdoches Police Department

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The following section of this report related to opioids and substance abuse is produced in large part from the oral and written testimony of the individuals above.

### *Introduction*

This hearing was held to examine the increasing misuse of opioids and other substances and their effects on law enforcement, first responders, and emergency department personnel. Upon overdose, a person's breathing and heartbeat are slowed and can even stop, potentially resulting in death. When a person has overdosed, it is imperative that an individual receives an opioid antagonist and emergency care either from 911 services or in an emergency department. Symptoms of overdose can return even after the first dose of an opioid antagonist, and multiple dosages may be required while waiting for emergency medical services. Opioid antagonists bind to opioid receptors to reverse and block the effects of opioids. When administered, naloxone can restore a person's breathing which has slowed or stopped due to opioid overdose.<sup>149</sup>

### *Charge 7: "Good Samaritan" Laws*

#### *Department of State Health Services (DSHS)*

Dr. Lamprecht of the Department of State Health Services (DSHS) testified that a drug overdose "Good Samaritan" law provides legal protection for individuals who call for emergency assistance in the event of a drug overdose. The law is intended to encourage use of emergency assistance to prevent overdose deaths, as 911 is not always called during overdose situations. Implementation requires buy-in and education of potential utilizers, law enforcement, the justice system, and first responders.

Drug overdose "Good Samaritan" laws vary across the country. Some require a foundation of acting in good faith, some provide legal protections addressing controlled substance possession, and some address drug paraphernalia possession. Laws may prevent arrest, arrest charges, prosecution, revocation of probation/parole, and violations of restraining orders. Forty states and D.C. currently have some form of a "Good Samaritan" law. The most common is controlled substance immunity during prosecution.

#### Current Overdose-Related Protections in Texas:

- Underage Drinking "Good Samaritan" Law – Alcoholic Beverage Code, Sec. 106.04(e), 106.05(e)
  - Minor does not commit an offense of consuming/possessing alcohol if certain conditions are met regarding seeking medical assistance; conditions include: minor must act, stay on the scene, and cooperate with authorities; and
  - 911 Lifeline Law passed in the 82nd Texas Legislative Session.
- Opioid Antagonists – Health & Safety Code, Chapter 483, Subchapter E
  - For persons possessing and/or administering opioid antagonists, including emergency services personnel;
  - Includes persons that administer or fail to administer opioid antagonists;
  - Protections address criminal prosecution, professional licensing, civil liability; and

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- Passed in the 84th Texas Legislative Session.
  - Liability for Emergency Care - Civil Practice & Remedies Code, Sec. 74.151
    - For persons administering emergency care in certain situations;
    - Civil damages protection not extended to person whose negligent act/omission was a producing cause of the emergency; and
    - Other specific civil liability protections for professionals responding in emergency situations.

DSHS referenced that recent research articles suggest drug overdose "Good Samaritan" laws reduce the number of drug overdose deaths. Despite an overall national increase in the number of drug overdose deaths, enactment of drug overdose "Good Samaritan" laws are associated with a 15 percent reduction in opioid overdose deaths. Drug overdose "Good Samaritan" laws are not proven to increase non-medical use of opioids, including prescription painkillers.

According to DSHS, utilization of "Good Samaritan" laws depend on various factors such as:

- Age - younger or early users are more likely to call;
- Knowledge of the law by affected individuals;
- Relationship to the overdosed individual - family members in fear of stigmatization are less likely to call for help;
- Prior experience with first responders;
- Housing situation - individuals afraid of losing federal housing are less likely to call; and
- Some bystanders might delay or decline to call 911 if naloxone is used and revives an individual on a first attempt.<sup>150</sup>

#### *Charge 5: Impacts on Law Enforcement, First Responders, and Emergency Department Personnel*

##### *Law Enforcement*

##### *Texas Department of Public Safety (DPS)*

In working to combat opioid trafficking and use in the state of Texas, the Department of Public Safety (DPS) highlighted the rising threat of fentanyl. Mr. Bateman informed that one reason fentanyl is so dangerous is because the substance is rapidly absorbed by the body through touching the substance or breathing it in. This causes a threat even through inadvertent exposure. Mr. Jones informed that only two milligrams of fentanyl is a lethal dosage. The potency allows for a higher risk of an overdose or an accidental death. Another danger is synthetic drugs that are laced with fentanyl.

This emerging threat is being managed at DPS by the development of two new trainings for state officers, awareness training and Narcan training to ensure officers know what to look for when they uncover drugs and how to react in an overdose or drug bust situation where fentanyl may be present. DPS has prioritized distributing Narcan to officers across the state. Currently all criminal investigation division (CID), state interdiction, and canine teams are equipped with Narcan to use in narcotics investigations.

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DPS officers no longer perform field testing of powder narcotics due to the threat posed by fentanyl. Officers now submit all products to a controlled lab environment for testing. Mr. Bateman informed that transitioning to only lab testing has delayed prosecution in some areas of the state because the wait time for getting test results back can be longer. DPS reported cases in other states where officers were exposed to fentanyl in the field and were hospitalized in critical condition or died.

Despite the emerging threat of fentanyl, DPS reported that Texas is primarily a "pass-through" state for fentanyl. The substance is primarily being moved through to California, Las Vegas, and the east coast.

In Texas, DPS is seeing an increase in methamphetamine and heroin use. However, because fentanyl is now being laced in substances such as heroin, determining if an overdose was due to heroin or fentanyl is becoming increasingly more difficult. Mr. Jones testified that in the lab, once heroin, cocaine or another specific substance is detected, they do not continue to test to see if fentanyl is also in the substance. Also, because such a small amount of fentanyl is needed to be lethal, the substance often goes undetected.

Another challenge discussed by DPS is how the CDC reports and categorizes substances. Mr. Jones informed that he is unable to determine how many deaths in Texas are related to fentanyl because fentanyl is categorized as a "synthetic opioid other than meth" and many other substances also fall under that category. Additionally, the CDC does not categorize deaths as being a result of overdose or a result of clinical use.<sup>151</sup>

#### *Nacogdoches Police Department (NPD)*

Nacogdoches Police Chief Sevey advises that his street crimes unit officers most frequently encounter prescription drugs on the street. The most often encountered drugs are hydrocodone, codeine, "oxy" of various types, and all opioids. He states that every day his department addresses issues and make arrests regarding drugs. He states that 85 percent of all crime is related to narcotics.

Thirty years ago 90-95 percent of DWIs were due to alcohol; in 2017, one-half of DWIs are drug related. Drugs are reportedly easier to obtain than alcohol.

Nacogdoches has a population of about 34,000 and county population of about 65,000. Chief Sevey discussed that the street population has exploded and that almost all of the street people in Nacogdoches are engaged in substance abuse. This has caused quality of life issues and costs to tax payers.

In 2017, Nacogdoches Police Department (NPD) officers filed 780 drug cases. These did not include drug evidence involved in DWIs, drug paraphernalia cases, or drugs that were seized but could not be attributed to a suspect in a possession case.

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In 2017, 220 individuals were treated at a mental health emergency center, and most cases involved some level of substance abuse. Only seven percent were covered by private insurance; the remainder were covered by Medicare, Medicaid, or had no ability to pay.

Chief Sevey presented a need for a comprehensive program that involves doctors, pharmacies, and law enforcement and sharing of information regarding drug users and dealers.<sup>152</sup>

#### *Kerrville Police Department*

Chief Knight of the Kerrville Police Department reported their community experienced 35 overdoses in the last five years; 15 were fatal; two were suicides; and 13 were accidental overdoses.

The city has about 25,000 in population and about 54,000 in the county. Kerrville has ten substance use treatment facilities and 19 sober group living homes. According to the special crimes unit, 80 percent of the individuals encountered are from the rehabilitation community.

Heroin and methamphetamine are the most prevalent substances abused. Prescription drugs such as hydrocodone and OxyContin are typically obtained for the purpose of selling the drugs.

Since 2009, 290 calls for service have been from group home addresses, with 72 calls in 2017 which represents an increase in calls to service.<sup>153</sup>

#### *Hardin County Sheriff's Department*

According to Hardin County Sheriff Davis, the predominant drug he sees is methamphetamine, but the county is also seeing an increase in prescription opioid misuse. Among school-age youth, unused prescriptions are the primary source. The county is beginning to have a growing number of addicts in their jail.

As an individual goes through painful drug withdrawals, the county jail must pay for detox services and hospital costs; Sheriff Davis reported the high financial costs of the opioid crisis are placing stress on the county justice system.

In response to the opioid crisis, Hardin County has equipped its officers with Narcan, but report a need for greater access. Hardin County has begun a pilot program with their local mental health authority (LMHA) to decrease the stress placed on their county jail and to improve treatment.

The Sheriff reported that co-occurring mental illnesses are very common.

Hardin County holds "no questions asked" drug take back events and has collection boxes throughout the county to prevent abuse of unused medications.<sup>154</sup>

#### *Val Verde County Sheriff's Department*

Val Verde County is in southwest Texas on the border of Mexico, and home to the Del Rio International Bridge and the Lake Amistad International Crossing.

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Sheriff Martinez reports that the extensive roadways, low population, and large square mileage of Val Verde makes it appealing to cartels and drug trafficking organizations (DTOs). While most of the heroin entering Val Verde County from Mexico transits the area for destinations further inland in the United States, abuse and poisoning statistics show some of the drugs remain in the area.

In 2016, 130 deaths due to heroin poisoning occurred in south Texas high-intensity drug trafficking areas (HIDTA) and area of responsibility (AOR) counties, accounting for 24 percent of the Texas statewide total. Bexar County reported the most deaths at 73. Deaths were also reported in Travis and Webb Counties.

Aside from the Lower Rio Grande Valley Corridor, all other corridors experienced an increase in the seizure weights of heroin in 2017. The Del Rio/Eagle Pass Corridor saw a 58 percent increase in the weight seized in 2016. The Austin/San Antonio Corridor also experienced a 16 percent increase revealing more heroin successfully transiting the United States and Mexico border for delivery to locations within the United States.

The south Texas HIDTA region issued a strategy in 2015 to attack the increasing seizure weights of heroin and synthetic opioids. This strategy focused investigative, intelligence, and preventative resources on the heroin and synthetic opioid crisis through investigation of opioid seizures, opioid related deaths and overdoses, and prevention education related to opioid use and abuse.<sup>155</sup>

#### *First Responders*

##### *City of Houston Emergency Medical Services*

According to the Medical Director of Houston Emergency Medical Services, Dr. Persse, the Houston Fire Department (HFD) transported 3,227 non-alcohol drug overdoses from June 1, 2017 until June 1, 2018; 219 were heroin overdoses, and 274 were opioid overdoses. As the city collects approximately 40 percent on EMS billings, these transports represent a large cost to city taxpayers.

For those abusing opiates, heroin was once the drug most commonly abused; however, data reflects a significant increase in the use of fentanyl and its related compounds. Kush/K2 is also an issue in Houston.

The Harris County Institute of Forensic Science reported 616 drug-related deaths for 2017. Of the 571 deaths that were classified as accidental, 257 involved opiates. The accidental deaths involving heroin rose 78 percent between the first and second six months of 2017, and fentanyl deaths showed a 58 percent increase.

According to Dr. Persse, the assumption that overdoses are common only to people on-the-streets or in low-income housing is false. Every area of Houston has been impacted by drug overdoses.

Sharing information among providers, first responders, and law enforcement, could be helpful in locating and treating victims, and increasing the identification and prosecution of the suppliers. Houston Fire Department, Houston Police Department, and others within the city of Houston are committed to identifying a multidisciplinary approach going forward.<sup>156</sup>

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*Texas Emergency Medical Services Alliance (TEMSA)*

The Texas EMS Alliance represents EMS agencies that provide 911 services to communities throughout Texas, urban and rural.

Although opiate use is concerning, EMS officials across the state are witnessing overdoses related to methamphetamine and other illegal substances. For example, in Austin, EMS responds to an average of 140 calls per month related to K2 synthetic marijuana overdoses.

A March 2018 TEMSA survey asked members to report their frequency of opioid overdose responses. Consideration that an EMS agency may have difficulty in determining whether a response was related to an opioid overdose or related to a different substance is required; the responses included:

- Big Bend region ambulance service indicated only one response for opioid overdose, and that was in 2016. However, like many EMS agencies in the west Texas region, the service indicated an increase in opioid overdose calls is expected as the oil field moves closer;
- Cooke County reported two responses related to opioid overdoses;
- Balmorhea EMS indicated zero opioid overdose responses over the past year, but five years ago, the service had five overdose responses;
- An EMS agency that covers a rural west Texas area with a population of approximately 17,000 indicated approximately 96 opioid-related calls over a 10-year period; and
- The city of Paris EMS, which provided service to Lamar County, indicated approximately two opioid overdose responses each year. In comparison, the EMS agency indicated responses to K2 overdoses on a weekly basis.<sup>157</sup>

*Emergency Departments*

*Texas Hospital Association (THA)*

Dr. Berg, representing the Texas Hospital Association (THA), reported an increased number of patients in the emergency department going through withdrawals and that patients going through withdrawals can be violent and aggressive.

Dr. Berg advises that opioids are increasingly affecting younger populations of children and teens as they access unused prescriptions at home. She additionally reported the prevalence of methamphetamine and K2 cases in the emergency department.<sup>158</sup>

*Parkland Health and Hospital System (Parkland)*

Dr. Johnson, with Parkland Health and Hospital System (Parkland), reports that Dallas County recorded 427,000 behavioral health hospital visits in 2016; 31 percent of those visits occurred at Parkland. The Parkland ED has almost 250,000 visits per year; Parkland is the only hospital in Dallas that has a specific emergency room (ER) for behavioral health which sees approximately ten percent of the population coming through the ED. Within the behavioral health ER, 37 percent

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of the visits are alcohol related, and ten percent are opioid related. Parkland employs certified peer support specialists in the behavioral health ER.

Dr. Johnson comments that substance use patients are not limited to the ED. Parkland sees substance use patients in the inpatient medical surgical department and the women's health floors. For this reason, Parkland implements the substance use screening, Screening, Brief Intervention, and Referral to Treatment (SBIRT) and suicide screening across all hospital levels to ensure no patient's needs go unmet. Parkland also implements MAT for qualifying patients.

Dr. Johnson noted an increase in workplace violence, especially in the ED with the nursing staff, corresponding with the increase in opioid related visits. In response, Parkland developed a Behavioral Emergency Response Team (BERT) based on a rapid medical assessment team model, that handles behavioral health emergencies. The team was initiated in October 2017 and has been utilized in almost every inpatient area of the hospital.<sup>159</sup>

*Texas College of Emergency Physicians (TCEP)*

Dr. Jeffrey, of the Texas College of Emergency Physicians, reports that an ED is hectic, constantly interrupted, and patient information needs to be readily available; electronic health records have been helpful.

In his experience, not as many overdoses are seen but rather drug seeking patients who can become verbally and/or physically aggressive and disruptive to an ED. If after checking the PMP and determining a patient is drug seeking, instead of just refusing to prescribe medication, Dr. Jeffrey recommends speaking with the patient about his/her prescription history and drug use, and referrals to the needed resources.

Regarding treatment, Dr. Jeffrey testified that evidence-based practices are key. He recommends that physicians evaluate which situations require opiates and which can be remedied with over the counter medications. He emphasized addressing pain and making it more tolerable.<sup>160</sup>

*St. David's HealthCare (St. David's)*

Dr. Mitchell, Chief Medical Officer for St. David's HealthCare (St. David's) reports that the impact of the opioid crisis on communities, hospitals, and EDs has been vast. Between July of 2016 and September of 2017 ED visits related to opioids rose 30 percent in Texas. An estimated 60 percent of patients presenting in the emergency room with opioid-related issues require admission to the intensive care unit of the hospital which can be very costly.

In 2017, the average cost of a patient admitted to a hospital intensive care unit with opioid-related issues was approximately \$90,000, up from \$60,000 in 2009. St. David's saw around 2,300 opioid-related patients through EDs across the statewide hospital system.

According to Dr. Mitchell, hospitals are being proactive in responding to the opioid epidemic and references the Texas Hospitals' Guidelines to Curb Opioid Use and Abuse which were approved by the THA board in February 2018.



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Dr. Mitchell reported that many of the hospitals within St. David's HealthCare have already implemented many of the THA Guidelines and that St. David's ED physicians adopted many of the guidelines independently prior to THA formally adopting them. St. David's has also implemented strategies at all of their acute care hospitals to reduce opioid utilization in inpatient settings. Strategies involve reliance on non-opioid, non-narcotic medications to manage pain.

St. David's has also developed a "high alert" program across all hospitals for patients with frequent visits to EDs and inpatient settings. Another local hospital system uses a similar system, however, due to firewall and HIPAA constraints, the two systems are not able to share information on frequent user patients.

Dr. Mitchell expresses for continuing efforts, hospitals require additional flexibility to implement strategies to combat the opioid epidemic. Additional challenges include: hospitals do not generally employ physicians, therefore implementing new hospital guidelines often takes time as physicians typically have their own approaches to patient care; integration of the PMP into the electronic health records to ease the burden on the physicians of checking a different system for each patient is needed; hospitals report receiving negative feedback from patients when utilizing non-opioid and non-narcotic medication or practices to manage pain if the patient feels they are being labeled as a "pill-pusher" or the patient was not prescribed the medication he/she wanted; and Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey results, which include patient pain management satisfaction ratings as mandated by CMS, are linked to value based purchasing, and therefore can have a negative fiscal impact on hospitals.<sup>161</sup>

### *Community Program*

#### *Bexar County Joint Opioid Overdose Prevention Task Force*

San Antonio and Bexar County officials have been pro-active in addressing substance abuse.

Dr. Bridger, Director of the San Antonio Metropolitan Health District, reported that pain is the number one reason people seek medical attention in America. Chronic pain affects more Americans than diabetes, coronary heart disease, stroke and cancer combined, and costs our society \$635 billion annually.

The Joint Opioid Overdose Prevention Task Force (Task Force) was formed to address the increase in opioid overdose deaths in Bexar County and San Antonio. The Task Force includes more than 30 members divided into four groups.

The four work groups and tasks are:

1. The Naloxone Workgroup to expand the availability and use of overdose reversal medications;
2. The Provider Education Workgroup to improve training for healthcare providers on evidence-based opioid prescribing protocols including the use of the statewide prescription drug monitoring database;
3. The Community Education Workgroup to educate the community on how to safely dispose of prescribed opioids and the risks that accompany the use of heroin and other opioids, particularly in adolescents; and

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4. The Treatment Workgroup to improve access to and navigation of treatment services for addiction.

In addition to the original workgroups, two other interest groups have evolved from the task force:

- A group exploring treatment and recovery options for neonatal abstinence syndrome (NAS) mothers and their babies; and
- A group meeting with the district attorney and hosting a "syringe services summit" to help spread the word that syringe services programs are allowed in Bexar County.<sup>162</sup>

SAPD Lieutenant Luzius reports that costs due to the opioid crisis have increased significantly. Recent changes have increased access to naloxone, but SAPD reports that greater naloxone access is still needed.<sup>163</sup>

Mr. Mayes, Chief of Staff to Judge Nelson Wolff, reports that the naloxone initiative aims to provide naloxone to first responders. The initiative utilizes an effective "train the trainers" programs via the UT San Antonio (UTSA) school of nursing and HHSC. SAPD has participated in these trainings.

The Task Force emphasizes community education and cooperation. Through mobile drug take back programs and community collection boxes, the Task Force has collected over 47,000 pounds of unused medications. Educational advertisements about opioid management and disposal are also played at movie theaters to 567,000 Bexar County residents.

Mr. Mayes reports that the diversion program is revenue neutral because of offsets to detaining an individual. Participants in Bexar County jail diversion programs have a four percent recidivism rate, compared with 21 percent recidivism of the general population.<sup>164</sup>

### *Challenges*

- The manner in which CDC reports and categorizes substances for example, the number of fentanyl deaths is unknown as all are categorized as synthetic opioids.
- The rise in methamphetamine and fentanyl overdoses.
- Emergency department physicians are typically not employees of the hospital.
- Lack of coordinated program to share information between law enforcement and first responders, hospital emergency departments, physicians and other entities to identify "doctor shoppers," users, and suppliers.

### *Recommendations*

- Consider options for funding and equipping first responders, schools, and possibly households with a naloxone product.
- Review for increased funding for law enforcement to divert low level criminal offenders to substance abuse treatment.

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- Report additional details in substance-specific criminal offenses, including more specific data for activity in jurisdictions and regions across the state, for better identification of “hot spots” of specific substance crises for more direct substance-specific resources to combat, treat and prevent substance-related problems.
  - Create a statewide data system to break down case level data including the type of drugs involved in drug cases.
  - Evaluate merit of statewide collection of toxicology reports of adults and juveniles.
  - Make as state policy regarding law enforcement that handling and field testing of powdered substances shall require law enforcement agencies to adopt best practices to ensure the safety of their officers who may have direct contact with these substances.
  - Enhance punishment levels in criminal statutes for the use, possession, manufacturing and/or distribution of fentanyl due to the serious and obvious dangers surrounding the substance.
  - Generate a public awareness initiative highlighting protections available for “Good Samaritans.”
  - Enact "Good Samaritan" legislation to provide basic legal protection for those who assist a person who is injured or in danger (ensure stipulations regarding drug dealers, certain amounts of drugs, etc.).
  - Consider implementing a pilot program that would allow public health professionals to track individuals who have received naloxone.
  - Consider harm reduction efforts related to public health.
  - Increase awareness among communities regarding safe needle disposal practice and associated resources available to patients.
  - Consider pros and cons of counties' and municipalities' abilities to fund syringe exchange services programs and similar harm reduction initiatives.
  - Consider creating a program for sharing of information among providers, first responders, and law enforcement, to locate and treat victims, and to increase the identification and prosecution of the suppliers.
  - Develop a universal substance use screening tool and supplement SBIRT.

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**PUBLIC HEARING 5: CHARGE 6 - REVIEW OF THE IMPACT OF SUBSTANCE ABUSE ON TEXANS INVOLVED WITH THE CRIMINAL JUSTICE SYSTEM AND/OR THE CHILD PROTECTIVE SERVICES SYSTEM, AND CHARGE 8 - REVIEW OF THE EFFECTIVENESS OF SPECIALTY COURTS IN TEXAS**

The Committee held its fifth public hearing related to opioids and substance abuse on August 7, 2018 at 10:00am in Austin, Texas in the Capitol Extension, Room E2.012. The following organizations/individuals were invited to testify:

*Charge 6 - Examine the impact of substance abuse and substance use disorders on Texans who are involved in the adult or juvenile criminal justice system and/or the Child Protective Services system. Identify barriers to treatment and the availability of treatment in various areas of the state. Recommend solutions to improve state and local policy, including alternatives to justice system involvement, and ways to increase access to effective treatment and recovery options.*

Kristene Blackstone, Department of Family and Protective Services  
Camille Cain, Texas Juvenile Justice Department  
Bill Gravell, Judiciary, Williamson County  
Carey Green, Texas Department of Criminal Justice  
Elizabeth Henneke, Lone Star Justice Alliance  
Katie Olse, Texas Alliance of Child and Family Services  
Lisa Ramirez, The Health and Human Services Commission  
Lori Robinson, Texas Juvenile Justice Department  
David Slayton, Texas Judicial Council  
Douglas Smith, Texas Criminal Justice Coalition  
Brock Thomas, Judiciary, Harris County  
Hank Whitman, Department of Family and Protective Services

*Charge 8 - Identify the specialty courts in Texas that specialize in substance use disorders. Determine the effectiveness of these courts and consider solutions to increase the number of courts in Texas.*

Carey Green, Texas Department of Criminal Justice  
Ruben Reyes, Judiciary, Val Verde County  
David Slayton, Texas Judicial Court  
Brock Thomas, Judiciary, Harris County  
Julie Turnbull, Dallas District Attorney's Office; Texas Association of Specialty Courts  
Reilly Webb, Office of the Governor

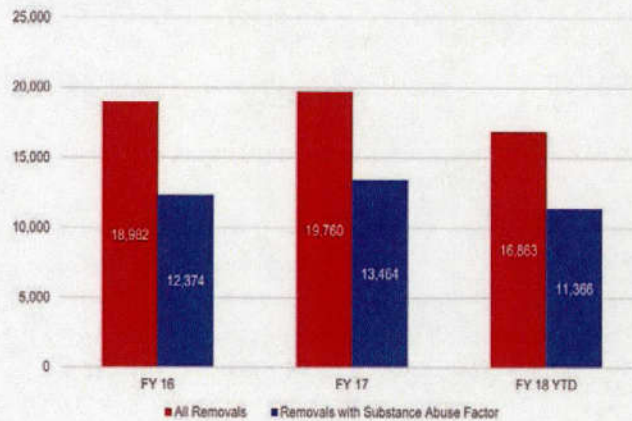
The following section of this report related to opioids and substance abuse is produced in large part from the oral and written testimony of the individuals above.

*Charge 6: Review of the Impact of Substance Abuse on Texans Involved with the Criminal Justice System and/or the Child Protective Services System*

*Department of Family and Protective Services (DFPS)*

Texas Statistics from Department of Family and Protective Services:

- Substance abuse is a factor in nearly 70 percent of child removals; removal rates in some states have tripled because of the opioid crisis;
- In 2017, 52 percent of fatalities caused by abuse or neglect involved a parent or caregiver actively using a substance that affected their ability to care for the child; and
- In 2017, of 190,260 total unique families served, 61,536 families had substance abuse issues.<sup>165</sup>



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When the Department of Family and Protective Services (DFPS) receives a report of abuse or neglect in a home, the main concern is the child's safety and an investigation occurs. Investigators often find that abuse has occurred to the child due to exposure to substances or neglectful supervision of the child by an impaired caregiver. Substance use itself may not be grounds for removal, but substance use could contribute to parental neglect and child fatalities. Risk factors such as substance abuse, mental health concerns, and domestic violence are common factors in confirmed child abuse and neglect fatalities.

DFPS utilizes the 14 Outreach, Screening, Assessment, and Referral Centers (OSARs) around the state for their clients. At each OSAR, families can access inpatient and outpatient treatment, education, counseling, and other community-based services to help cope with their substance use. After receiving referrals from the OSAR, DFPS involved individuals typically receive treatment services from HHSC providers.

In FY 2017, DFPS investigated 46,750 families for substance use issues, provided 22,749 families with substance use issues with family-based safety services, and provided 11,829 families with substance use issues with substitute care.

DFPS uses \$5.28 million of the agency's annual state appropriations for drug testing. Commissioner Blackstone highlighted the importance of drug testing as another tool that can be used to determine a child's safety and whether or not they should be removed from the home. Although DFPS involved individuals primarily receive treatment services from HHSC providers, DFPS also receives approximately \$3 million annually for the 2018-19 biennium to pay for services on an "as needed" basis. For example, if a parent involved with DFPS is on a waitlist for services, DFPS is able to provide counseling or treatment services.

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Barriers to treatment for parents include lack of availability of services, waiting lists, insurance coverage, employment challenges, and child-care availability.

To increase coordination of care, DFPS is working to improve interagency coordination. Enhanced cooperation with the Texas Juvenile Justice Department (TJJD) focuses planning on serving crossover populations, both parents and children, and enhanced transition planning to ensure proper placement of children transitioning from one agency's care to another.

Commissioner Blackstone references that an example of a county-led initiative to combat SUDs within the DFPS population is the Bexar County Children's Court (Court). The Court is an innovative, family-based, early intervention drug treatment court for parents with SUDs who have children in the foster care system. The Court works to determine the needs of parents with addiction issues with the goal of keeping families together.

DFPS discussed the importance of county-led initiatives, such as the family court in Bexar County, and other specialty courts to sustain families through innovative treatment and judicial solutions. DFPS voiced a need for enhanced services to support parents in maintaining sobriety once their children are returned home.<sup>167</sup>

#### *Texas Juvenile Justice Department (TJJD)*

Statistics from Texas Juvenile Justice Department:

- In 2017, 38,798 youth were referred to the juvenile justice system, and 25 percent of those referred were identified as having a need related to substance use;
  - 9,653 were identified as having a need for substance abuse treatment;
  - 3,687 youth were diagnosed with a substance use disorder (SUD) or co-occurring disorder; and
  - 4,048 participated in SUD prevention, intervention, or treatment.
- Of the 802 admissions to TJJD in 2017, 78 percent had a treatment need that was identified by the validated risk assessment tool that examines youth's alcohol and drug use;
  - Almost 38 percent of juveniles with high or moderate substance abuse needs had a high or moderate mental health need; and
  - The higher their substance abuse need, the more likely a youth to also have mental health needs.

Texas Juvenile Justice Department (TJJD) recommends expanding treatment capacity focused on trauma and adverse childhood experiences (ACE). For example, a parent that had a parent with a mental illness, abuse in the home, parental divorce or substance use, or other "traumatic" experiences, could constitute an adverse childhood experience that later affects his/her child. Children watching or experiencing their parent deal with his/her own childhood trauma leads to multigenerational trauma that can have lasting effects.

TJJD currently has about 860 youth in secure facilities, and approximately 20 children with acute mental health needs at a time. Children with acute mental health/SUD needs require differentiated, special services.<sup>168</sup>

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*Health and Human Services Commission (HHSC)*

The Health and Human Services Commission (HHSC) has launched several projects.

The medication assisted treatment (MAT) and pregnant postpartum intervention (PPI) programs for pregnant and postpartum inmates were developed in partnership with the Texas Commission on Jail Standards. Services include physician consult, delivery of medications, dose observation, case management, motivational interviewing, overdose prevention education, and prenatal/postpartum education. The program receives funding from the state and services are available statewide.

Recovery support reentry programs are federally funded through the Texas Targeted Opioid Response (TTOR) grant to support people reentering society after incarceration who are vulnerable to overdose in the days following release. Provider locations include: My Health My Resources (MHMR) of Tarrant County, The Harris Center for Mental Health and IDD, and Tropical Texas Behavioral Health.

Pre-arrest diversion programs federally funded through a TTOR carryover request are available in Bexar, Harris, and Travis counties.

Ms. Ramirez discussed the value of MAT in the criminal justice system. She testifies that MAT's combination of counseling and behavioral therapy with medication is associated with better treatment retention, reductions in the spread of infectious diseases, and lower rates of criminal behavior. She references that MAT results in decreased criminal justice expenditures: the average cost for a full year of methadone treatment is approximately \$4,700 per patient, compared to the costs for a full year of incarceration, which is approximately \$18,400 per person.

According to HHSC, for every \$1 invested in addiction treatment, a \$4 to \$7 return is yielded in reduced drug-related crime, criminal justice costs, and theft. Total savings related to healthcare can exceed costs by a ratio of 12:1.

HHSC also referenced the need for services for pre-trial detainees. These individuals may be released or transferred in a short period of time, and may be less likely to receive treatment for substance and opioid use disorders

The pregnant postpartum intervention (PPI) program eligibility and services were expanded to include individuals involved in DFPS during the 83<sup>rd</sup> Texas Legislative Session. The program was further expanded to include a targeted response to maternal opioid use during the 84<sup>th</sup> Texas Legislative Session. The program is aimed at reducing impact, severity, and costs, associated with a substance exposed pregnancy, to families and the community.

During the 83<sup>rd</sup> legislative session, the Parenting Awareness and Drug Risk Education (PADRE) program was created to reduce the impact of SUDs on the individual and family. The target population is parents and expecting fathers who are at-risk of or have a SUD and are involved with DFPS. Services include intensive case management, motivational interviewing, home visitation, and evidence-based education.<sup>169</sup>



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*Foster America*

National foster care statistics:

- Children in foster care are five times more likely to abuse drugs;
- Approximately 70 percent of the youth in the juvenile justice system have been involved in foster care;
- One-third of homeless young adults were previously in foster care;
- A majority of girls who are sexually trafficked were in foster care; and
- African American children are twice as likely as Caucasian children to end up in foster care.

From a national perspective Ms. Lachman, Executive Director of Foster America expresses that opioid and substance abuse are driving the numbers of children in the foster care system up at alarming rates. According to data 440,000 children are in foster care in the United States compared to 400,000 in 2011. Poverty and neglect are historically the primary reasons a child is removed from his or her parents, and that is still true today. However, the number of children being removed from their parents because of parental drug addiction has increased more than any other reason over the past several years, and now accounts for at least one third of the cases in foster care around the country.

Ms. Lachman advises the root of the issue can be linked to not investing in children early enough and emphasizes that early intervention and treating the entire family unit is imperative to reaching children before they become involved in substance abuse or other illicit activities.

Child welfare agencies are not able to keep up with the growing demand of children entering the foster care system, and with the rise of parental drug addiction, child welfare agencies are now expanding their duties to help find drug treatment for the parents of children in foster care. She states that not enough effective family drug treatment programs are available and not enough foster families are available to support the growing numbers of children entering the foster care system.

The federal government has taken steps to address the foster care system. In February, 2018, Congress passed the Family First Prevention Services Act which will, among other items, allow states to use federal foster care entitlement dollars on evidence-based drug treatment for families at imminent risk of losing their children. Previously, those dollars could only be spent on children already in foster care. This is a preventative measure to help keep families together. States must put up a 50 percent match to receive the federal funds.

Family drug treatment programs that already exist in Texas include family drug courts. She references the family drug court operating in Dallas County which has been successful in increasing the percentage of parents who complete drug treatment and reunite with their families compared to traditional family courts.

Ms. Lachman recommends scaling the family drug court methodology throughout the entire state of Texas and expanding other family drug treatment programs that are holistic in the sense that they counsel the parents and the children to keep families together.<sup>170</sup>

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*Texas Alliance of Children and Family Services (TACFS)*

Texas Alliance of Child and Family Services (TACFS) advises that when discussing the impacts of opioids and substance abuse on the CPS system, one must recognize that CPS in Texas is built to serve children and parents who have a SUD, and the system must be equipped to handle both.

According to Ms. Olse, Texas is outpacing the national child removal rate where substance use is a factor in the removal. In FY 2016, substance use was reported to be an issue in over 66 percent of removals, which is double the national rate. However, Ms. Olse also testified that removals are typically multi-faceted issues, and the national data may be more reflective of other removal factors.

She states that despite the increase in the number of children entering foster care from 2015 to 2018, the increase is not due to physical abuse, physical neglect, and sexual abuse which have historically accounted for the most removals; the increase is instead driven by negligent supervision, a broad category that includes substance use.

Children in foster care receive healthcare services through STAR Health, a Medicaid program administered by HHSC, to ensure their medical and behavioral health needs are being met. Upon entering conservatorship, STAR Health administers substance use disorder screenings to determine if the child is in need of services or treatment. STAR Health reports 80 out of approximately 35,000 children in the state's conservatorship have a SUD diagnosis.

Every child in conservatorship over the age of three receives a comprehensive assessment called the Child and Adolescent Needs and Strengths (CANS) assessment within the first 30 days of entry. Determining which children and/or families need services and how many children and/or families are actually receiving services for substance use, is difficult. Ms. Olse states that the bottom line is that if a child is not diagnosed, the child is not receiving the needed treatment.

Increased removals increase the need for more foster placements, and permanency placements take longer for children who were removed due to a parent with an SUD. These children also often require a more intensive therapeutic setting creating a need for more therapeutic foster families willing to take in higher needs children.

Another barrier is the lack of coordination of care for children in foster care with several different screenings and groups contributing to a child's care network: CPS, community organizations, a medical consenter, STAR Health, DFPS, and a judge. Ms. Olse contends care can be misguided with so many entities involved who do not always all work together, or work with the entire family unit, to treat the child.<sup>171</sup>

*Williamson County*

During youth drug cases, Judge Gravell asks juveniles in his court what substances they are currently using and how much they are paying. In Williamson County, his court experiences show that substance use is changing, and prices are changing. Historically in Williamson County, the top three abused substances were weed, alcohol, and sedatives; Judge Gravell is concerned opioids

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could move up to the second most used substance. He also reported that drug prices are increasing for marijuana and pills like OxyContin.

The Outreach, Screening, Assessment, and Referral (OSAR) for Williamson County is Bluebonnet Trails Community Services, and Judge Gravell's court orders that children go there for drug assessments. He reported that three years ago, he saw no youths being treated for opioid use; within the last 12 months, six and one-half percent of youths in Judge Gravell's court were being treated for opioid use.

Judge Gravell remains hopeful and emphasized the value of his local OSAR. His court typically sees first offense cases, and after receipt of services Judge Gravel reported that 98 percent of youths in his court do not reoffend.<sup>172</sup>

*Texas Department of Criminal Justice - Community Justice Assistance Division (CJAD)*

Statistics from Community Justice Assistance Division:

- In 2017, 24,558 (43.9 percent) of Texas felony placements were for controlled substance or Driving While Intoxicated (DWI); and
- In 2017, 44,258 (51.6 percent) of Texas misdemeanor placements were for controlled substance or DWI.

Various community supervision substance abuse programs are available through the Texas Department of Criminal Justice, Community Justice Assistance Division (CJAD). Programs are offered through drug courts, outpatient substance abuse programs, Treatment Alternative to Incarceration Programs (TAIP), Substance Abuse Felony Punishment Facilities (SAFPF), state-contracted intermediate sanctioned facilities, and contracted residential services.

Additionally, Community Corrections Facilities (CCFs) are designed to treat and support individuals, and prepare them for after-care upon release. Each facility is required to use the Risk-Needs-Responsivity (RNR) assessment tool, which is recommended as a best practice by SAMHSA and National Institute on Drug Abuse for justice involved individuals.

Ms. Green acknowledged the value of evaluating programs on adherence to guidelines and evidence-based practices. TDCJ reported 60 to 75 percent success with their SUD treatment facilities and CCFs, and a recidivism rate of approximately 13 percent.

Pre-trial diversion programs are gaining popularity according to TDCJ; 73 percent of pre-trial diversions are linked to substance use. In the past 10 years, the population in pre-trial diversion programs has more than doubled, and programs are supported by funds appropriated from the state.<sup>173</sup>

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*Advocates for Intervention Programs*

*Texas Criminal Justice Coalition (Coalition)*

The Texas Criminal Justice Coalition (Coalition) referenced Texas' strained capacity to divert people into treatment. From 2013 to 2017, 54,000 people were arrested for possession of less than four grams of a controlled substance. According to Mr. Smith, detaining someone with a SUD for a nonviolent offense, like possession of a controlled substance, can be expensive and inefficient. He reported that a typical police department spends between \$55 and \$97 per person to arrest and book someone into county jail, and a sheriff's office incurs another \$152.99 per booking and \$96.71 per jail bed day.

Mr. Smith says that individuals with substance use problems are more likely to serve jail time than be diverted to services/care, which continues the cycle of justice involvement. The Coalition informs that many persons incarcerated for drug possession will be rearrested within three years, while diverting people into community services lowers recidivism by 30 to 50 percent. He references that because of the shortage of services available, people are more likely to access treatment services entering into the criminal justice system.

The Coalition recommends improvement of local capacity to serve justice-involved Texans with substance use disorders in the community, rather than in jail, by providing counties with resources to increase treatment capacity to support jail/prison diversion initiatives. Mr. Smith discussed the value of diversion to community programs and pre-trial diversion programs and recommended funding pretrial intervention at same rate as felony supervision and creating a graduated sentence structure.<sup>174</sup>

*Lone Star Justice Alliance*

Lone Star Justice Alliance informs:

- Emerging adults aged 17 to 24 are at high risk for development of serious mental health conditions, which are commonly accompanied by co-occurring mental health conditions;
- Emerging adults are overrepresented in the adult criminal justice system in Texas: in 2012, emerging adults made up 10 percent of the U.S. population, 29 percent of arrests, and 21 percent of people admitted into adult prison; and
- Risk is even greater for emerging adults of color: The 2012 rate of incarceration in either state or federal prison was more than nine times greater for black males 18-19 than white males 18-19, and nearly three times the rate of Hispanic men of the same age.

Ms. Henneke comments that without appropriate intervention, emerging adults are likely to deteriorate, resulting in an increased chance of making contact with law enforcement. Ms. Henneke states that currently over 75 percent of justice-involved emerging adults recidivate, which is the highest short-term recidivism rate of any age group.

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Ms. Henneke discussed the importance of investing in promising and evidence-based policies to address substance abuse in the criminal justice system. She highlights common elements among existing, successful intervention programs across the county. Those common elements include:

- Intensive, Individualized Case Management: Research shows that behavior change is attached to one's own values.
- Risk-Needs-Responsivity Structure: The risk principle advises services and supervision be applied in direct proportion to an individual's criminogenic risk. The need principle promotes the administration of treatment and programming according to individuals' assessed needs that are amenable to change. The responsivity principle states that interventions should be tailored to an individual's learning style, level of motivation, abilities, and strengths so that services are delivered in a way youth will be most receptive.
- Specialized Skill Training with Directed Practice: An evidence-based principle suggesting that cognitive-behavioral techniques and "social learning" should be a central part of treatment programming.
- Engage Ongoing Support in Natural Communities Through Restorative Justice: Research shows connecting individuals with prosocial activities in their own community promotes positive behavior. Restorative justice and harm reduction initiatives include support networks that bring individuals into moral community through accountability to bear the weight of their actions.
- Incentive-Based Behavior Response System: Positive reinforcement coupled with a set of clear boundaries are effective in supporting sustainable behavior change and developing consequential thinking.
- Measure Processes and Practices and Provide Outcome Feedback: Interventions must be consistently tracked and evaluated to be proven successful, therefore, there is a need for programs to collect data on an ongoing basis, conduct rigorous analysis of procedures and outcomes, and regularly manage performance by providing feedback.

Ms. Henneke recommends Texas adopt alternatives to incarceration that redirect resources from the criminal justice system to public health social services to better address the needs of those with a SUD. With community services, all can benefit, and not just individuals involved in criminal justice.<sup>175</sup>

### *Pre-Trial Intervention Program*

#### *Harris County Responsive Interventions for Change (RIC) Docket*

The Harris County Responsive Interventions for Change (RIC) Docket was designed to reduce over-reliance on local and state jails, high recidivism rates, and racial and ethnic disparity among low-level felony drug offenders. The docket was created and implemented in FY 2017 and has allowed Harris County to consolidate over 5,000 low-level felony drug and prostitution offenses, typically distributed across the 22 district courts each year, into one docket. The RIC docket has provided an opportunity for nonviolent drug offenders to receive treatment in lieu of cycling in and out of jail for years to come. Prior to the RIC Docket 79, percent of cases received a conviction

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and were sentenced to incarceration and 21 percent of cases were diverted to community supervision and treatment.

Around eight percent of RIC cases are identified with misuse of, abuse of, or dependence on opiates. Opiate users referred to residential and intensive outpatient programs are screened by an addiction psychiatrist for MAT. Additionally, an addiction psychiatrist is available via tele-psychiatry on demand for opiate users in high risk situations.

Upon referral, individuals complete a comprehensive assessment and are required to participate in treatment programs as recommended. Treatment programs are designed to address a combination of substance abuse, mental health, and broader criminogenic needs. Cases are dismissed by the district attorney (DA) upon program completion; the pre-trial interventions have an 89 percent successful completion rate.

Since the RIC Docket began in October of 2016, 8,899 cases were filed and assigned, and 6,068 cases have been disposed. Because of the docket, 85 percent of the cases were diverted to community supervision (PTI or Deferred Adjudication) and 15 percent received a conviction and were sentenced to incarceration. One year after the RIC Docket began, the number of jail days occupied by low-level felony drug and prostitution cases was reduced by 100,000 days compared to similarly situated defendants from the prior year. One year after the RIC Docket started, the median number of jail days occupied by people of color was reduced from 40 days to five days or less.<sup>176</sup>

### *Challenges Related to Charge 6*

- Access to substance use services, in both availability/location of services and waiting lists/insurance coverage.
- Parent-specific barriers include employment challenges and child-care availability/frequency.
- A high percentage of justice-involved youth have mental health needs and co-occurring disorders; integrated mental health and substance use services are needed in the juvenile justice system.
- Foster care and other service capacity is not keeping up with increased child removals.
- Service deserts for justice-involved youth exist in many rural/medically underserved areas.

### *Charge 8: Specialty Courts*

#### *Office of the Governor - Criminal Justice Division (CJD)*

A specialty court provides specialized direct services, usually drug treatment, to offenders as an alternative to incarceration. Courts must comply with best practices approved by the Texas Judicial Council. Specialty courts in Texas include drug, family, veterans, mental health, commercially exploited persons, or public safety employee treatment courts. A specialty court in Texas may not operate without written verification from the Office of the Governor Criminal Justice Division (CJD).

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Texas has 176 registered specialty courts, and 71 specialty courts receive some level of grant support from CJD. In 2018, CJD dedicated \$8.6 million to specialty courts with drug courts receiving \$4,494,568, the bulk of the CJD investments. The goal of CJD funding is to support long-term sustainability.

According to CJD, a model drug court targets high risk/high need participants, meets often, has personalized judge/offender interaction, performs frequent and random tests for drugs and alcohol, and has graduated incentives and sanctions. Following treatment via a continuum of care with supportive social services and a multi-disciplinary team is also important.

In 2017, 1,794 persons were successful graduates of Texas specialty courts programs. Sixteen percent were rearrested within one year of graduation; however, 82 percent of participants score as "high" or "moderate" risk.<sup>177</sup>

*Judge Reyes, 72nd District Court Lubbock & Crosby Counties and Former President of the Texas Association of Specialty Courts*

Judge Reyes advises that specialty courts provide the state with an innovative approach to addressing individuals with substance use disorders in the criminal justice system and testified that imprisonment has little effect on drug use. He reports that after being released from prison, 60 to 80 percent of drug users commit a new crime and are incarcerated again, and approximately 95 percent of individuals return to abusing drugs upon release from prison. He also informed that providing treatment without any performance or attendance accountability for the offenders is ineffective and that unless the offenders are supervised by a judge, 60 to 80 percent drop out of their treatment programs prematurely.

Specialty courts bring together judges, prosecutors, defense attorneys, court personnel, probation officers, CPS, case workers, and treatment providers to target high-risk and high-needs populations to address the substance abuse issue in the criminal justice system. The specialty court model has grown substantially since being first implemented in 1989, with over 3,000 specialty courts across the country.

Effectiveness of specialty courts in Texas:

- 75 percent of specialty court graduates remain arrest-free;
- A 45 percent reduction in crime compared to other sentencing options;
- 78 percent of graduates obtained/retained employment;
- 21 percent obtained a high school diploma or GED;
- 12 percent enrolled in college; and
- 14 percent enrolled in vocational training.

Specialty courts save the state money:

- Every dollar spent on specialty courts equals \$3.36 in avoided criminal justice costs alone;
- Every dollar spent on specialty courts equals \$27 in reduced health care services and victimization costs; and

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- Incarceration of drug-using offenders costs \$20,000 to \$50,000 per person per year, whereas a comprehensive drug court system typically costs approximately \$2,500 per offender per year.

Judge Reyes emphasized the importance of increasing funding to expand the specialty court network in Texas. However, expansion must be calculated to ensure the new drug courts are operating effectively.<sup>178</sup>

*Julie Turnbull, Dallas County District Attorney's Office and Current President of the Texas Association of Specialty Courts*

As a prosecutor in the district attorney's office in Dallas County twenty years ago when a specialty drug court was first proposed in the county, Ms. Turnbull informed the Committee that she initially viewed the program as a "get out of jail free card" of sorts. However, now Assistant DA, Chief of the Reformatory Justice Unit, and working with the Dallas County specialty courts program every day, she has witnessed and fully supports the success of specialty drug courts. She has watched the program grow from the first drug court that began operations in 1998 to currently operating 15 specialty courts across Dallas County.

Ms. Turnbull emphasized the importance of including the district attorney's office in the drug court process. The office advocates on behalf of the public's safety and victims' interests, and holds participants accountable for meeting obligations of the program. Additionally, she advises that according to National Association of Drug Court Professionals research, graduation rates and participation increase, and costs decrease when a DA regularly attends staff meetings and drug court sessions.

The Dallas DIVERT Adult Drug Court has a 58 percent graduation rate, 99 percent of graduates are either employed, seeking education, or are otherwise adequately supported upon graduation; their three year recidivism rate is 21 percent.

The Texas Association of Specialty Courts (TASC), established in 2002, promotes drug courts and assists with training across the state. Primary strategic planning goals of TASC moving forward include scaling specialty court programs in different areas of the state, continuing to evaluate the effectiveness of specialty courts, ensuring that best-practices are being followed, and assisting with treatment needs.

Ms. Turnbull highlighted the need for a statewide data system that would allow specialty courts across Texas to track certain data points in the same way to improve the quality of data collected by specialty courts and provide more accurate data on effectiveness and success specific to each specialty court, as well as across the state as a whole.<sup>179</sup>



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*Regarding the Criminal Justice System and Specialty Courts*

*Texas Judicial Council (TJC)*

Data collected by the Texas Judicial Council (TJC) shows that the number of misdemeanor drug possession cases filed have been steadily increasing over the past 20 years and hit a new peak of 88,684 cases filed in courts across Texas in FY 2017. Misdemeanor drug possession cases now make up more than 20 percent of criminal cases filed in Texas.

Mr. Slayton advised that TJC data collection data is limited due to only being allowed differentiating between marijuana offenses and other drug offenses collect data that would record the prevalence of other drugs that are being abused in the state.

Felony drug possession cases reached an all time high in Texas in FY 2017, reaching 55,520 cases filed. Felony drug possession cases made up the majority of all criminal cases filed in FY 2017.

Mr. Slayton testified that all other criminal charges other than drug possession (both misdemeanor and felony) charges are decreasing across the state.

He comments about increasing numbers of drug cases coinciding with increasing numbers of new child protection cases. TJC data shows that new child protection cases increased by 29 percent over the last five years and peaked with 13,768 new cases opening in FY 2017.

Specialty courts fit into the state structure as what are often referred to as “problem-solving courts” that treat the underlying issues that bring people to court in the first place with the goal of reducing recidivism.

The Texas Judicial Council (TJC) performed a study of Texas judges regarding the prevalence of the opioid crisis. Approximately 500 responses were received during the two week response period in April 2018, from judges ranging in type of judge, age, and region of the state. Over 70 percent of respondents view the opioid crisis as a moderate or major problem, and 25 percent of respondents see an individual with an opioid addiction in their court once per week.

The judges were also asked to identify the top three addictive substances in the state:

- 63 percent ranked alcohol number one;
- 38 percent ranked methamphetamines number one;
- 54 percent ranked marijuana number two; and
- 64 percent ranked opioids number three, followed closely by prescription drugs at 61 percent.

Comments from the judges include obstacles regarding availability of providers for MAT; how methamphetamines are destroying families and children; and how most crime can be traced back to drugs.

TJC recommendations are for the Legislature to establish a statewide Opioid Task Force; for the Legislature to fully fund collection of relevant case level data from all court levels; for the

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Legislature to amend Title 2, Subtitle K of the Government Code to provide the Judicial Branch increased oversight of specialty courts; and for the Legislature to appropriate funds to the Office of Court Administration for the development of a statewide specialty court case management system.<sup>180</sup>

### *Challenges Related to Charge 8*

- State dollars fund less than one-half of the specialty drug courts.
- Waiting lists for substance use treatment and MAT.
- The state does not know the prevalence of specific substances due to collection of data being limited to only differentiating between marijuana offenses and other drug offenses.

### *Recommendations*

- Leverage the opportunities for funds from the federal Family First Prevention Services Act.
- Review expanding treatment which focuses on trauma and adverse childhood experiences (ACEs).
- Ensure children of drug abusers and other at-risk children have access to psychological counseling and education regarding drug abuse.
- Support the expansion of specialty drug courts.
- Review creating a family counseling program for families who have successfully completed Family Drug Treatment Courts (FDTC) programs focused on maintaining sobriety, rebuilding the family unit, and other family therapy services.
- Review creating a statewide data system to track people involved in the specialty drug court system.
- Explore an increase for funds and accessibility for substance abuse treatment programs in prison.
- Study funding mechanisms for alternatives to incarceration diversion and pretrial diversion and treatment providers.
- Review resources for therapeutic foster care services for youth in foster care with severe mental, emotional, or behavioral health needs.
- Allow collection of data on all drug offense drugs for a record of the prevalence of substances being abused in the state.
- Consider establishing a statewide Opioid Task Force.
- Review means for collection of relevant case level data from all court levels.
- Consider amending Title 2, Subtitle K of the Government Code to provide the Judicial Branch increased oversight of specialty courts.
- Consider funds to the Office of Court Administration for the development of a statewide specialty court case management system.

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## **PUBLIC HEARING 6: PUBLIC TESTIMONY**

The Committee held its sixth and final public hearing related to opioids and substance abuse on August 8, 2018 at 9:00am in Austin, Texas in the Capitol Extension, Room E2. 012. The following individuals testified:

Andrea Anderson, Self, The Alliance for the Treatment of Intractable Pain  
Jarvis Anderson, Bexar County Community Supervision and Corrections Department and TPA  
Kaleigh Becker, Texans Standing Tall  
Craig Benton, Texas Chiropractic Association  
Anais Biera Miracle, The Children's Shelter  
Matt Boutte, Texas Academy of Physician Assistants  
Drew Dutton, Phoenix House of Texas  
Ralph Fabrizio, Self, RecoveryPeople  
Laura Guerra-Cadrus, MD, Self, Children's Defense Fund Texas  
Greg Hansch, National Alliance on Mental Illness (NAMI) Texas  
Julia Heath, Self, Chronic Pain Patients  
Jason Howell, Self, RecoveryPeople  
Carl Hunter, Self, RecoveryPeople  
Kenneth Johnson, Quest Diagnostics Inc.  
Adriana Kohler, Texans Care for Children  
Richard Laker, Self, National Alliance on Mental Illness (NAMI) Texas  
Pace Lawson, Self, RecoveryPeople  
Teresa May, Harris County CSCD and TPA  
Kristin McGarity, Self  
Rodolfo Morales Urby, Self, Texas Doctors for Social Responsibility  
Robin Peyson, Self, Communities for Recovery  
Doug Reed, Phoenix Houses of Texas  
Lauren Rose, Texans Care for Children  
Donald Shipley, Self  
James Strader, Self  
Alissa Sughrue, National Alliance on Mental Illness (NAMI) Texas  
Ivonne Tapia, Association of Substance Abuse Programs  
Rebecca Vance, Self, Drug Prevention Resources, ASAP

### *Introduction*

The committee was charged to review the impact of the substance use and substance use disorders in Texas, to examine the services available, and to make recommendations to prevent overdoses and related health impacts and deaths. For a thorough review, an opportunity for public testimony was provided.<sup>181</sup>

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## CONCLUSION

The opioid epidemic and substance use disorder crisis in Texas is real. The data is alarming. Although the substance abuse and opioid crisis facing the state of Texas may not be as statistically poor as is reflected in some other states, Texas faces significant challenges.

Positive steps have been taken in Texas to address problems associated with opioid addiction and substance use disorders, but we must remain vigilant in our efforts to stay ahead of the deadly scourge. Improved prevention practices, better education, enhanced prescription monitoring, better supply management/medication disposal programs, and expanded treatment options, as well as, cooperation from all stakeholders, including manufacturers, prescribers, dispensers and patients alike, is essential for further progress and positive, meaningful and measurable outcomes for our state.

Continued engagement regarding this matter must remain a priority in Texas to maintain the state's path to prosperity.

This report reflects a great amount of time, study and hard work by the membership and staff of this committee. The document should serve as a catalyst for considerations for enhancement of current programs, for implementation of new programs, and as a framework for policy changes, legislative & non-legislative, to improve Texas' ability to respond to the opioid epidemic and prevent further tragedies and costs.

As a committee, we remain committed to working together and with all of our colleagues to position Texas for the future and successfully address the many challenges that now exist across our state.

For continued follow-up and study of the status of the epidemic throughout the United States, the websites of the Substance Abuse and Mental Health Services Administration (SAMHSA) <https://www.samhsa.gov/> and CDC <https://www.cdc.gov/drugoverdose/opioids/prescribed.html>, are informative.

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**APPENDICES**

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## APPENDIX A: Proclamation

### PROCLAMATION

#### APPOINTMENT OF SELECT COMMITTEE ON OPIOIDS AND SUBSTANCE ABUSE

Pursuant to Rule 1, Section 16, House Rules, I, Joe Straus, Speaker of the Texas House of Representatives, create the House Select Committee on Opioids and Substance Abuse.

The House Select Committee on Opioids and Substance Abuse will, not later than November 1, 2018, develop and present concrete principles and action items to reduce the scourge of opioids in Texas and to provide legislative solutions to address these issues, as well as examine other issues related to substance abuse in Texas.

In developing these principles and action items, The House Select Committee on Opioids and Substance Abuse shall:

1. Study the prevalence and impact of substance use and substance use disorders in Texas, including co-occurring mental illness. Study the prevalence and impact of opioids and synthetic drugs in Texas. Review the history of overdoses and deaths due to overdoses. Also review other health-related impacts due to substance abuse. Identify substances that are contributing to overdoses, related deaths and health impacts, and compare the data to other states. During the review, identify effective and efficient prevention and treatment responses by health care systems, including hospital districts and coordination across state and local governments. Recommend solutions to prevent overdoses and related health impacts and deaths in Texas.
2. Review the prevalence of substance abuse and substance use disorders in pregnant women, veterans, homeless individuals, and people with co-occurring mental illness. In the review, study the impact of opioids and identify available programs specifically targeted to these populations and the number of people served. Consider whether the programs have the capacity to meet the needs of Texans. In addition, research innovative programs from other states that have reduced substance abuse and substance use disorders, and determine if these programs would meet the needs of Texans. Recommend strategies to increase the capacity to provide effective services.
3. Review policies and guidelines used by state agencies to monitor for and prevent abuse of prescription drugs in state-funded or state-administered programs. Include in this review policies implemented by the Texas Medicaid Program, the



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Division of Workers' Compensation of the Texas Department of Insurance, the Teacher Retirement System, and the Employee Retirement System. Make recommendations regarding best practices.

4. Monitor and evaluate the implementation of legislation passed by the 85th Legislature regarding the Prescription Monitoring Program. In addition, review the prescribing of addictive drugs by physicians and other health care providers within various geographic regions of this state. Determine the role of health care professionals in preventing overutilization and diversion of addictive prescriptions. Provide recommendations that will improve efforts to prevent overutilization and diversion of addictive prescriptions.
5. Identify how opioids have impacted the normal scope of work for law enforcement, first responders, and hospital emergency department personnel.
6. Examine the impact of substance abuse and substance use disorders on Texans who are involved in the adult or juvenile criminal justice system and/or the Child Protective Services system. Identify barriers to treatment and the availability of treatment in various areas of the state. Recommend solutions to improve state and local policy, including alternatives to justice system involvement, and ways to increase access to effective treatment and recovery options.
7. Examine the impact of overdose reporting defense laws known as "Good Samaritan" laws.
8. Identify the specialty courts in Texas that specialize in substance use disorders. Determine the effectiveness of these courts and consider solutions to increase the number of courts in Texas.

The committee shall have 13 members. The following members are hereby appointed to the House Select Committee on Opioids and Substance Abuse:

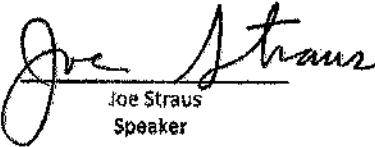
Rep. Four Price, Chair  
Rep. Joe Moody, Vice Chair  
Rep. Carol Alvarado  
Rep. Garnet Coleman  
Rep. Jay Dean  
Rep. Ina Minjarez  
Rep. Andy Murr  
Rep. Poncho Nevarez  
Rep. Kevin Roberts  
Rep. Toni Rose

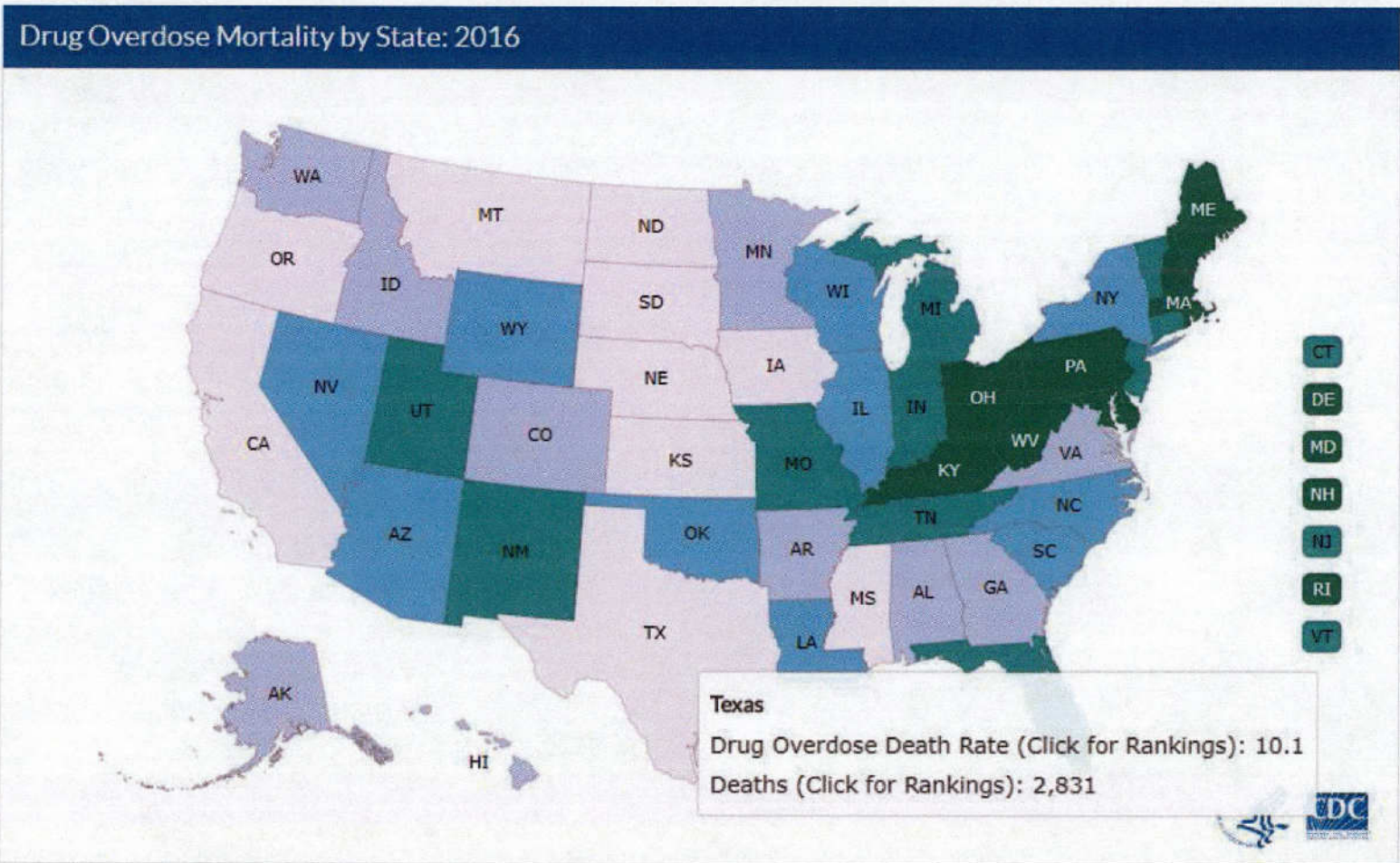
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Rep. J.D. Sheffield  
Rep. Gary VanDeaver  
Rep. James White

This committee may request the assistance of other committees and other legislative service agencies in obtaining information.

The committee shall file a final report in the manner provided by Rule 4, Section 61, House Rules, not later than November 1, 2018.

  
Joe Straus  
Speaker



## Age-Adjusted Death Rates\*

United States 19.8

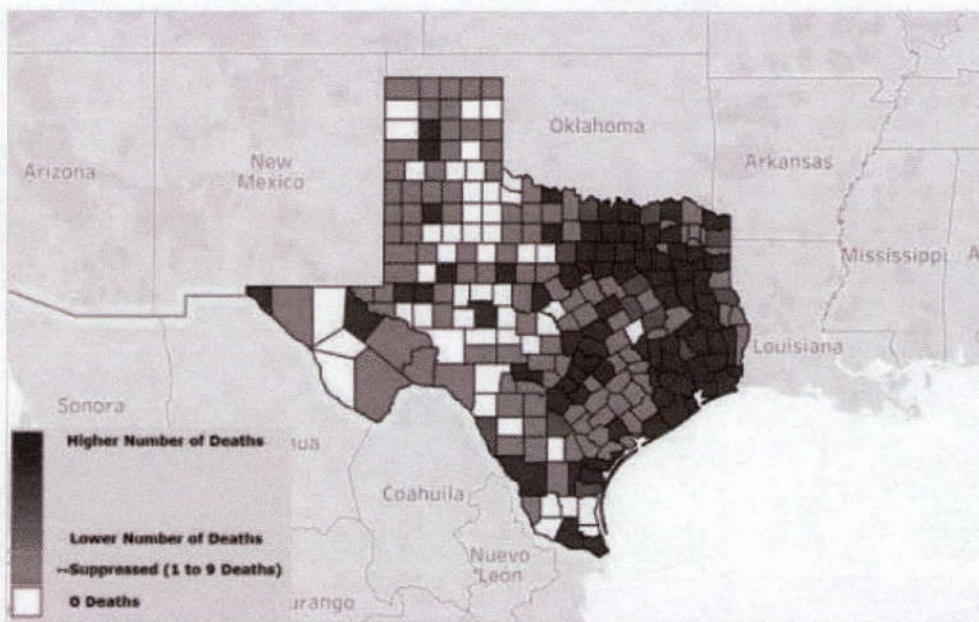
- 6.4 - 12.1
- 12.5 - 16.8
- 17.0 - 21.8
- 22.2 - 27.4
- 28.7 - 52

### Data Table

Location	Drug Overdose Death Rate (Click for Rankings)	Deaths (Click for Rankings)
Alabama	16.2	756
Alaska	16.8	128
Arizona	20.3	1,382
Arkansas	14.0	401
California	11.2	4,654
Colorado	16.6	942
Connecticut	27.4	971
Delaware	30.8	282
Florida	23.7	4,728
Georgia	13.3	1,394
Hawaii	12.8	191
Idaho	15.2	243
Illinois	18.9	2,411
Indiana	24.0	1,526
Iowa	10.6	314
Kansas	11.1	313
Kentucky	33.5	1,419
Louisiana	21.8	996
Maine	28.7	353
Maryland	33.2	2,044
Massachusetts	33.0	2,227
Michigan	24.4	2,347
Minnesota	12.5	672
Mississippi	12.1	352
Missouri	23.6	1,371
Montana	11.7	119
Nebraska	6.4	120
Nevada	21.7	665
New Hampshire	39.0	481
New Jersey	23.2	2,056
New Mexico	25.2	500
New York	18.0	3,638
North Carolina	19.7	1,956
North Dakota	10.6	77
Ohio	39.1	4,329
Oklahoma	21.5	813
Oregon	11.9	506
Pennsylvania	37.9	4,627
Rhode Island	30.8	326
South Carolina	18.1	879
South Dakota	8.4	69
Tennessee	24.5	1,630
Texas	10.1	2,831
Utah	22.4	635
Vermont	22.2	125
Virginia	16.7	1,405
Washington	14.5	1,102
West Virginia	52.0	884
Wisconsin	19.3	1,074
Wyoming	17.6	99

\*The number of deaths per 100,000 total population.

## Accidental Opioid-Related Poisoning Deaths: County-level Data, 1999-2015



Source: Texas Death Certificates  
Accidental Poisonings based on County of Occurrence  
Prepared by Texas Department of State Health Services, Center for Health Statistics 3/6/2018



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## APPENDIX D: Substance Details

### Prescription Opioids

- Opioids may be prescribed to treat acute or chronic pain and are frequently prescribed following an injury or surgery, or for health conditions like cancer or end of life care;
- Opioids reduce the body's perception of pain by binding to specific receptors within the brain, spinal cord, and gastrointestinal tract;
- These drugs stimulate the brain's "reward centers", giving the substances potential for abuse as they provide both pain relief and a sense of euphoria. Stimulating the brain's opioid receptors can also affect the body's systems that regulate mood, breathing, and blood pressure;
- Some commonly prescribed opioids are morphine, codeine, methadone, oxycodone (OxyContin, Percodan, Percocet), hydrocodone (Vicodin, Lortab, Norco), fentanyl (Duragesic, Fentora), hydromorphone (Dilaudid, Exalgo), and buprenorphine (Subutex, Suboxone);<sup>184 185</sup> and
- Fentanyl is a synthetic opioid pain reliever that is 50 times more potent than heroin and 100 times more potent than morphine. Pharmaceutical fentanyl is approved for managing severe pain, in cases of cancer or end-of-life palliative care.<sup>186</sup>

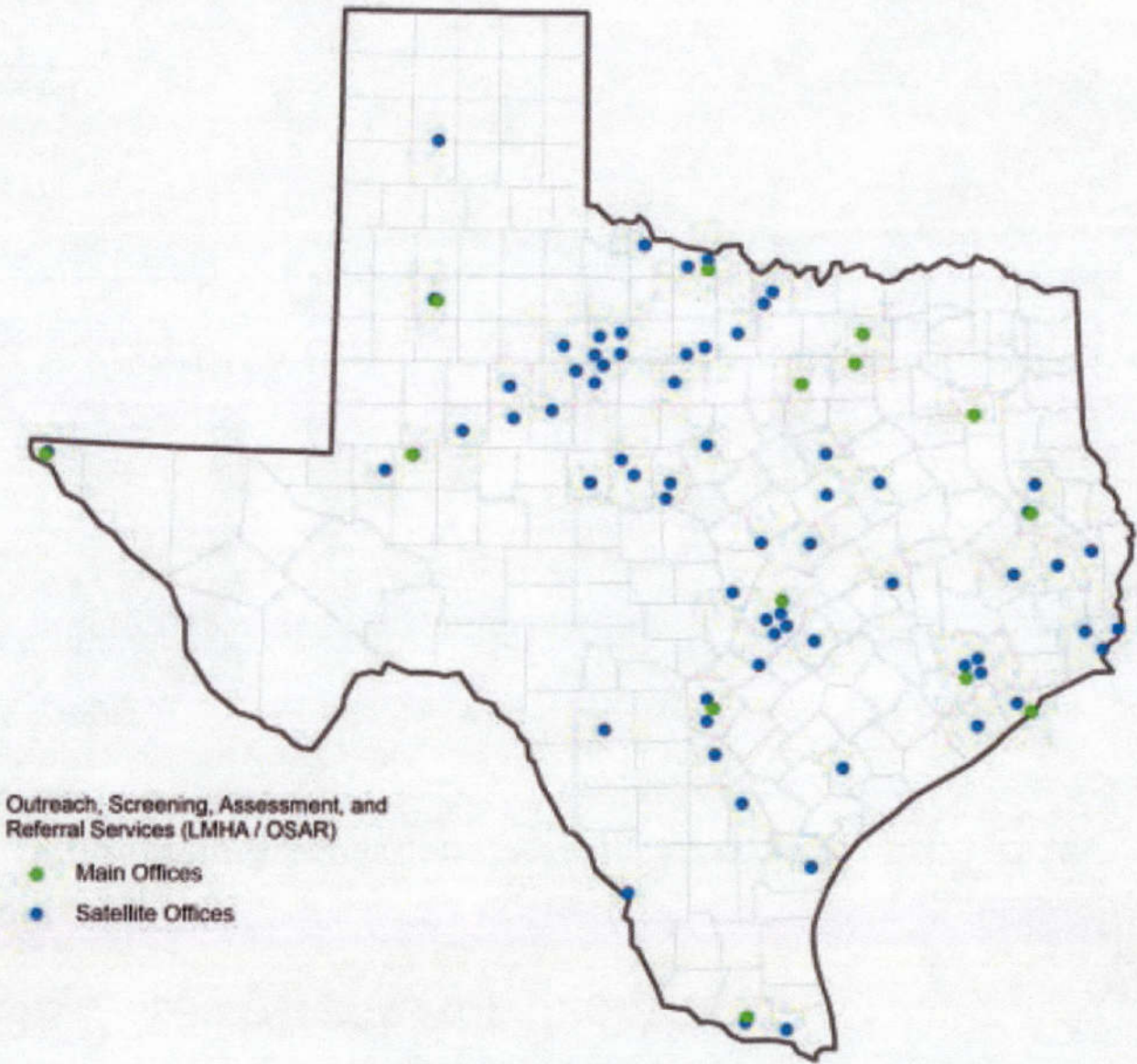
### Illicit Substances

- Heroin is an illegal and highly addictive drug that produces euphoria as well as symptoms of drowsiness, respiratory distress, constricted pupils, nausea, and dry mouth;<sup>187</sup>
  - Heroin is frequently injected but can also be smoked and snorted;
  - Injection of heroin comes with increased risk of long-term viral infections such as HIV, Hepatitis C, and Hepatitis B, as well as bacterial infections of the skin, bloodstream, and heart;<sup>188</sup>
- Non-pharmaceutical fentanyl, also known as illicitly manufactured fentanyl (IMF), is frequently sold mixed with heroin and/or cocaine, with or without the user's knowledge, to increase the drug's euphoric effects;<sup>189</sup> and
- Methamphetamine (meth) is a stimulant that can be taken orally, smoked, snorted, or injected. The long-term damaging effects of chronic meth abuse include anxiety, insomnia, paranoia, aggression, visual and auditory hallucinations, mood disturbances, and delusions.<sup>190</sup>

### Opioid overdose

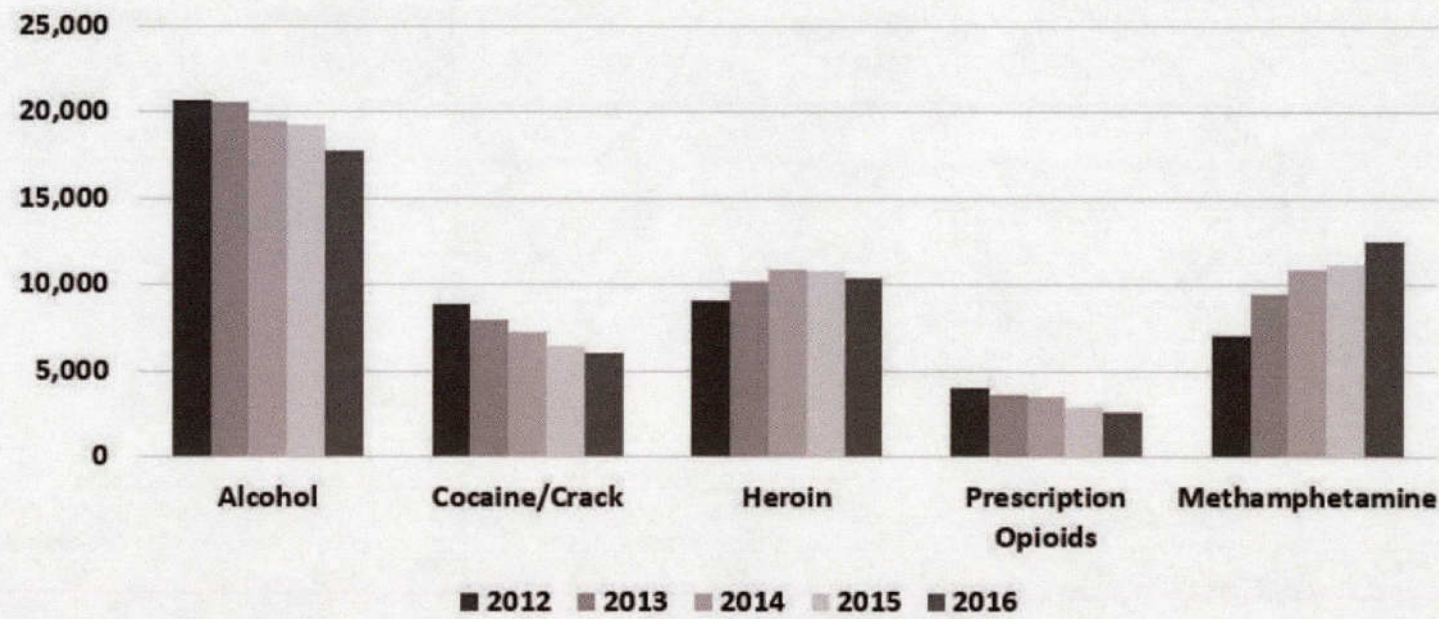
- After taking opioids, effects such as pleasure, nausea, vomiting, severe allergic reactions (anaphylaxis), and overdose can occur.
- During an opioid overdose, an individual's breathing and heartbeat are slowed or even stop. An overdose can occur if someone intentionally misuses a prescription opioid or an illicit substance, such as heroin.
- An overdose can also occur when a patient takes a prescription as directed, but the prescriber miscalculated the dose, the dispensing pharmacist made a mistake, or if the patient misunderstood the directions for use.<sup>191</sup>

**APPENDIX E: OSAR Locations<sup>192</sup>**



# HHSC Treatment Admissions

## Treatment Admissions by Select Substances, 2012 - 2016



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## ENDNOTES

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