

Fighting Opioid Abuse

Policy Proposals to Further Combat the Opioid Abuse Problem in Maryland



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Executive Summary

Maryland's opioid problem is a complex and multi-faceted issue that poses a significant threat to public health and economic prosperity in the State. The number of heroin and opioid deaths have more than doubled over the last decade, and opioid dependency continues to rise each passing year.¹ There are many causes for this problem, which are difficult to isolate and address. As a result, policy options to approach the heroin and opioid epidemic from multiple angles should, and have been, pursued. Although Maryland has implemented a number of responses, the sheer size and scale of heroin and opioid abuse in Maryland calls for more to be done. As such, this report recommends that the State implement the following policies:

- 1. Develop a Social Impact Bond program in the State to target heroin and opioid abuse, and addiction that incentivizes private sector and nonprofit innovation to address this issue;**
- 2. Join the Interstate Corrections Compact and form a partnership with other states to more efficiently incarcerate high-level narcotics traffickers;**
- 3. Implement a treatment program – subsidized for low-income residents – that gives post-overdose patients the ability to treat their addiction and reduce rates of overdose recidivism.**

The implementation of these policies will provide added relief for those already suffering from addiction, reduce the statewide supply and organization of illicit opioid distribution, and contribute to the development of innovative and effective future solutions to the opioid abuse problem.

¹ Maryland. Department of Health and Mental Hygiene. *Drug- and Alcohol-Related Intoxication Deaths in Maryland, 2014*. 2014: 5. Print.

The Opioid Problem

Addiction to opioids including heroin, morphine, and prescription pain relievers, as well as the abuse of these analgesics, is a serious national health crisis. Addicts become less economically productive, have an increased risk of involvement in criminal activity, and face significant health risks from both short- and long-term abuse of the substances. In addition, the negative externalities caused by the drugs increase as they spread throughout society. Due to the negative impact of opioids upon the health and economic welfare of society opioid use has become recognized by experts and policymakers nationwide as a significant threat.

This national issue is seen on a more local scale in Maryland, where heroin and opioid use have been classified as an “urgent public threat”² by the Maryland Department of Legislative Services, and as an epidemic by Governor Hogan. The abuse of heroin and other opioids in Maryland is an ongoing problem that impacts not only the State’s urban areas, but also its suburban and rural regions. The number of overdose deaths in the State continues to rise in spite of increased efforts to educate citizens and improve access to treatment for those suffering from addiction. In 2013, Maryland saw 464 individuals perish as a result of heroin overdose.³ In addition, 578 died in 2014, which nearly represents a twenty-five percent increase over the course of a single year.⁴ In 2015, overdose deaths related to heroin rose another twenty-nine percent to 748.⁵ In total, approximately eighty-six percent of Maryland’s 1,259 drug and alcohol overdose deaths in 2015 were directly linked to heroin, prescription opioid medications, or

² Maryland Department of Legislative Services. "2015 Legislative Session Results." (2015): n. pag. Web. 1 July 2016.

³ Maryland. Department of Health and Mental Hygiene. *Drug- and Alcohol-Related Intoxication Deaths in Maryland, 2014*. 2014: 5. Print.

⁴ *Ibid.*

⁵ "State data show 21% increase in '15 fatal overdoses over previous year." *DHMH Newsroom*. Maryland Department of Health and Mental Hygiene, 9 June 2016. Web. 27 July 2016.
<<http://dhmh.maryland.gov/newsroom/Pages/Maryland-combats-opioid-epidemic---2015-data0609-8056.aspx>>.

acetylfentanyl.⁶ Moreover, the rate of heroin and opioid dependency in the State has more than doubled over the past decade, and some parts of Maryland have been recognized as some of the highest per-capita heroin use areas in the United States.⁷

These alarming trends have prompted action by many concerned stakeholders. Activists, public officials, and private citizens have continued to seek policies to provide solutions for this issue. Governor Hogan has repeatedly stated that dealing with this issue is a high priority. For this reason, dozens of policies have been proposed, which have been aimed at how to assuage opioid abuse by Marylanders. Yet, as overdose deaths continue to rise, more can be done. This report will therefore discuss several policy options public officials can consider moving forward.

Through the first quarter of 2016, overdoses continued to rise in Maryland. Officials including Maryland Department of Health & Mental Hygiene Secretary Van T. Mitchell attribute the 2016 increase, in part, to the increased availability of fentanyl. According to Secretary Mitchell, individuals in some cases thought they were using heroin but instead had been sold fentanyl or the fentanyl analog acetylfentanyl.⁸ Acetylfentanyl is many times more powerful than heroin and its increasing availability during this time is in part related to its manufacture in illicit, underground laboratories, thus removing the need for a prescription that exists with its legally prescribed analog. Secretary Mitchell stated that other drugs are being laced with fentanyl and acetylfentanyl, greatly increasing the danger of overdose that users experience.⁹ This issue is compounding the problem that was mainly posed by heroin abuse until recent years.

⁶ *Ibid.*

⁷ "Heroin Facts." Office of the Governor of Maryland. Office of Lt. Governor Boyd Rutherford, n.d. Web. 05 Jul 2016.

⁸ Cohn, Meredith. "Maryland Reports 383 Overdose Deaths in First Three Months of 2016." *Sun* [Baltimore] 29 June 2016: n. pag. Print.

⁹ Cohn, Meredith. "Maryland Reports 383 Overdose Deaths in First Three Months of 2016." *Sun* [Baltimore] 29 June 2016. Print.

Maryland's overdose rate has steadily increased over the past decade, leading to an increased total number of deaths from opioids. However, there are other serious, non-fatal physical and mental health impacts that affect opioid addicts. Long-term abusers may be plagued by serious chronic health problems caused by opioids themselves, or the physical actions necessary for use.¹⁰ Further complicating the issue, heroin elicits both tolerance and physiologic dependence in the user in a short amount of time. The combination of tolerance and dependency caused by opioids makes medical public policy to combat addiction a challenge.

Abuse of opioids causes major economic damage to the State. For instance, in 1996, a cost-illness analysis concluded that heroin addiction damaged the United States' economy in four main areas (*as listed*): 1. Productivity loss (53%), 2. Criminal Activity (24%), 3. Medical Care (23%), 4. Social welfare (0.5%). In 1996, these costs amounted to \$21 billion nationally. Opioid addiction has increased exponentially since then, so it can be reasonably assumed that the economic cost of opioid abuse has risen in a manner comparable to the growth of the rate of abuse. In 2007, the Centers for Disease Control and Prevention estimated that Maryland incurred health care costs of \$451,018,165 from opioid abuse.¹¹ Pursuing policy to prevent proliferation and addiction to the drugs is essential to deflating medical costs, reducing criminal justice expenditures, and preserving the economic productivity of the State. According to the Director of the National Institute for Drug Abuse, "the medical and social consequences of drug use...have a

¹⁰Patterson, Eric. "The Effects of Heroin Use." DrugAbuse.com. Drug Abuse Center, 17 July 2012. Web. 05 Jul 2016.

¹¹ MATRIX GLOBAL ADVISORS, LLC. "Health Care Costs from Opioid Abuse: A State-by-State Analysis." Memo. Apr. 2015. *drugfree.org*. Web. 27 July 2016. <http://www.drugfree.org/wp-content/uploads/2015/04/Matrix_OpioidAbuse_040415.pdf>.

devastating impact on society and cost billions of dollars each year.”¹² Maryland must face these rising costs much like the nation as a whole.

Origins of The Problem

Heroin and opioid abuse in Maryland has historically been associated with Baltimore City, part of an urban landscape that popular culture has portrayed as one cursed by the scourge of drug abuse on the part of the city’s poorest residents. Yet, through the first quarter of 2016, Baltimore City has been one of the few jurisdictions to witness overdose deaths decrease. During the first three months of 2016, heroin-related deaths in Baltimore fell by twenty-four percent from the numbers during the same period in 2015, and overdose deaths during this period were down by eight percent overall.¹³ Overdose deaths also decreased during this period in Carroll, Garrett, Kent, Montgomery, Somerset, and Washington Counties; however, overdoses continued to increase in places such as Anne Arundel, Cecil, Harford, Frederick, and Talbot Counties.¹⁴

Thus, the stereotype of heroin abusers as poor, urban minorities with little education is incorrect. According to Anne Arundel County Police, the most common opioid abuser in the county is instead a white, middle-aged male.¹⁵ Those addicted to heroin and other opioid drugs are often driven to abuse the medications after having first been prescribed opioid painkillers by a physician. Lt. Ryan Frashure of the Anne Arundel County Police Department said that individuals abusing heroin and other opioids often suffered a workplace or sports injury, were

¹² Volkow, Nora. "Letter From the Director." National Institute on Drug Abuse (NIDA), n.d. Web. 08 July 2016. <https://www.drugabuse.gov/publications/research-reports/heroin/letter-director>.

¹³ Department of Health and Mental Hygiene. *Drug- and Alcohol-Related Intoxication Deaths in Maryland Data update through 1st quarter 2016*. 8, 2016. Print.

¹⁴ *Ibid.*

¹⁵ Belt, Deb. "Heroin Epidemic Escalates Across Maryland." *Annapolis Patch*. N.p., 4 July 2016. Web. 27 July 2016. <<http://patch.com/maryland/annapolis/heroin-epidemic-escalates-across-maryland>>.

prescribed an opioid analgesic to reduce pain, and then had the prescription end. As a result, these individuals turn to heroin or other illicit opioids to fill the void created.¹⁶

Examples of Policies in Other States

In June of 2016, New York passed a bill¹⁷ to fight heroin and opioid addiction in the state. The new law increases prevention efforts and improves the access to and quality of treatment. The bill makes an effort to focus on giving addicted users access to naloxone, a drug that can block or reverse the effects of an opioid overdose.

Before the bill was signed, insurance companies were not required to cover inpatient services to treat users suffering from substance abuse. However, as a result of the 2016 law, insurers are now required to cover inpatient services to treat substance abuse problems for as long as the individual needs care. It also guarantees that every patient who receives treatment for an opioid issue, receives at least 14 days of uninterrupted, covered care before the insurer can get involved. Also, to ensure that people can receive instant care if they suffer from an opioid overdose, the bill requires insurance companies to cover the cost of naloxone when prescribed to an addicted individual.

The law also aims to enhance treatment for New Yorkers who suffer from opioid addiction. Before this bill was passed, individuals were only guaranteed 48 hours of emergency treatment due to opioid overdoses and/or complications. Now, since the bill has passed, individuals may receive 72 hours of emergency treatment so families have more time to consider long-term treatment options while also ensuring that their loved ones have time to be treated. Also, once patients finish their emergency treatment, hospitals must also provide planning

¹⁶ *Ibid.*

¹⁷ Governor Cuomo Signs Legislation to Combat the Heroin and Opioid Crisis. (2016). Retrieved July 20, 2016, from <https://www.governor.ny.gov/news/governor-cuomo-signs-legislation-combat-heroin-and-opioid-crisis>

services to connect them to nearby longer-term treatment options. Moreover, in an effort to ensure the safety of overdose victims, trained professionals are authorized to administer naloxone in emergency situations without fear of losing their professional license.

The prevention section of the bill aims to get to the root of the problem through addiction education and implementing new regulations in the healthcare industry. The new law lowers the limit for opioid prescriptions for acute pain from 30 days to a week, with exceptions for certain conditions. It also requires health care professionals go through three hours of education every three years on addiction, pain management, and palliative care. To better understand the problem and measure progress, the State Commissioner of Health is now required to report county-level data on opioid overdoses and usage of opioid-reversal drugs on a quarterly basis.

Like New York, Vermont also faced a recent upsurge in heroin and opioid use.¹⁸ To combat this, the state focused on improving treatment and preventative measures. On the treatment side, in 2016, Governor Shumlin announced that naloxone would be available to individuals without a prescription at CVS pharmacies¹⁹ in the state. In addition to this effort, and in March 2014, Vermont announced that every state trooper would be equipped with naloxone, and that the drug would be distributed to opiate addiction treatment centers. The state has since distributed over 7,000 overdose reversal kits that have been used to reverse at least 400 overdoses.

The Vermont state budget incorporated response plans to the heroin and opioid epidemic in which \$200,000 is dedicated to the naloxone pilot program. This program allows offenders, who are being released from a correctional facility, to receive naltrexone to reduce the urge for

¹⁸ Craig, K. (2015, September 10). Heroin epidemic hits Vermont community hard. Retrieved July 20, 2016, from <http://www.cbsnews.com/news/heroin-epidemic-hits-vermont-community-hard/>.

¹⁹ Office of Governor Peter Shumlin. (2016, March 30). *Naloxone Now Available in CVS Pharmacy Locations in Vermont* [Press release]. Retrieved July 20, 2016, from <http://governor.vermont.gov/press-release/naloxone-now-available-cvs-pharmacy-locations-vermont>.

opioids. The budget also provides an additional \$150,000 for needle exchange programs, \$420,000 to open a new treatment center in northwestern Vermont, and \$9.9 million for the employees of the Department of Children and Families, the Judiciary, the States' Attorneys, and the Defender General who are working to prevent opioid abuse.²⁰

Current Maryland Efforts

In response to the opioid epidemic within the State of Maryland, Governor Hogan issued an Executive Order 01.01.2015.12 on February 24, 2015, which created the Heroin & Opioid Emergency Task Force. This Task Force, chaired by Lt. Governor Rutherford, was created to prevent, treat, and reduce heroin and opioid abuse in Maryland, as well as to advise the Governor in setting up a coordinated statewide course of action. In an effort to identify recommendations as they relate to the State of Maryland, the Task Force held six regional summits throughout the State, in 2015, to hear testimony from those with substance abuse disorders, addiction treatment professionals, and other stakeholders.

Pursuant to the Executive Order, the Task Force was required to submit recommendations, in the form of a report, by December 1, 2015, in which 431 stakeholders contributed. Based on the results of this report (*Heroin & Opioid Emergency Task Force Final Report*), and under the leadership of Lt. Governor Rutherford, 33 recommendations were made. These recommendations were organized into seven categories to include the following:²¹

1. Expanding Access to Treatment, 2. Enhancing Quality of Care, 3. Boosting Overdose Prevention Efforts, 4. Escalating Law Enforcement Options, 5. Reentry and Alternatives to Incarceration, 6. Promoting Educational Tools for Youth, Parents, and School Officials, 7. Improving State Support Services.

²⁰ Governor delivers \$5.8 billion, balanced budget to Legislature. (2016, January 21). Retrieved July 20, 2016, from <http://www.vermontbiz.com/news/january/governor-delivers-58-billion-balanced-budget-legislature>.

²¹ Rutherford, Boyd K., comp. *Heroin and Opioid Emergency Task Force*. Rep. N.p.: n.p., n.d. 2015 Print.

Since this time, several efforts have occurred within the State of Maryland to include the following:

- Good Samaritan Act: “Defined the act of seeking, providing, or assisting with the provision of medical assistance for another person who is experiencing a medical emergency after ingesting drugs or alcohol may be used as a mitigating factor in a criminal prosecution of ... 1) The person who experienced the medical emergency; 2) Any person who sought, provided or assisted in the provision of the medical assistance.”²²
- Maryland Prescription Drug Monitoring Program (PDMP): “The PDMP collects and securely stores information on drugs that contain controlled substances and are dispensed to patients in Maryland. Drug dispensers, including pharmacies and healthcare practitioners, electronically report the information that is stored in the PDMP database. Use of prescription information improves providers’ ability to manage the benefits and risks of controlled substance medications and identify potentially harmful drug interactions.”²³
- Maryland Overdose Response Program (ORP): The Department of Mental Health launched the ORP to “train and certify qualified individuals—e.g. family members, friends and associates of opioid users; treatment program and transitional housing staff; and law enforcement officers—most able to assist someone at risk of dying from an opioid overdose when emergency medical services are not immediately available. Successfully trained individuals will receive a certificate allowing them to obtain and have filled a prescription for Naloxone, a life-saving medication that can quickly restore the breathing of a person who has overdosed on heroin or prescription opioid pain medication like oxycodone, hydrocodone, morphine, fentanyl or methadone.”²⁴

²² *Maryland's "Good Samaritan" Law*. Rep. ANNE ARUNDEL: MARYLAND DEPARTMENT OF HEALTH, 2015. Web. <<https://www.ahealth.org/pdf/GoodSamStatute-10-2015.pdf>>.

²³ U.S.A. Maryland Department of Health and Mental Administration. Behavioral Health Administration. *Maryland Prescription Drug Monitoring Program*. Maryland Department of Health and Mental Hygiene, n.d. Web. <<http://bha.dhmv.maryland.gov/pdmp/Pages/Home.aspx>>.

²⁴ "Welcome to the Overdose Response Program (ORP)." *Overdose Prevention*. Maryland Department of Health and Mental Hygiene, n.d. Web. <<http://bha.dhmv.maryland.gov/NALOXONE/Pages/Overdose-Prevention.aspx>>.

- Justice Reinvestment Act (JRA): The JRA relates to reducing the heroin and opioid epidemic in Maryland through the prison sentencing reforms. The JRA seeks the “reduction of maximum incarceration for numerous nonviolent offenses, plus preference for treatment over incarceration of drug offenders”²⁵ The JRA aims to put more victims of heroin/opioid addiction in treatment, rather than incarceration.

Despite the continued efforts of the Maryland government, the current policies of Maryland can be expanded to more effectively limit the heroin and opioid epidemic.

Evaluative Criteria

To deal with this epidemic, this report will make a series of policy recommendations that can be pursued towards the opioid abuse problem in the state. In order for the prioritization of policy actions, evaluative criteria are necessary. These criteria are “specific dimensions of policy objectives that can be used to weigh policy options or judge the merits of ...programs” (Kraft et al. 2004, 183).

The first evaluative criterion to be considered is political and social feasibility, which is defined as the “extent to which elected officials accept and support a proposal” and the extent to which the public will accept...a policy” respectively (Kraft et al. 2004, 185). While no formula is available for estimating these feasibilities, it should still be among the concerns of policymakers, as if a policy cannot pass, or causes irreparable political damage through its passage, it will not survive the policy arena.

The second major criterion the report will consider is cost. This is a “specific measurement of costs in relation to the benefits” or “gaining the most benefits for a fixed cost” (Kraft et al. 2004, 188). From an economic perspective this is the most logical criteria to

²⁵ "Maryland Justice Reinvestment Act." *Justice Reinvestment*. Maryland Alliance For Justice Reform, 04 Jan. 2016. Web. 01 July 2016. <<http://www.ma4jr.org/justice-reinvestment/>>.

consider as accurate measurement of cost is . While the benefits may not always be as accurately projectable, they must also be considered relative to the cost.

Finally, effectiveness must be considered as a criterion. This refers to a policy's ability to reach its stated goals and objectives" (Kraft et al. 2004, 186). Evaluation of this type generally requires that indicators of progress exist, that are observable and measurable. As many of the proposals in this report are relatively untested it may be difficult to prove the potential effectiveness of each in the state. To deal with this difficulty, the effectiveness criterion will mainly be based on evidence of similar programs and their effectiveness in other states and locations.

Using the above criterion, the policy recommendations put forward can be ranked and prioritized accordingly, to reach a greater efficiency of resource allocation in dealing with the opioid epidemic facing the state.

Policy Recommendations

Social Impact Bonds

As Marylanders continue to perish as a result of addiction, State policies appear to be limited in their effectiveness in combating this issue. Because of this, innovative, success-driven solutions should be sought. Public-private partnerships provide the ability for Maryland to seek new, innovative solutions to its continuing opioid abuse problem by including non-governmental entities in the development of publicly impactful policy reforms. Past public-private partnerships have been based upon implementation of new policy rather than result-based solutions, limiting the efficacy of these programs.

A new funding model, the Social Impact Bond, also called Pay for Success (PFS), should be utilized to ensure result-based partnerships develop. A private financing institution or

philanthropic organization with a desire to see positive public outcomes would initially purchase the PFS bond, thus providing up-front funding for unique solutions. The PFS bond would then only be repaid by the state if the service provider selected by the funder meets goals agreed upon by the state and the service provider prior to bond issuance. Interest on the bond is determined by the level of success shown in meeting the stated goals.

Five groups take part in the Social Impact Bond structure: the funder, the service provider, the third-party assessor, the client, and the guarantor (*described below*).

1. The funder provides initial funding for the program being developed, covers all fees for service providers and third-party assessors (TPA), and expects repayment only under successful circumstances as determined by the TPA. The funder may be a philanthropic organization or another company with sufficient ability to provide needed funding.
2. The service provider is vetted for ability to handle the social issue being addressed and determines clients for which its program may provide solutions. The service provider determines project scope and outcomes with the client. Typically, the service provider is not directly connected to the funder, but may have previous working relationships with the funder or client.
3. Guarantors are secured by the funder and service provider. The guarantor repays principal and interest on the bond if measurable success occurs. Program failure does not require repayment. In this model, the State would serve as guarantor.
4. The TPA is appointed by the funder, agrees to outcomes with the service provider and client, and develops the evaluation and reporting plan.

5. The client benefits from the programs and sees little or no direct costs. In conjunction with the service provider, the client determines what needs they have, how these needs should be rectified, and how wide a scope the project should have.²⁶

PFS programs first began use in the United Kingdom in 2010.²⁷ President Obama brought PFS to the United States in 2011 by including up to \$100 million in the 2012 budget for a PFS pilot program.²⁸ According to a 2011 article in *The Economist*, early interest in PFS was seen from American groups and governments that included Baltimore City.²⁹ Maryland has explored use of PFS in areas of education and other areas of crime prevention and reform.

Maryland has developed a number of policies to combat the current heroin epidemic. Utilizing PFS would open another avenue to bring private interests into a problem that impacts all Marylanders. PFS would also provide incentive to private-sector companies and individuals to explore unique and innovative solutions not yet utilized by the State. Costs will be reduced because private providers have a profit-driven incentive to seek savings in implementing programs, but, because PFS repayment is result-based, these cost savings will not lead to ineffective implementation by providers. The use of a third-party assessor will ensure that reports regarding the progress to meeting stated outcomes are accurate. This reduces risk for the State by implementing this funding model.

Criticism of PFS centers upon the removal of government and the introduction of third-party investors into the delivery of social services. Because donors will seek funds for matters

²⁶ "Pay for Success 101." *Pay for Success Learning Hub*. Nonprofit Finance Fund, n.d. Web. 28 July 2016. <<http://www.payforsuccess.org/learn-out-loud/pfs-101>>.

²⁷ *Ibid*.

²⁸ "Paying for Success." *Office of Management and Budget*. The White House, 2011. Web. 28 July 2016. <<https://www.whitehouse.gov/omb/factsheet/paying-for-success>>.

²⁹ "Who succeeds gets paid." *The Economist* 17 Feb. 2011: n. pag. Web. 28 July 2016. <<http://www.economist.com/node/18180436>>.

which can be quantifiably determined as successes or failures, more difficult issues will continue to be addressed by government. Yet, as a matter of drug policy, these criticisms should be viewed as minimally determinant in the efficacy of a PFS program. Results in this area are already narrowly focused, and outcomes sought are relatively direct.

Currently, eleven PFS programs have been implemented in the United States.³⁰ Of these, only two, in New York and Utah, have been concluded.³¹ Most programs in the United States have focused upon criminal recidivism, education, and homelessness. One of the first PFS efforts in the United States was funded by Goldman Sachs in New York and sought to reduce recidivism rates at the Rikers Island Prison in New York City by ten percent.³² The program did not meet that stated goal, and Goldman was thus not reimbursed by the city or state for the funds it had invested.³³ Utah utilized a program also funded by Goldman Sachs in conjunction with the United Way to provide preschool programs for three- and four-year old students in the Granite School District. The goal of the program was to reduce costs for students over the course of their education by providing quality programs for young students. At the time, Utah was one of only ten states that was not providing funding for preschool programs.³⁴

Utah's PFS program was the first of any kind to succeed according to the pre-determined criteria established for the program. As such, it was the first to result in payment to the plan's investors.³⁵ However, critics of the program argue that the metrics put into place to measure

³⁰ "Pay for Success Projects." *Pay for Success Learning Hub*. Nonprofit Finance Fund, 2016. Web. 28 July 2016. <<http://www.payforsuccess.org/provider-toolkit/pfs-projects>>.

³¹ *Ibid*.

³² *Ibid*.

³³ Porter, Eduardo. "Wall St. Money Meets Social Policy at Rikers Island." *Times* [New York] 28 July 2015: n. pag. Print.

³⁴ "Goldman, Pritzker & United Way Team up for Latest SIB Pilot." *Pay for Success Learning Hub*. Nonprofit Finance Fund, n.d. Web. 28 July 2016. <<http://www.payforsuccess.org/resources/goldman-pritzker-united-way-team-latest-sib-pilot>>.

³⁵ Popper, Nathaniel. "For Goldman, Success in Social Impact Bond That Aids Schoolchildren." *Times* [New

success were faulty, and that the success of the program should thus be called into question. Proponents counter that the metrics used were agreed upon by the state and the investors, negating any nefarious profit-seeking motives held by Goldman for entering the agreement. Though criticism exists in the regarding the predetermined outcomes, the model itself worked as expected, providing a payout only because the goals had been met.

PFS has seen no prior use in areas of drug policy. Instead, elementary education, inmate recidivism, and homeless health have been primary areas of implementation for PFS. Michael Reddy, a fellow at Harvard University's Kennedy School of Government, states, "The reason many PFS projects are in the criminal justice space, for example, is the direct connection between reduced recidivism and jail/prison bed day budgets. That being said, many governments are willing to pay on positive outcomes and cost efficiencies rather than direct savings."³⁶ Use of PFS in developing effective drug policy will see direct savings to the state, as well as long-term benefits that impact the state economically, socially, and financially.

Interstate Corrections Compact Policy

Currently Maryland is making efforts to check the growing overdose and fatality rates, but these efforts are not taking into account the problem of drug distributors after they are incarcerated. The drug dealers and distributors that are arrested, prosecuted, and sentenced in Maryland are placed into correctional facilities within Maryland. From these correctional facilities the drug distributors or dealers still have the capacity to communicate with their gangs or the hierarchy of their illegal narcotics business. In being able to communicate with and have individuals visit them, they are able to continue to produce, distribute, and sell illegal narcotics,

York] 7 Oct. 2015: n. pag. Print.

³⁶ Reddy, Michael. "Pay for Success/Social Impact Bonds- Maryland Governor's Office." Message to Andrew Bradshaw. 7 July 2016. E-mail.

specifically heroin and opioid based narcotics. The best way to effectively limit inmate's' ability to do that would be for Maryland to join with other states in the Interstate Corrections Compact, with specific regard to the transfer of high level drug trafficking criminals.

The Interstate Corrections Compact is a federal law that coordinates within the U.S., states, territories, and districts in the transportation, housing, and treatment of prisoners.³⁷ States are able to partner with other states in the interment of certain prisoners. If one state decides that it is in the best interest of the state and/or prisoner to move them, they can move them to another correctional facility in another state. A sending state sends and pays for the inmate to be transferred to the receiving state's correctional facility. The receiving state cares for the treatment and incarceration of the inmate that has been sent to their facility. States form partnerships within the Interstate Corrections Compact for specific inmates that need to be transferred.³⁸

Maryland is able to form partnerships with one or several other specific states through the Interstate Corrections Compact. This partnership would enable Maryland to transfer high-level drug traffickers or distributors out of state, and preferably a distance away, that discourages or makes common visitations unfeasible. Inmates involved in high-level drug trafficking and distribution with sentences of five-years or more need to be isolated away from co-conspirators in their specific criminal enterprise in order to disrupt the distribution and sale of narcotics in Maryland. Other states, along the Mid-Atlantic and Mid-Western region, are facing similar problems in regard to the heroin and opioid crisis. One solution is for Maryland to make an

³⁷ "INTERSTATE CORRECTIONS COMPACT." (2011): n. pag. Thomson Reuters. Web. <<http://apps.csg.org/ncic/PDF/Interstate%20Corrections%20Compact.pdf>>.

³⁸ Justice, U.S. Department Of. "INTERSTATE TRANSFER OF PRISON INMATES IN THE UNITED STATES." *INTERSTATE TRANSFER OF PRISON INMATES IN THE UNITED STATES* (2006): n. pag. *Special Issues in Corrections*. National Institute of Corrections, Feb. 2006. Web. 01 July 2016. <<http://static.nicic.gov/Library/021242.pdf>>.

agreement with one or several states for the transfer of mid- to high-level drug smuggling and trafficking convicted inmates.

The Maryland state government should adopt the Interstate Corrections Compact for the purpose of transferring high-level Maryland drug offenders out of the state and away from their criminal organizations. If implemented, this policy could disrupt the flow of narcotics into the State, as well as the sale of the narcotics. Subsequently, this should cut down on overdoses and fatalities originating from heroin and opioid narcotics.

Treatment Policy Reform

In reference to one of the seven categories identified in the *Heroin & Opioid Emergency Task Force Final Report (Expanding Access to Treatment)*³⁹, additional efforts should occur to ensure that heroin and opioid treatment prevents Marylanders from turning back to, or experimenting with opioids.

Since 2015, the State has given protection from arrest and prosecution for certain drug-related crimes through the Good Samaritan Law. The law dictates that if an individual calls 911 to assist someone else during an overdose, or they themselves are experiencing an overdose, their parole and probation status won't be affected, and they won't be arrested, charged, or prosecuted for: possession of a controlled dangerous substance, possession or use of drug paraphernalia, and providing alcohol to minors.⁴⁰

The Good Samaritan Law incentivizes people who are, for example, overdosing on opioids to seek emergency medical assistance; however, once those individuals come back into society, they're still at risk for taking illegal opioids. If the State were to offer individuals who

³⁹ *Final Report* (Rep.). (2015, December 1). Retrieved July 31, 2016.

⁴⁰ Good Samaritan Law. (n.d.). Retrieved July 31, 2016, from http://bha.dhmdh.maryland.gov/OVERDOSE_PREVENTION/Pages/Good-Samaritan-Law.aspx

received emergency treatment for an opioid overdose the ability to enter a treatment program, they would be less at risk of returning to illegal opioid use.

In order to still incentivize people to seek medical assistance when faced with an overdose, while also ensuring that individuals will receive treatment to discourage future illegal opioid use, a state-supported treatment program should be implemented for individuals that used – or had their friends use on behalf of them – the Good Samaritan Law after an opioid overdose. This program would allow each individual to enroll in a treatment center for opioid-related problems immediately following their medical care. The State will assist individuals in finding a state-supported drug treatment center in their area, and if they are low-income residents, will fully subsidize their treatment. If the State determines that certain individuals can afford to pay for their treatment, then the financial costs of the treatment will be left to them.

Under this new program, Marylanders still will not have to face arrest, be charged and prosecuted, or be given a changed parole and probation status if they called 911 in response to an emergency overdose by themselves or someone else. However, after they have received their necessary medical treatment, the State will offer them enrollment in an opioid treatment program, and, depending on their financial status, fund their treatment as well. The program's length will be determined on a case-by-case basis with the assistance of any medical care professionals that worked with the patient, the treatment center that the patient will enroll in, the patients themselves, and any other relevant actors. The precise treatment that each individual will undergo will also be under the jurisdiction of the treatment centers that each individual enrolls in.

This program will aim to prevent people from returning to opioid use after they've overdosed, and as a result, have to undergo further medical treatment. It will focus on decreasing

the amount of Maryland residents that have gone into an emergency room for a heroin-related problem, a number that has been increasing since 2010.

Since in 2014, there were 11,242 drug and alcohol-related emergency department visits⁴¹ from Maryland residents, it is necessary, financially, for the State to limit the amount of low-income people it can support in the program. So if the patient's medical professionals agree that the individual is neither (1) addicted to opioids and related drugs nor (2) at risk of becoming addicted to opioids and related drugs, then the State will not be responsible for subsidizing opioid treatment for that individual.

Prioritization of Recommendations

Based on the evaluative criteria discussed above, this report finds that the creation of a social impact bond program within the state should be prioritized as a policy option. PFS has a number of attributes allowing it to meet our criteria. While most traditional contractual private-public partnerships focus upon delivery of services or putting into place specific structural changes, PFS moves away from this to instead focus upon results-based funding. In other words, latitude and freedom is introduced to allow service providers and clients to determine how to tackle a problem, with success determined not by the implementation of the program, but rather by the results following that implementation. Because payment on the bond is contingent upon success in meeting predetermined goals, it becomes difficult for a provider to minimize the level of services provided in search of increased profit following implementation of the program. Because the bonds are result-based, taxpayers are not left making payment for failed services and initiatives. Additionally, because the programs are monitored by a third-party, oversight is

⁴¹ Substance Use in Maryland: Opioids. (2015, December). Retrieved July 31, 2016, from http://dls.state.md.us/data/polanasubare/polanasubare_das/hhs_substanceabuseinmarylandopoids.pdf

provided that ensures transparency for all parties engaging in the PFS. This structuring prevents high cost overruns and ensures outcomes that are acceptable to the State.

Budgeting for such programs can be planned years in advance of completion. This allows policymakers time to shift funding from other, underperforming programs toward PFS programs that are showing measured success. The ability to focus funding only toward programs showing demonstrable success provides public and political feasibility that might otherwise not be seen with experimental programs. While criticism often occurs when public policy is handed to private business, the PFS model differs from traditional outsourcing. The PFS model provides a partnership in determining goals and allows for neutral oversight, ensuring that government is not divorced from policy. While experimental policies are often derided and avoided because they may cost a great deal and show no success, PFS avoids this pitfall by only providing payment when a program is deemed successful. “Surprise” costs are not present in the PFS model, and, because payment is wholly dependent upon successful outcomes, controversy related to payment for ineffective policy is reduced.

PFS meets all our evaluative criteria based upon the above aspects. Though measured “success” will differ with each program to which this model is applied, because the model is wholly result-based, repayment will only follow successful outcomes. Political and social feasibility should also be high. Because costs are only incurred through success, typical derision for experimental programs should be limited. Further, because repayment is result-based, criticism of the employment of private providers to meet public policy needs should also be limited. Social and political feasibility should also be expected because the model can be adjusted and utilized in a number of diverse and unique communities impacted by opioid abuse. PFS is not a “one size fits all” policy, but instead allows for tailoring to needs as they appear.

The Interstate Corrections Compact policy alternative is economically feasible because while for any inmate that Maryland transfers to another state facility will have to be paid for by Maryland, any states sending inmates to Maryland will have to pay for the costs of those inmates in return, balancing the cost theoretically. This policy has potential to draw social and political criticism among some members of the state because of the possibility that inmates will be separated from families or loved ones. However, the positive would be a reduction in crime within the prison and the surrounding communities, including less distribution, sale, and addiction of illegal narcotics. The success of this policy has the possibility of variance, the transportation of certain individuals could lead to better or worse results than the movement of other individuals. Based on the evaluative criteria, the social impact bonds are the more feasible option to support over the Interstate Corrections Compact.

The Treatment Policy Reform option meets the first evaluative criterion of being politically and socially feasible. With new treatment-focused policies being implemented in states where heroin and opioid abuse has become an epidemic, like New York and Vermont, a treatment plan aimed at treating addiction and reducing rates of overdose recidivism should elicit public support. By implementing this policy, Maryland would be following other states in prioritizing treatment for its citizens. However, the financial costs for this program would be significantly high, especially considering that the State will be fully subsidizing the treatment programs of low-income residents. With thousands of emergency department visits for drug-related issues, the State would be paying a large amount for results that, although predictably positive, are not fully guaranteed. By giving Marylanders who overdosed on opioids a pathway to receive treatment, a decline in overdose recidivism should be expected. However, since the

Social Impact Bonds and the Interstate Corrections Compact are both more cost-efficient, they should be prioritized over the Treatment Policy Reform option.

Conclusion

The growing levels of heroin and opioid addiction continue to be problematic for the entire State of Maryland. While the General Assembly and Governor strive to pursue policy actions to address this epidemic, this report stresses that more can be done, and offers policy recommendations that, if adopted, will contribute towards the fight against the heroin and opioid epidemic to ensure the continued health and economic well-being of the State.