Prepared Testimony of Patricia Strach before the Joint Senate Task Force on Opioids, Addiction, and Overdose Prevention, October 3, 2019

Thank you for inviting me here today to talk to you about opioid use in New York State.

I am a professor of political science and public administration & policy at the University at Albany, State University of New York (SUNY), and the interim executive director of the Rockefeller Institute of Government, the public policy think tank for the 64-campus SUNY system.

Although there is a lot of research out there on opioids, we still don't know:

1. what the problem looks like on the ground;
2. how communities are responding; and
3. what communities need to get a better handle on the problem.

For the past two years, I have been working with Katie Zuber and Elizabeth Pérez-Chiqués at the Rockefeller Institute of Government to answer these questions, examining opioid use in New York State. We chose to look in depth at three counties: rural Sullivan County, suburban Orange County, and urban Queens County. To date, we have conducted more than 150 interviews with people on the frontlines of the opioid epidemic: law enforcement, lawyers, judges, doctors, nurses, social workers, government officials, activists, families, and people in recovery.

I am here to share with you the results of our findings.

Opioids are highly lethal and disproportionately affect white, rural Americans, described by media as "deaths of despair."

Opiods are highly lethal. According to National Center for Health Statistics (NCHS) data, in 1999 there were 8,050 opioid overdose deaths in the United States. By 2017, that number had skyrocked to 47,885, driving up drug overdose death rates overall in 2017 to 70,237 — four times what it had been 20 years earlier. Although preliminary data show that overdose deaths have declined in 2018 (to 47,608 opioid overdose deaths and 68,588 drug overdose deaths), the numbers are still far too high.

These deaths disproportionately affect white Americans and rural communities.

To explain why white, rural Americans are so hard hit, the media, unfortunately, has grabbed on to "deaths of despair." In short, people in rural communities that have lost major industries have turned to drugs. The problem, however, is that it just isn't true.

Looking more concretely at the data show that physician prescribing patterns and access to treatment may better account for why some people (white Americans) in some places (rural communities) are disproportionately affected.

While it is true that White Americans have higher opioid overdose rates, they also have greater access to healthcare and greater access to prescription opioids within the healthcare system. Meghani et al. found that Hispanic Americans were as likely to be prescribed some sort of pain medication, but 22

percent less likely than their white counterparts to receive opioids.[1] Black Americans were 22 percent less likely to receive *pain medication of any kind*, and 29 percent less likely to receive *opioids* than white Americans for similar conditions.

For types of pain that require physician discretion to evaluate, it's even higher. When physicians prescribe for nonsurgical/trauma pain (e.g., backache or migraine rather than back surgery or an accident), Hispanic Americans are *30 percent less likely to receive opioids*, and Black Americans are *34 percent less likely* than white Americans to receive opioids for similar conditions.[2]

Physicians in rural areas are much more likely to prescribe opioids than physicians in urban areas ().[3] In New York State, the highest prescribing rates are in the most rural areas. Sullivan County, for example, has an age-adjusted prescription rate of 66.5 people, while New York City (Queens) has a rate of only 20.6.

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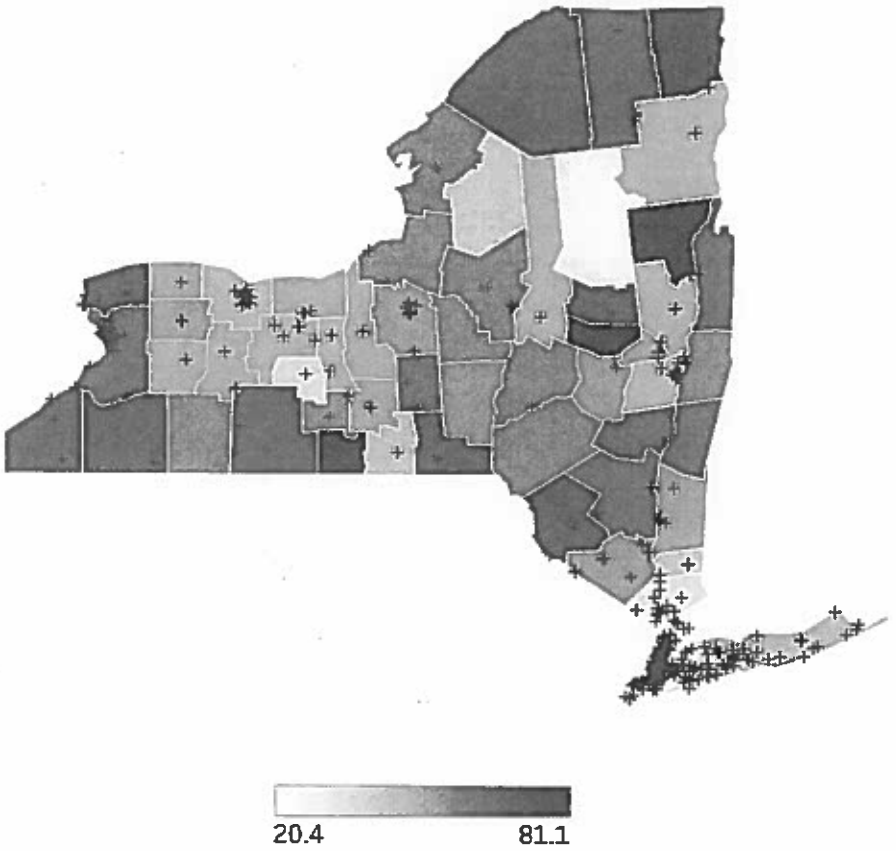
[1] Salimah H. Meghani, Eeeseung Byun, and Rollin M. Gallagher, "Time to Take Stock: A Meta-Analysis and Systematic Review of Analgesic Treatment Disparities for Pain in the United States," Pain Medicine 13, 2 (2012): 150-174.

[2] Ibid.

[3] Ameet Sarpatwari, Michael S. Sinha, and Aaron S. Kesselheim, "The Opioid Epidemic: Fixing a Broken Pharmaceutical Market," *Harvard Law & Policy Review* 11 (2017): 463, https://harvardlpr.com/wp-content/uploads/sites/20/2017/07/SarpatwariSinhaKesselheim.pdf.

Figure 2. Rural Communities Are Also Least Likely to Have Treatment Options



Source: 2017 Opioid prescription rate per 100 people (blue) and treatment options (+) from CDC data.

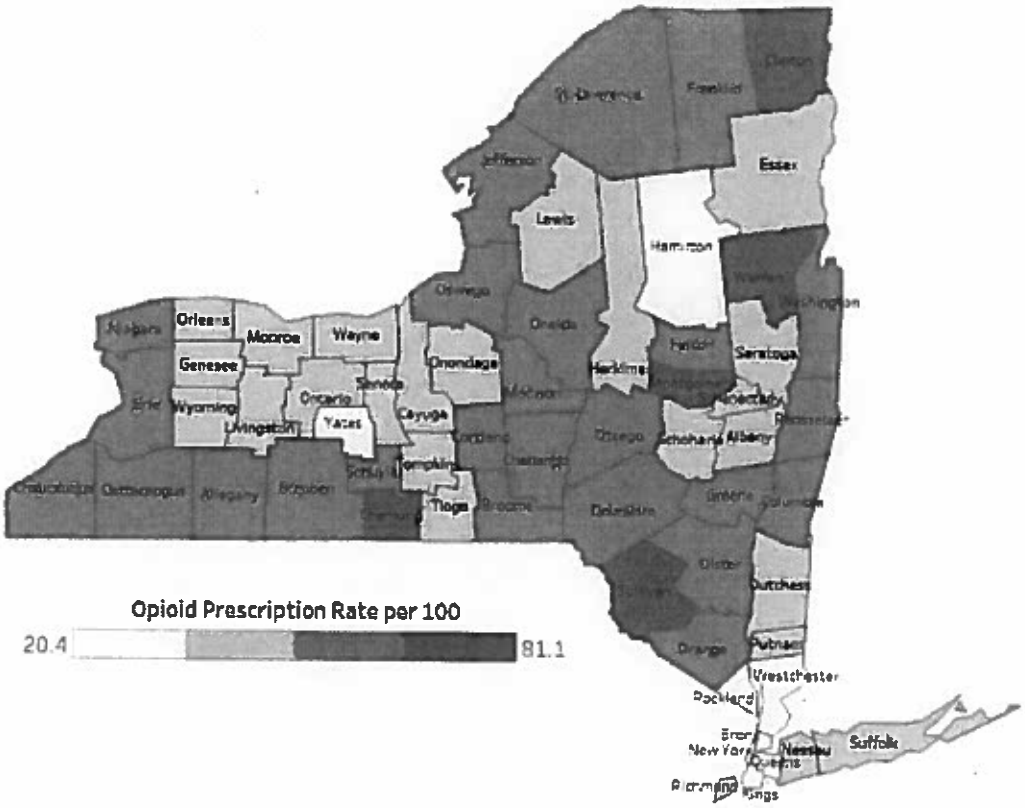
There are three real barriers to getting treatment that can be hard to see from Albany.

From the very first day doing interviews, we heard about the problem with "beds" — from grassroots organizers who told us "there are no beds" to the commissioner of Health and Family Services who said "getting a bed is a wait." But when we used the State's bed locator tool, we found hundreds of open beds. How can people on the frontlines tell us that there are no beds when the database says that there are?

The answer is an illusion of services. Beds are open and available, but people who show up at the door cannot actually access them because of three factors: (1) medical model of care; (2) admissions criteria; and (3) staffing shortages.

(1) Medical Model of Care: Although federal flexibility allows physicians at hospitals to treat emergency withdrawal using medications like buprenorphine, and although a state waiver allows hospitals to convert every medical bed into a detoxification bed, hospitals still turn patients away because they do not meet the medical criteria for withdrawal, where individuals have to be experiencing physical withdrawal before they are admitted. Essentially, people who come to the emergency department for help are sent home unless they are experiencing very painful symptoms, including shakes, sweats, whole

Figure 1. New York's Highest Prescribing Rates are in Rural Areas



Source: 2017 age-adjusted opioid prescription rates per 100 population by county from Centers for Disease Control and Prevention (CDC) data.

What's more, these same rural areas are least likely to have treatment options. In short, there is a mismatch between those areas hit hardest by the epidemic and the infrastructure needed to address it. There are not enough physicians to provide medication-assisted treatment (MAT), which gives patients prescription drugs to block the effects of opiate withdrawal. MAT — through methadone, buprenorphine, or naltrexone — is the most effective treatment for opioid-use disorder when combined with intensive mental health and behavioral counseling. Yet, more than half of US counties lack physicians who can prescribe buprenorphine, leaving 30-million people without access.[4]

[4] Roger Rosenblatt et al., "Geographic and Specialty Distribution of US Physicians Trained to Treat Opioid Use Disorder," *Annals of Family Medicine* 13, 1 (2015): 23-26.

body aches, severe body aches, restlessness, nausea, vomiting, or diarrhea. Prospective patients are often told to leave and come back when the symptoms are more severe.

(2) Admissions Criteria: Unlike emergency departments, which are open 24 hours a day, community treatment facilities may only be open during business hours. As one provider explained, "If we have clients who work or have childcare issues, 9-5 Monday through Friday might not work." People who come for help after hours are not seen because the office is closed and there is no qualified staff member to admit them.

Even when treatment facilities are open, they do not accept every patient who comes through their doors. Facilities may turn people away if they fail to meet age or sex requirements for beds. Some beds are available only for adults, whereas other beds are only available to a particular sex (male-only beds are not available to women, for example).

Treatment facilities may also turn people away if they cannot provide the appropriate level of care. For instance, not all facilities are licensed to provide medically supervised detoxification. Under the Mental Hygiene Law, inpatient[5] and outpatient[6] treatment facilities cannot turn patients away based solely on their:

+ prior treatment history;

+ referral source;

+ pregnancy status;

+ history of contact with the criminal justice system;

+ HIV and AIDS status;

+ physical or mental disability;

+ lack of cooperation by significant others in the treatment process; or

+ medication-supported recovery for opioid dependence prescribed and monitored by a physician, physician's assistant, or nurse practitioner.

The NYS Office of Alcoholism and Substance Abuse Services (OASAS) encourages providers to complete mental health screenings to ensure appropriate care,[7] but current law does not explicitly preclude denial of addiction services based on a patient's use of antidepressants or other medications designed for treating co-occurring mental health disorders.

(3) Staffing Shortages: Even when there are facilities with beds to treat people, severe staffing shortages mean those beds are, in practice, inaccessible to people who need them. Increased coverage for mental health means greater demand for psychologists and psychiatrists without an adequate

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[5] NYS Mental Hygiene Law, Part 820 Residential Services, https://www.oasas.ny.gov/regs/documents/Part820ResidentialServices.pdf.

[6] NYS Mental Hygiene Law, Part 822 General Service Standards for Chemical Dependence Outpatient (CD-OP) and Opioid Treatment Programs (OTP), https://www.oasas.ny.gov/regs/documents/822.pdf.

[7] "Co-Occurring Disorders," NYS Office of Alcoholism and Substance Abuse Services," accessed September 30, 2019, https://www.oasas.ny.gov/treatment/cod/index.cfm.

supply.[8] The staff problem is widespread: a lack of social workers, credentialed alcoholism and substance abuse counselors (CASACs), and nurse practitioners. Half of agencies specializing in substance use say they have difficulty filling open positions, primarily because of a lack of qualified applicants.[9] Turnover is high (19 percent nationally, but 40 percent in some reports) because of low pay, few benefits, and heavy caseloads as well as the stigma of working with addictions.[10] As one person who worked for a nonprofit provider explained: "[T]his is the frustration of the treatment programs ... they keep expanding access to treatment, but you can't find a nurse practitioner to write buprenorphine." What few people there are who specialize in addiction services are hard to hire, and county governments and nonprofits cannot compete with hospitals and for-profit providers who can afford to pay higher salaries.

Staff shortages mean that beds can remain empty. A nonprofit worker in Orange County, whose job it is to connect clients to services, explained how one local treatment facility "is a great place. Clients are really happy with the treatment." But, as much as she would like to place people there, "no one is answering the phone. You have to leave a message, and nobody gets back to you." If there is no receptionist to answer the phone or nurse to do intake, people who need help cannot get it.

Although federal rules and regulations could alleviate the problem of staff shortages — by incentivizing people to pursue training as addiction specialists, for example — existing policies do just the opposite: they make it harder for people to find a provider who can prescribe MAT. Under existing law, physicians, dentists, veterinarians, physician assistants, nurse practitioners, and nurse midwives in New York can prescribe opioids, but MAT requires specialized clinics, trainings, and authorization. Methadone is a Schedule II drug, available only through highly regulated clinics, which patients have to visit daily when they first start methadone maintenance. Buprenorphine, a Schedule III drug, can be prescribed in physicians' offices, but it requires practitioners to obtain a Drug Enforcement Agency (DEA) waiver, which includes an eight-hour training for doctors and an additional 16 hours of online training for physicians' assistants and nurse practitioners.[11] Ironically, it is far easier to prescribe opioids than the medication-assisted treatment to help people stop using them.

In addition to limiting which medical personnel can provide MAT, federal regulations also limit how many patients they can treat. During the first year of buprenorphine certification, physicians can have up to 30 patients under treatment at one time. After a year, they can apply to have the number increased to 100, then 275.[12] In 2016, less than 4 percent of physicians were waivered to prescribe buprenorphine in the US.[13] Of the 55,000 physicians who can prescribe buprenorphine in the US: 72 percent are 30 Patient Certified, 20 percent are 100 Patient Certified, and 8 percent are 275 Patient

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[8] Mark Olfson, "Building the Mental Health Workforce Capacity Needed to Treat Adults with Serious Mental Illnesses," Health Affairs 35, 6 (2016): 983-90.

[9] Michael A. Hoge et al., "Mental Health and Addiction Workforce Development: Federal Leadership Is Needed to Address the Growing Crisis," *Health Affairs* 32, 11 (2013): 2005-12.

[10] Ibid.

[11] Opioid Treatment Programs and Related Federal Regulations (Washington, DC: Congressional Research Service, updated June 12, 2019), https://fas.org/sgp/crs/misc/IF10219.pdf.

[12] "Apply to Increase Patient Limits," SAMHSA (Substance Abuse and Mental Health Services Administration), accessed September 30, 2019, https://www.samhsa.gov/medication-assisted-treatment/buprenorphine-waiver-management/increase-patient-limits.

[13] Sarah E. Wakeman and Josiah D. Rich, "Barriers to Medications for Addiction Treatment: How Stigma Kills," *Substance Use & Misuse* 53, 2 2017): 330-33.

Certified.[14] Even if every physician prescribed at the limit there would still be more patients than treatment slots. But most physicians do not prescribe to the limit.[15] Ten percent of the population (more than 30 million people) do not have access to a single prescriber of medications for addiction treatment — the overwhelming majority (21 million) in rural areas.[16]

As one hospital administrator explained: "[W]e can write [prescriptions] for the drugs that cause the problem without *any* kind of waiver whatsoever but we can't write for the drugs that can fix the problem.... I liken it to any other chronic illness.... [I]f I had a diabetic patient who came in to my practice and, all of a sudden, tomorrow you told me I can't treat any more than 250 diabetics the world would stop."

Problems addressing opioids are exacerbated in rural communities.

Rural communities may have a more difficult time addressing the opioid epidemic.

> **Access:** Access in urban areas means having the services but not be able to use them. But in many rural communities, there just aren't services.
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> **Transportation:** Transportation was an issue raised in nearly every one of our interviews. People suffering from substance use disorders who need outpatient treatment may not have a driver's license or a car and the bus only runs twice a week. Medicaid will pay for taxis to medical appointments, but it does not pay for transportation for other necessities, like trips to the pharmacy or grocery store. Ironically, the lack of transportation does not disrupt the flow of drugs into the county, which generally travel along two main corridors — up the New York State Thruway and across Route 17. "We can't get a pizza delivery," one mom observed, "but we can get a heroin delivery."
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> **Aftercare and Housing:** For people who successfully complete treatment, there are few housing supports or other wraparound services available to aid in their recovery. As a lawyer explained to us, once people with addictions finish a program, they are typically forced back into the same communities they came from and they relapse: "Aftercare treatment is homelessness," he explained, or, as someone else described it, a room in "a flea-shit-bag hotel." In these kinds of settings, life-skills training and job counseling do not exist. Instead, people in recovery are "thrown back into the street, thrown back into their parents' house, they're just thrown back into the same place they were, but without the right tools ... to succeed."
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> **Capacity:** Although they did not create the problem, local governments are held responsible for cleaning it up. Yet, local governments cannot do this on their own. Existing government infrastructure limits what the county can do. According to one provider, "The county doesn't seem to have the resources, nor sufficient infrastructure, to keep its attention focused on ... health-related issues." Local officials have applied for competitive grants to improve

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[14] "Practitioner and Program Data," SAMHSA (Substance Abuse and Mental Health Services Administration), accessed September 30, 2019, https://www.samhsa.gov/programs-campaigns/medication-assisted-treatment/training-materials-resources/physician-program-data.

[15] Christopher M. Jones et al., "National and State Treatment Need and Capacity for Opioid Agonist Medication-Assisted Treatment," American Journal of Public Health 105, 8: e55-63.

[16] Rosenblatt et al., "Geographic and Specialty Distribution of US Physicians Trained to Treat Opioid Use Disorder."

infrastructure in the county, but they feel as though they are in competition with more urban counties like Albany and Westchester. "It becomes tough for us to compete," the Sullivan county manager explained. Part of the issue is that grants are designed to have the greatest impact, therefore rural communities with smaller populations may be ineligible.

Opioids are not just a healthcare or even criminal justice issue. They spill over into families, foster care, schools, and the labor force too.

Families: Opioid addiction is a family disease. Opioid use can be, in the words of one parent, "devastating" to families. According to a national survey conducted by the 2004 Faces & Voices of Recovery Campaign, more than two-thirds of American families have been touched by addiction.[17] Facilities treat *individuals* with opioid addictions, one mother said, but they don't provide help, support, or therapy for families. Families need support. But it can feel as if the system is designed to punish them. Sam is on probation: How's he going to get there, his mother asks. They've taken away his license, and he doesn't have a car anyway. She either has to take time off work to get him to his appointments or he does not live up to the terms of his probation and goes back to jail. "Who's being punished?" his mother asks. "My son is, of course, because you're not giving him the tools to ever make it out." But she's been living in the wake of addiction for years. Without the proper supports, parents in this situation feel like they are "left to their own devices."

Foster Care: Researchers have estimated the number of children removed because of parental substance or alcohol abuse rose from 14 percent to 34 percent between 1998 and 2016.[18] Roughly 35 percent of children whose parental rights were terminated in 2012 had been removed for parental alcohol or drug use.[19]

In fact, 40 percent of new opioid-dependent adults are estimated to live in households with children.[20] Moreover, parents involved in the child welfare system who use opioids are less likely than other drug users to retain custody of their children.[21] Finally, there has been a substantial

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[17] Susan G. Parker, *The Faces & Voices of Recovery Campaign Raises Awareness About Recovery from Addiction* (Princeton: Robert Wood Johnson Foundation, last updated December 13, 2012), https://www.rwjf.org/en/library/research/2009/07/the-faces---voices-of-recovery-campaign-raises-awareness-about-r.html.

[18] "Number of children in foster care continues to increase," U.S. Administration for Children & Families, November 30, 2017, https://www.acf.hhs.gov/media/press/2017/number-of-children-in-foster-care-continues-to-increase."

[19] Only higher for children removed for neglect (Sid Gardner, *State-Level Policy Advocacy for Children Affected by Parental Substance Use* (Lake Forest: Children and Family Futures, August 2014), http://childwelfaresparc.org/wp-content/uploads/2014/08/State-Level-Policy-Advocacy-for-Children-Affected-by-Parental-Substance-Use.pdf; "Number of children in foster care continues to rise," Administration for Children & Families (ACF), November 30, 2017, http://www.acf.hhs.gov).

[20] L.R. Bullinger and C. Wing, "Trends in opioid abuse and dependency in households with children," unpublished paper, 2017.

[21] Martin T. Hall et al., "Medication-Assisted Treatment Improves Child Permanency Outcomes for Opioid-Using Families in the Child Welfare System," *Journal of Substance Abuse Treatment* 71 (December 2016): 63-7.

increase during the past fifteen years of in utero exposure to opioids in mothers involved in the child welfare system.[22]

Foster care strains county budgets. The costs of foster care provision are substantial, running about $21,535 per year for each child in a regular foster care placement, and up to $81,441 for institutional placements (FY 2011 estimates) in New York State.[23] The average annual cost of placing a child in foster care in New York State is $51,943 (in FY 2017), which is more expensive than tuition at Harvard.[24]

Children in foster care are an extremely vulnerable population. They are at higher risk for experiencing adverse life outcomes, such as homelessness, higher rates of teenage pregnancy, and lower earnings.[25] Additionally, children in foster care are more likely to drop out of school and to experience substance abuse problems themselves.[26] They exhibit higher rates of behavioral, emotional, and health problems, which not only result from the experiences that led to their placement, *but from the experience of the foster care system itself*.[27]

Schools: Although opioid deaths are highest among New Yorkers age 45 to 54,[28] the effects of opioid use by grandparents and parents has an effect on schools, as does the smaller (but growing) number of youth who use opioids.[29] The cost of treating opioid addiction — through county programs, Medicaid, Medicare, private insurance, or out-of-pocket costs — is so high that many people push for prevention to avoid problems. Still, schools in Sullivan County — like New York State more generally — are overwhelmed with requests for teachers to do a lot more than simply teach the basics. One teacher explained that for prevention programs to work,

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[22] Gregory Bushman et al., "In Utero Exposure to Opioids: An Observational Study of Mothers Involved in the Child Welfare System," *Substance Use & Misuse* 53, 5 (2017): 844-51.

[23] Gerard Wallace and Ryan Johnson, *New York State - Child Welfare Costs and Kinship Services* (Rochester and Delmar: NYS Kinship Navigator, n.d.), http://www.nysnavigator.org/pg/professionals/documents/NewYorkStateChildWelfareCostsandKinshipCare.pdf.

[24] *FY 2017 Executive Budget Financial Plan* (Albany: NYS Division of the Budget, n.d.), https://openbudget.ny.gov/historicalFP/fy1617archive/eBudget1617/financialPlan/FinPlan.pdf.

[25] Mark E. Courtney, Sherri Terao, and Noel Bost, *Midwest Evaluation of the Adult Functioning of Former Foster Youth: Conditions of Youth Preparing to Leave State Care* (Chapin Hall Center for Children at the University of Chicago, 2004), http://www.tndev.net/mbs/docs/reference/Transitioning_Youth/Midwest_Study_Former_Foster_Youth.pdf; Joseph J. Doyle, "Child Protection and Child Outcomes: Measuring the Effects of Foster Care," *American Economic Review* 97, 5, December 2007: 1583–1610.

[26] Mark E. Courtney et al., *Foster Youth Transitions to Adulthood: Outcomes 12 to 18 Months After Leaving Out-of-Home Care* (Madison: School of Social Work, University of Wisconsin-Madison, 1998).

[27] Scott Cunningham and Keith Finlay, "Parental Substance Use and Foster Care: Evidence from Two Methamphetamine Supply Shocks," *Economic Inquiry* 51, 1 (2013): 764-82; Doyle, "Child Protection and Child Outcomes."

[28] Jim Malatras, *By the Numbers: The Growing Drug Epidemic in New York* (Albany: Rockefeller Institute of Government, April 2017), https://rockinst.org/wp-content/uploads/2017/11/2017-04-20-By_numbers_brief_no8-min.pdf.

[29] Jim Malatras, *Opioid Deaths Continue to Surge in New York State* (Albany: Rockefeller Institute of Government, March 15, 2018), https://rockinst.org/wp-content/uploads/2018/03/2018-03-21-By-The-Numbers-Opioid-Deaths.pdf.

teachers have to really believe in them and not see them as just another thing they have to do. And they have to resonate with students.

Labor and Workforce: People who have addictions or who have criminal records (often because of their addictions) have a difficult time finding and maintaining steady employment. Although many of the best resort jobs dried up when the tourism industry died down, the county did bring in a new casino to the area, which opened in February 2018. But even here, local residents wondered how many local people would be hired, especially given constraints on the skills they have, the addictions they are combatting, and the criminal records that follow them.

What do people on the frontlines want policymakers to do? Listen.

The one question we always ask the people we talk to is: What do you want state and federal policymakers to do or to know?

The answer is not what we expected.

Certainly, people in communities want more resources. But they spent the most time talking about how they want to be heard and understood. When we asked one provider what she wanted from state and federal officials, she said: "The information that's down here, the people that are in the trenches, doesn't get up there. It just doesn't. And then they make decisions based on a disconnect. And then people scream loud enough and in 10-20 years we come back around and are having the same argument all over again. If that makes sense. So, besides the obvious, I really think they need to turn off their brains, turn on their ears."

And another provider told us: "People are suffering. People are hurting.... Walk *into* one of these rat den buildings that they rent out in Newburgh. And say *if I had to live there every night, what would it be like for me?* You know. How easy would it be to get up and look for a job if I ... have rats and cockroaches ... where I have to put cotton balls in my kid's ears so a roach doesn't crawl into their ear and get stuck there. You know, see what people live through, not with [a] camera, by yourself. Go out with one of my caseworkers one day. And see what they have to do in a day to help families."

People in the community seem to think that other levels of government do not care. They feel left behind. As one mom noted, "if it's a crisis, why don't you treat it like one?"

Conclusion: Public Policy Solutions

In sum, the opioid epidemic is deadly, and it is hitting communities hard. But rather than a cloud of despair hanging over communities, there are concrete mechanisms (like physician prescribing and lack of treatment) that better explain overdose deaths. To better address the problem, policymakers ought to address the concrete challenges that communities face: getting people who want treatment, who ask for treatment, into appropriate treatment. Some suggestions to make treatment more accessible are as follows:

1. Make access easy and open. Every community needs a place where people with substance-use disorders can get help, whether that point of entry is a hospital emergency department or a stand-alone clinic, where they won't be turned away.

2. Achieve parity in protocols for treating people with substance-use disorders and other life-threatening conditions. Opioid withdrawal can be dangerous because its symptoms cause dehydration and desperation. Even more problematic, the next dose of a controlled substance, especially illicit opioids, could be a person's last dose. If there's one factor that distinguishes opioids from other drugs,

it's their lethality. Getting people to treatment and making sure they have what they need to get better is imperative if we're to make progress on this problem.

3. Help treatment providers meet their staffing needs. If treatment beds are available, but nobody is there to answer the phone or do intake, it's as if the bed didn't exist at all. Treatment providers have trouble hiring qualified doctors, nurses, CASACs, and social workers. It's hard work. The pay is terrible. Positions stay empty for a long time and, even when they are filled, turnover is high. Finding a way to incentivize people to get the required education, take a job, and stay in it is essential for providing necessary services.

4. Pay providers reasonable reimbursement rates to cover the costs of services. When reimbursement rates for some conditions and services are generous and others are not, hospitals, doctors, and medical professionals gravitate to more lucrative fields in the most desirable locations. If we want to make sure people get the treatment they need, it cannot be a money-losing endeavor.

5. Incentivize medication-assisted treatment. If it's easier and more lucrative to prescribe opioids than the medication to treat substance-use disorder, should we be surprised that people become addicted and cannot find help? Even though medication-assisted treatment is the standard of care for the treatment of opioid addictions, there is still pushback from physicians, patients, and their families who think that it is substituting one drug for another.[30] There aren't enough doctors who can prescribe medication-assisted treatment. Those doctors who do cannot accept enough patients. And these doctors aren't located in the communities (often rural) that need them most.

Additionally, policymakers can address the spillovers that the opioid epidemic has created for families, foster care, schools, and the workforce.

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[30] Nora D. Volkow et al., "Perspective: Medication-Assisted Therapies — Tackling the Opioid-Overdose Epidemic," *New England Journal of Medicine* 370, 22 (2014): 2063-6