

Real Help-Real Hope: Where Do We Go From Here? *A community-based approach*

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Opioid Treatment Providers of Georgia Conference

Real Help-Real Hope: How Can We Access You? Part 3

November 11, 2024



AGENDA

HOW DID WE GET HERE AND HOW DO WE FIX IT?

- Foreground
- Setting the Context: The Opioid Crisis in Georgia
- A Public Health Perspective on Preventing Drug Misuse
- Regulatory Frameworks and Proactive Public Health Policy
- Prevention in Community Context
- The Intersection of Multiple Public Health Crises
- Summary and Discussion



THE OPIOID EPIDEMIC IN THE UNITED STATES

■ **Introduction**

- The opioid epidemic in the United States remains a significant public health concern
- Nationally, opioid-related overdose deaths have risen more than eightfold since 1999
- In 2023, there were an estimated 107,543 total drug overdose deaths in the United States. Out of these, approximately 81,083 (75.4%) deaths involved opioids



Official Obituary of

Lisa Marie Salerno

September 7, 1963 - February 18, 2022

[Obituary & Events](#)

[Tribute Wall](#)





FOREGROUND

WHERE DO WE GO FROM HERE?



FUNDING AND PREVENTION STRATEGIES FOR THE OPIOID EPIDEMIC

- **Funding Support:** State, local, and tribal governments in the U.S. will receive over \$50 billion from opioid-related settlements to support recovery efforts
- **Balanced Planning:** Local leaders managing settlement funds have an opportunity to be balanced in their use of recovery and prevention strategies

Condensed Summary of Approved Purposes*

Core Strategies

- Naloxone or other FDA-Approved Drug to reverse opioid overdoses
- Medication-Assisted Treatment Distribution and other opioid-related treatment
- Pregnant & Postpartum Women
- Expanding Treatment for Neonatal Abstinence Syndrome
- Expansion of warm hand-off programs and recovery services
- Treatment for incarcerated population
- Prevention programs
- Expanding Syringe Service Programs
- Evidence-based data collection and research analyzing the effectiveness of the abatement strategies within the state

Approved Uses

Treatment:

- Treatment of Opioid Use Disorder
- Support people in treatment and recovery
- Connect people who need help to the help they need (connections to care)
- Address the needs of criminal justice-involved persons
- Address the needs of pregnant or parenting women and their families, including babies with neonatal abstinence syndrome

Prevention:

- Prevent over-prescribing and ensure appropriate prescribing and dispensing of opioids
- Prevent misuse of opioids
- Prevent overdose deaths and other harms (Harm reduction)

Other Strategies:

- First responders
- Leadership planning and coordination
- Training
- Research

*The Georgia MOU defines “Approved Purposes” to mean the List of Opioid Remediation Use in Exhibit E of National Distributor Settlement and the Approved Opioid Abatement Uses in Schedules A and B to Exhibit G to the Notice of Filing of Eighth Plan Supplement Pursuant to the Fifth Amended Joint Chapter 11 Plan of Reorganization of Purdue Pharma L.P. and its Affiliated Debtors, In re: Purdue Pharma L.P., et al., Case No. 19- 23649-RDD, Dkt. 3121 (Bankr. S.D. N.Y. July 8, 2021). While the Purdue Pharma settlement is not part of this briefing and still being negotiated, any funds received through it will be received by the Georgia Opioid

WHERE DO WE GO FROM HERE?

- Opioid settlement funds have created an opportunity to invest in evidence-based public health strategies strategically
 - Acknowledge the damage done by ‘War on Drugs’ policies grounded in criminalization, incarceration, and **anti-evidenced-based** approaches to drug use
 - Implement **proactive public policies** that minimize mass incarceration, mass death, and mass harm, including the dual pandemics of HIV and hepatitis C, as well as poverty and homelessness.
 - Examine how minoritized communities have been **disproportionately impacted** by the harms of these policies
 - Use a data-driven approach to **direct funds toward those disproportionately impacted** by deaths, nonfatal overdoses, and individual and community health and social harms

TEN INDICATORS TO ASSESS THE READINESS OF STATE AND LOCAL GOVERNMENTS TO RECEIVE THE OPIOID SETTLEMENT FUNDS

- **Informed, evidence-based decision-making (10 principles; 4 categories)**
 - Is there a recent public assessment of substance use services and needs, broken down by race/ethnicity, that can guide funding decisions?
 - Has the jurisdiction conducted a recent public review of its own laws, regulations, and policies and their racial impact to identify obstacles to using settlement funds and support programs based on evidence and equity?
- **Proactive public health policy**
 - Harm reduction, treatment, and recovery services must be complemented with ***primary prevention strategies*** and ***community-based solutions*** that are intended to reduce substance misuse ***before it begins***



Ben, a 15-year-old gay White adolescent, lived in a rural area in a wealthy two-parent family. Bored and insecure, he began hanging out with the ‘wrong crowd’ and started drinking and taking pills. Eventually, the recreational use turned to a heroin addiction.

Resources for substance misuse treatment in his community were limited, and he felt stigmatized for his drug misuse and being gay. Struggling to support his addiction, he turned to theft, which led to multiple arrests and stints in jail. Each time he was released, the stigma of a criminal record made it increasingly difficult to find stable employment, further compounding his feelings of isolation and hopelessness.

Eventually, Ben experienced an overdose at age 46. Fortunately, a friend had naloxone, and he survived. He was transported to a treatment facility and remained committed to recovery.

Elena, a Latina college student, was a talented athlete with dreams of competing professionally. However, a sports injury during college derailed her plans. The physical pain and emotional distress from her injury led her to seek relief from substances, complicating her recovery.

As her addiction grew, so did her financial burdens. The mounting student debt from college left Ana feeling trapped, and her inability to focus on her studies further jeopardized her future. The pressure of potential eviction from her off-campus apartment due to unpaid bills exacerbated her anxiety, leading her deeper into addiction. In a pivotal moment, Elena discovered a support group on campus for students facing similar challenges. This community provided counseling and resources for financial management and recovery. Ana began reclaiming her life with the encouragement of her peers and mentors.

James, an African American man in his 40s, battled with opioid use after a workplace injury. Unlike Ben and Elena, he lived in a community prioritizing access to supportive housing and recovery services. Recognizing his growing dependence on opioids, he reached out for help at a local recovery center that offered both treatment and transitional housing.

With stable housing, he could focus on his recovery without the constant threat of losing his job. The center provided comprehensive healthcare services, including mental health support and job training programs, which were crucial for his recovery.

As he progressed, he found strength in his recovery and became a mentor, helping others navigate their journeys.



WHEN THINKING ABOUT THESE FAMILIAR STORIES, WHAT
TYPES OF QUESTIONS COULD WE ASK TO PRIORITIZE
COMMUNITY-LEVEL STRATEGIES THAT SUPPORT
PREVENTION AND RECOVERY?



DISCUSSION FRAMEWORK & KEY OBJECTIVES

- These narratives illustrate how identification, economic strain, and access to resources are deeply intertwined with addiction and recovery. Addressing these impacts requires:
 - **Allocation of Resources:** How can we create environments that prioritize resources (e.g., stable housing and accessible treatment) for individuals, helping to reduce stigma and encourage recovery?
 - **Implementation:** What policies and programs are crucial to recovery, and how can these models be expanded to serve diverse populations better?
 - **Research:** How can we leverage data to learn about the types of programs, policies, and services that meet the needs of the most impacted communities over time?
 - **Context:** What historical and systemic factors have contributed to the disparities in access to treatment for vulnerable groups, and how can understanding these contexts inform proactive public health policies?

MEASURING THE IMPACTS OF THE OPIOID EPIDEMIC

THE CONTEXT OF RECOVERY



INFORMED, EVIDENCE-BASED
DECISION-MAKING (PART I)

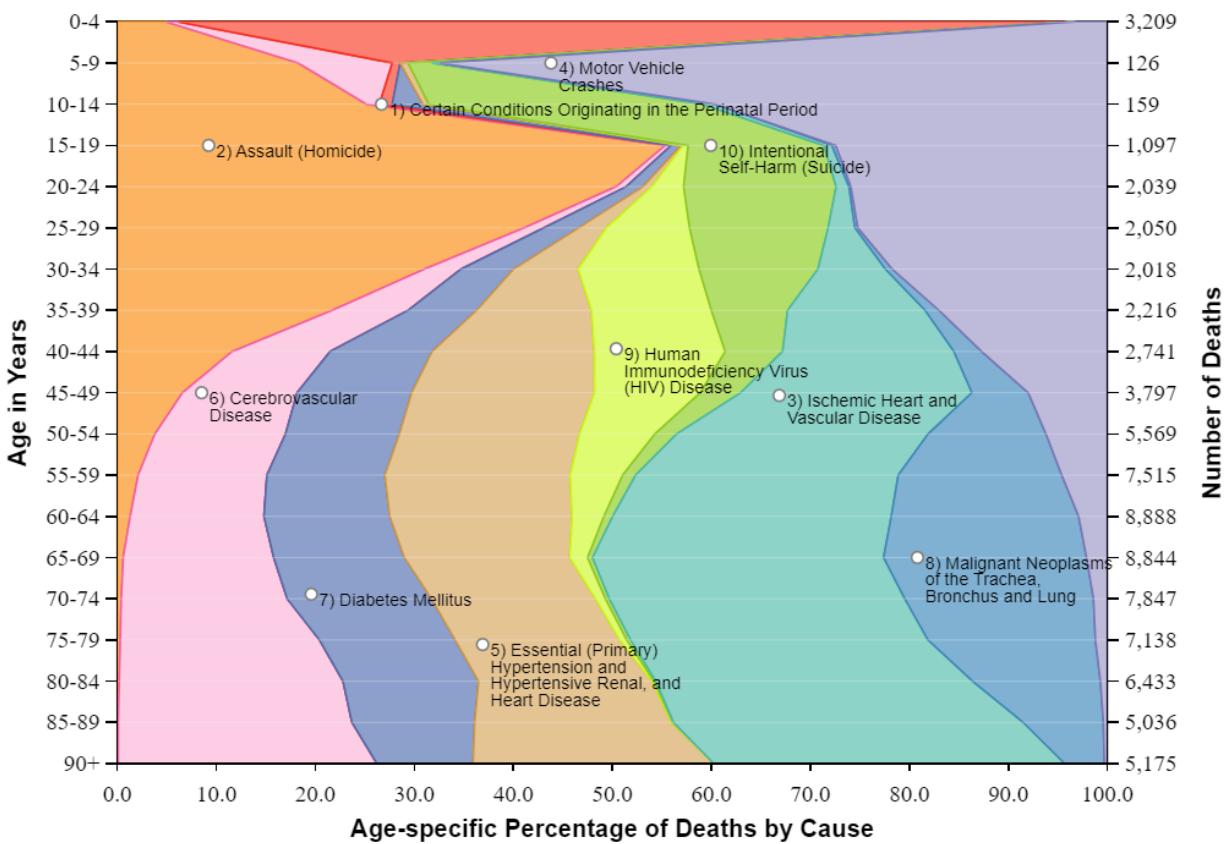


PRELIMINARIES

What do you notice in comparing these two charts of mortality prior to COVID-19?

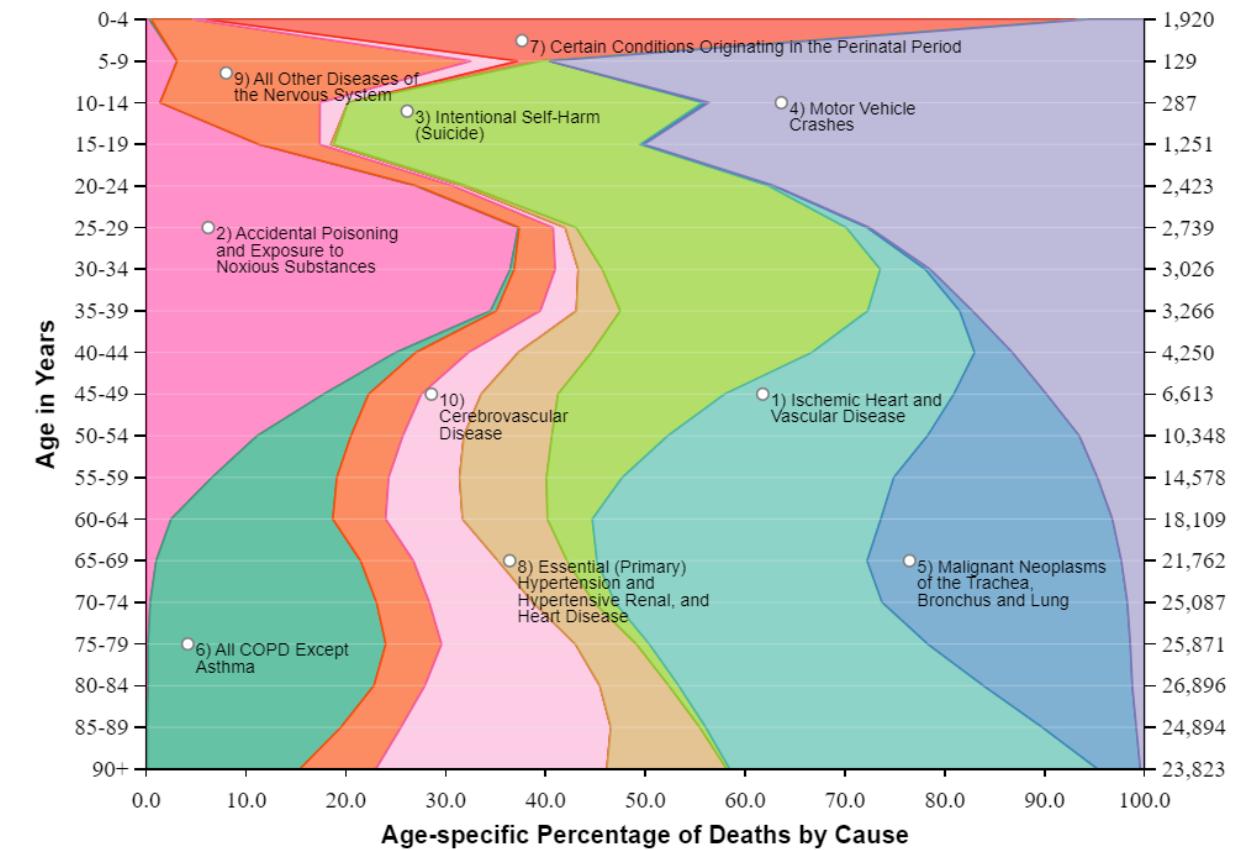
**Lifespan Histomap of Mortality, Black or African-American,
Georgia, 2010 - 2019**

Based on the Top 10 Causes* of Years of Potential Life Lost (YPLL)



Lifespan Histomap of Mortality, White, Georgia, 2010 - 2019

Based on the Top 10 Causes* of Years of Potential Life Lost (YPLL)



*Using Georgia Rankable Causes

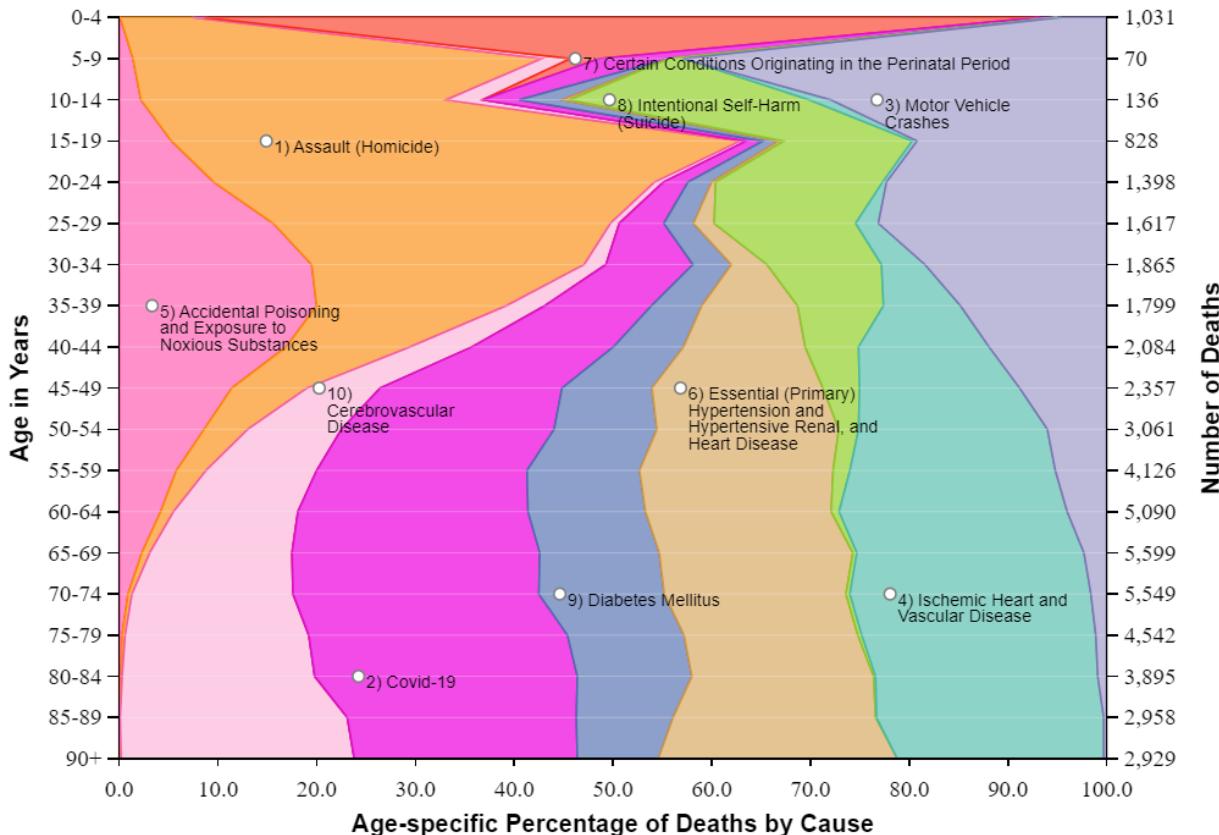
*Using Georgia Rankable Causes

Summary: Before COVID-19, racial disparities in mortality were stark: Black Americans, especially young men, were disproportionately affected by homicide, while middle-aged White Americans faced higher risks of death from accidental poisoning and suicide.

What do you notice in comparing these two charts of mortality during and after COVID-19?

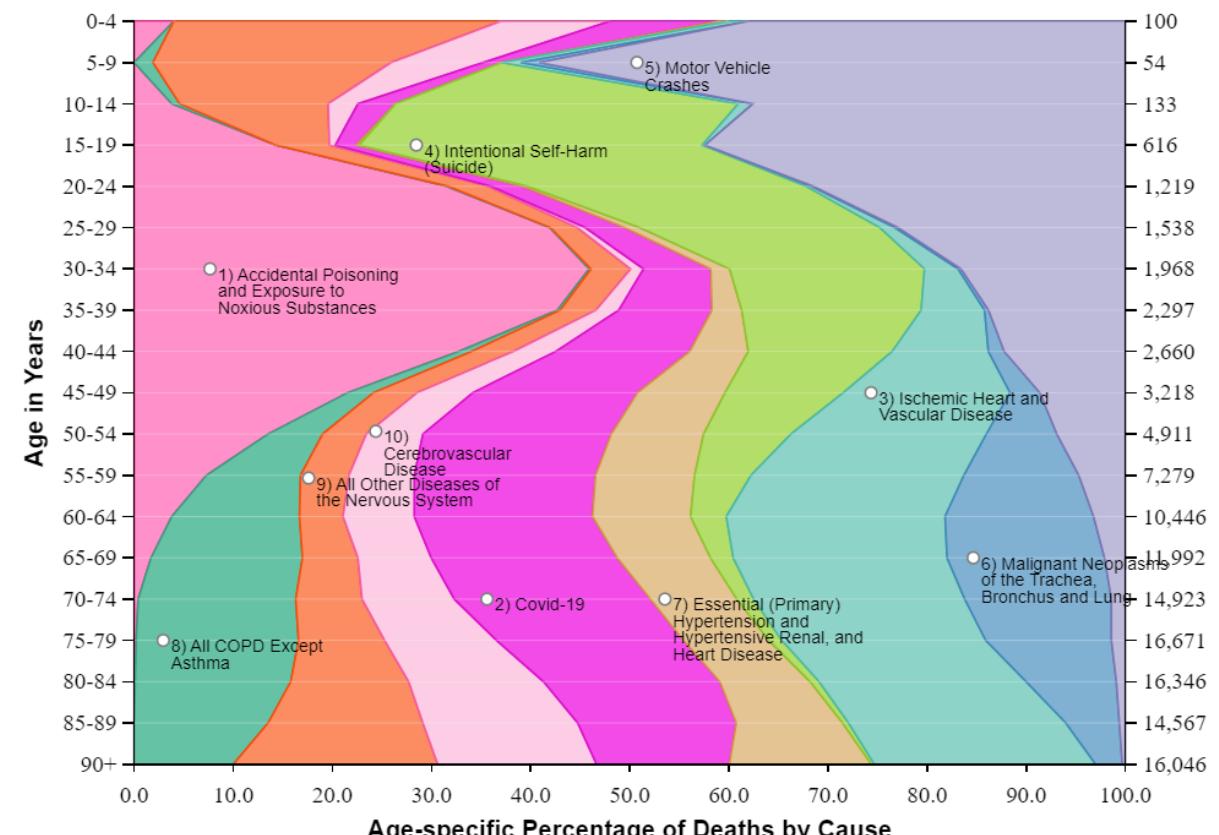
**Lifespan Histomap of Mortality, Black or African-American,
Georgia, 2020 - 2023**

Based on the Top 10 Causes* of Years of Potential Life Lost (YPLL)



Lifespan Histomap of Mortality, White, Georgia, 2020 - 2023

Based on the Top 10 Causes* of Years of Potential Life Lost (YPLL)



*Using Georgia Rankable Causes

*Using Georgia Rankable Causes

Summary: Post-COVID, accidental poisoning deaths surged among Black and AFAM populations, homicidal deaths continued to be the leading cause of death for Black/AFAM youth, and COVID-19 had a disproportionate impact on older Black and AFAM adults, highlighting shifting mortality patterns and ongoing health disparities for Black/AFAM Georgians.



KEY TAKEAWAYS:

We must begin to acknowledge the syndemic of co-occurring diseases that interact with each other, exacerbating their individual and collective impacts on health.

These diseases are not just co-occurring, they are influenced by social, economic, and environmental factors that contribute to their severity and unequal burden across race/ethnicity.

The unequal burden on Black and African Americans means that the syndemic constitutes both a public health crisis as well as a ***civil rights*** crisis requiring a commitment to social justice and equity to address structural factors contributing to these disparities

INFORMED, EVIDENCE-BASED
DECISION-MAKING (PART II)



THE OPIOID EPIDEMIC

Age Adjusted Death Rate (All Opioids) in Georgia (2010 - 2023)

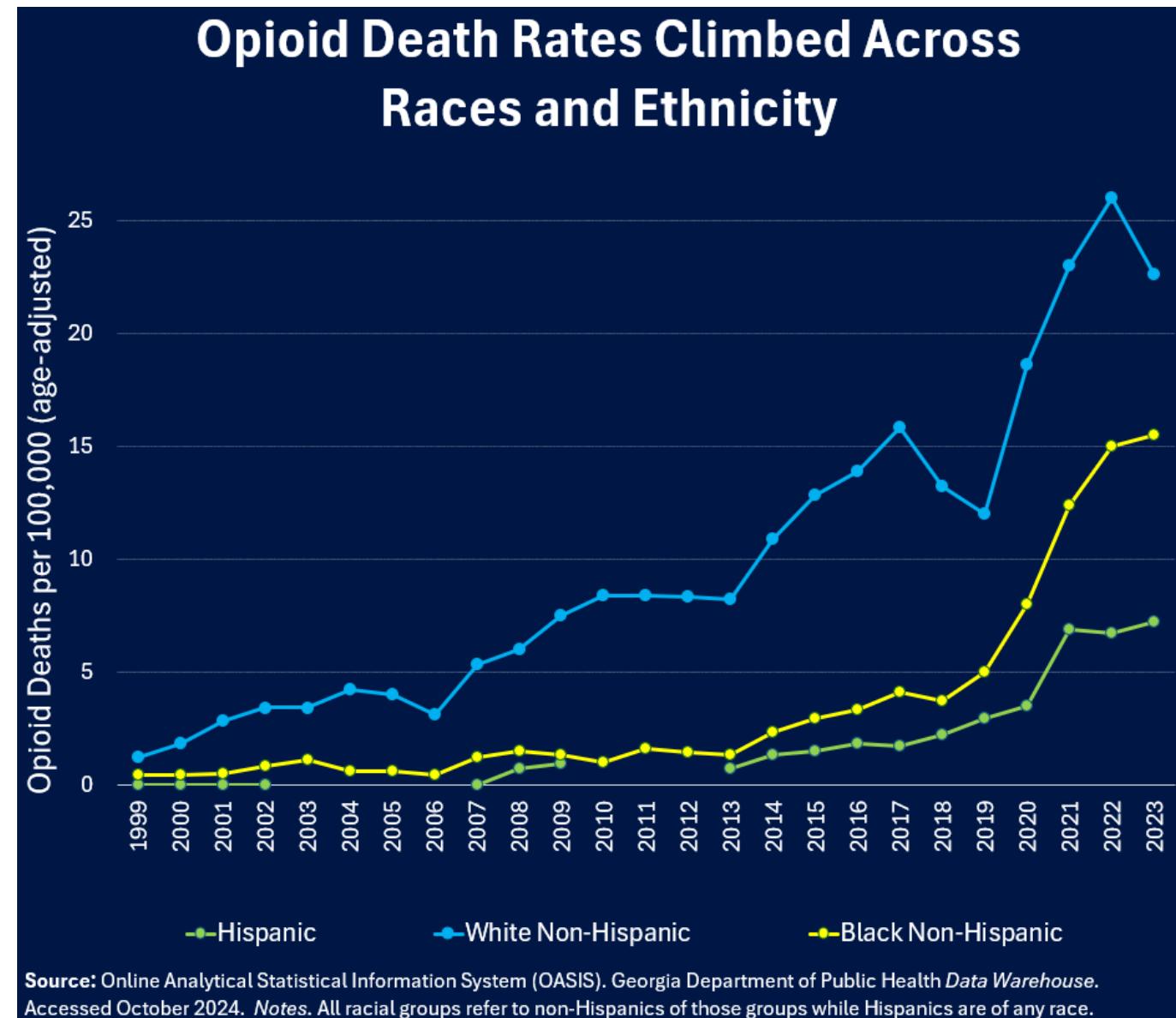
- The overall death rate rises from 5 per 100,000 people in 2010 to 18.6 in 2022
- The age-adjusted death rate more than doubled from 8.1 per 100,000 in 2019 to 18.6 per 100,000 in 2022, a 130% increase in three years.



Source: Georgia Department of Public Health, Office of Health Indicators for Planning
2003-24 <https://oasis.state.ga.us/oasis/webquery/qryDrugOverdose.aspx>

Summary: There was an alarming and rapid increase in the death rate, with age-adjusted rates showing significant spikes between 2019 and 2022 before leveling off.

- **Highest Rates:** Non-Hispanic Whites consistently experience the highest opioid-related death rates throughout the period.
- **Fastest Growth:** The death rate for AFAMs rises dramatically reaching a high in 2023 (15.5), surpassing the rates seen in prior years.
- **Lower Rates but Rising:** Hispanic deaths exhibit an upward trend increases steadily to 7.2 in 2023.

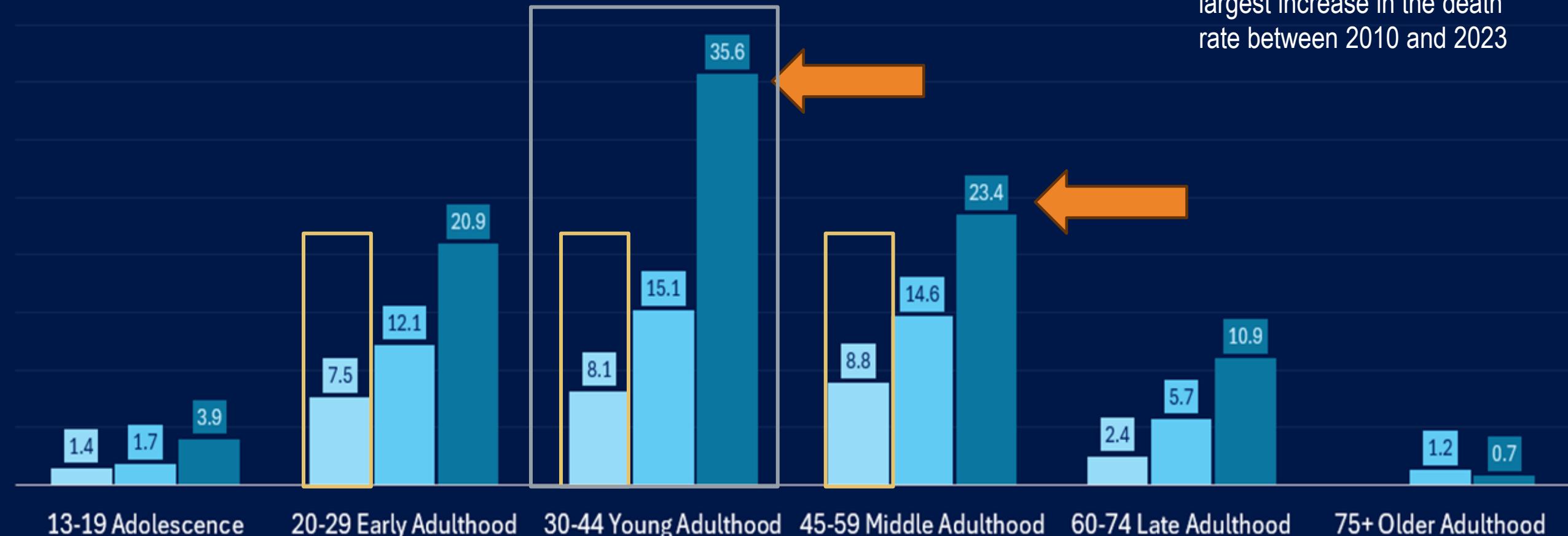


Summary: White populations have consistently higher death rates; however, opioid-related mortality is increasing among Black and Latino/Hispanic populations.

As the number of opioid deaths climbed, the crisis spread to all age stages of life

■ 2010 ■ 2016 ■ 2023

Summary: The death rate increased for all age groups except older adults, with young adults (30-44) experiencing the largest increase in the death rate between 2010 and 2023



Source: Online Analytical Statistical Information System (OASIS). Georgia Department of Public Health *Data Warehouse*.

Accessed October 2024. Notes. A single death may involve multiple substances

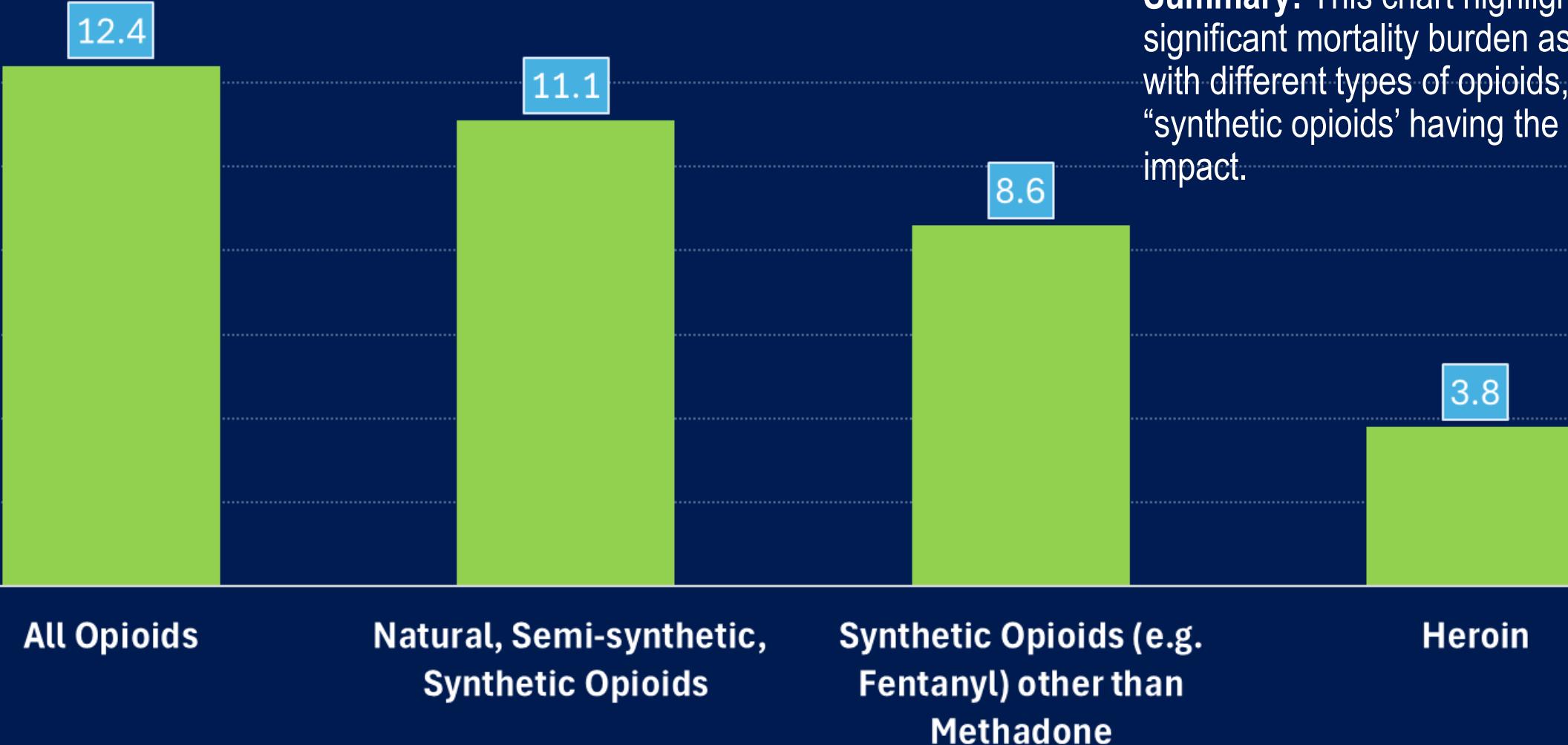


KEY TAKEAWAYS:

The sharp rise in death rates among young adults (ages 30-44) from 2010 to 2023, along with increasing rates across most age groups, underscores the expanding reach of the opioid epidemic

These trends highlight the urgency to create targeted community-based interventions focused on a broader range of demographics, including younger persons and minoritized groups

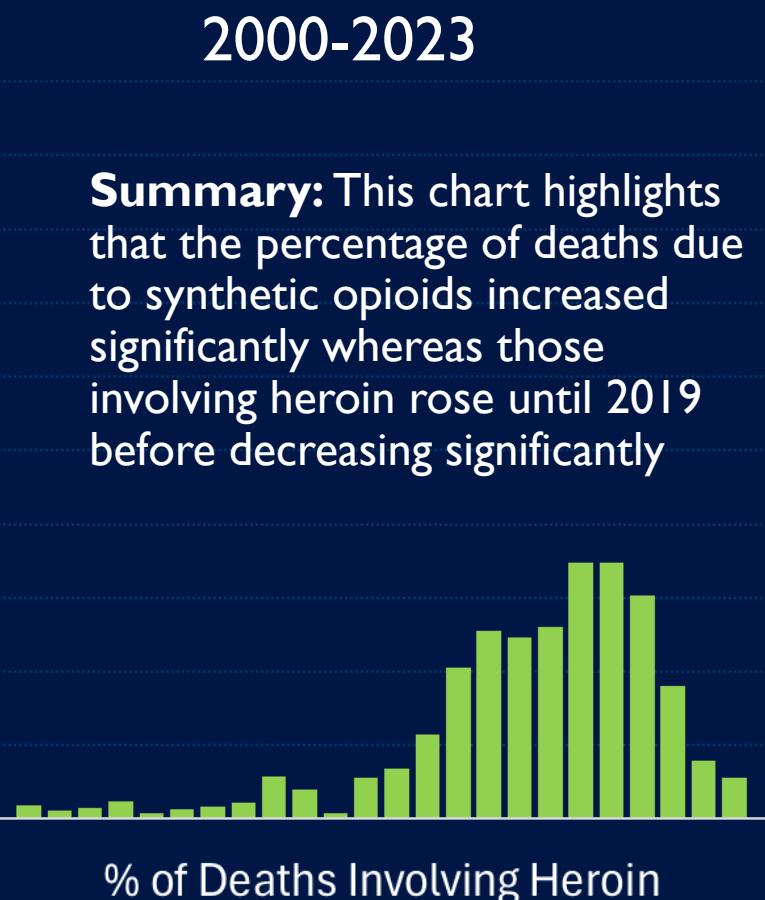
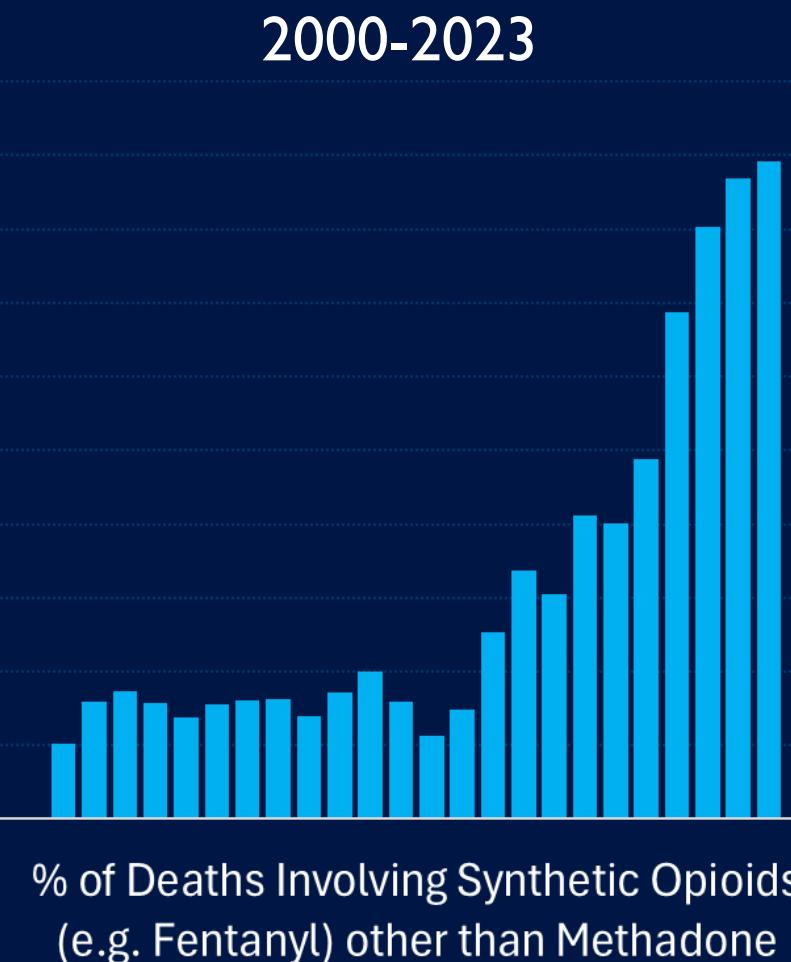
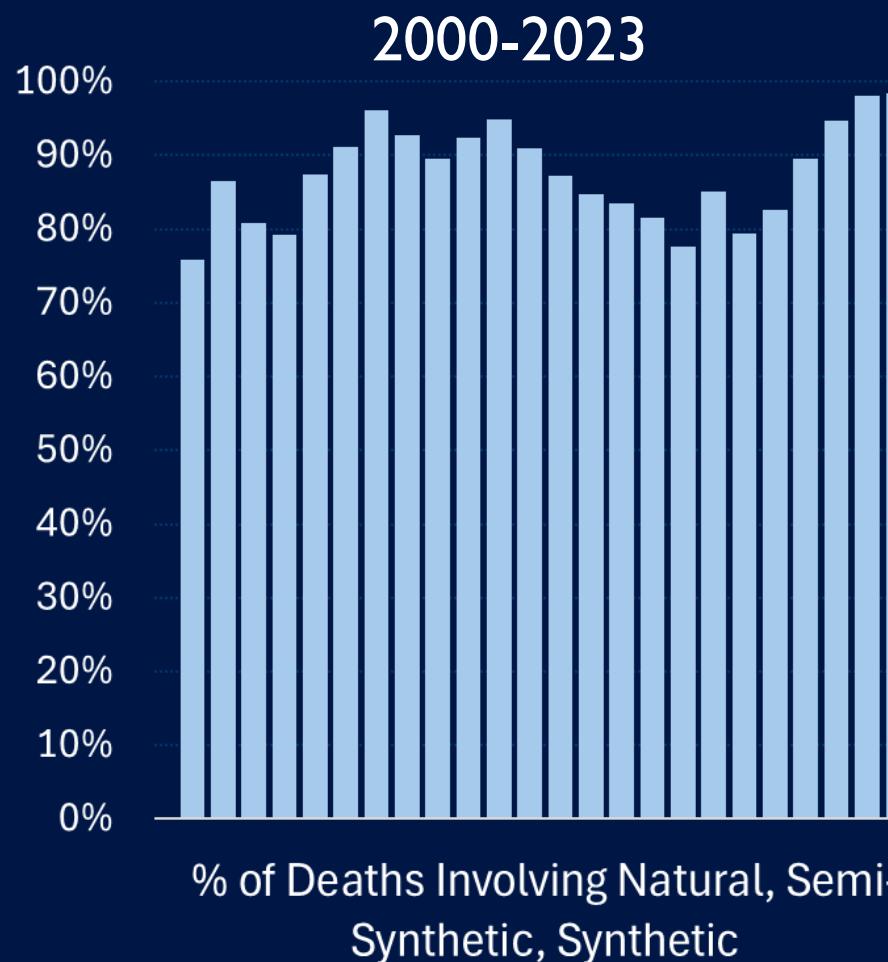
Age Adjusted Death Rate by Opioid Type



Summary: This chart highlights the significant mortality burden associated with different types of opioids, with “synthetic opioids” having the highest impact.

Source: Online Analytical Statistical Information System (OASIS). Georgia Department of Public Health *Data Warehouse*. Accessed October 2024. Notes. A single death may involve multiple substances

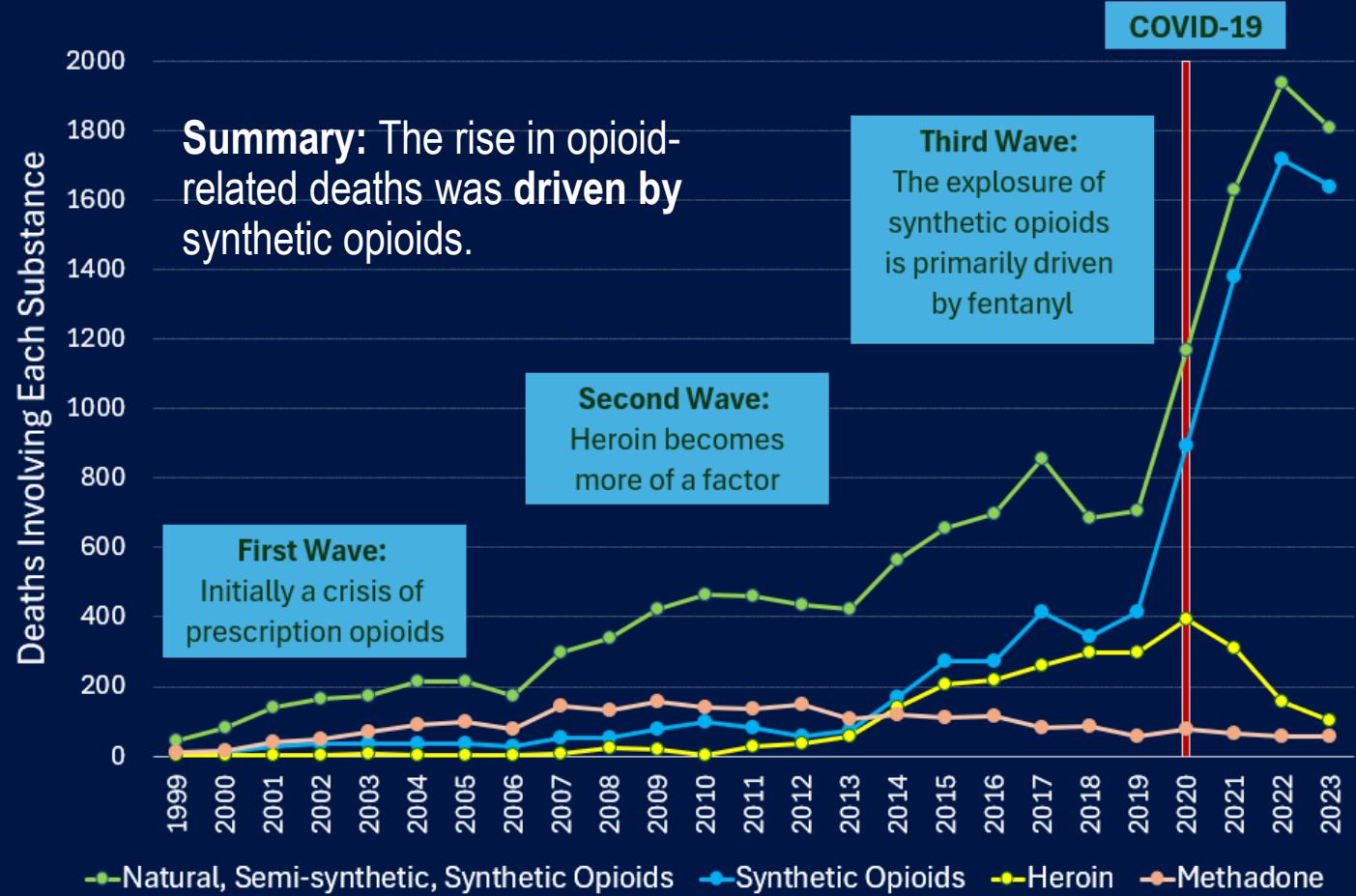
Opioid deaths increasingly involve synthetic opioids, including fentanyl



Summary: This chart highlights that the percentage of deaths due to synthetic opioids increased significantly whereas those involving heroin rose until 2019 before decreasing significantly

- The largest **percent change** in the number of deaths due to natural, semi-synthetic, and synthetic opioids was between **1999 and 2000**, with an increase of **78.26%**.
- Since 2000, the **largest percent change** occurred between **2019 and 2020**, with an increase of **65.48%**.

Data Point to Increase in Synthetic Opioid Deaths During the Pandemic



Source: Online Analytical Statistical Information System (OASIS). Georgia Department of Public Health Data Warehouse. Accessed October 2024. Notes. A single death may involve multiple substances



WHAT DID WE LEARN FROM COVID-19?

- Exacerbation of Opioid Use
 - COVID-19 exacerbated opioid use and overdoses due to opioid misuse.
- Impact of Policies
 - Policies to reduce transmission severely limited access to in-person treatment and recovery programs
- Social Isolation
 - The social isolation resulting from the pandemic is considered a risk factor for substance misuse

SOCIAL DISTANCING, AREA LEVEL DEPRIVATION AND OPIOID-RELATED FATALITIES DURING COVID-19

- **Rising Overdose Risk During the Pandemic:** We found that the risk of drug overdose deaths and the inequalities in neighborhood risk grew significantly worse in the first months of the COVID-19 pandemic
- **Impact of Deprivation on Overdose Risk:** Communities that were more socially deprived saw a 44.5% increase in the risk of drug overdoses.
- **Social Distancing Had No Direct Effect:** The number of people staying home in each area, measured by the social distancing index, did not affect the risk of an opioid-related drug overdose.
- To create effective and safe harm reduction strategies during a global crisis, it is important to understand how both location and time affected overdose risk *before the pandemic*.

Table 2 Latent structure model — autoregressive order 1 CAR model. Posterior quantities for selected parameters and DIC

	Median	2.5% CrI	97.5% CrI	Geweke diagnostic
Intercept	-4.038	-5.175	-2.89	-0.4
ADI	0.027	0.019	0.036	0.7
Stay-at-home	0.683	-0.663	2.107	0.2
τ^2	1.257	0.828	1.995	0.0
ρ_s	0.987	0.962	0.997	-0.4
ρ_t	0.932	0.795	0.996	0.0
Model diagnostics	DIC=2763.142; p.d.=210.6138; LMPL= -1408.14			

Results from the Bayesian spatiotemporal conditional autoregressive (CAR) model of relative risk for a fatal opioid-related overdose. *ADI*, Area Deprivation Index; τ^2 , process variance parameter; ρ_s , spatial autocorrelation; ρ_t , temporal autocorrelation; *CrI*, credible interval; *DIC*, Deviance Information Criterion; *p.d.*, estimated effective number of parameters; *LMPL*, log marginal predictive likelihood

APPROXIMATELY 90% OF ALL OPIOID DEATHS

involved a synthetic opioid product in 2023

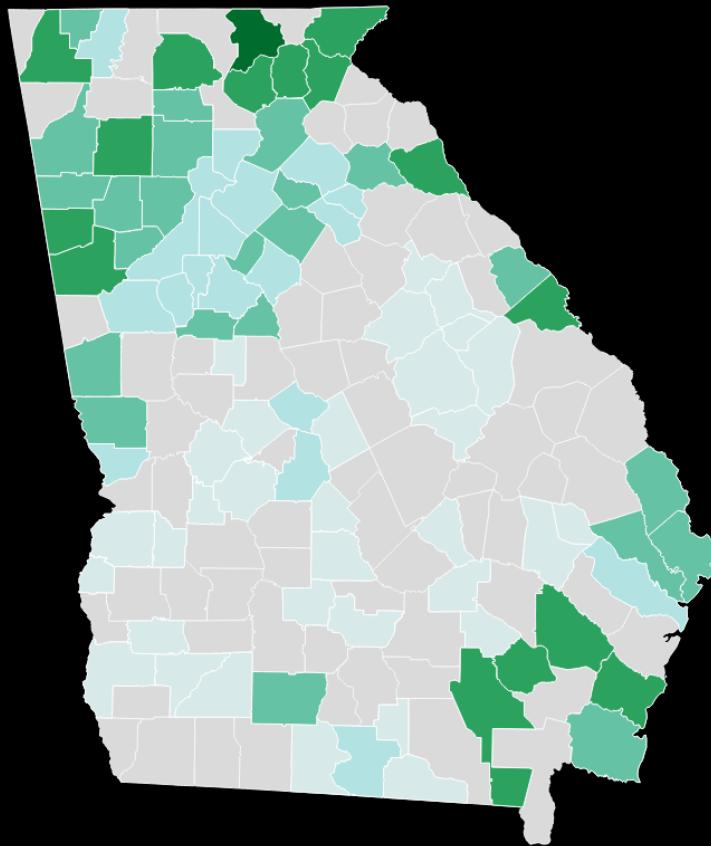
KEY TAKEAWAYS:

The opioid epidemic increased in magnitude and has also changed in character since 2000

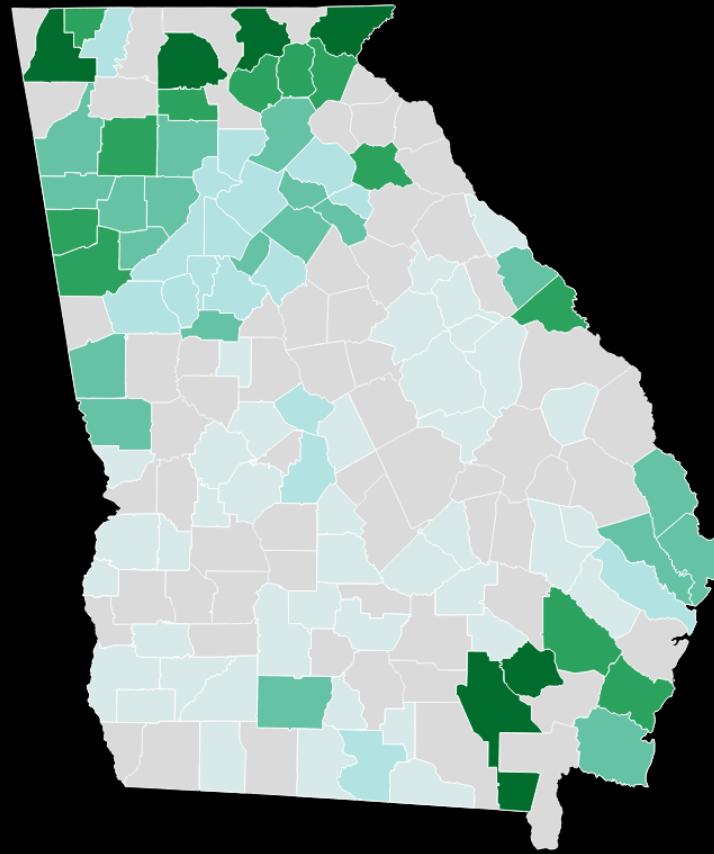
The rise in opioid-related fatalities began before the COVID-19 pandemic but continued to increase throughout the height of the pandemic before leveling off

The impact of the twin syndemic of COVID-19 and opioid misuse was exacerbated by pre-existing neighborhood vulnerabilities in areas of higher social deprivation

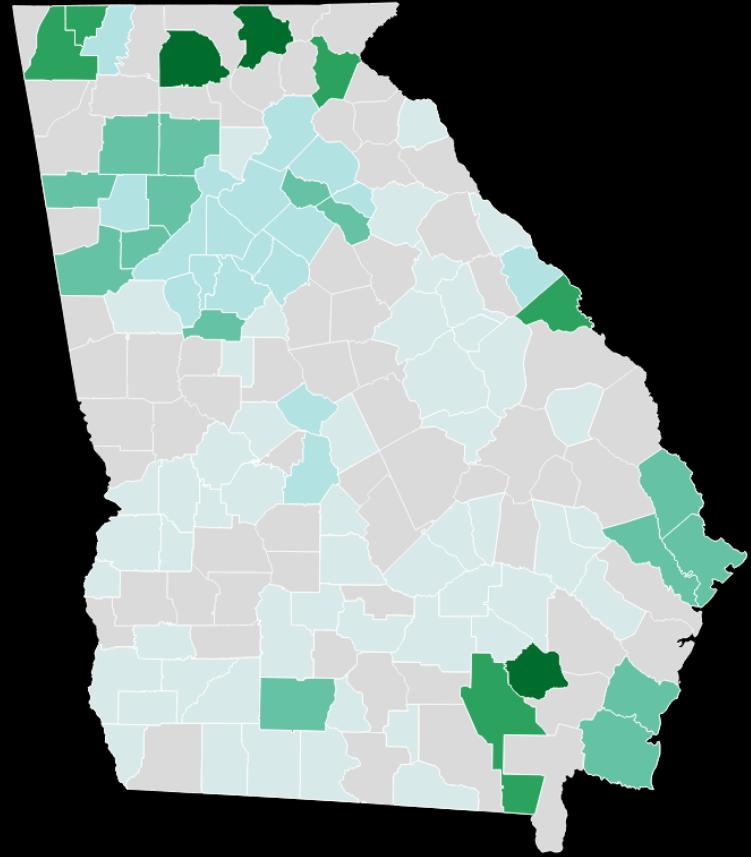
Geographic Variability in Opioid-Related Age-Adjusted Death Rates (2020)



All Opioids



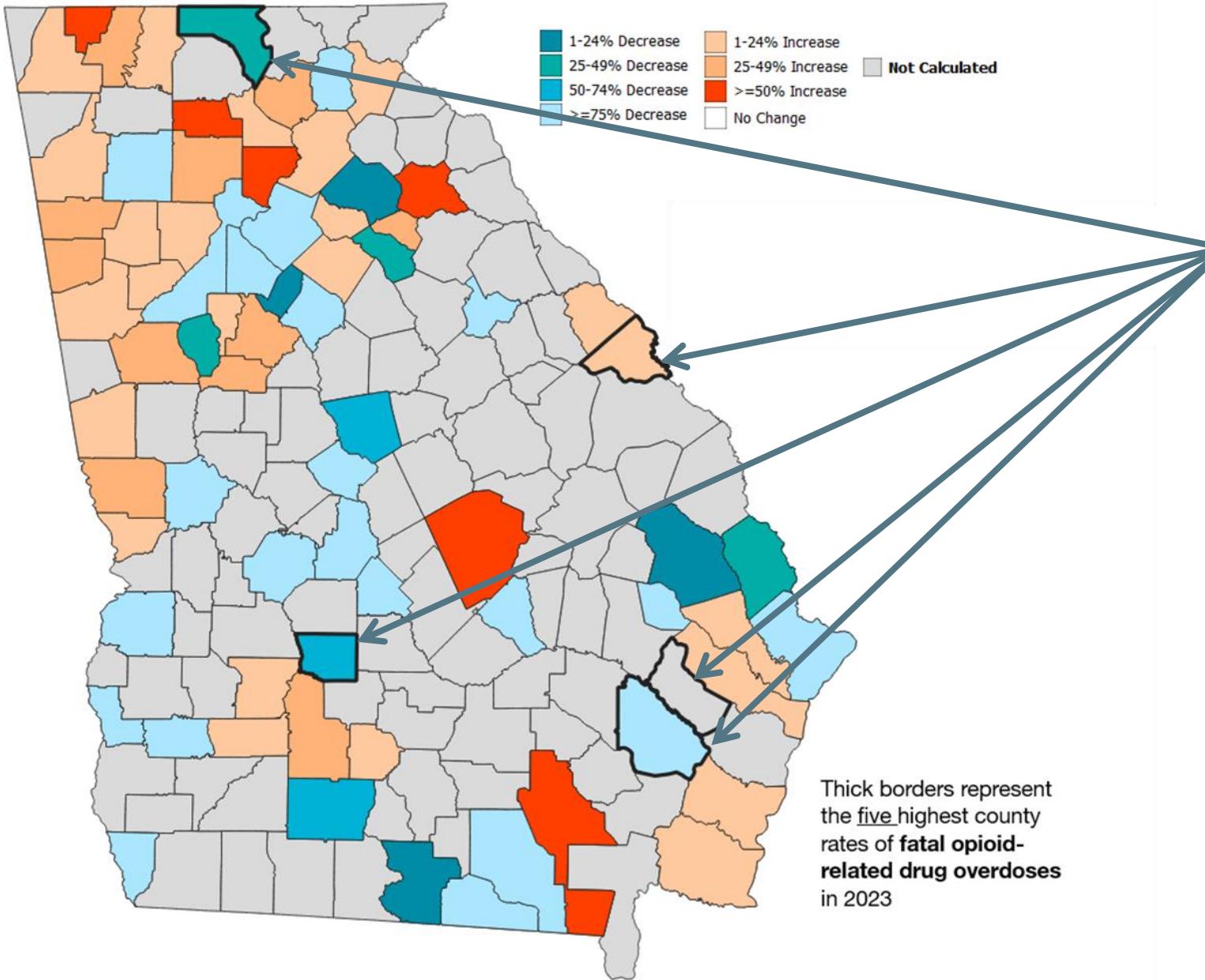
Natural, Semi-synthetic,
Synthetic Opioids



Synthetic Opioids (e.g. Fentanyl)
other than Methadone

Very Low Very High

Summary: There is significant geographic variation in death rates across the state. This distribution has implications for prevention.



The five counties with the highest fatality rate in 2023 include Fannin, Long, Wayne, Crisp, and Augusta

There was also variability within counties as some counties saw relatively larger **increases** in the opioid fatality rate, whereas some counties saw relatively larger **decreases**.

Opioid-Related Deaths by Social Vulnerability Level, All Counties



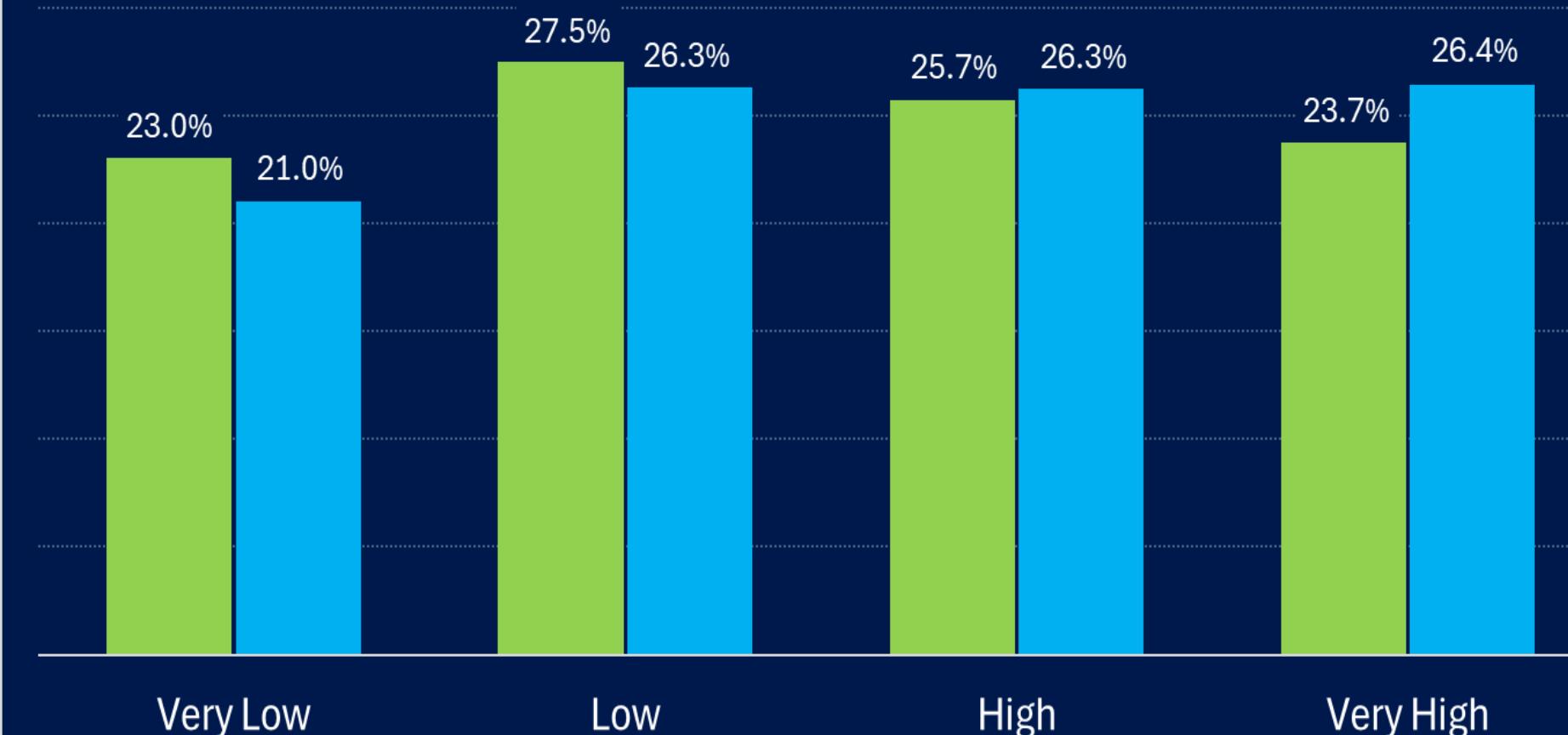
Summary: We must consider local contexts in prevention efforts. The most deaths occurred in the highest vulnerability strata. However, Georgians living in areas of low vulnerability are also at high risk. Clearly, socioeconomic status alone does not explain the variation in opioid fatality across areas of social vulnerability.

Percent of Opioid-Related Deaths within Social Vulnerability Strata (1999-2023)

Pre-COVID Post COVID-19

The average percentage of deaths within SES vulnerability strata was nearly equal between 1999 and 2023

There was a slight shift in the distribution of deaths after the COVID-19 pandemic



Source: Online Analytical Statistical Information System (OASIS).

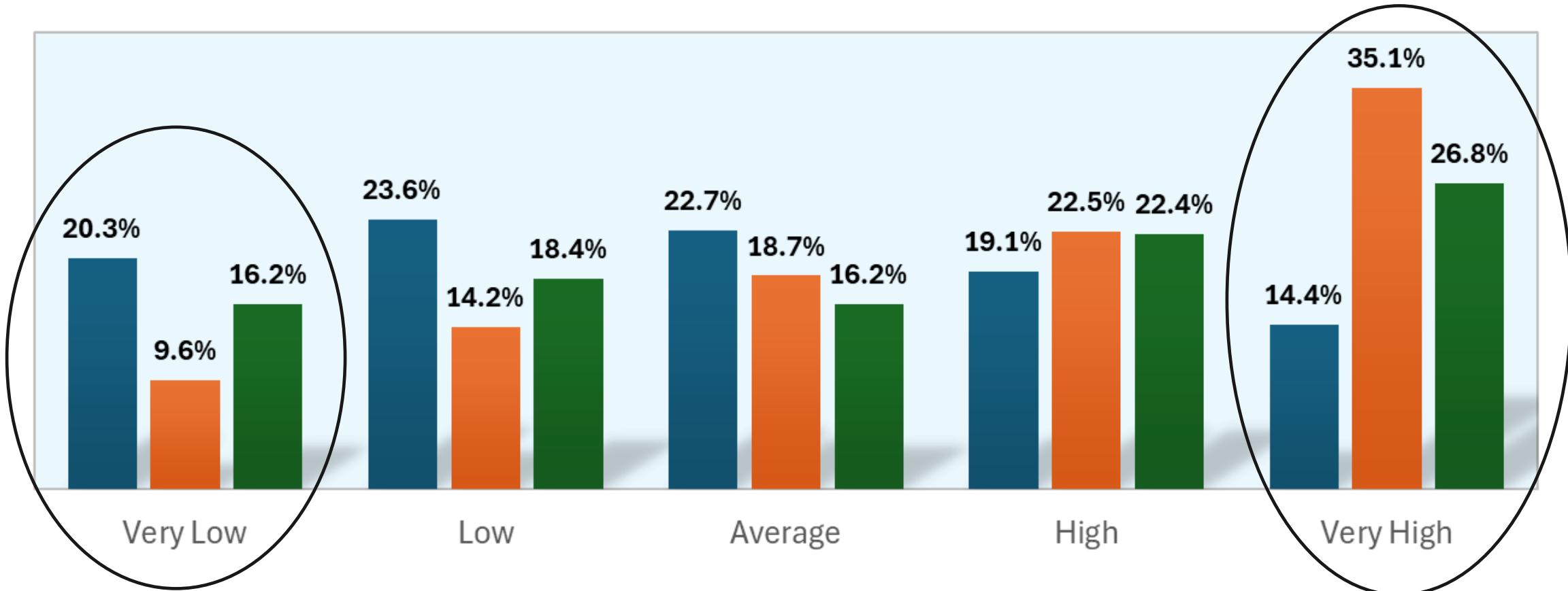
Georgia Department of Public Health *Data Warehouse*. Accessed October 2024.

Notes. Social Vulnerability Index is a measure developed by the Centers for Disease Control (SVI).

Summary: An analysis of opioid-related death rates across different levels of county social vulnerability and race/ethnicity shows that Black/African Americans living in the most socially vulnerable areas have a higher likelihood of opioid-related death, whereas White individuals in similarly vulnerable regions have the lowest probability of dying from an opioid-related cause

Percent of Opioid Deaths (All Cause) within SES Vulnerability Strata by Race/Ethnicity

■ White (Non-Hispanic) ■ Black or African-American (Non-Hispanic) ■ Hispanic





KEY TAKEAWAYS:

Not all communities are equally prepared to address the opioid epidemic therefore understanding local community contexts is critical to support the allocation of resources that impact the communities most affected

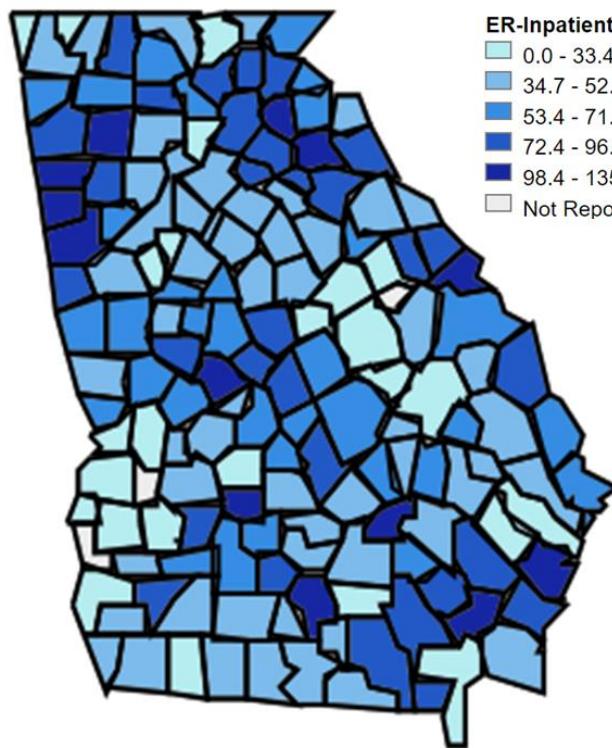
Evidence from Georgia suggests that individuals who are from historically minoritized populations who live in the most socially vulnerable areas are most impacted by the opioid epidemic



WHAT ABOUT NONFATAL OVERDOSES?

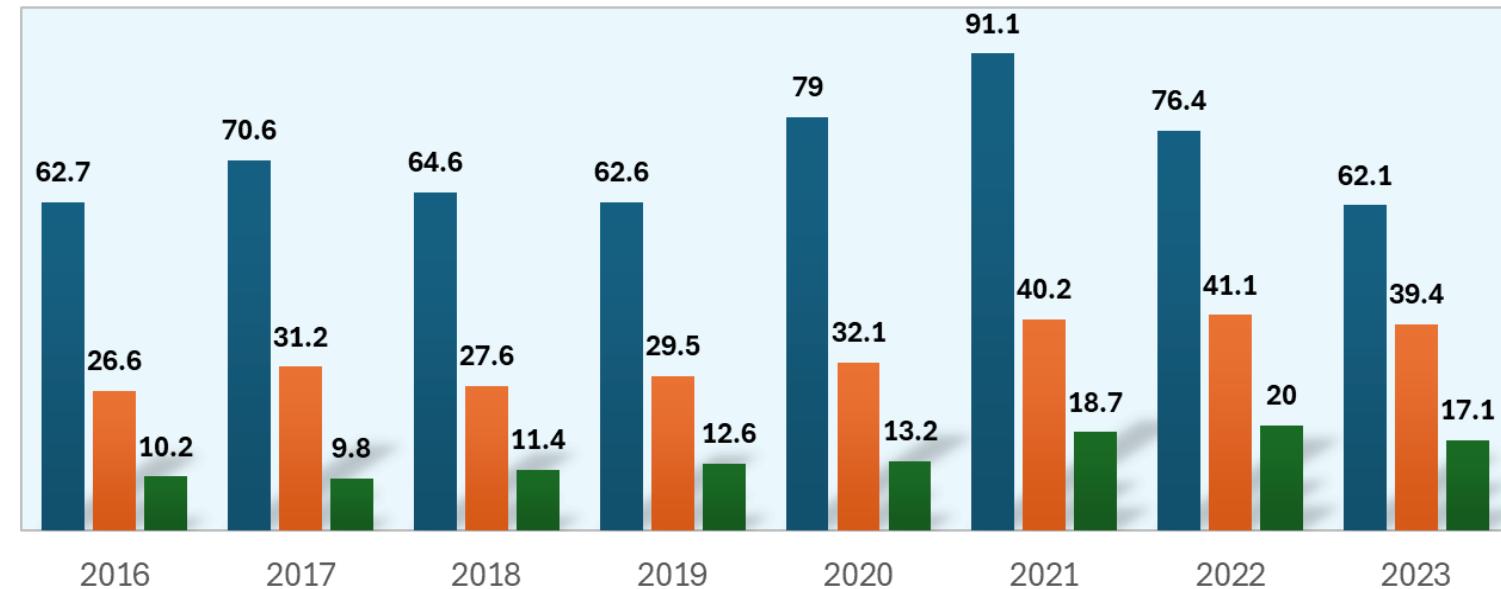
- Nonfatal Overdoses are a Significant Public Health Concern
 - For every fatal overdose, there are approximately 30 nonfatal overdoses related to opioids alone.
 - Contribute to a large burden on emergency services, healthcare systems, and communities
- Quantifying the impact of nonfatal overdoses
 - One way to quantify this burden can include measures relating to nonfatal overdoses, such as rates of emergency department visits, hospitalizations, and calls to poison control centers

ER-Inpatient Visit Rate Involving ANY OPIOID OVERDOSE by County of Residence (2019 – 2023)



Age Adjusted ER-Inpatient Visit Rate (All Opioids) by Race

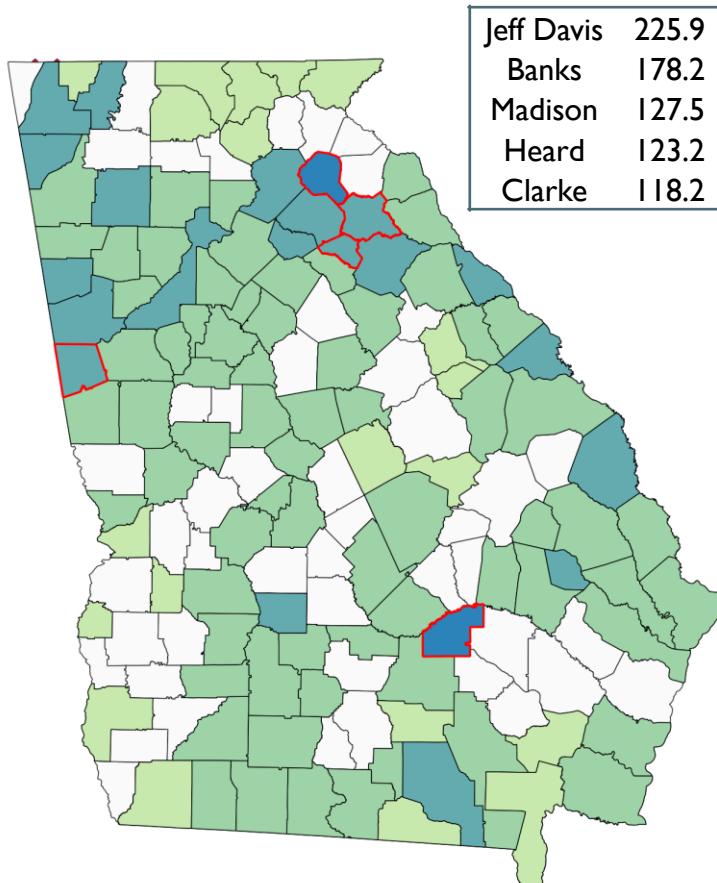
■ White (Non-Hispanic) ■ Black or African-American (Non-Hispanic) ■ Hispanic



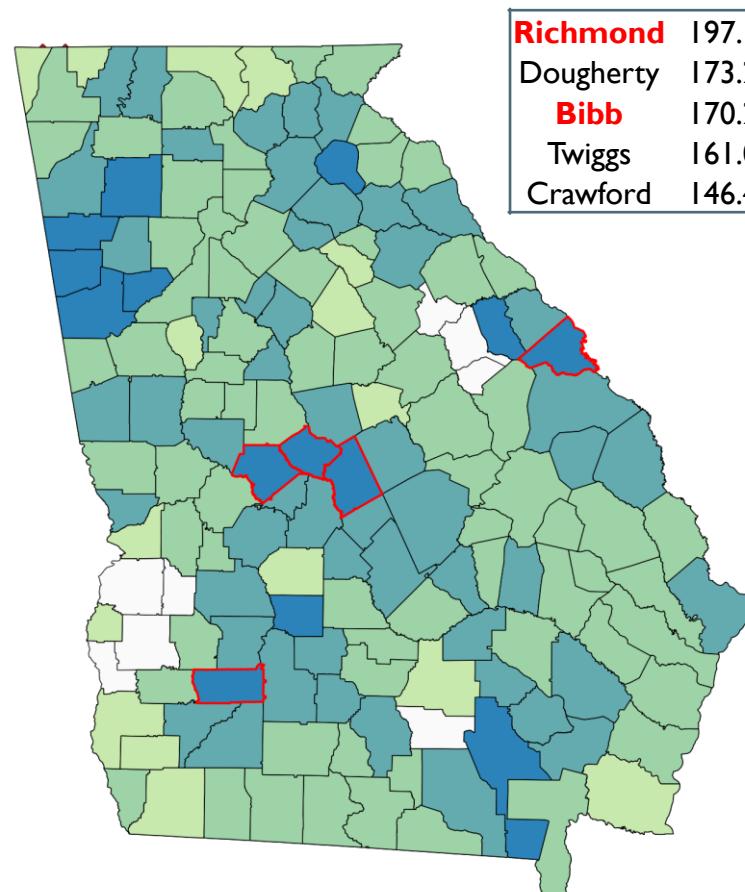
Summary: The age-adjusted ER-inpatient Visit Rate for opioid-related harm is consistently higher for non-Hispanic Whites, reaching its highest level in 2021 at 91.1 visits per 100,000 persons

Red outline represents the counties with the highest ER-Inpatient Visit Rates for that racial/ethnic group

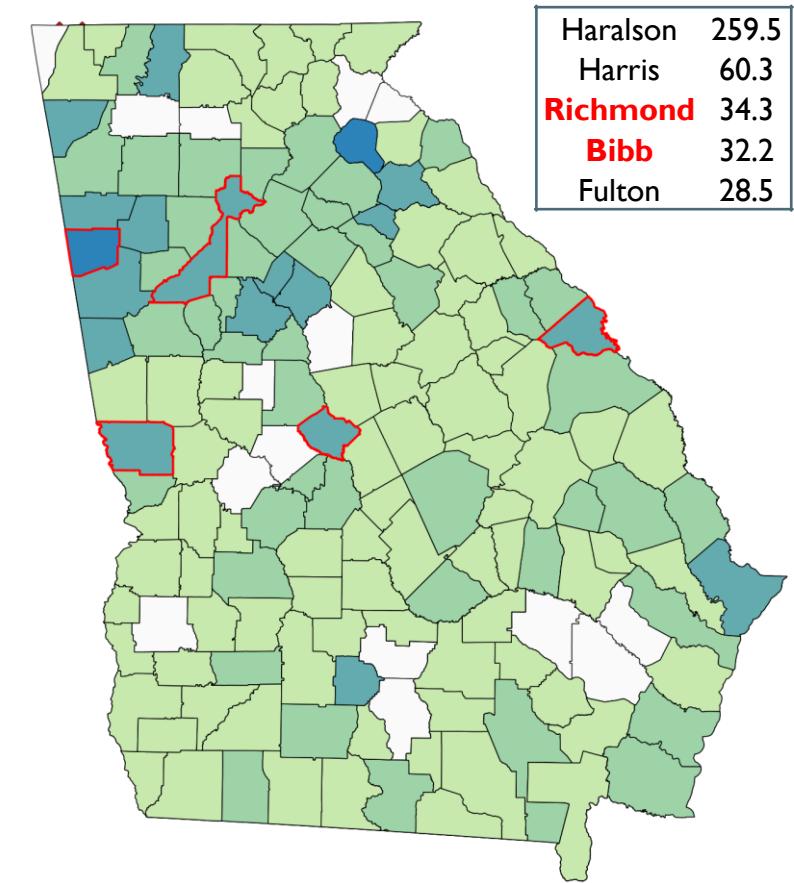
ER-Inpatient Visit Rate for Non-Hispanic Blacks



ER-Inpatient Visit Rate for Non-Hispanic Whites



ER-Inpatient Visit Rate for Hispanics



ER-INPATIENT VISIT RATES FOR AN OPIOID-RELATED HARM

- Both rural and non-rural areas experienced an increase in visit rates during the peak years of the COVID-19 pandemic (2020-2021)
- Both regions see a substantial increase in death rates during the pandemic period (2020-2022)

	ER-Inpatient Visit Rate		Number of ER-Inpatient Visits		Age-Adjusted Death Rate	
Year	Rural Counties	Non-Rural Counties	Rural Counties	Non-Rural Counties	Rural Counties	Non-Rural Counties
2019	54.3	46.3	1,214	3,879	7.9	8.2
2020	63.1	54.7	1,417	4,633	13.1	12.2
2021	70.9	62.2	1,593	5,315	17	16.2
2022	64.7	54.9	1,465	4,746	19.7	18.4
2023	52.3	47.4	1,198	4,147	15.1	17.6



KEY TAKEAWAYS:

Nonfatal overdoses have widespread impacts beyond the immediate health effects on victims, including lasting mental and physical health challenges, reduced quality of life, and increased strain on families.

Additionally, the economic impact on communities is substantial, with nonfatal overdoses contributing to lost productivity and higher healthcare costs.

Both ER visit rates and opioid-related death rates have decreased from their pandemic peaks; however, rural counties may still be facing more significant health outcome challenges compared to their non-rural counterparts.

Rural counties may have less access to resources that impact the ability to recover



SITUATING THE OPIOID CRISIS IN COMMUNITY CONTEXT

THE NEED FOR A PUBLIC HEALTH APPROACH

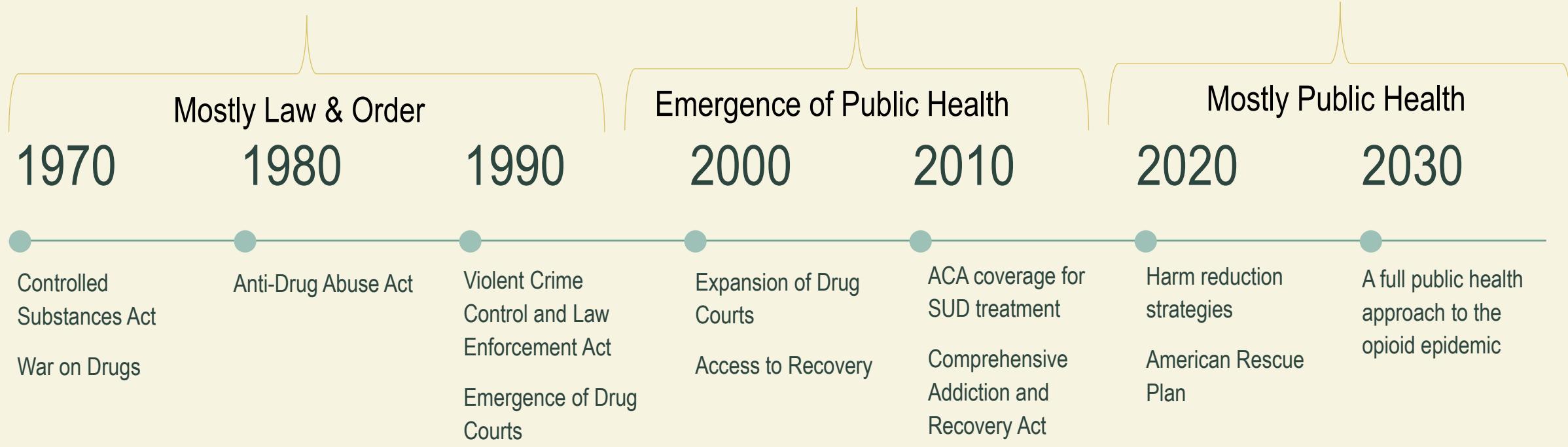


A PREVENTION FRAMEWORK

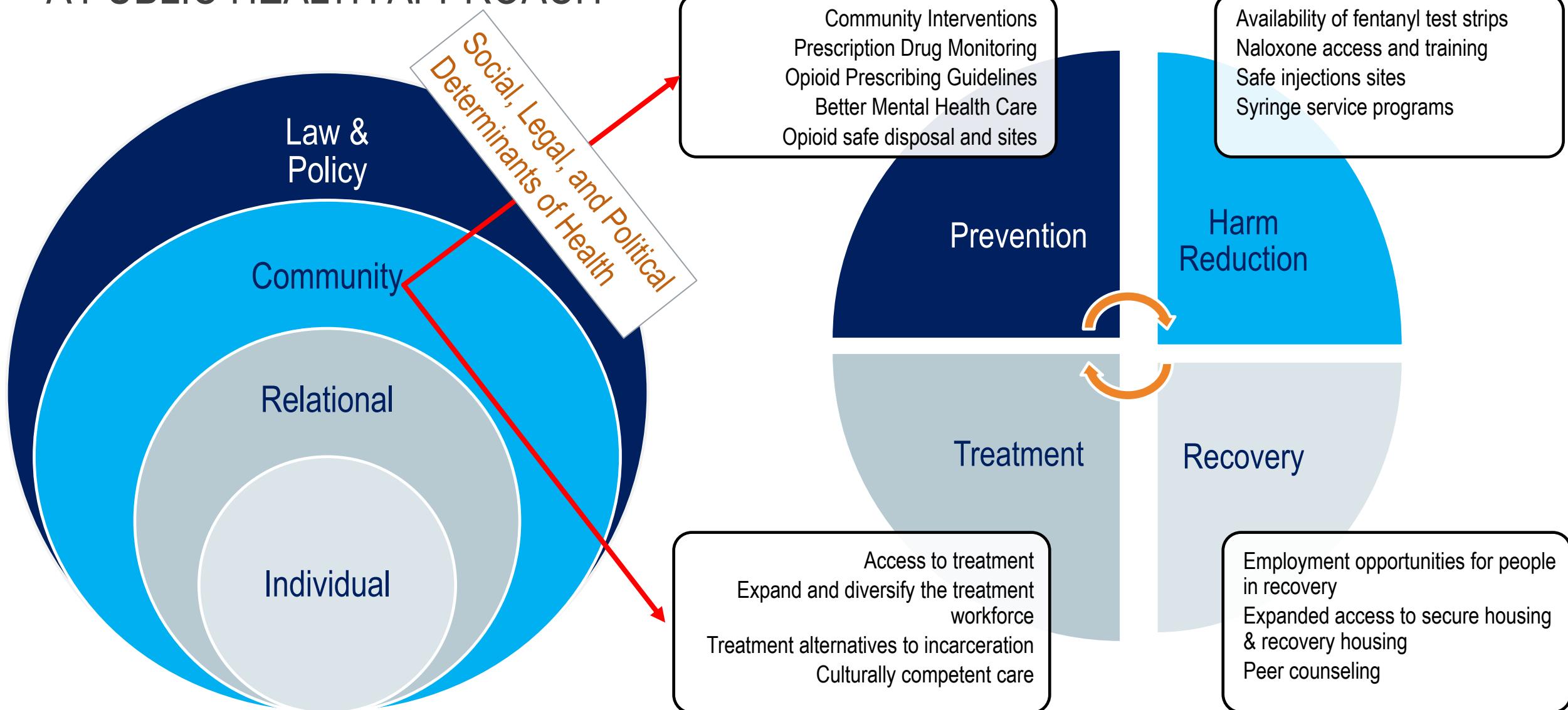


PROACTIVE PUBLIC HEALTH POLICY

Brief Overview of US Policy on Drug Addiction Since 1970



A PUBLIC HEALTH APPROACH



	Criminal Justice Approach	Public Health Approach
Focus	Punishment and deterrence	Prevention and health promotion
Primary Goal	Reducing crime through law enforcement and legal sanctions	Reducing risk factors and promoting protective factors
Target	Perpetrators and criminal behavior	Entire population and community health
Interventions	Arrest, prosecution, incarceration	Education, social support, community programs
Outcome Measurement	Crime rates, recidivism	Health outcomes, reduction in risk behaviors
Perspective	Individual responsibility and culpability	Social determinants of health and structural racism
Individual Outcome	Offenders, difficulty reintegrating	Recovery, social integration
Examples of Strategies	War on Drugs	Harm reduction programming

KEY DIFFERENCES BETWEEN PUBLIC HEALTH APPROACHES AND PUNITIVE RESPONSES

TRENDS AND GEOGRAPHIC
DISPARITIES IN GEORGIA



HARM REDUCTION STRATEGIES

The dispensing rate measures the number of opioid prescriptions dispensed per capita (individuals)

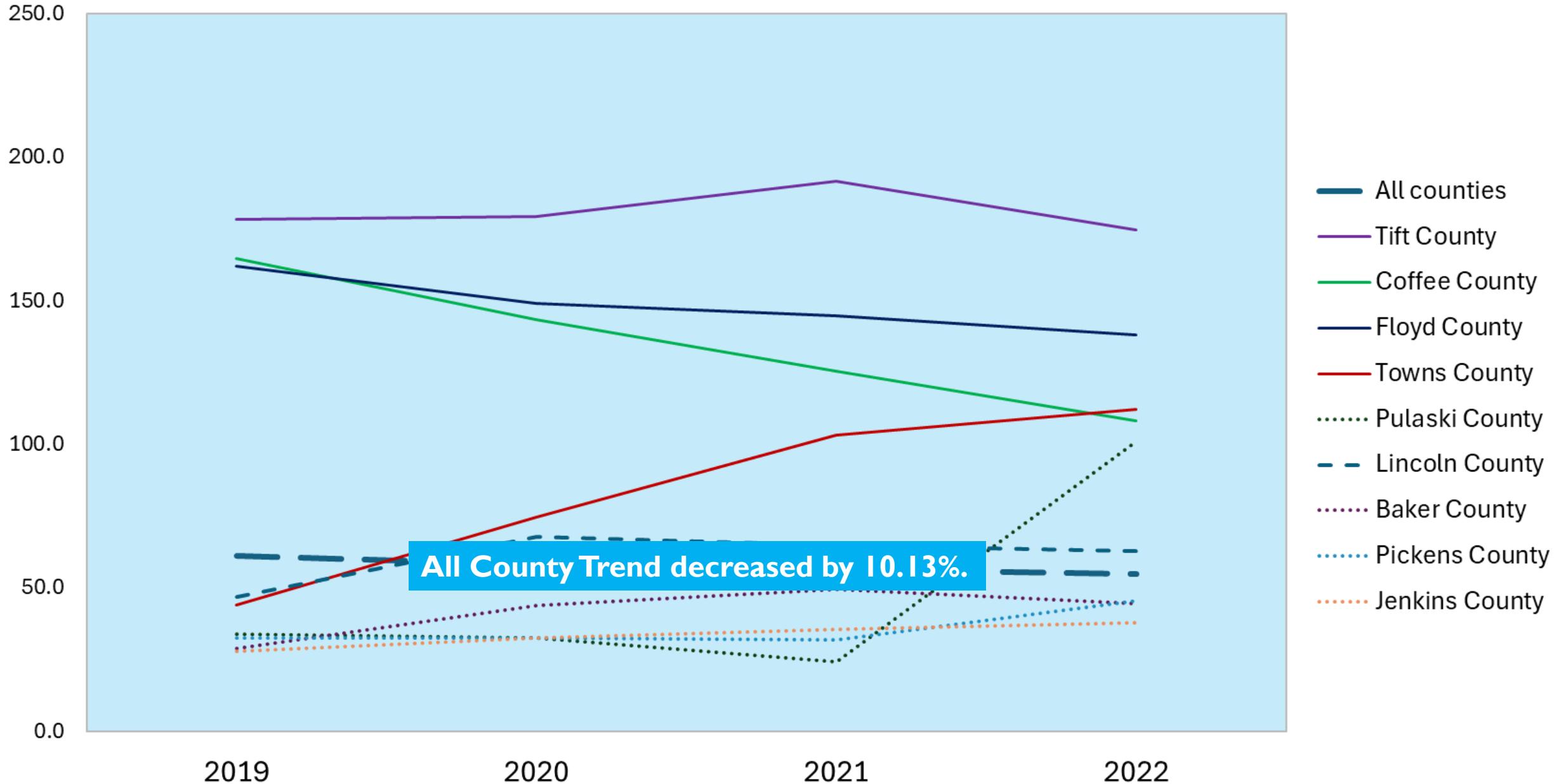
One indication of widespread misuse

Here is where Georgia stands in relation to the national average and surrounding states

The overall national opioid dispensing rate declined steadily from a rate of 46.8 opioid prescriptions dispensed per 100 persons in 2019 to a rate of 39.5 opioid prescriptions dispensed per 100 persons in 2022.

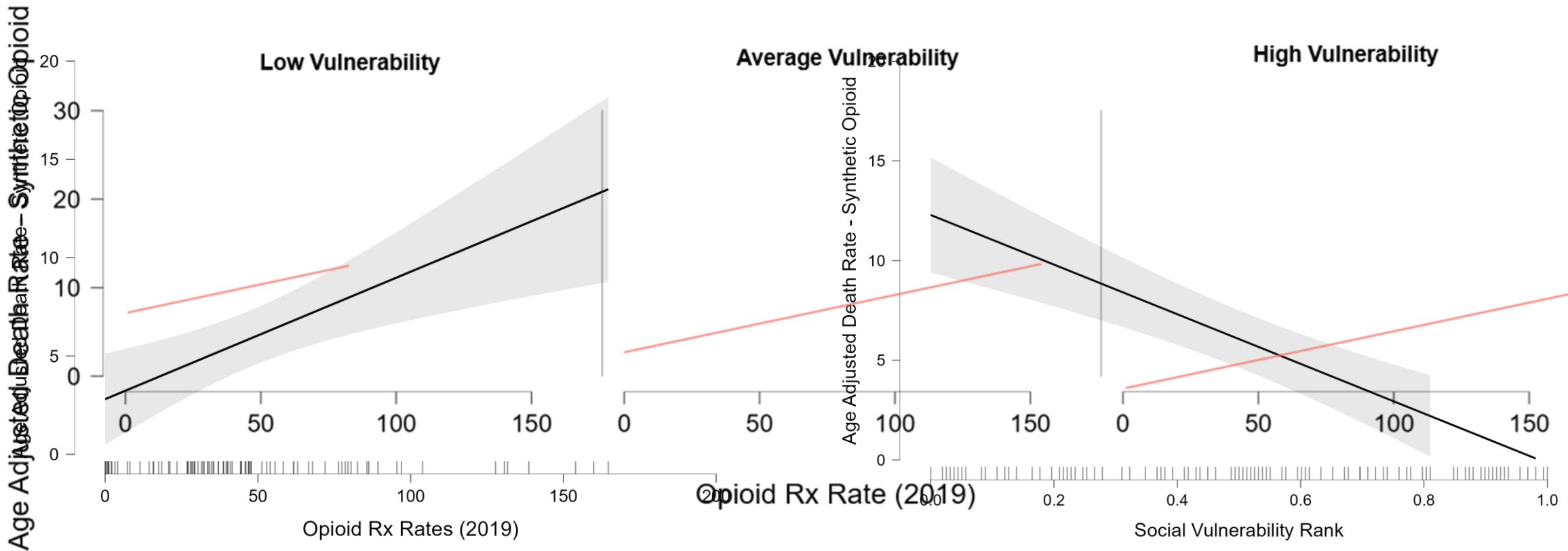
	2019	2020	2021	2022	4-year average
United States	49.7	45.9	44.7	42.1	45.6
Georgia	58.1	54.0	52.8	49.8	53.7
Alabama	86.0	78.9	77.3	74.5	79.2
Tennessee	74.7	68.2	66.0	61.5	67.6
North Carolina	60.6	57.7	55.2	51.5	56.3
South Carolina	56.9	53.8	52.1	48.9	52.9
Florida	45.5	43.8	42.7	40.0	43.0

TRENDS IN OPIOID PRESCRIBING RATES OVERALL AND BY SELECT COUNTIES



	2019	2020	2021	2022	Percent Change (2019-2022)
All counties	61.2	58.4	56.7	55.0	-10.13%
Tift County	178.6	179.6	191.9	174.8	-2.13%
Coffee County	164.7	143.6	125.6	108.4	-34.18%
Floyd County	162.2	149.2	144.9	138.3	-14.73%
Towns County	44	74.7	103.5	112.4	155.45%
Pulaski County	34.1	32.7	24.5	101.2	196.77%
Lincoln County	46.9	67.9	65.1	63.1	34.54%
Baker County	29.2	44.1	49.7	44.8	53.42%
Pickens County	32.7	32.7	32	45.7	39.76%
Jenkins County	27.9	32.8	35.7	38	36.20%

OPIOD PRESCRIBING RATES PREDICT DEATH RATES DUE TO SYNTHETIC OPIOIDS (2019)



Summary: Rx rates increase the synthetic opioid death rate regardless of social vulnerability. However, there is a faster rate of change in areas of higher vulnerability.



Key Takeaways:

Due to increased awareness of the risks of addiction and overdose and following the implementation of stricter prescribing guidelines and regulations, the rate of prescription opioid use and overdose deaths related to prescription opioids has decreased

Not all counties follow the general trend, some county prescribing rates increased significantly during the four-year period

Prescription opioids contribute to opioid-related deaths directly or indirectly, even after considering county-level social vulnerability

NALOXONE DISPENSING RATE PER 100 PERSONS

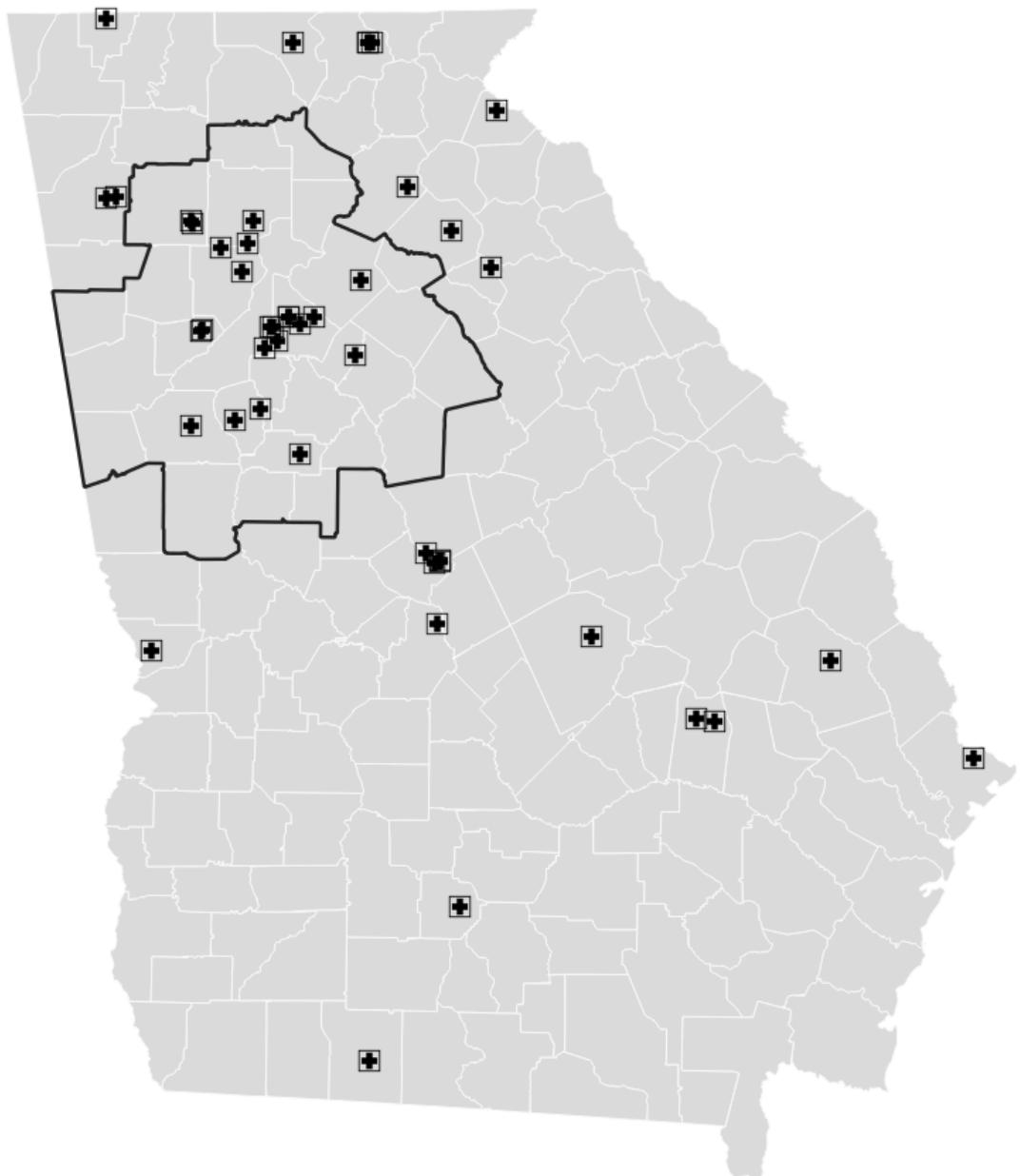
- States with the lowest naloxone dispensing rates per 100 persons in 2022 include Texas (0.2), New Hampshire (0.2), South Dakota (0.2), and Georgia (0.2).
- Link to increase in deaths across race/ethnicity

	2019	2020	2021	2022	4-year average
United States	0.30	0.30	0.40	0.60	0.40
Georgia	0.10	0.20	0.20	0.20	0.20
Alabama	0.20	0.20	0.30	0.30	0.30
Tennessee	0.20	0.20	0.20	0.30	0.20
North Carolina	0.40	0.40	0.50	1.00	0.60
South Carolina	0.20	0.20	0.70	1.00	0.60
Florida	0.30	0.40	0.40	0.50	0.40

HARM REDUCTION

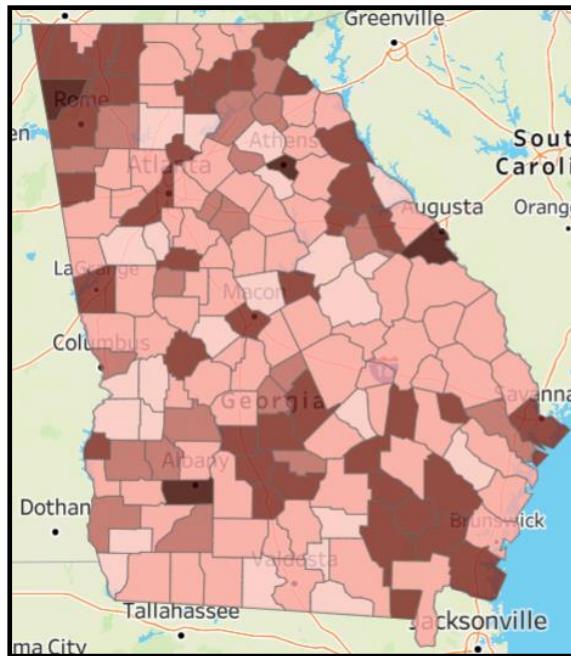
There are 45 Naloxone Distribution Boxes across the State

Most of them are in the Atlanta Metro region

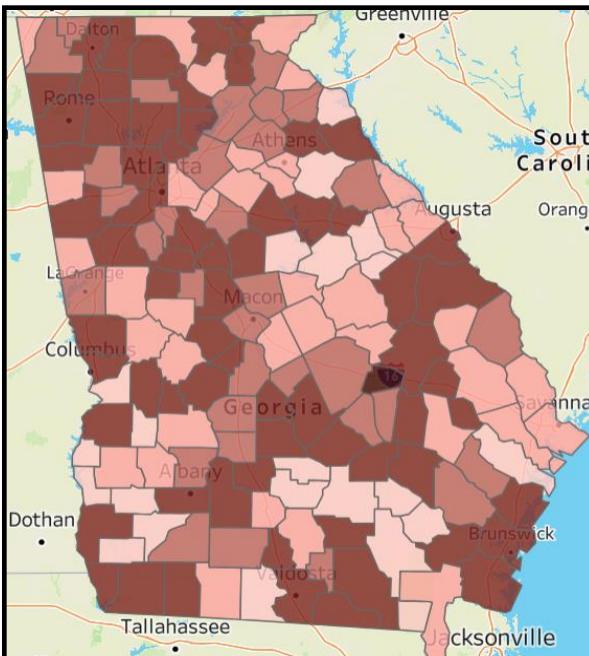


National

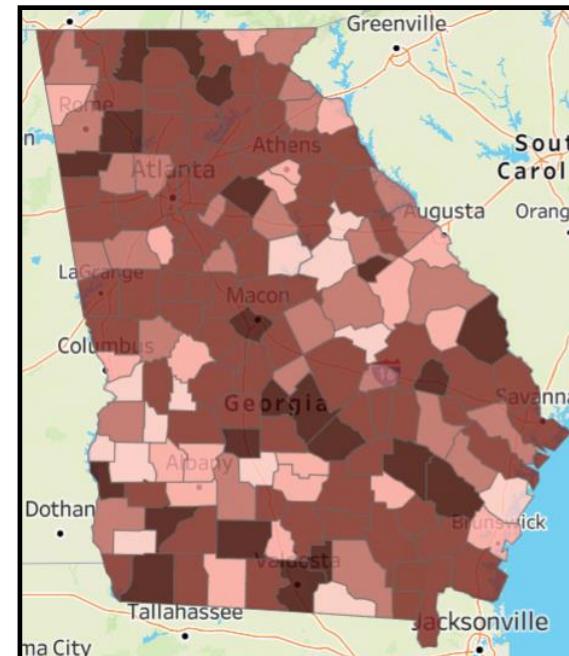
Number/Rate 2023 Fatal Overdoses
105,002 or 31.5 (-3.4%)



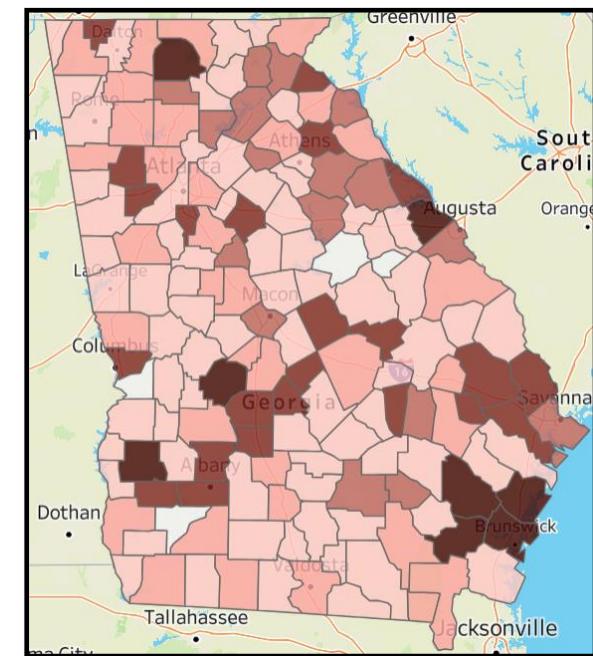
Percent of Patients Receiving Naloxone
40.4% (-14.4%)



Average EMS Time to Patient
13.1 minutes (+4.6%)



Patients Not Transported
17.1% (-4.9%)

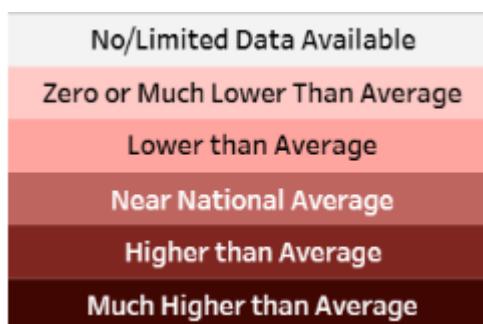


Rate of fatal overdose

% patients receiving NX

Average time to patient

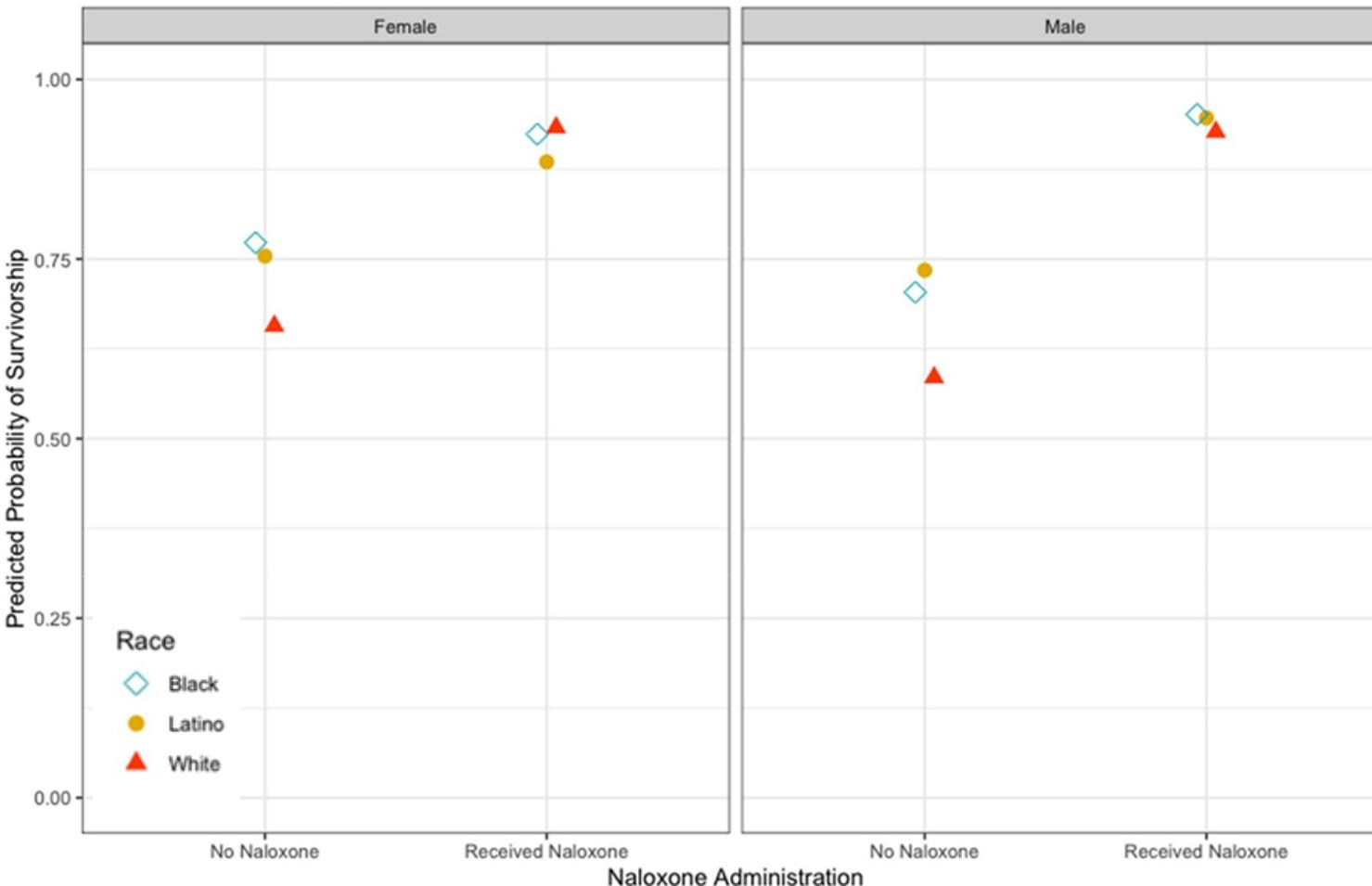
% not transferred to a facility



Probability of survivorship by naloxone administration and race/ethnicity

Survivorship by Naloxone Administration, Gender and Race/Ethnicity

Adjusted Predictive Margins



The **likelihood of surviving a drug overdose is more than 5 times higher if naloxone is administered regardless of race/ethnicity**

Racial differences in fatal drug overdose exist **in the absence** of naloxone administration

No racial differences in survivorship were noted following **naloxone** administration

Naloxone Administration and results by race/ethnicity

	Non-Hispanic Black	Non-Hispanic White	Hispanic
Naloxone doses	1.50(0.861)	1.54(0.764)	1.46(0.695)
Naloxone unit (mg)	2.31(1.83)	2.32(1.75)	2.44(1.88)
Third-Party Administration Description			
Emergency Medical	16.7	13.3	14.5
Fire department	5.1	2.2	4.1
Good Samaritan	1.4	1.5	1
ODIN partner agency	59	66.9	69.4
Response time			
< 1 min	7.92	12.07	10.24
Response to naloxone			
Combative	4.46	3.48	2.87
Responsive & angry	4.74	6.84	3.39
Responsive & alert	35.65	38.41	34.2
Responsive but sedated	38.72	24.8	44.39
No response to naloxone	16.43	26.47	15.14
Transition of care			
Arrest	1.99	1.8	3.19
Refused transport	15.34	14.63	14.7
Referred to treatment	11.93	16.1	7.67

Key Takeaways:

Georgia has one of the lowest Naloxone dispensing rates in the country, according to the Centers for Disease Control (CDC)

The likelihood of surviving an opioid-related overdose is substantially higher following Naloxone administration

White individuals are less likely to survive if Naloxone is not administered, but racial differences disappear if Naloxone is administered

This result is probably due to differences in polysubstance use, Naloxone distribution and EMS response times in areas with larger shares of Whites

Naloxone is not primary prevention. There should be a mechanism to transport persons to treatment. Nobody should be arrested.

Voronoi tessellation helps visualize the influence or service area of each health center, showing which areas are most directly served by which centers.

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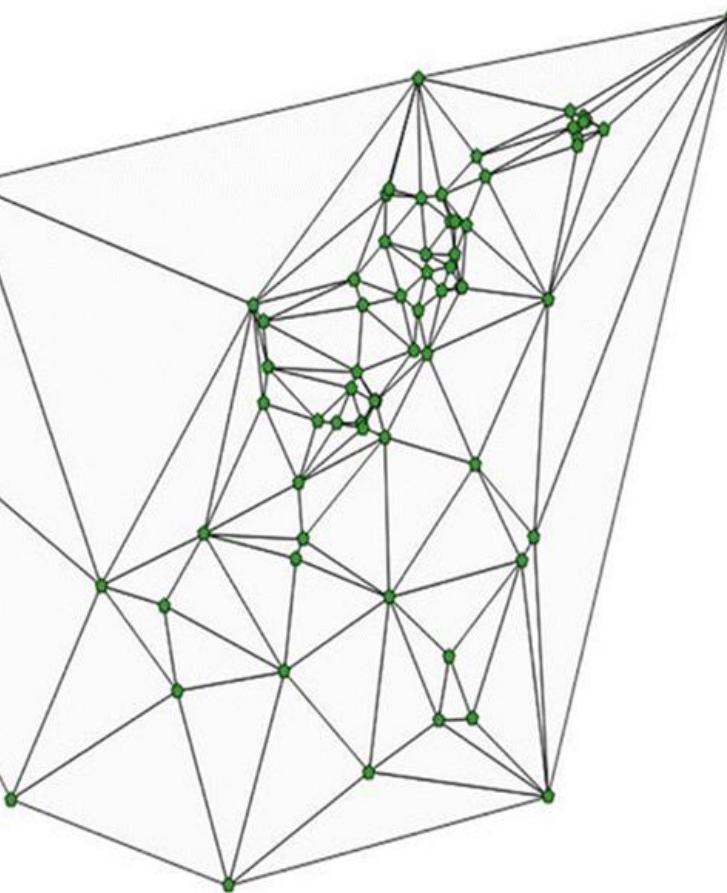
Lag

Reg

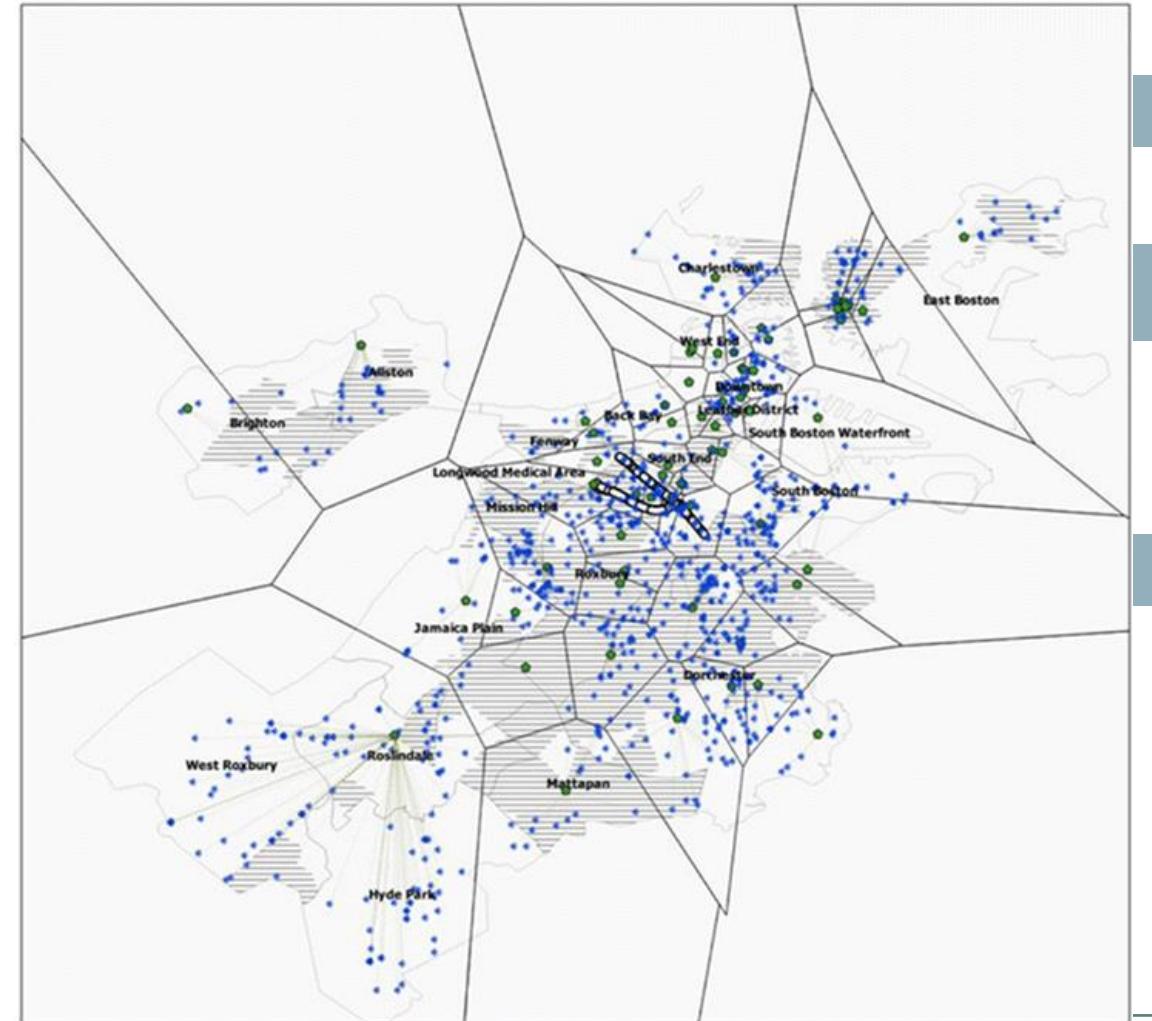
BP

LR

R-s



b





BUILDING TRUST IN HARM REDUCTION: THE NEED FOR LEGAL PROTECTIONS

- For harm reduction strategies to work optimally, participants must have confidence that they will not encounter police interference or face penalties based on their acquisition or return of syringes
 - Research has found problematic inconsistencies and limitations in the law of SSP-participant syringe possession.
 - Many states that have authorized SSPs or otherwise reduced barriers to distribution continue to lack protection for possession and/or exempts employees of SSPs but not participants

HOW DOES THE LEGAL
ENVIRONMENT IMPACT
RECOVERY OUTCOMES?

THE REGULATORY FRAMEWORK OF HARM REDUCTION

Summary of Georgia Legislation

Law	Title	Summary	Significance
Ga. Code Ann. § 26-4-116.2	Immunity Provisions	Provides immunity to practitioners prescribing opioid antagonists, as well as pharmacists and others dispensing or administering them, <u>if acting in good faith.</u>	Protects healthcare providers and individuals administering opioid antagonists from civil or criminal liability, promoting wider access to overdose treatment.
Ga. Code Ann. § 31-11-55.1	Opioid Antagonist Training	Mandates training for first responders who have access to or administer opioid antagonists.	Ensures that first responders are properly trained to administer life-saving overdose reversal drugs.
Ga. Code Ann. § 31-1-10	Standing Order	Authorizes the State Health Officer to issue a standing order for prescribing opioid antagonists statewide, facilitating broader distribution and access.	Increases access to naloxone by allowing pharmacists and other individuals to dispense it without a patient-specific prescription.
Ga. Code Ann. § 16-13-32.2	Possession of Drug-Related Objects	Criminalizes the possession of drug-related objects, with exceptions for hypodermic needles and syringes under specific conditions (e.g., Syringe Services Programs).	Helps facilitate harm reduction by allowing legal syringe access while <u>maintaining criminal penalties for other drug paraphernalia.</u>

Summary of Georgia Legislation

Law	Title	Summary	Significance
Ga. Code Ann. § 16-13-5	Good Samaritan Law	Grants immunity from arrest or prosecution for drug possession when seeking medical assistance during an overdose situation.	Encourages <u>individuals to seek help</u> during overdoses, which can reduce overdose fatalities.
Ga. Comp. R. & Regs. 511-2-9-.01 to -.08 (2023)	Syringe Services Programs (SSP)	Establishes legal provisions for Syringe Services Programs, including registration and protection from liability for employees and volunteers distributing syringes.	Supports harm reduction efforts by legally <u>protecting SSPs</u> , which help prevent the spread of diseases like HIV and Hepatitis.
Ga. Code Ann. § 16-13-1, § 16-13-32, etc.	Drug Paraphernalia and Syringes	Defines drug paraphernalia and provides legal distinctions for syringes used in harm reduction programs, excluding them from certain criminal penalties.	Separates harm reduction tools (syringes) from general drug paraphernalia to support public health while <u>maintaining other drug-related laws</u> .
Ga. Comp. R. & Regs. 360-3-06 (2013)	Controlled Substance Prescribing	Sets the standard of care for prescribing controlled substances, including specific requirements for patient history, examinations, and treatment agreements.	Regulates how physicians prescribe controlled substances, ensuring responsible pain management while preventing misuse.
Ga. Code Ann. § 16-13-32	Transactions in Drug-	Prohibits transactions involving drug-related objects, with exemptions for syringes used in	Prevents the <u>illegal distribution</u> of drug paraphernalia while supporting public health



HOW MIGHT WE STILL BE CRIMINALIZING DRUG MISUSE?

- Syringe Services Program (SSP)
 - Seven states (Arizona, Georgia, Illinois, North Carolina, Tennessee, Utah, and Virginia) allow participants to receive an unlimited number of hypodermic needles and syringes
 - Ten states (California, Colorado, Georgia, Maine, North Carolina, Ohio, Rhode Island, Tennessee, Utah, and Virginia) specifically require that SSPs consult with law enforcement
- Good Samaritan Laws
 - An eligible person may not be arrested, charged, or prosecuted for a “drug violation,” which is defined to include the possession and use of drug-related objects
 - Evidence for the arrest, charge, or prosecution of such drug violation must have resulted solely from the seeking of medical assistance.

EXAMPLE

- In a local park in Atlanta, Georgia, friends, including Alex and Jordan, are enjoying a sunny afternoon. As the day goes on, they draw the attention of other park-goers due to their rowdy, obnoxious behavior. At one point, Alex suddenly starts to feel unwell after taking a combination of alcohol and some prescription pills and collapses on the grass, unresponsive and showing signs of an overdose.
- Panicking, Jordan realizes he needs to act quickly. He calls 911 to report that Alex is in serious distress and needs immediate medical help. While waiting for the paramedics to arrive, Jordan tries to administer naloxone, hoping to revive Alex.
- When the police and paramedics arrive, they find Jordan by Alex's side, desperately trying to assist him. However, they also notice the chaotic scene, including the loud noise from the group and several empty alcohol containers scattered around.
- The officers assess Alex's condition and prioritize getting him medical attention but decide to place Jordan under arrest. Jordan argues his behavior falls within the protections of the Good Samaritan Law, and his arrest was therefore unlawful. Does he win?

EXAMPLE

- In a community center in Georgia, a syringe services program (SSP) is operating to provide clean syringes and harm reduction resources to individuals who use drugs. Alex, a regular participant, attends the SSP and receives a supply of clean syringes and information about safe injection practices.
- After leaving the SSP, Alex decides to host a small gathering at a nearby park with friends who also use drugs. During the meeting, Alex brings out the syringes obtained from the SSP and offers them to everyone present, encouraging them to use them instead of sharing used ones.
- However, during this gathering, an undercover police officer is present in the park as part of a routine patrol focused on drug activity. The officer observes Alex openly distributing the syringes to multiple individuals, offering them without any health or safety guidance.
- After witnessing this activity, the officer approaches Alex and informs them that distributing syringes, even to promote safer practices, constitutes illegal distribution of drug paraphernalia under Georgia law. Alex is arrested for the illegal distribution of syringes. Alex argues that syringes do not constitute drug paraphernalia under Georgia law, and his arrest was, therefore, unlawful. Does Alex win?

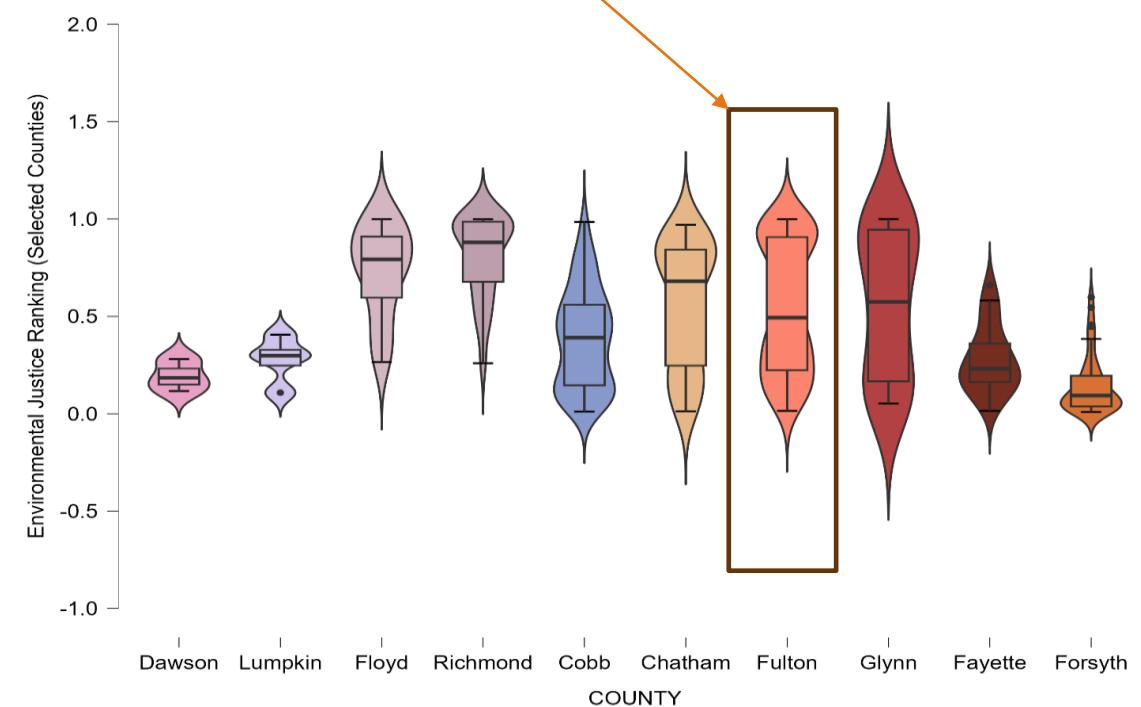
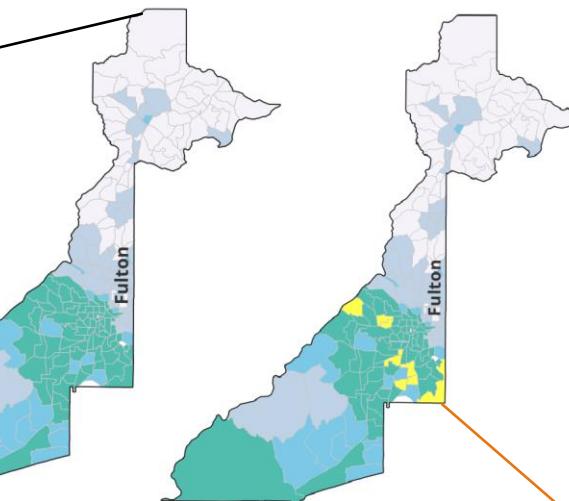
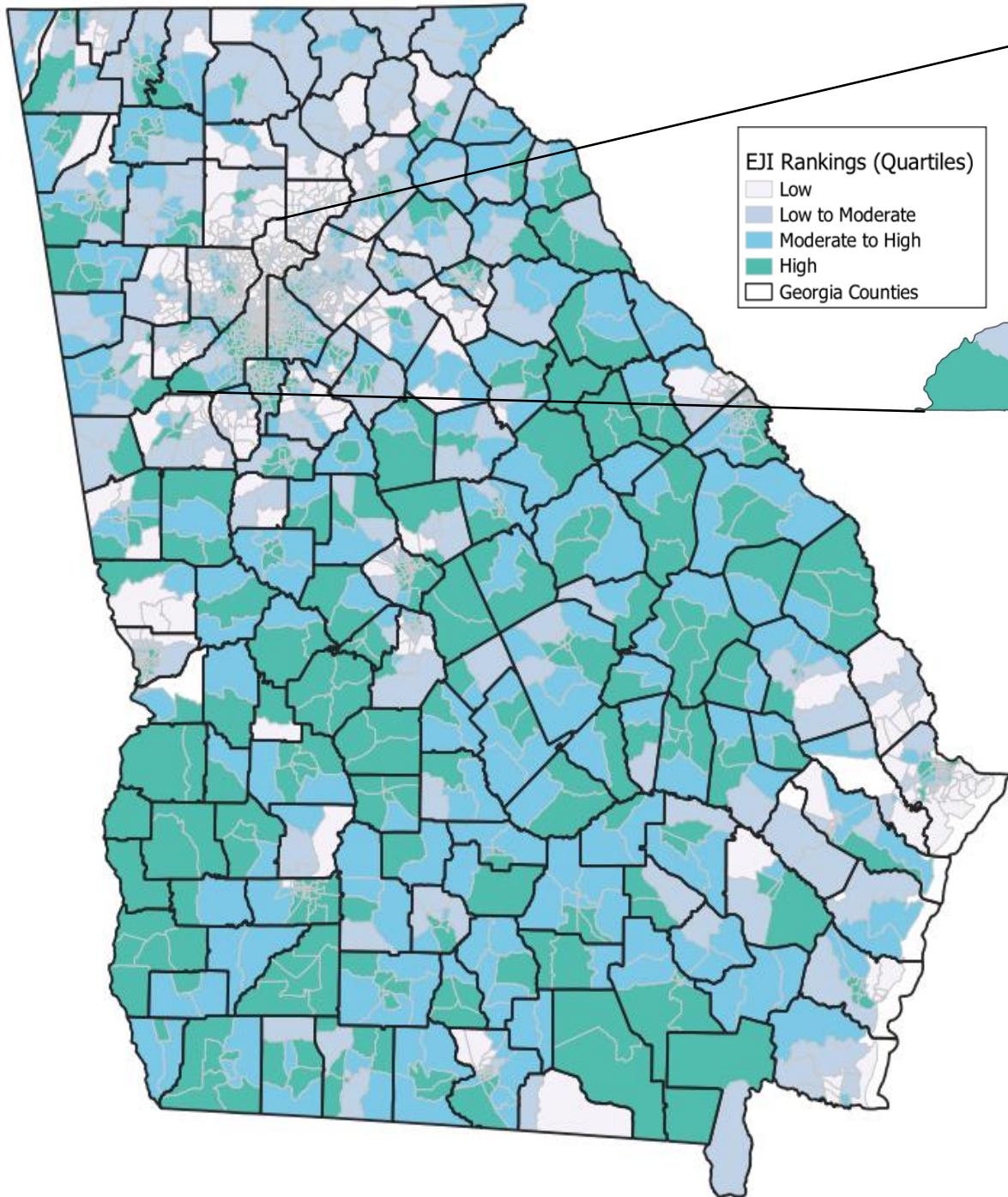
INTEGRATING PREVENTIVE
INTERVENTIONS INTO LOCAL
COMMUNITY CONTEXTS



LINKING THE REGULATORY FRAMEWORK TO COMMUNITIES

ENVIRONMENTAL JUSTICE RANK	Social Vulnerability	Member of a historically minoritized group	LGBTQ+ Race/ethnicity Disability Age		<h2>Chronic Disease Burden</h2> <p>Asthma Cancer High Blood Pressure Diabetes Mental Health Victimization</p>
		Socioeconomic status	Poverty Food Education Unemployment Housing tenure Housing Burden among low-income HHs Debt/Expenses		
		HH Characteristics	Age Children Disability Linguistic ability		
		Housing Type	Group Quarters Mobile Homes		
		Social context	Social Integration Social Support systems Community engagement Racism & discrimination Stress		
	Environmental Burden	Pollution	Impaired surface water Ozone PM2.5 Air toxins		<p>Provider Linguistic and Cultural Competency Coverage Quality of care Health insurance</p>
		Potentially Hazardous & Toxic Exposure	National priority list sites Toxic release Inventory sites Treatment, storage, and disposal sites Risk management plan sites		
		Built Environment	Presence, proximity and quality of recreational Housing stock Walkability, Bike-ability Intersection density		
		Transportation Infrastructure	Roads, Railways, Airports Transportation costs as a % of income Vehicle miles traveled Vehicle access Road safety vehicle		
		Disaster Risk	Wildfires Hurricanes Floods		
	Health Vulnerability	Chronic Disease Burden	Asthma Cancer High Blood Pressure Diabetes Mental Health Victimization		<h2>Health systems</h2> <p>Provider Linguistic and Cultural Competency Coverage Quality of care Health insurance</p>
		Health systems	Provider Linguistic and Cultural Competency Coverage Quality of care Health insurance		

Health Vulnerability



	Georgia	US
Social and Emotional Well-being		
Feeling socially isolated among adults	34.4	33.6
Food insecurity in the past 12 months among adults	18.3	15.9
Housing insecurity in the past 12 months among adults	15.6	13.5
Lack of reliable transportation in the past 12 months among adults	10.7	9.4
Lack of social and emotional support among adults	30.3	25.4
Received food stamps in the past 12 months among adults	16.5	14.4
Utility services shut-off threat in the past 12 months among adults	10.2	9.1
Prevention		
Annual Checkup	76.3	75.2
Cholesterol Screening	86.3	82.4
Colorectal Cancer Screening	64.5	60.7
Dental Visit	58.2	57.8
Lacks Health Insurance	15.1	10.3
High Blood Pressure Medication (among those with high BP)	77.3	69.9
Mammography	75.4	73.7

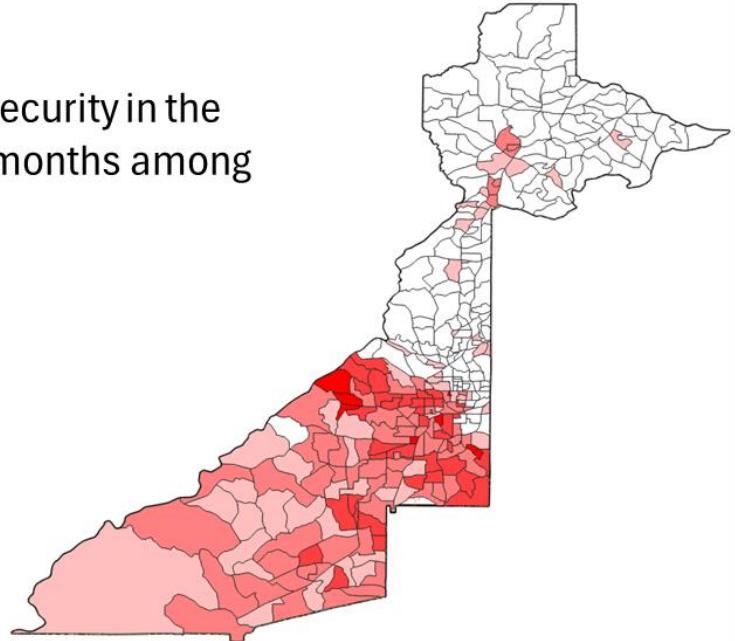
Source: Centers for Disease Control (CDC). (2024). Local Data for Better Health (Census Tracts; County) [PLACES]. <https://data.cdc.gov>

	Georgia	US
Health Risks		
Binge drinking among adults	15.1	17.7
Current cigarette smoking among adults	15.4	17.6
No leisure-time physical activity among adults	26.4	27.0
Short sleep duration among adults	38.8	36.7
Health Outcomes		
All teeth lost among adults aged >=65 years	15.7	16.0
Arthritis among adults	27.2	28.7
Cancer (non-skin) or melanoma among adults	7.3	8.1
Chronic obstructive pulmonary disease among adults	7.7	8.3
Coronary heart disease among adults	6.6	7.4
Current asthma among adults	10.6	10.8
Depression among adults	20.8	23.7

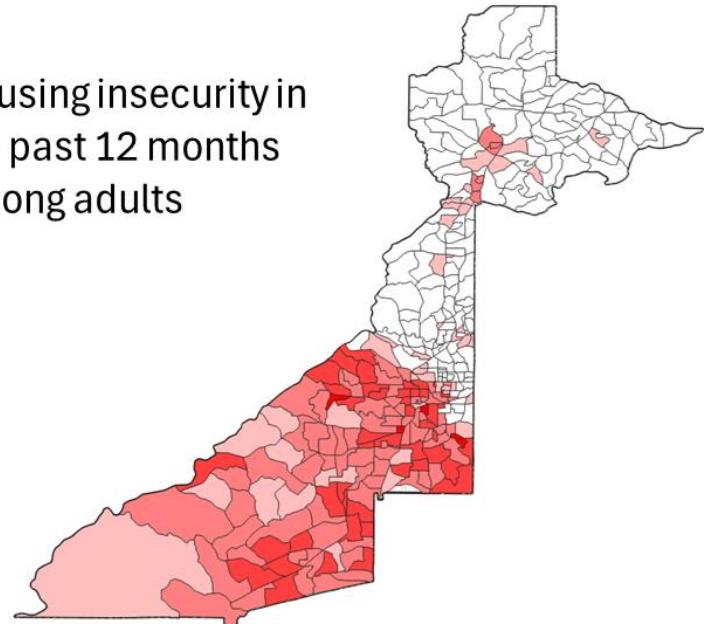
	Georgia	US
Disability		
Any disability among adults	31.4	33.7
Cognitive disability among adults	14.8	16.0
Hearing disability among adults	6.5	8.1
Independent living disability among adults	9.0	9.1
Mobility disability among adults	14.7	15.3
Self-care disability among adults	4.6	4.3
Vision disability among adults	6.5	6.0
Health Status		
Fair or poor self-rated health status among adults	20.2	20.3
Frequent mental distress among adults	17.2	18.0
Frequent physical distress among adults	13.8	14.2

Summary: Health-related vulnerabilities are concentrated in the middle and southern portion of the county.

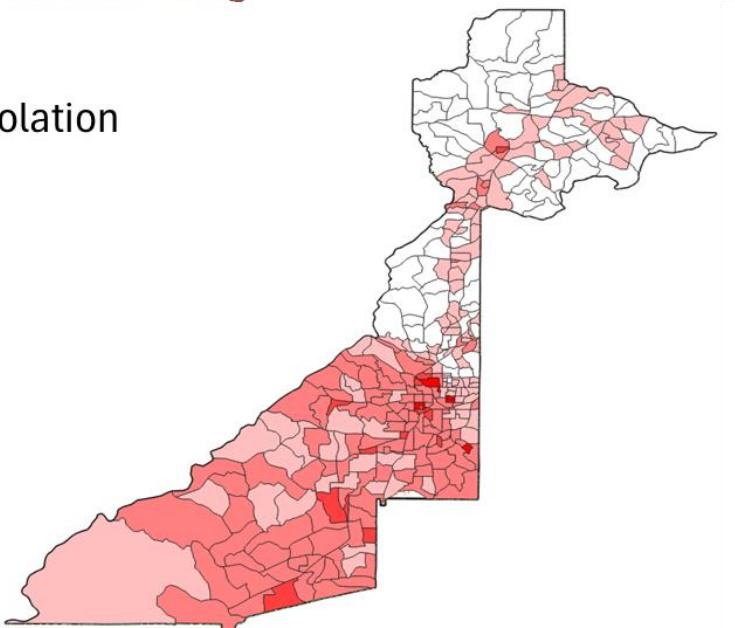
Food insecurity in the past 12 months among adults



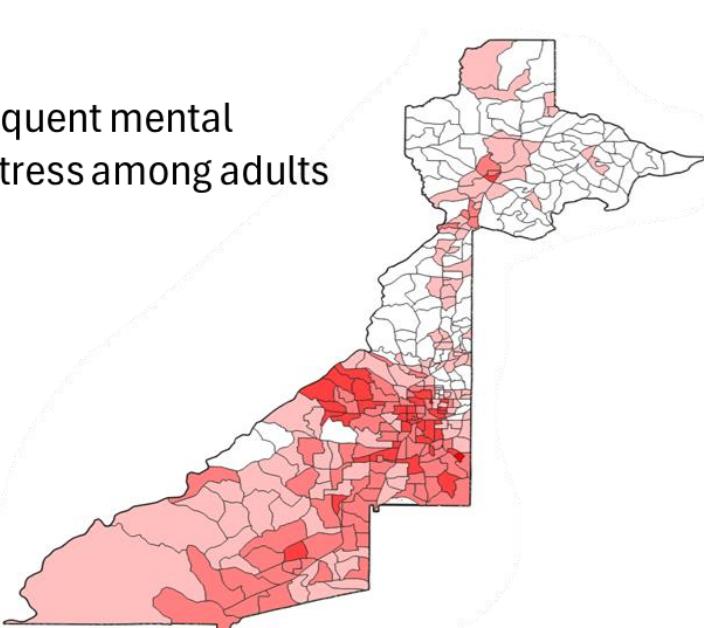
Housing insecurity in the past 12 months among adults



Social Isolation



Frequent mental distress among adults





Key Takeaways:

Georgia fares similarly to the nation on key indicators of prevention, health behaviors, health outcomes, social and emotional well-being, and disability, except for social and emotional support and lacking health insurance which is higher than the national average

Again, the importance of geographic context is evident as these indicators vary significantly across counties

Again, the data suggests the need to move beyond social status to consider multiple, overlapping measures of vulnerability that consider the intersection of the social (e.g., support) and built environment (e.g., open space)

HEALTH SYSTEMS, CHRONIC
DISEASE, AND THE OPIOID
EPIDEMIC

HEALTH VULNERABILITY

Mental Health

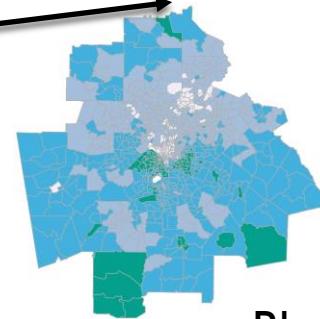
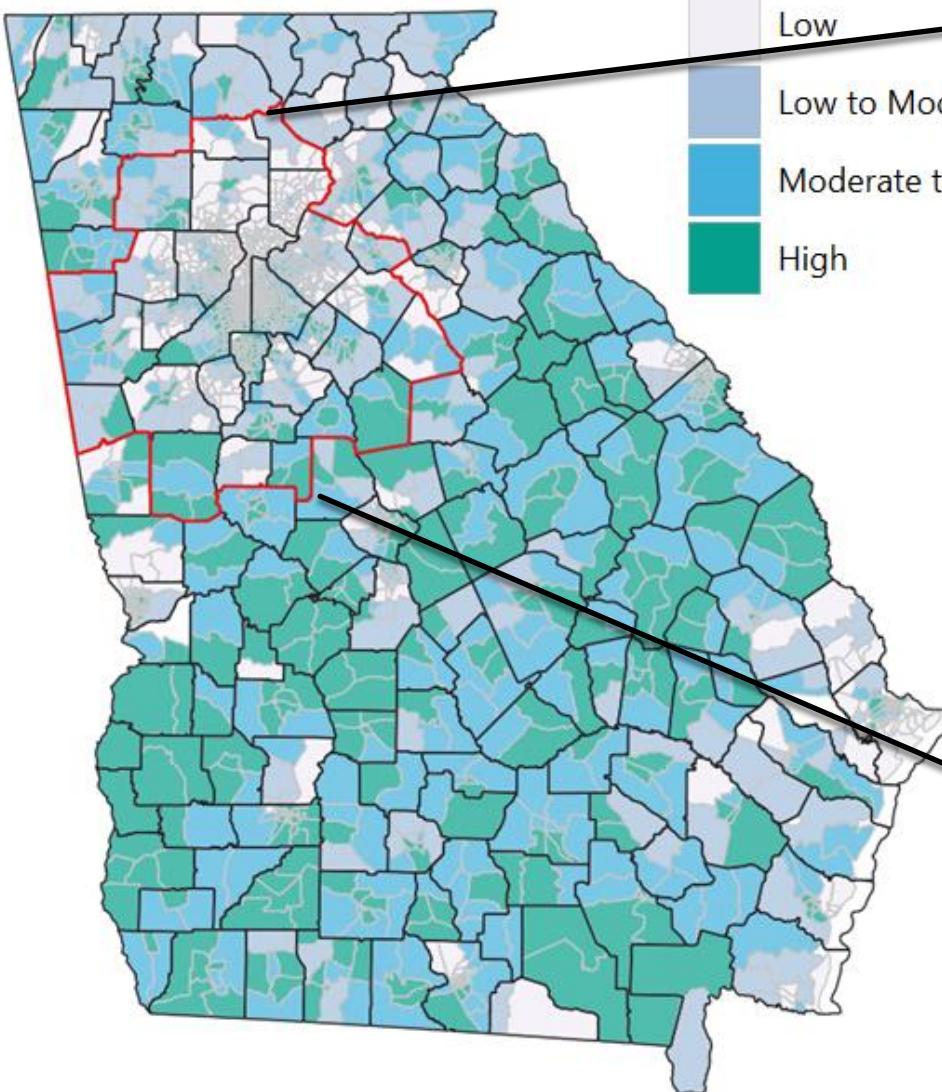
EJI Rankings (Quartiles)

Low

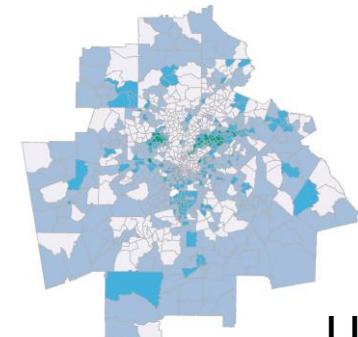
Low to Moderate

Moderate to High

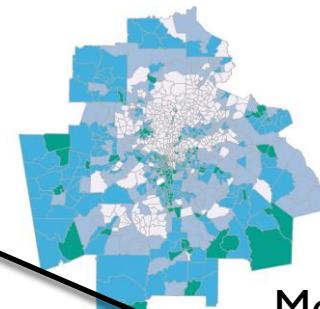
High



Blood Pressure



Uninsured



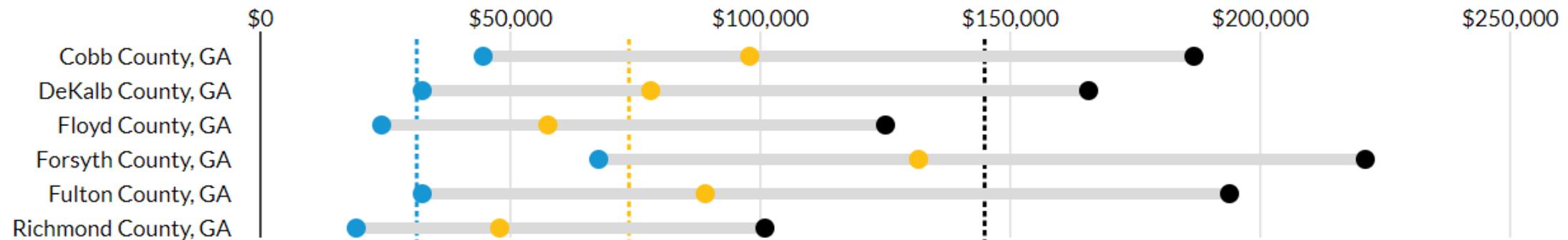
Mental Health

THE HOUSING CRISIS,
WEALTH INEQUALITY, AND THE
OPIOID EPIDEMIC

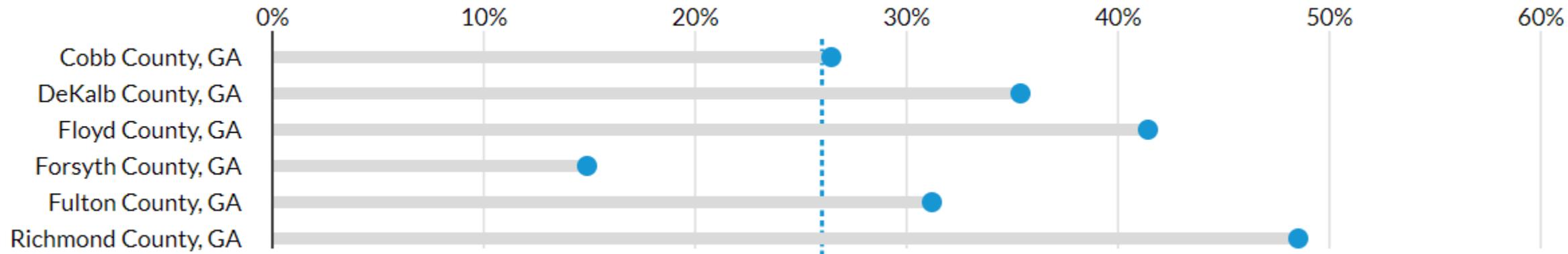


SOCIAL VULNERABILITY

● 20th percentile ● 50th percentile ● 80th percentile ... National median



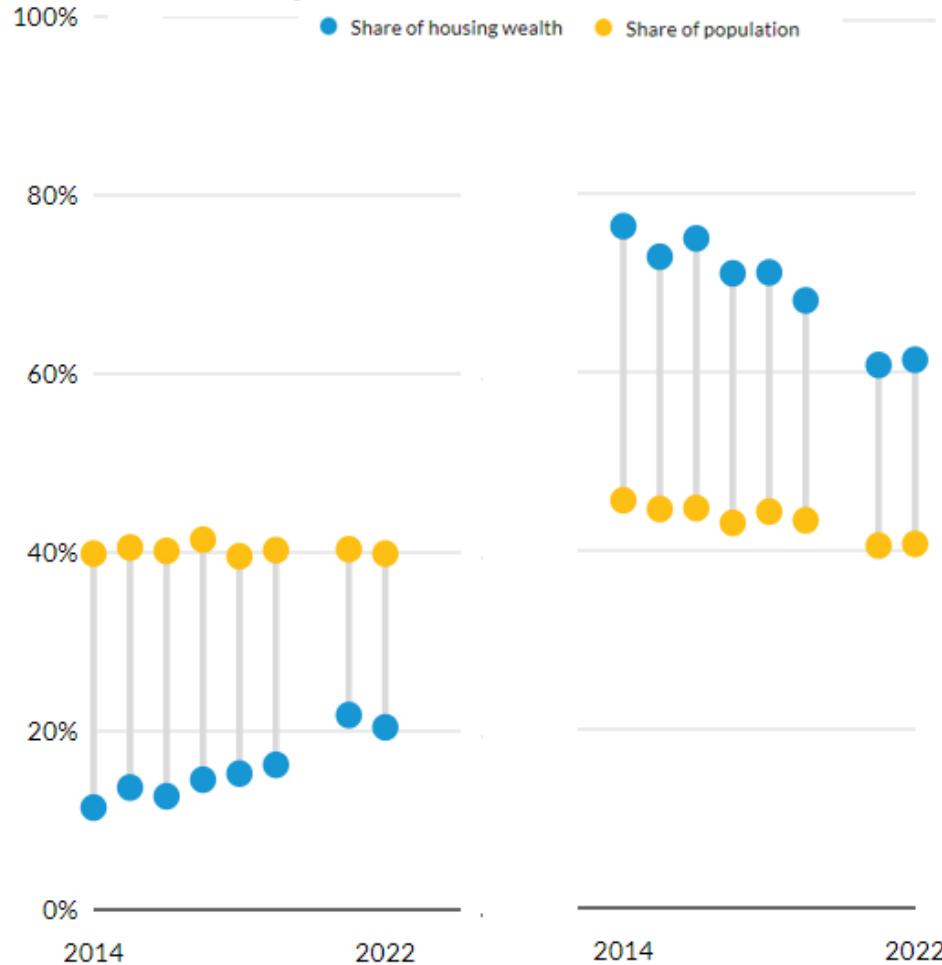
Household income at 20th, 50th, and 80th percentiles



Share of adults with debt in collections

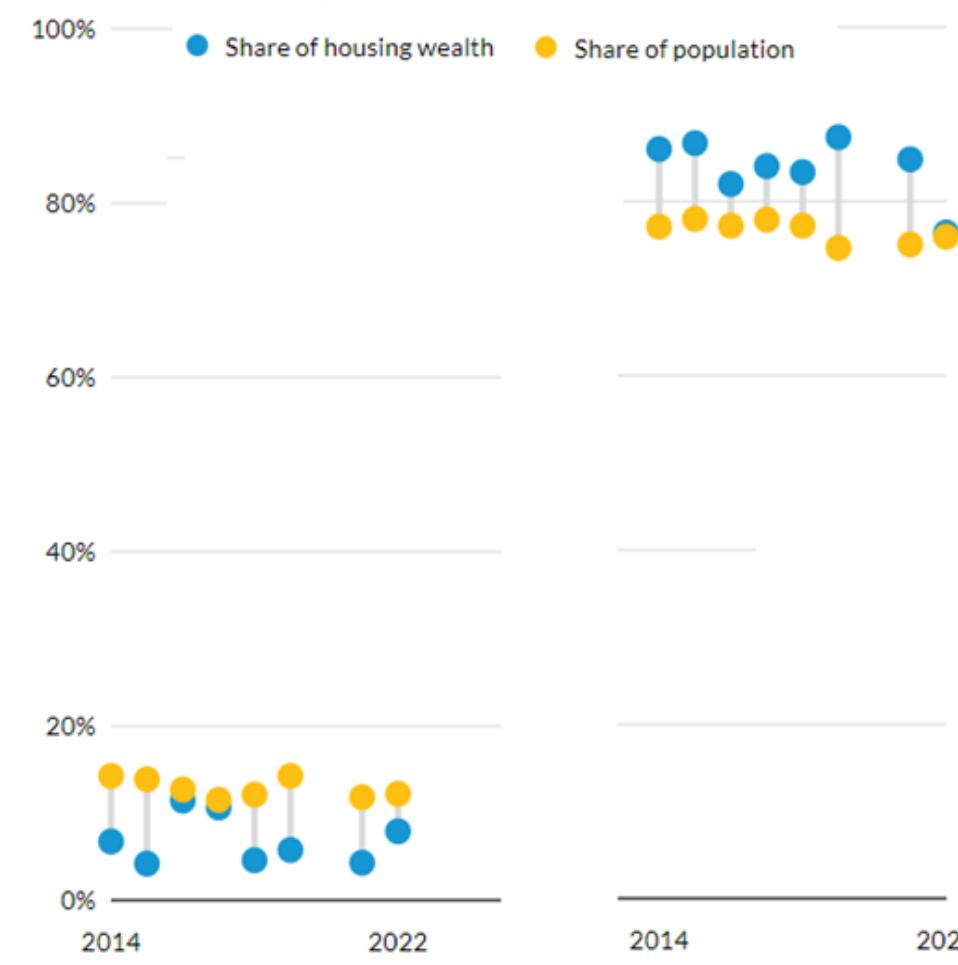
Fulton County

Non-Hispanic Black Non-Hispanic White

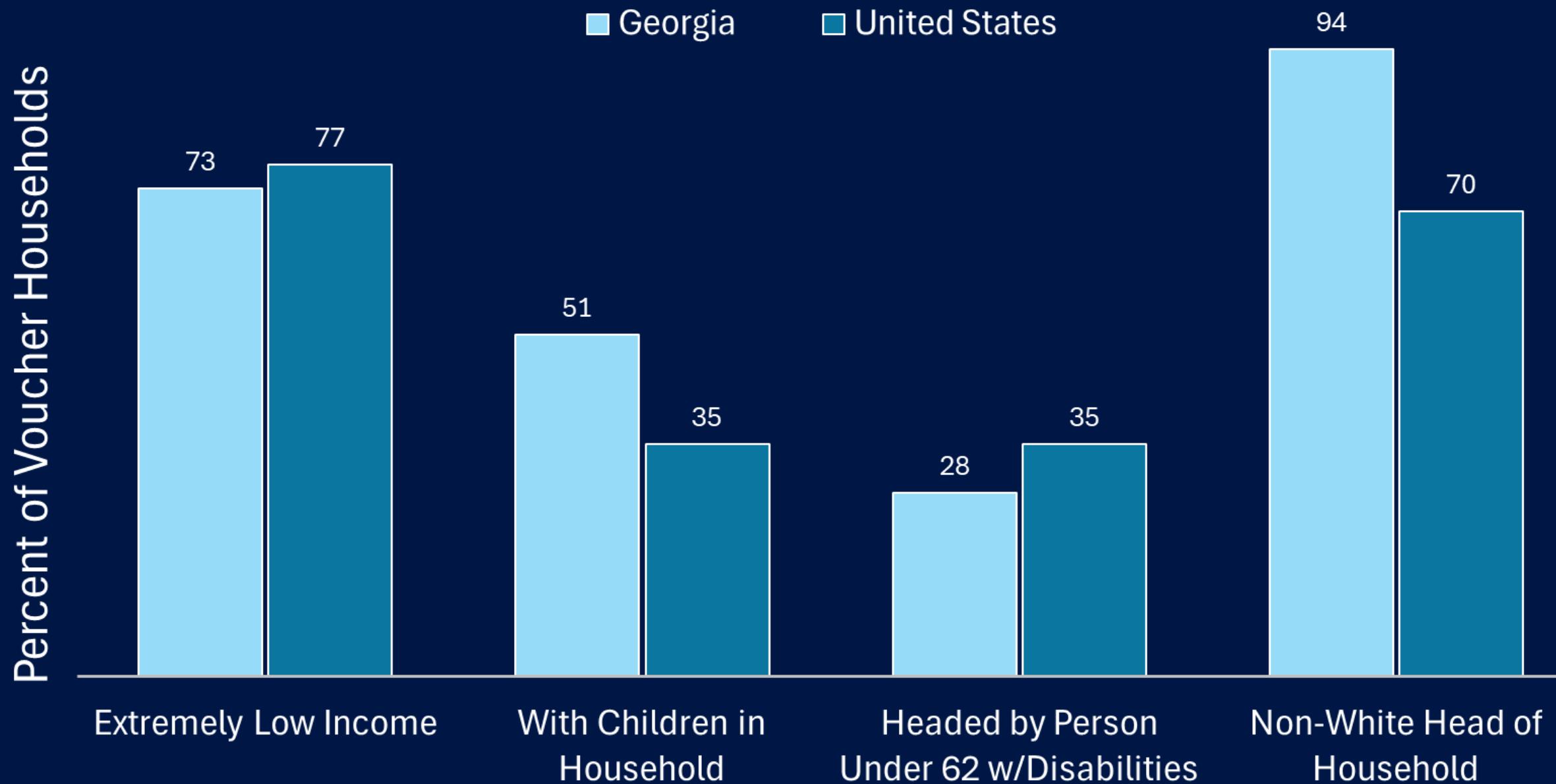


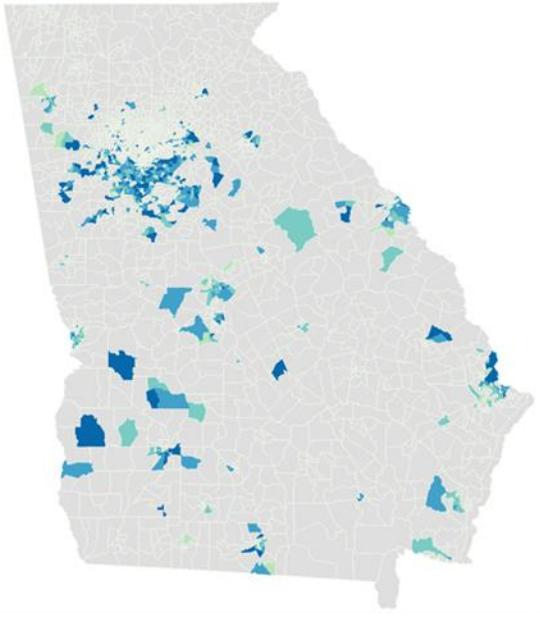
Floyd County

Non-Hispanic Black Non-Hispanic White

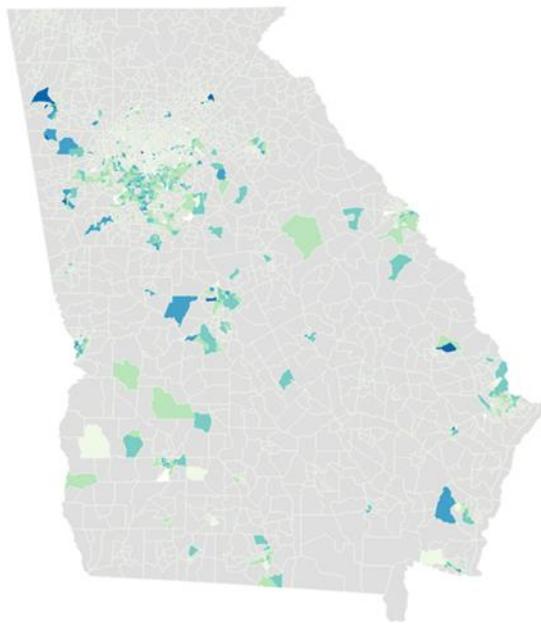


Householder Characteristics

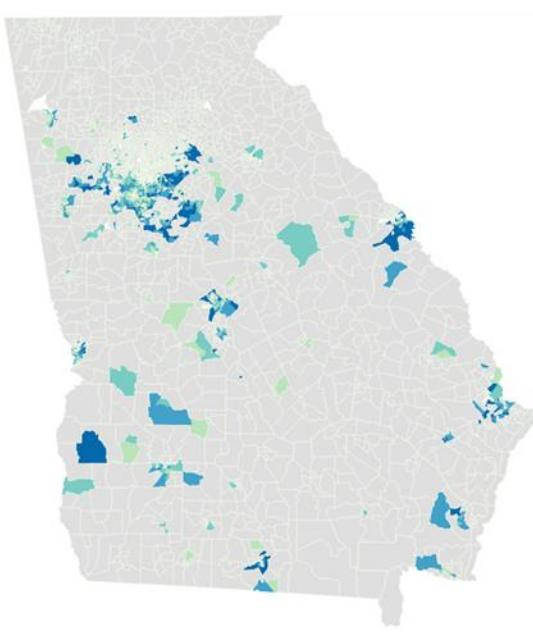




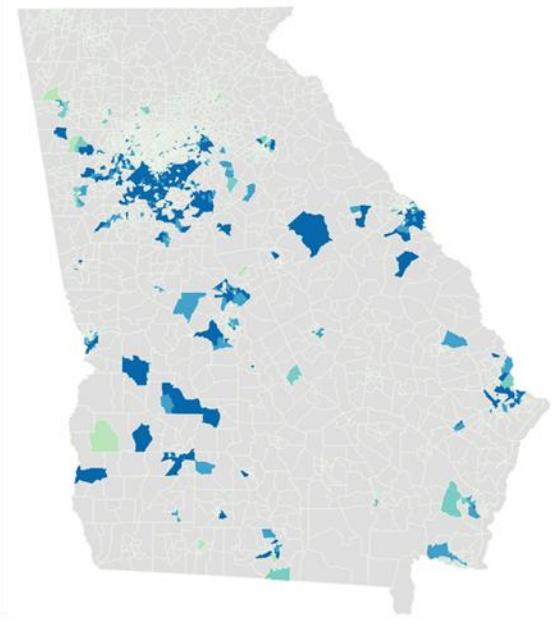
Extremely Low
Income



Headed by a person
under 62 w/disabilities

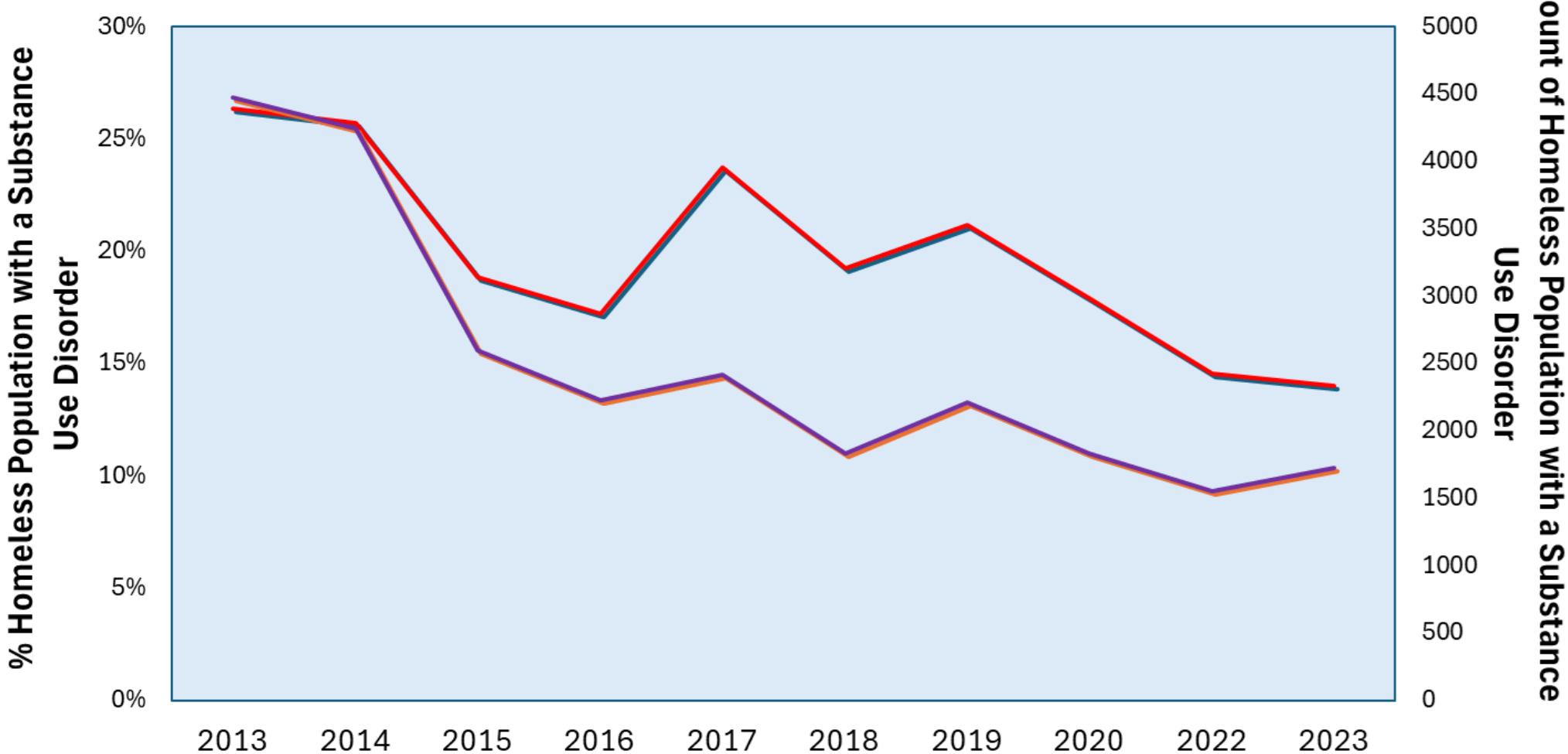


Female-Headed
HH with Children



Headed by a non-
White Head of
Household

CONTINUUM OF CARE (COC) POPULATION OF CHRONIC SUD AMONG PERSONS EXPERIENCING HOMELESSNESS IN GEORGIA



Source: U.S. Department of Housing and Urban Development. (2013-2023). 2013-2023 Continuum of Care

Historic redlining score and social vulnerability measures.

	Mainly A (N=9)	Mainly B (N=22)	Mainly C (N=59)	Mainly D (N=46)	Total (N=136)	p-value
SES Vulnerability	0.20	0.20	0.40	0.60	0.40	< 0.001 ¹
Household Vulnerability	0.20	0.10	0.20	0.30	0.20	0.102
Racial/Ethnic Vulnerability	0.20	0.30	0.50	0.70	0.50	< 0.001 ¹



Key Takeaways

Studies have shown that individuals with stable housing have better health outcomes, including lower rates of emergency room visits and hospitalizations.

Housing vouchers help secure a **safe and stable** living environment, a root cause of addiction, which **supports recovery** efforts and reduces the likelihood of relapse or overdose while addressing structural vulnerability.

Targeting supportive services, such as counseling, medical care, and addiction treatment programs, to residents with housing vouchers ensures that vulnerable populations, including those affected by opioid use disorder, have localized access to essential resources that address health, stability, and recovery needs within their communities

GREEN SPACE, PARKS, TREE
EQUITY, AND THE OPIOID
EPIDEMIC



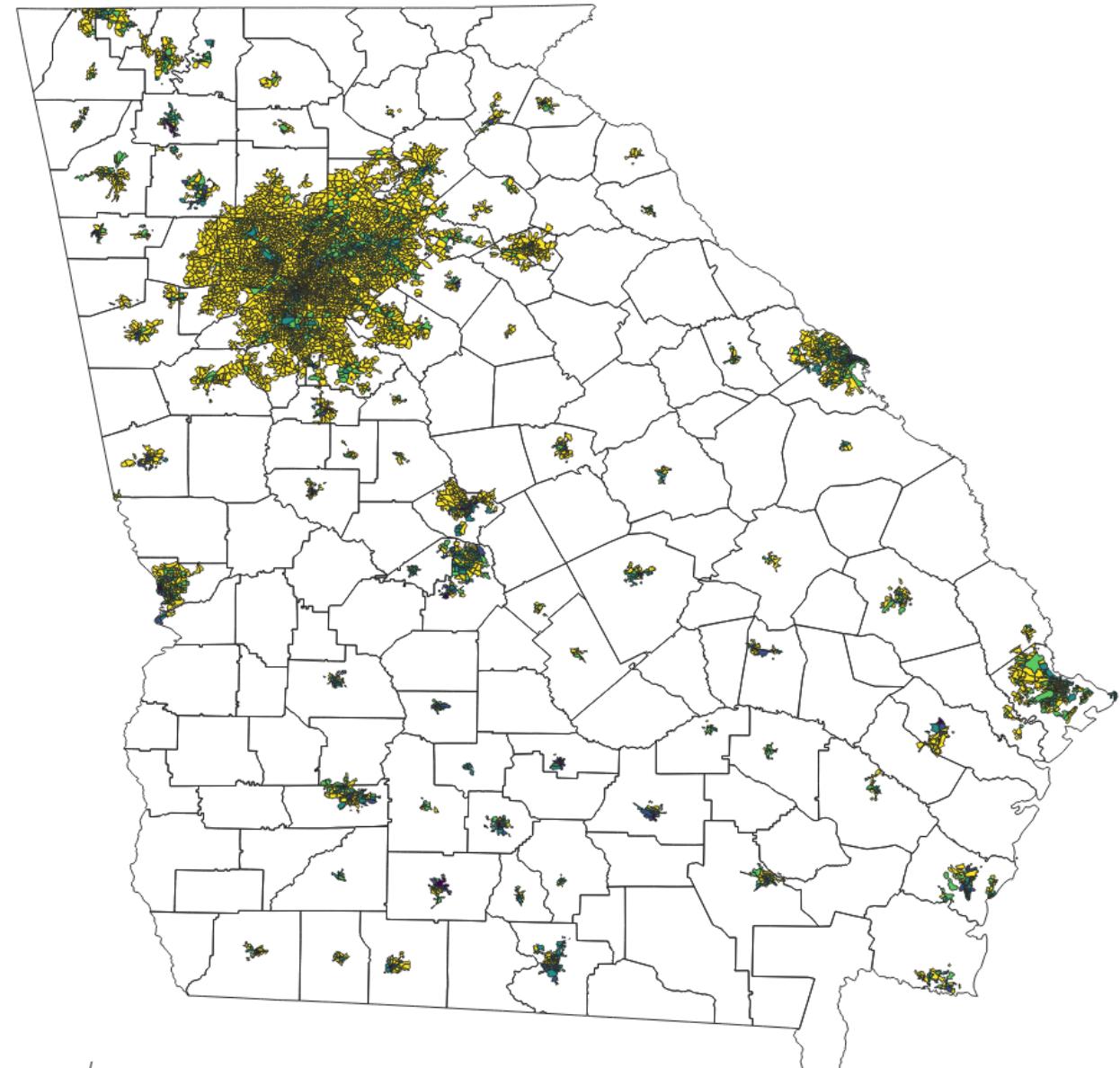
ENVIRONMENTAL BURDEN

THE PHYSICAL ENVIRONMENT

“Identifying the social-spatial (network) structures of community ties is critical to enhance our understanding of the spatial context of social relationships, and further distill risk heterogeneity in vulnerable populations within an equitable health framework.” Kolak (2021)

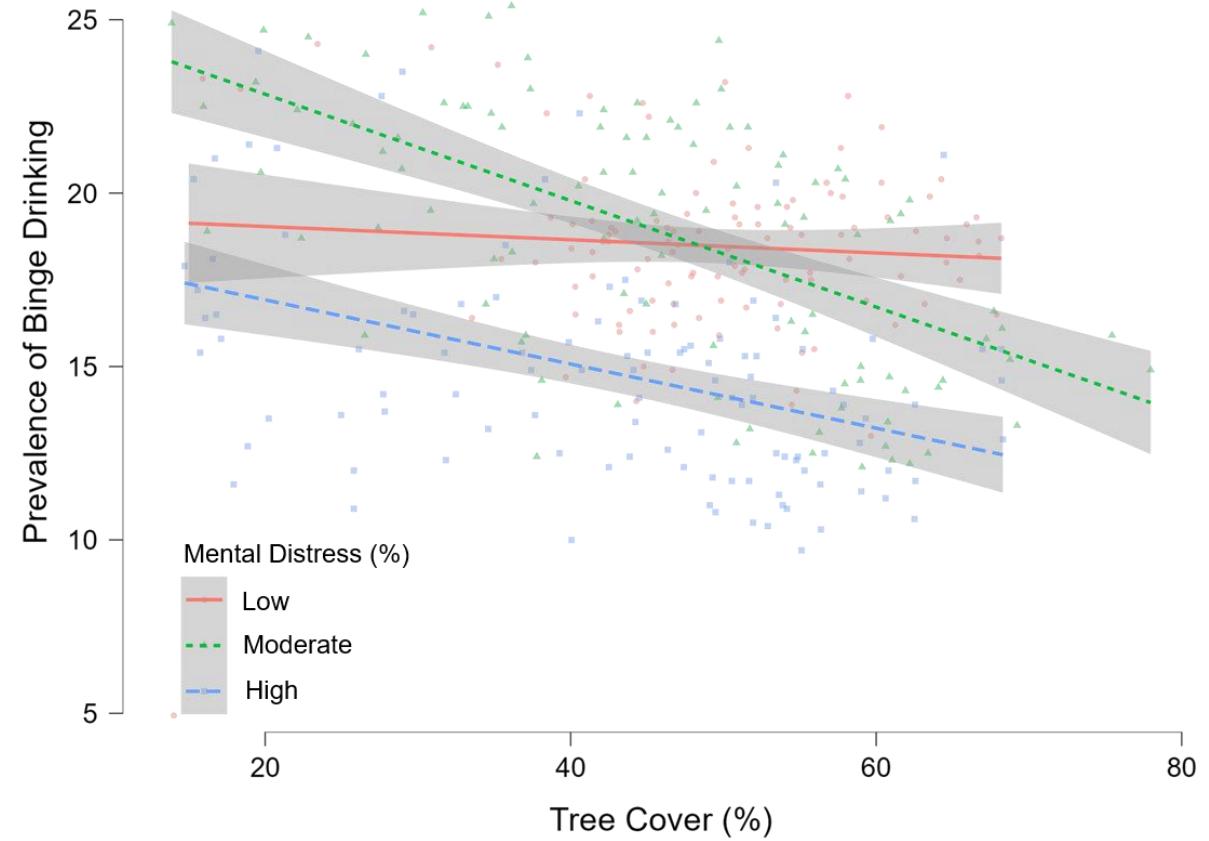
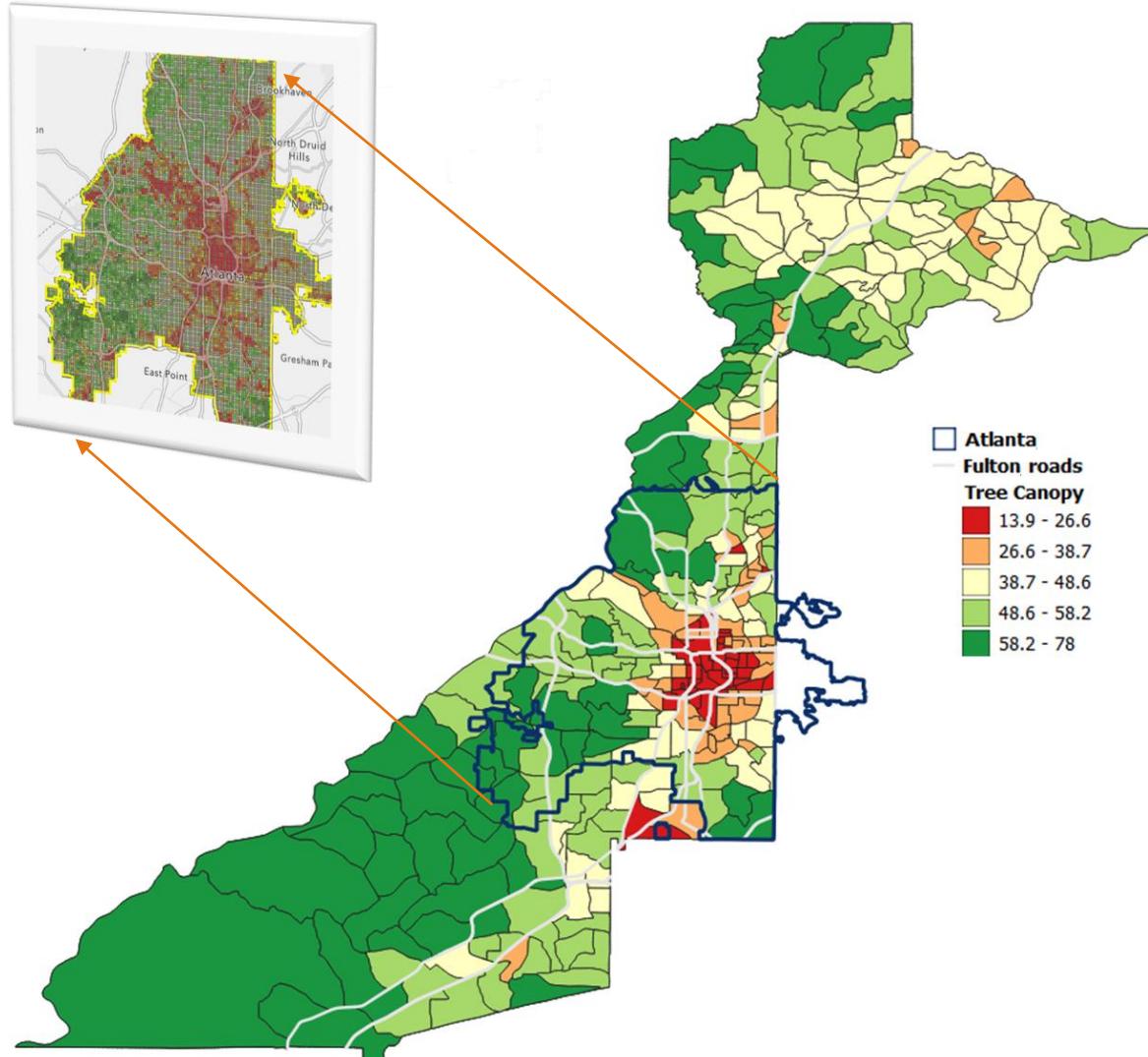
- **Built Environment:** Often overlooked but crucial for understanding social interactions and the opioid epidemic. Social interactions happen in space.
 - Determine where people live (e.g., zoning)
 - Can shape the spread and impact of poor health behaviors, or facilitate good behaviors, by structuring social interactions
 - Can determine how accessible neighborhood amenities are, such as healthcare, treatment providers, jobs, and parks (e.g., roads)
 - May be health promoting: the presence of trees (tree canopy) makes neighborhoods and urban areas more livable by providing aesthetic, social, and psychological benefits for residents

Summary: Urban tree canopy coverage and the equitable distribution of trees varies significantly across Georgia.

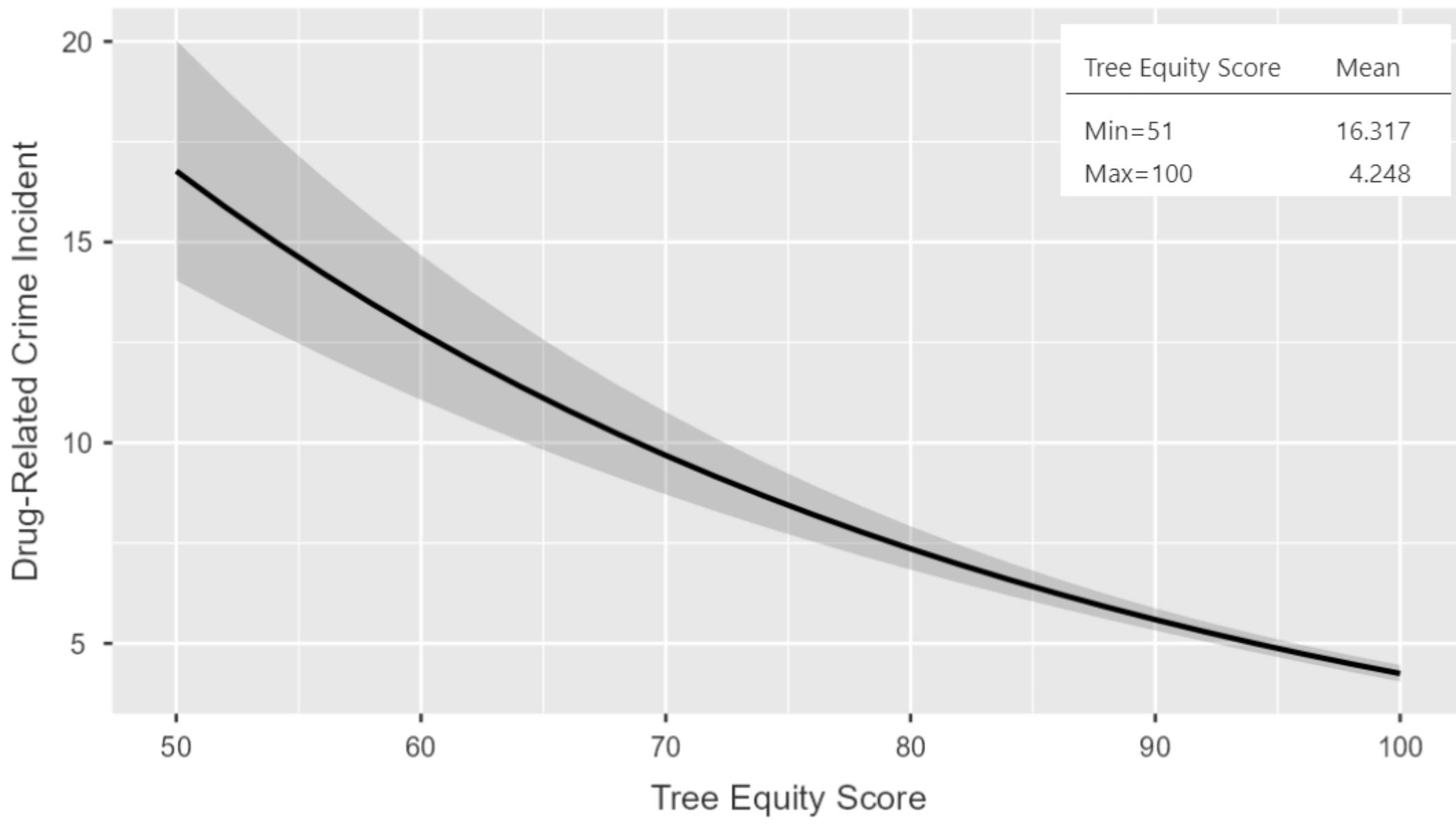


Source: American Forests. Tree Equity Score. (2024). <https://www.treeequityscore.org/>

Summary: Tree canopy cover is low in certain parts of the county, especially in Downtown Atlanta, which also faces significant health-related challenges. Increasing tree cover can help address health-related challenges. Here, we see that tree cover is associated with reduced binge drinking behavior. However, communities experiencing higher levels of mental distress benefit more from increased tree cover.

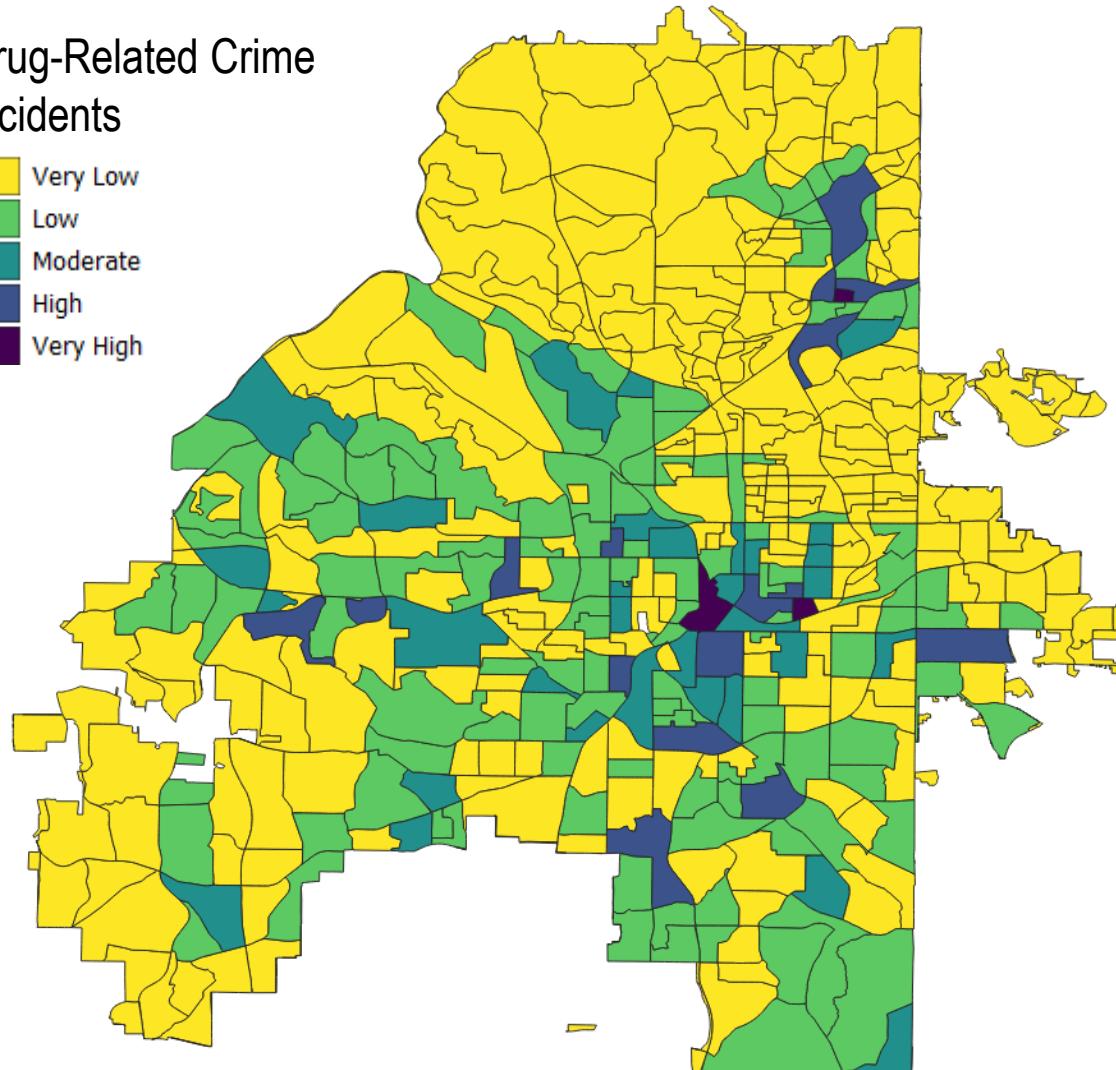


Source: Multi-Resolution Land Characteristics Consortium (MRLC). 2023. Tree Canopy Cover. <https://www.mrlc.gov/data>



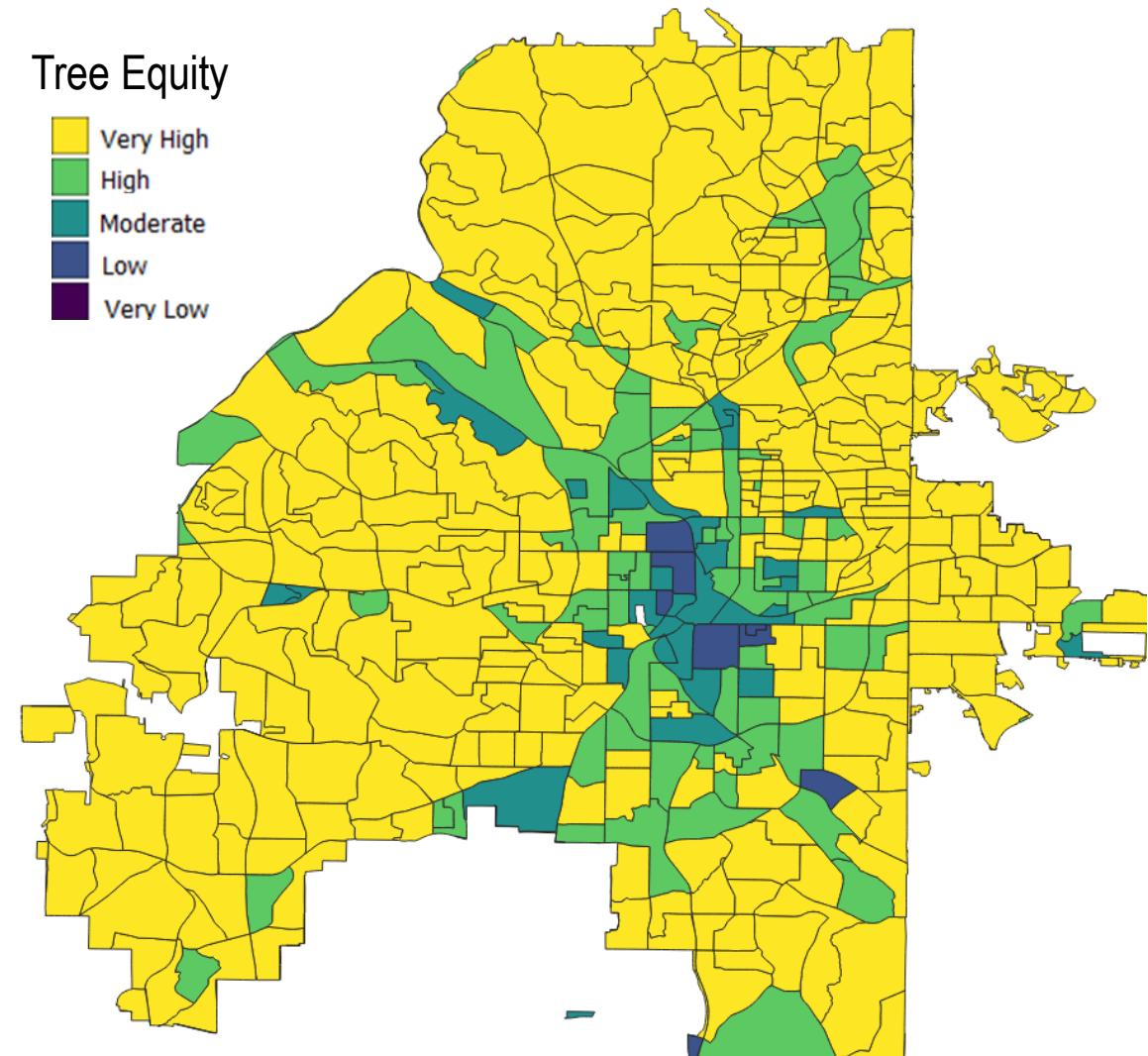
Drug-Related Crime Incidents

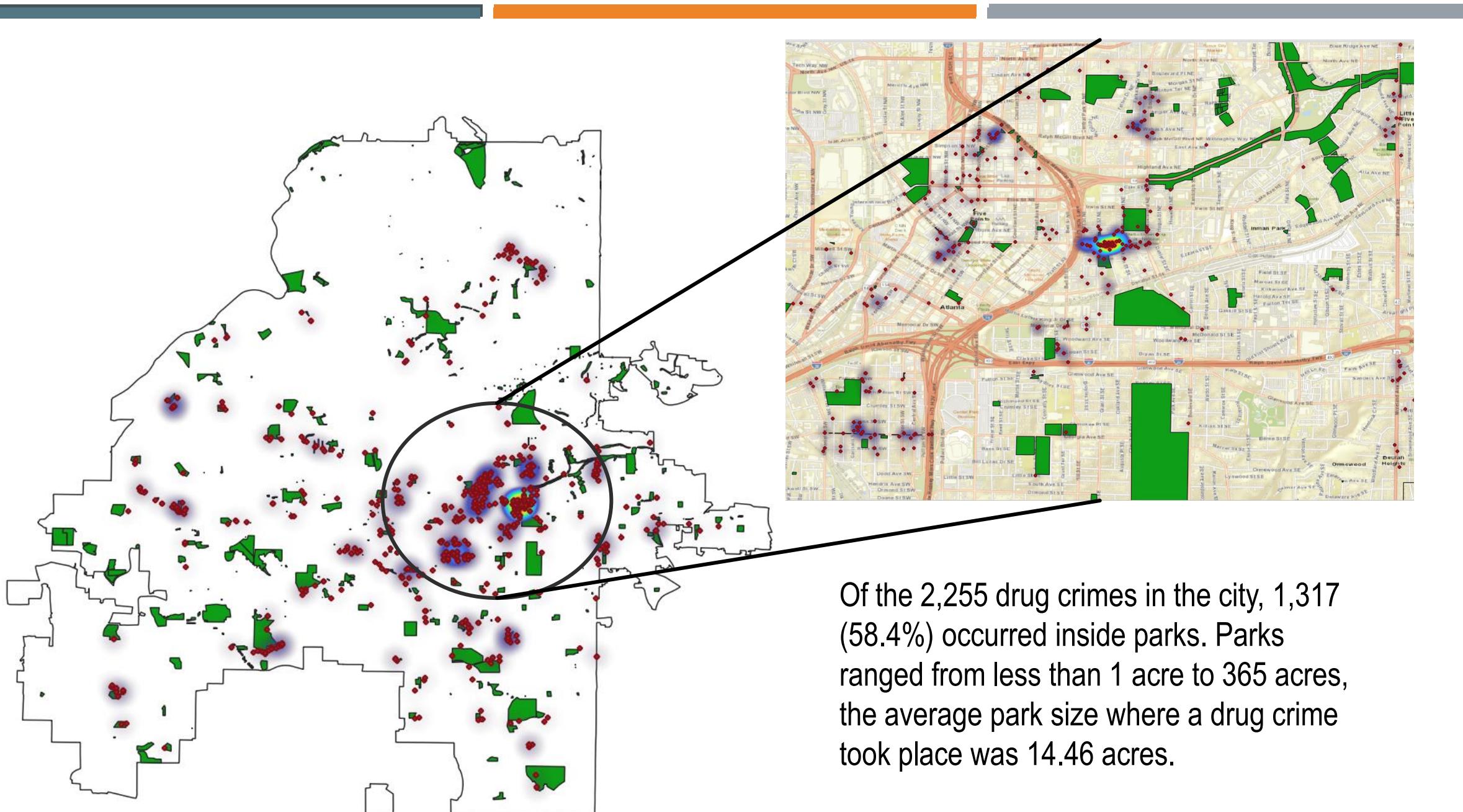
- Very Low
- Low
- Moderate
- High
- Very High



Tree Equity

- Very High
- High
- Moderate
- Low
- Very Low







Key Takeaways

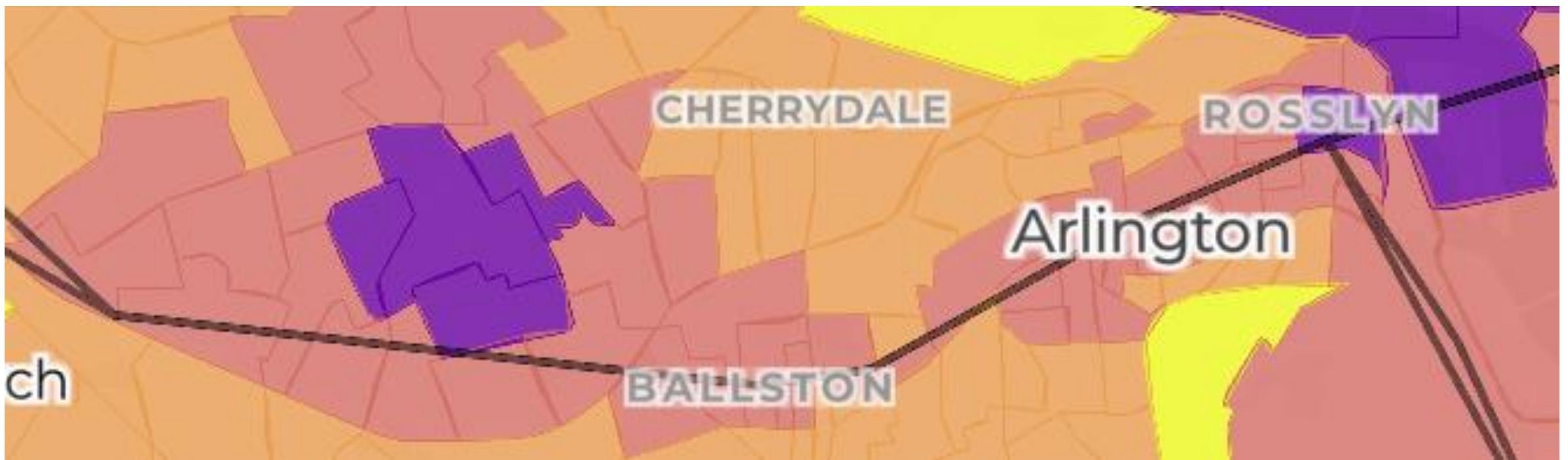
Urban tree canopy coverage varies widely and is influenced by zoning and land use, with residential areas having the most coverage and downtown areas the least.

Increasing tree cover and the equitable distribution of trees, particularly in areas like Downtown Atlanta with significant health challenges, can reduce substance misuse and provide greater benefits to communities with higher levels of mental distress.



GEOGRAPHIC ACCESSIBILITY AND INEQUITY

HOW REACHABLE ARE TREATMENT PROVIDERS IN GEORGIA?





WHAT IS GEOGRAPHIC ACCESSIBILITY AND WHY DOES IT MATTER?

- Geographic accessibility refers to the ease with which people can reach desired services and destinations from a given location. It is a crucial concept in transport geography and urban planning, as it directly impacts people's ability to access essential services like opioid treatment
- The area reachable within 30 minutes of driving from an opioid or buprenorphine provider- or "catchment area" - plays a vital role in accessibility, patient retention, health outcomes, and equitable healthcare delivery
- Studies show that proximity to care strongly influences whether patients remain in treatment programs, as longer travel distances can become a barrier, especially for patients with limited transportation options.
- By mapping these catchment areas, policymakers and public health officials can spot disparities and advocate for new facilities or mobile treatment units in places where people are outside this accessible radius.

“Most Georgians can travel fewer than 20 miles to reach ... a narcotic treatment program (NTP)”

How long would it take to travel 20 miles?

One approved purpose of allocating settlement funds is conducting a “Geospatial analysis of access barriers to MAT and their association with treatment engagement and outcomes.”

Any provider with a standard DEA registration can prescribe BP without additional waivers or caps

How accessible are NTPs in Georgia?



Georgia Department of Audits and Accounts Performance Audit Division

Greg S. Griffin, State Auditor

Leslie McGuire, Director

Why we did this review

The opioid epidemic has generated significant national attention in recent years due to the increasing number of opioid-related overdoses and deaths. While prevention efforts are also needed, we reviewed the state's efforts to ensure that the estimated 180,000 Georgians with an opioid use disorder have access to the recommended treatment when it is needed.

Nearly 1,000 Georgians died from opioid-related overdoses in 2016, an increase of 55% from 633 in 2012. The statewide age-adjusted death rate increased from 6.3 to 9.4 deaths per 100,000 residents.

Opioid Use Disorder – Access to Medication-Assisted Treatment

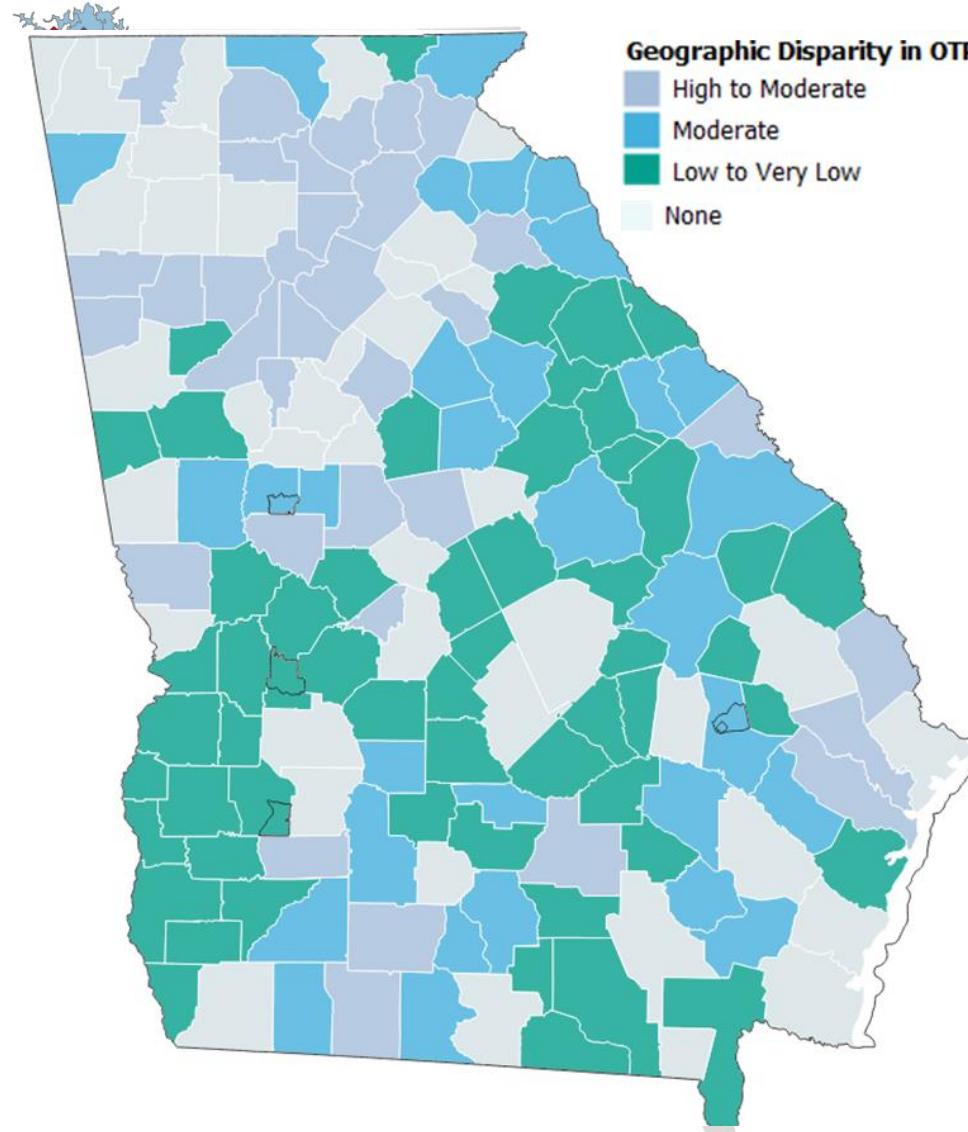
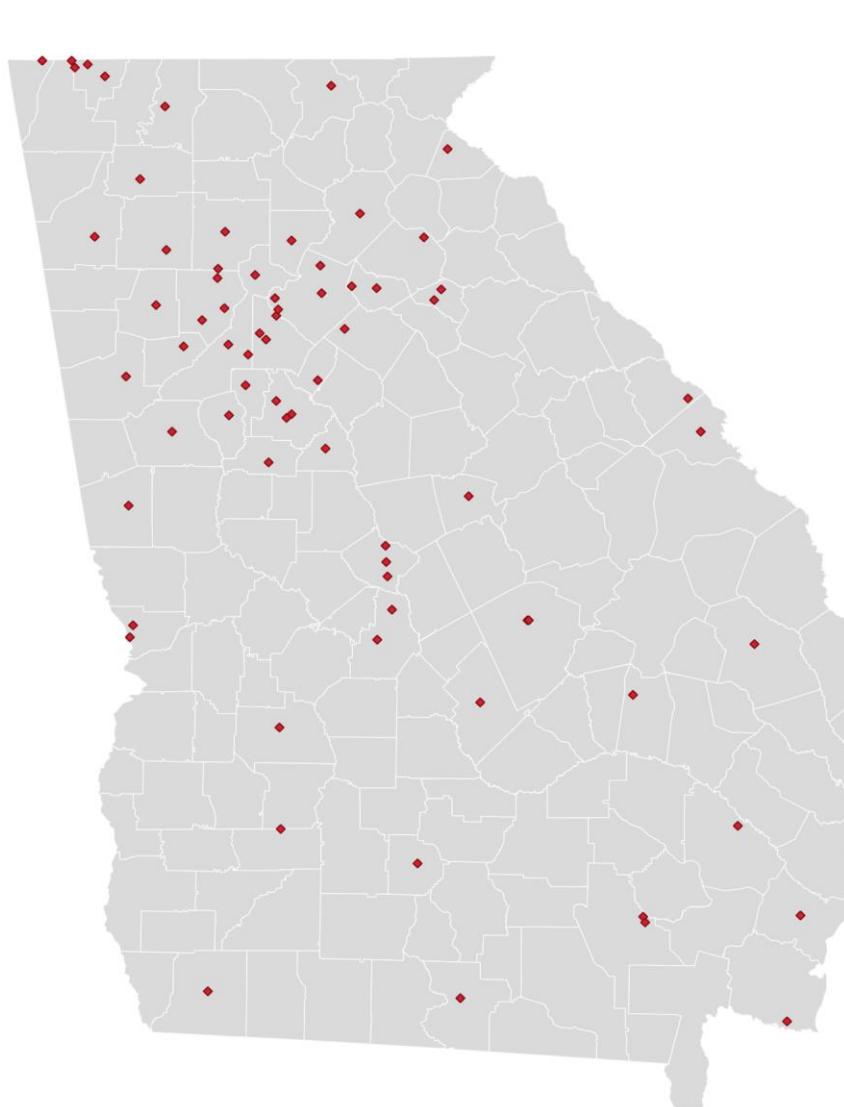
State plan needed to mitigate barriers

What we found

Georgia has not developed a comprehensive strategy to address all aspects of the opioid epidemic. While recent legislation addressed the availability of opioids, access to the overdose-reversing drug naloxone, and the regulation of narcotic treatment programs, the state's efforts to expand the availability of medication-assisted treatment (MAT) for those with opioid use disorder have been limited.

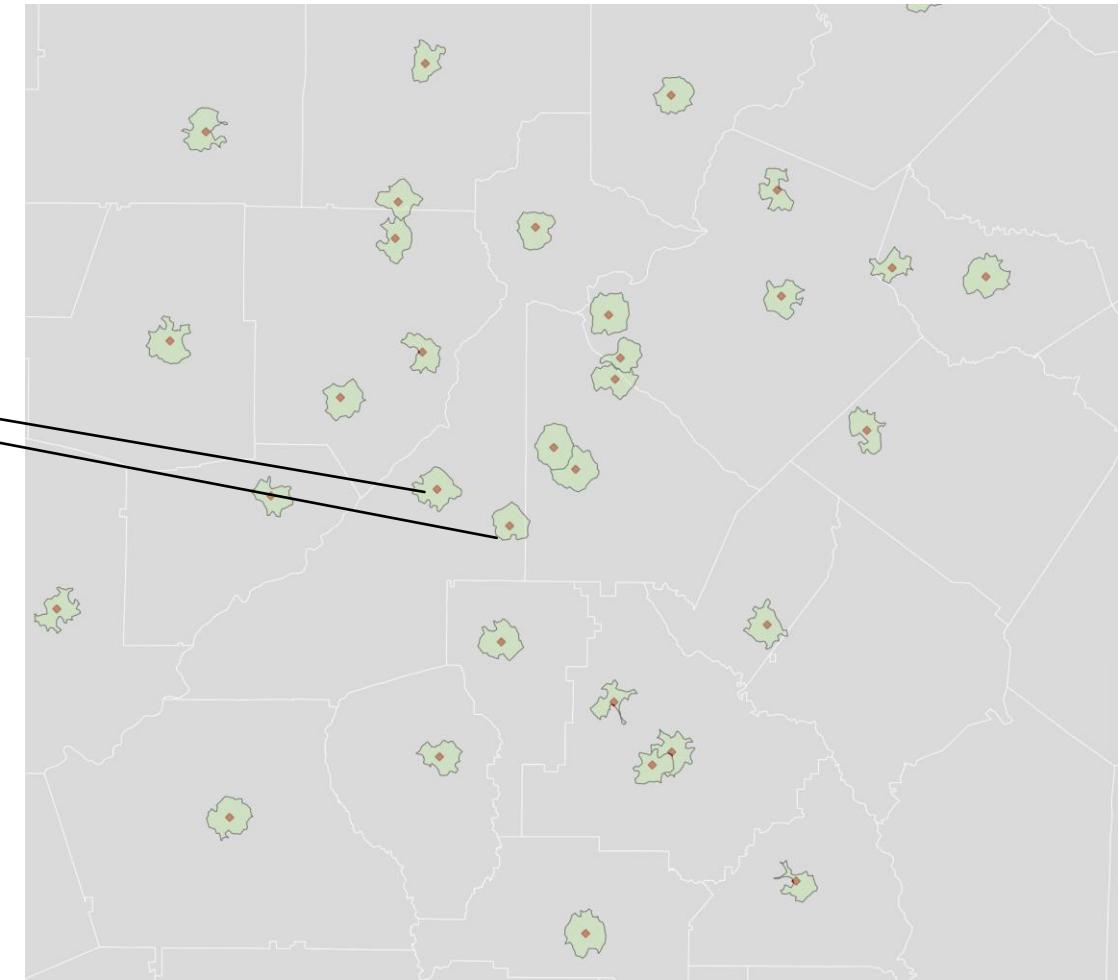
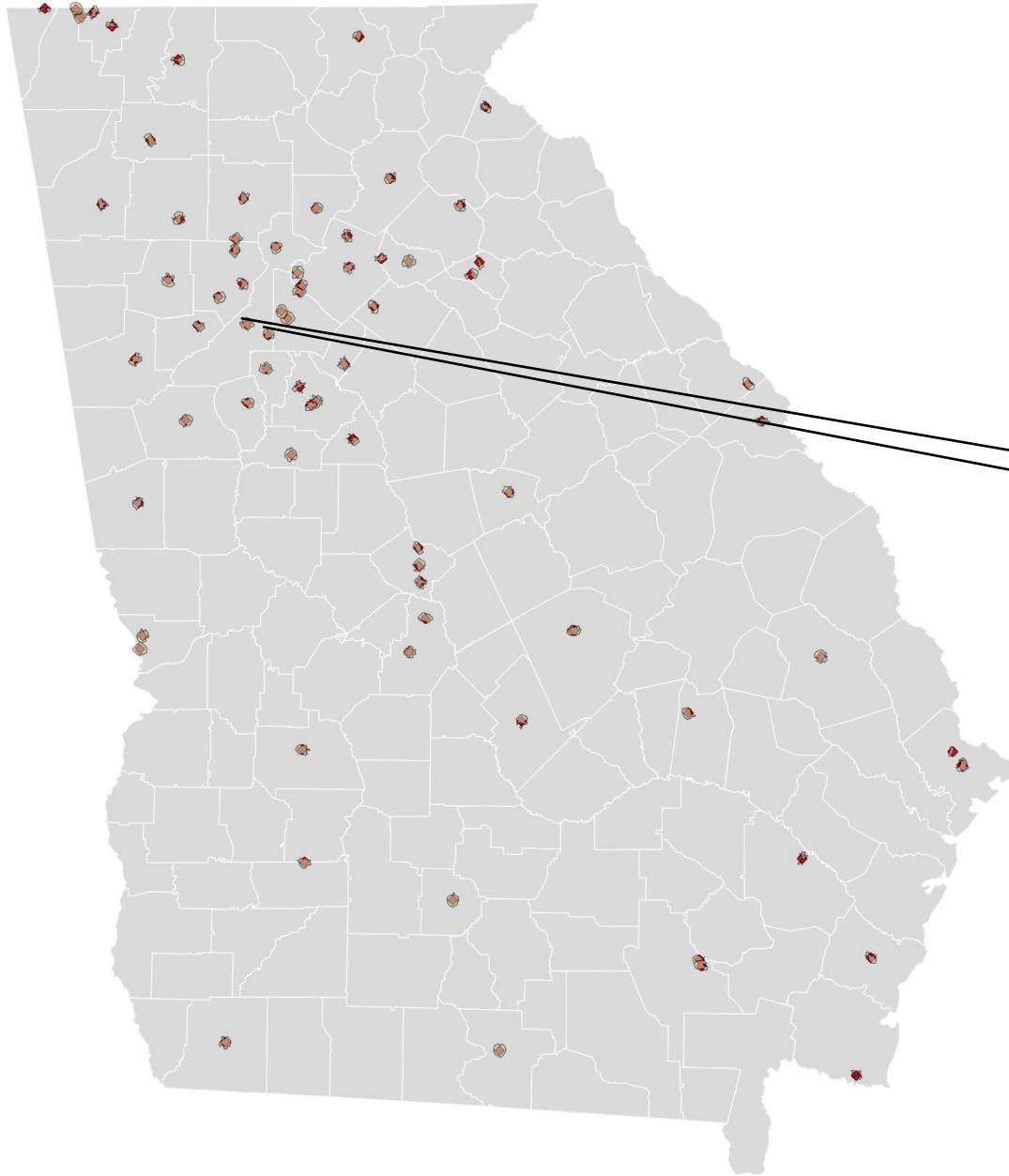
Geographic Distribution of OTPs and catchment area reachable within driving times from an OTP

150 minute catchment areas around OTPs



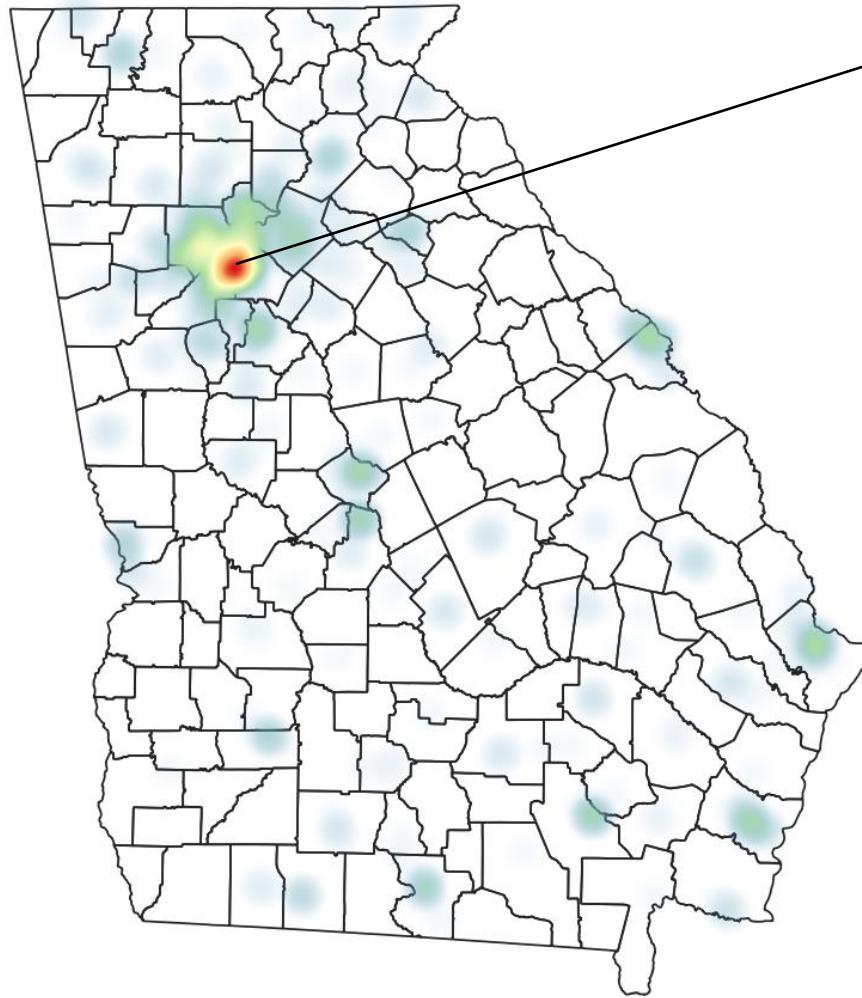
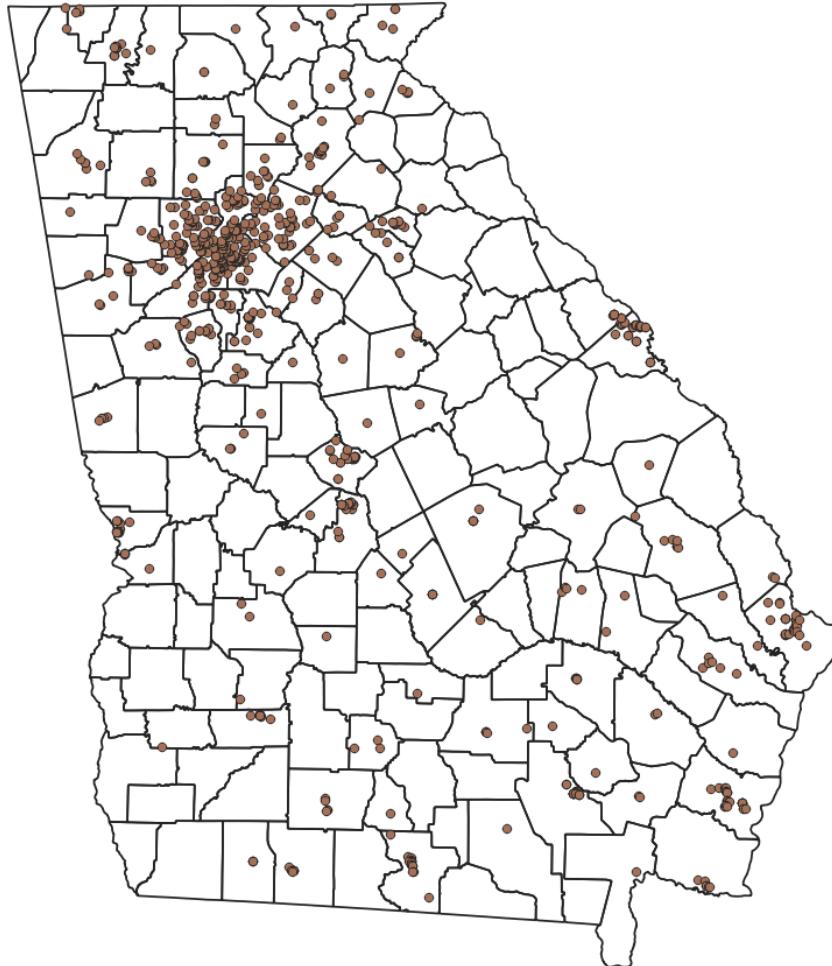
Summary: OTPs are not evenly distributed, leading to "treatment deserts." The catchment areas help identify gaps in treatment access. The gap can characterize whole counties or areas within counties where access is limited but not non-existent. But, even in areas of high concentration there can be gaps in access due to population size.

30-minute walkable catchment areas from OTPs





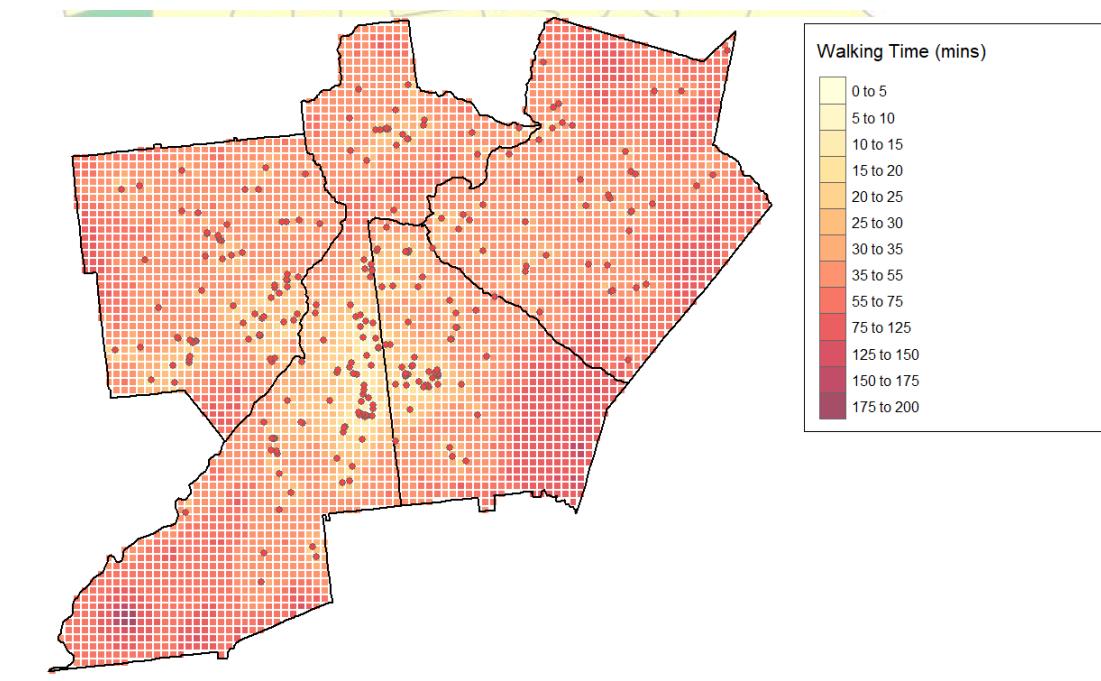
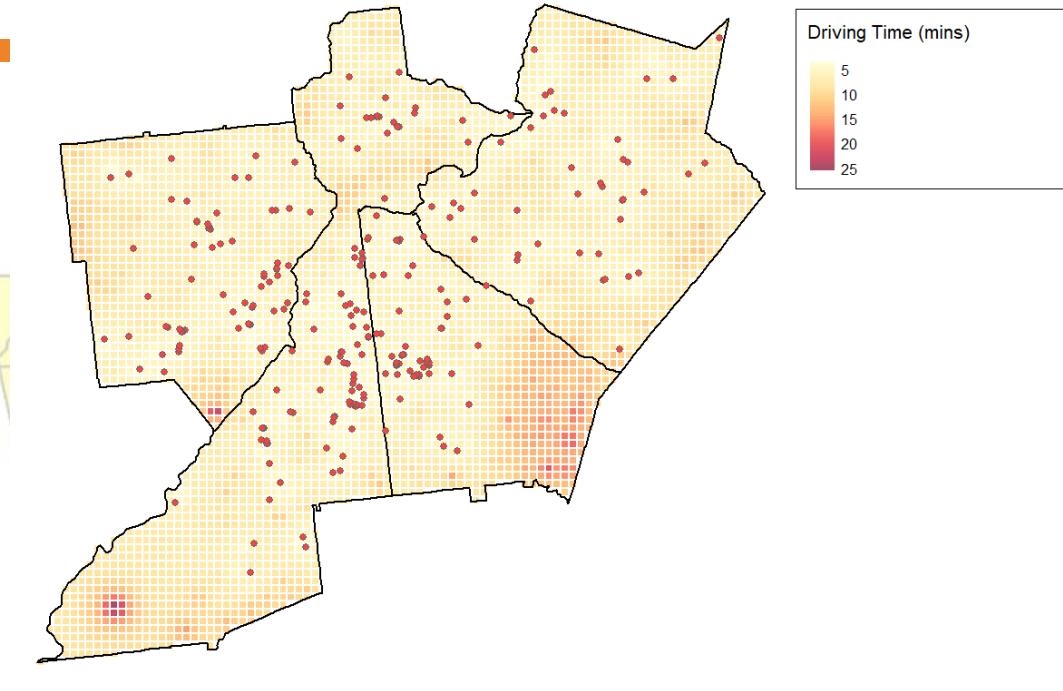
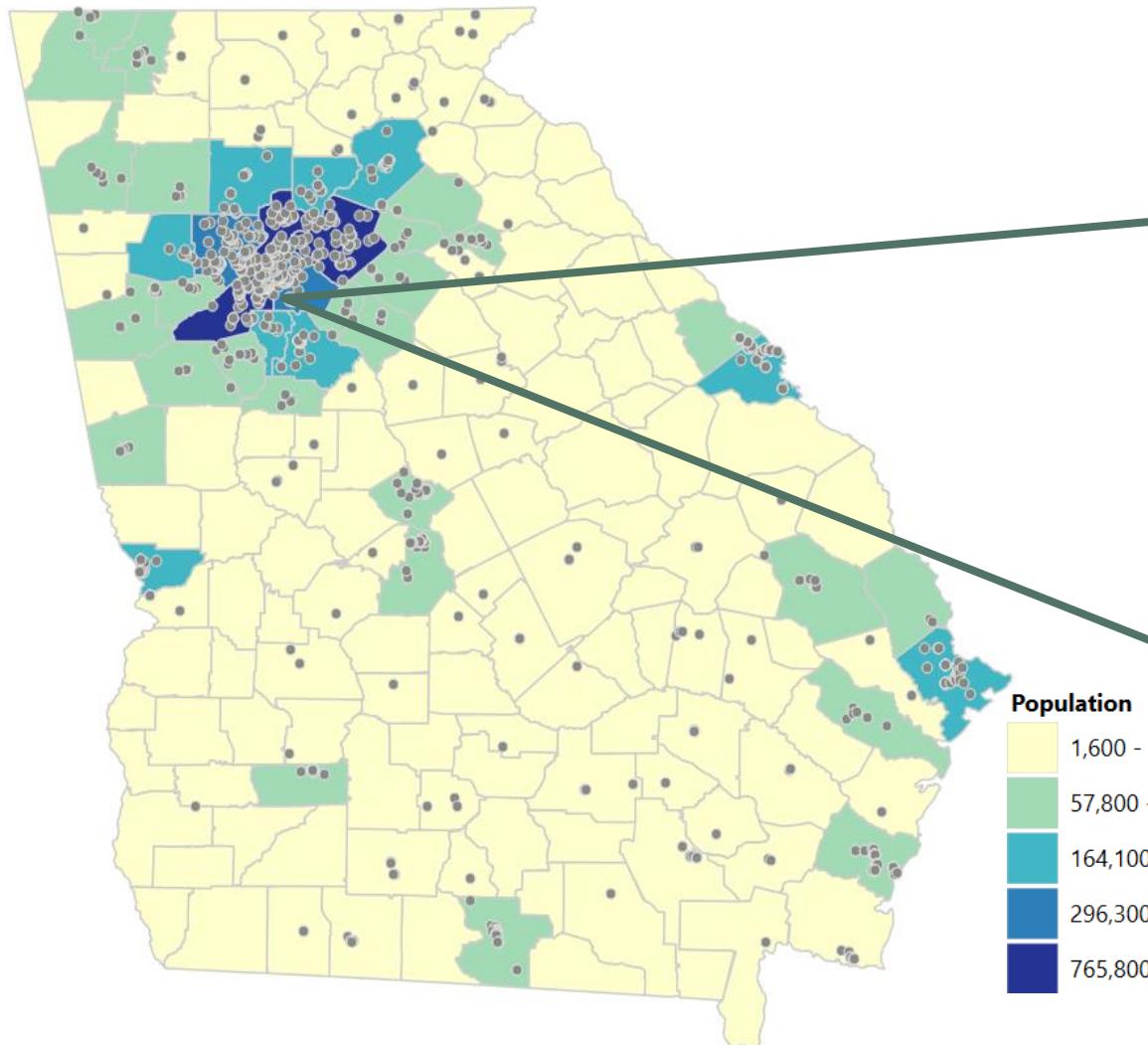
ACCESS TO BP PROVIDERS



→ Area of highest density



ACCESS TO BP



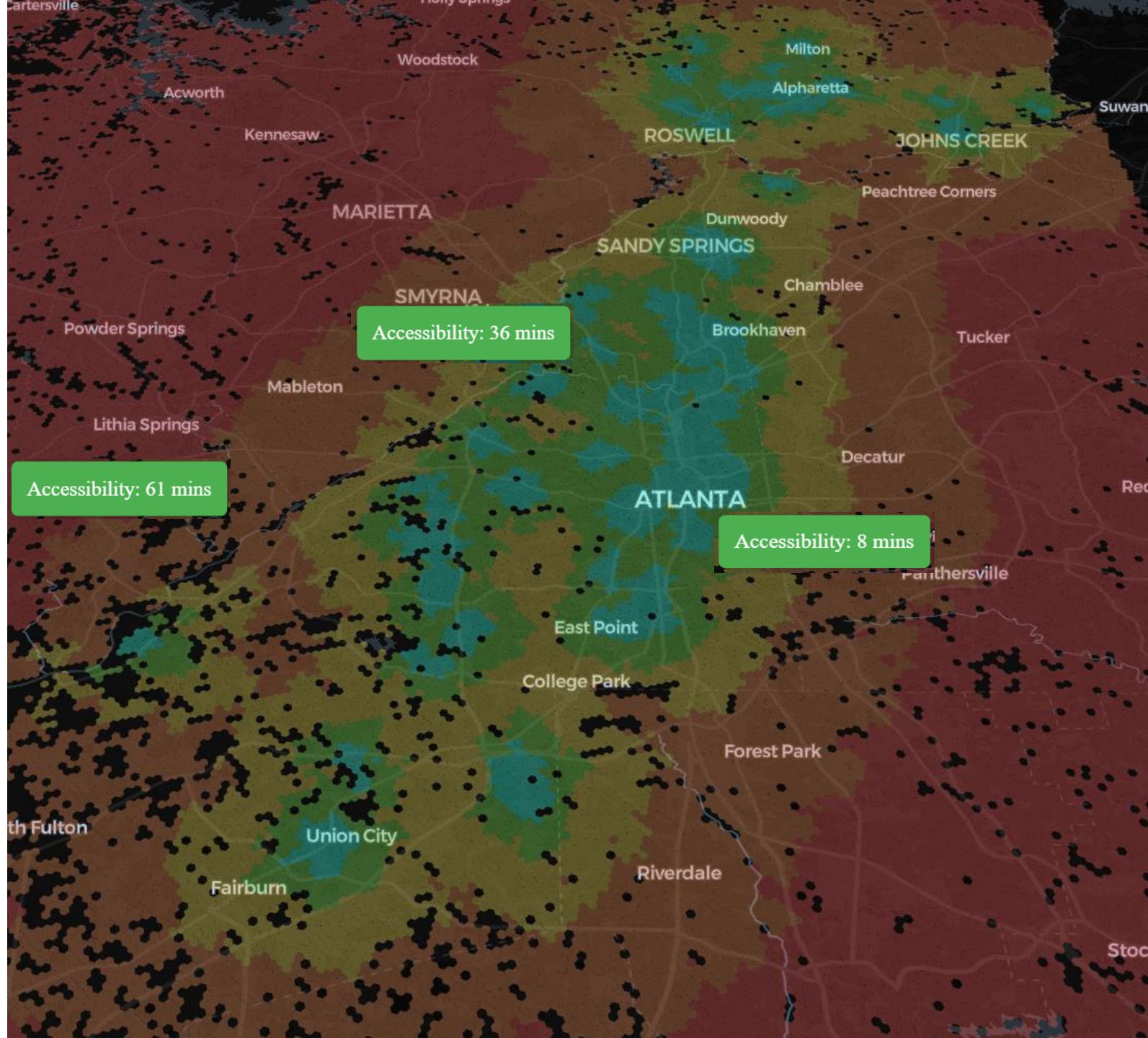
ACCESSIBILITY TO BPS

This map shows accessibility to BPs from various locations in Fulton County considering the street layout and driving time.

This means that instead of measuring straight-line distance, real paths and connections between streets are used — as if you were using google maps.

This is more realistic in showing actual travel times to consider the average driving speed and the structure of the road network.

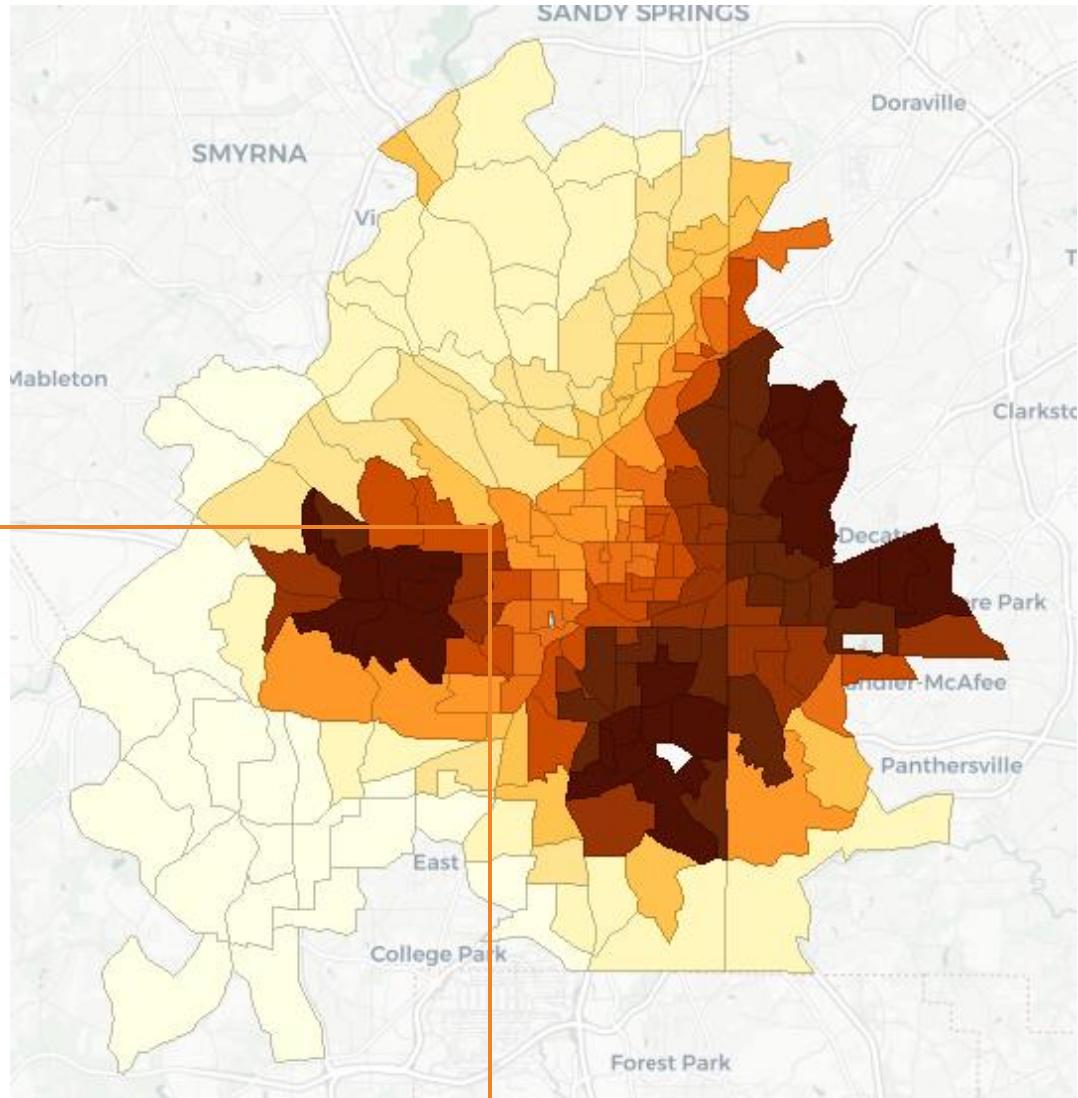
Even in areas where there are many BPs close together, the accessibility varies significantly based on both the distance people need to travel and the time it takes to drive there.



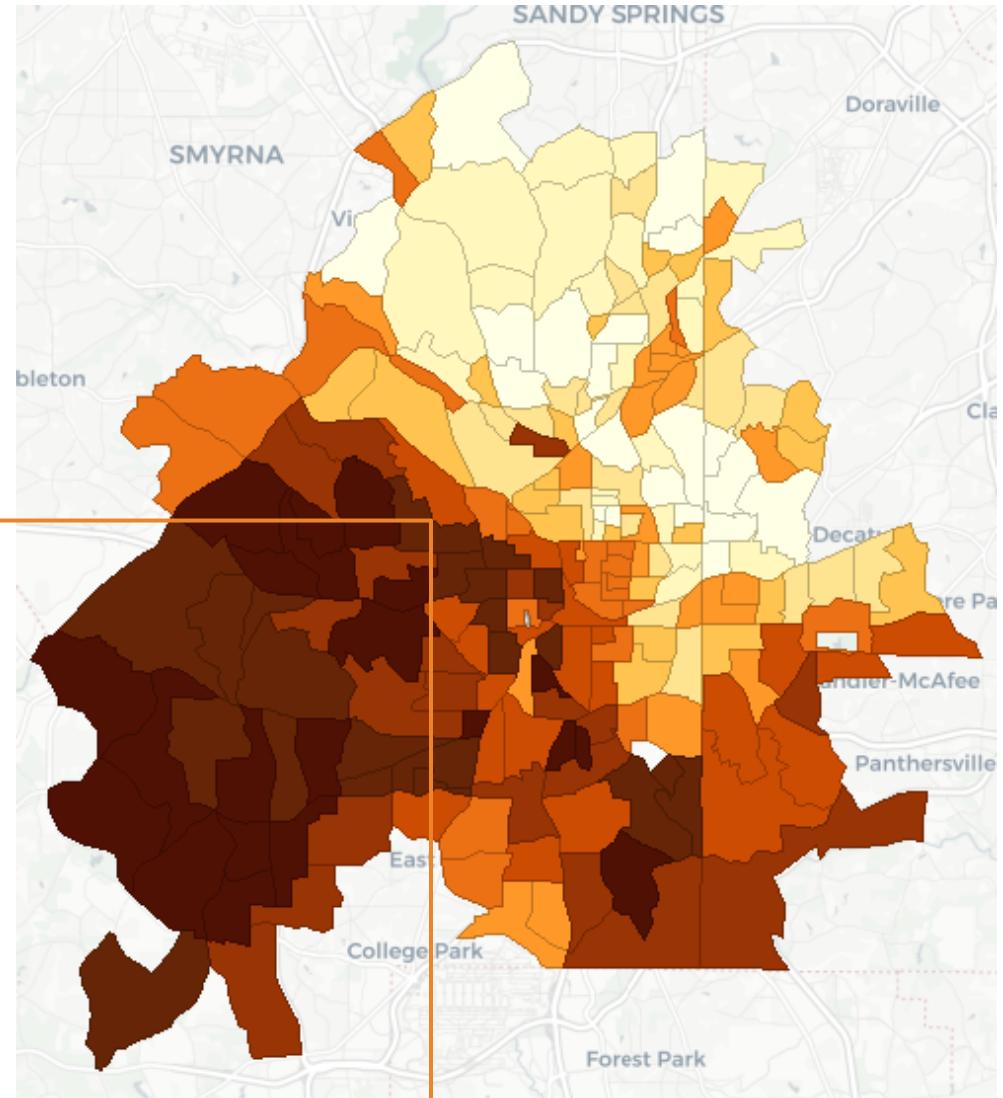
Summary: This table highlights the socioeconomic and transportation impacts on communities based on their travel time to the nearest Buprenorphine clinic. Increased travel time correlates with higher transportation costs, car dependency, and reduced public transit use, underscoring accessibility barriers to treatment for more distant communities.

Characteristic	< 5 min	5 to 15 min	15 to 30 min	30 to 45 min	45 to 60 min	> 60 min
Population Count	1,251	1,304	1,517	1,628	1,657	1,585
Housing + Transportation Costs % Income	44	48	50	45	43	46
Transportation Costs % Income	17.50	20.00	21.00	21.50	21.75	23.00
Automobiles per Household	1.67	1.91	2.05	2.06	2.08	2.20
Annual Transportation Cost	12,419	14,148	15,175	15,222	15,456	16,410
Auto Ownership Cost	10,467	11,993	12,859	12,922	13,040	13,772
Annual Transit Cost	192	102	38	26	23	7

The data underscores how limited accessibility to nearby clinics may hinder timely, equitable care, particularly in communities with fewer transit options and higher associated travel expenses.



Geographic Accessibility to OTPs



Percent Black Population



KEY TAKEAWAYS:

Understanding accessibility to treatment depends on travel itineraries, including travel times and mode of travel.

A large portion of the population is within 30 minutes of an OTP. However, how many people can each provider serve? Population size should determine where resources are needed the most. Given the distribution of OTPs, only 1 OTP can be accessed by the catchment population within a 30-minute drive.

A geographic analysis of accessibility must include an equity analysis across different socioeconomic contexts

- Accessibility is drastically reduced when we change the transportation mode to walking, which is an important consideration for persons without access to a car or public transport (i.e., unsheltered)
- Also, there is an inequity in the level of access by level of social vulnerability. As travel time to providers increases, so do transportation costs and reliance on personal vehicles, which can pose significant access barriers for those needing treatment.

A FOCUS ON SPECIAL
POPULATIONS



THE OPIOID EPIDEMIC AND SYSTEMIC HARM



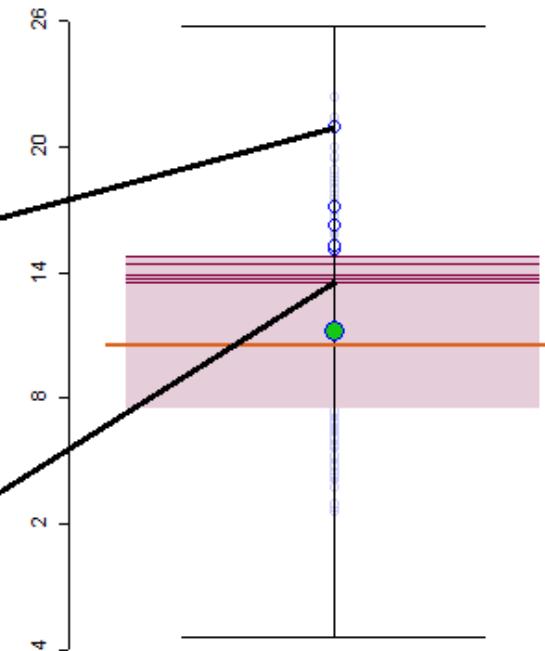
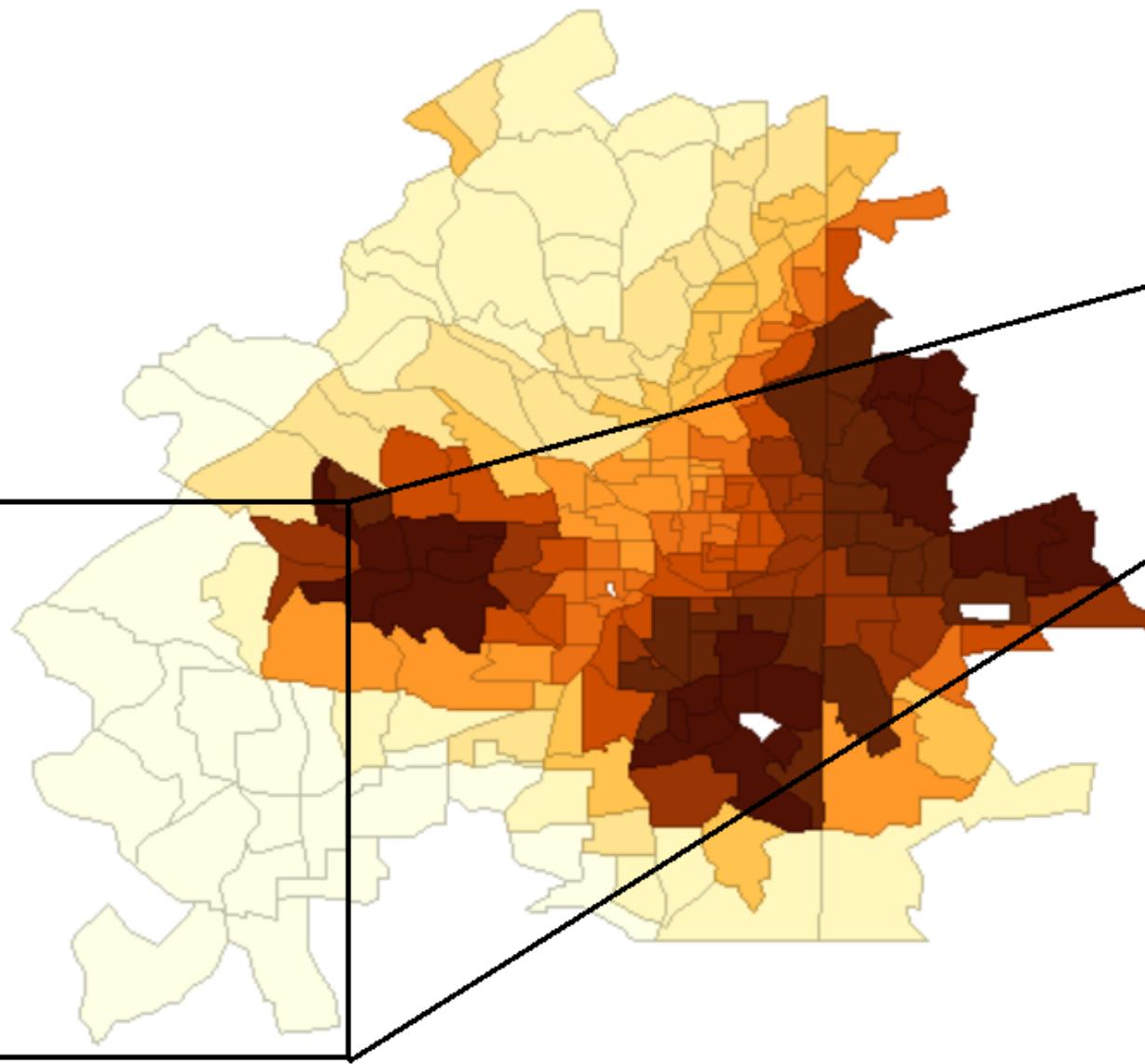
OTHER PUBLIC HEALTH & CIVIL RIGHTS' CRISES

- Family policing
- Maternal and child health and well-being
- Abortion

THE FAMILY POLICING SYSTEM

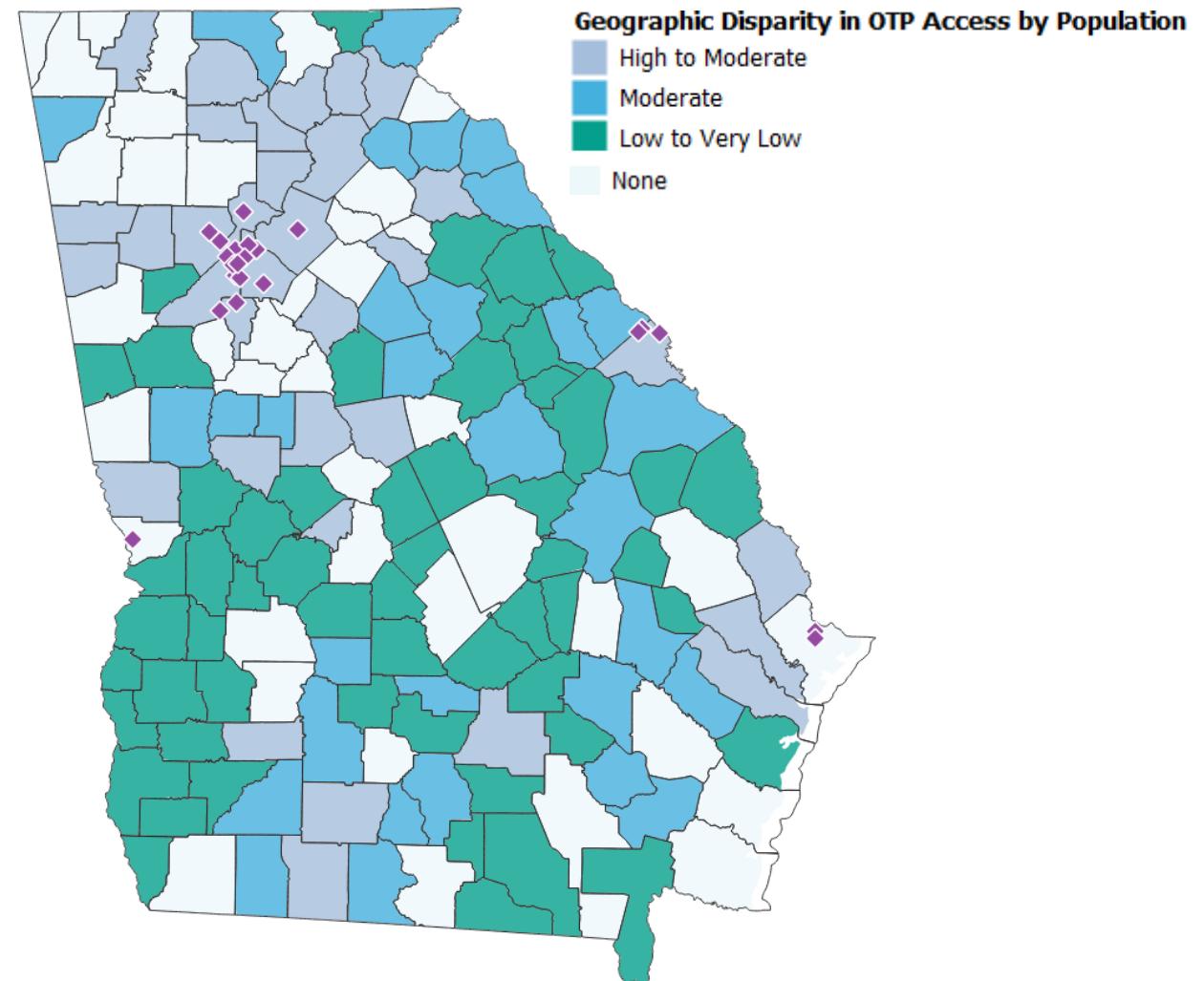
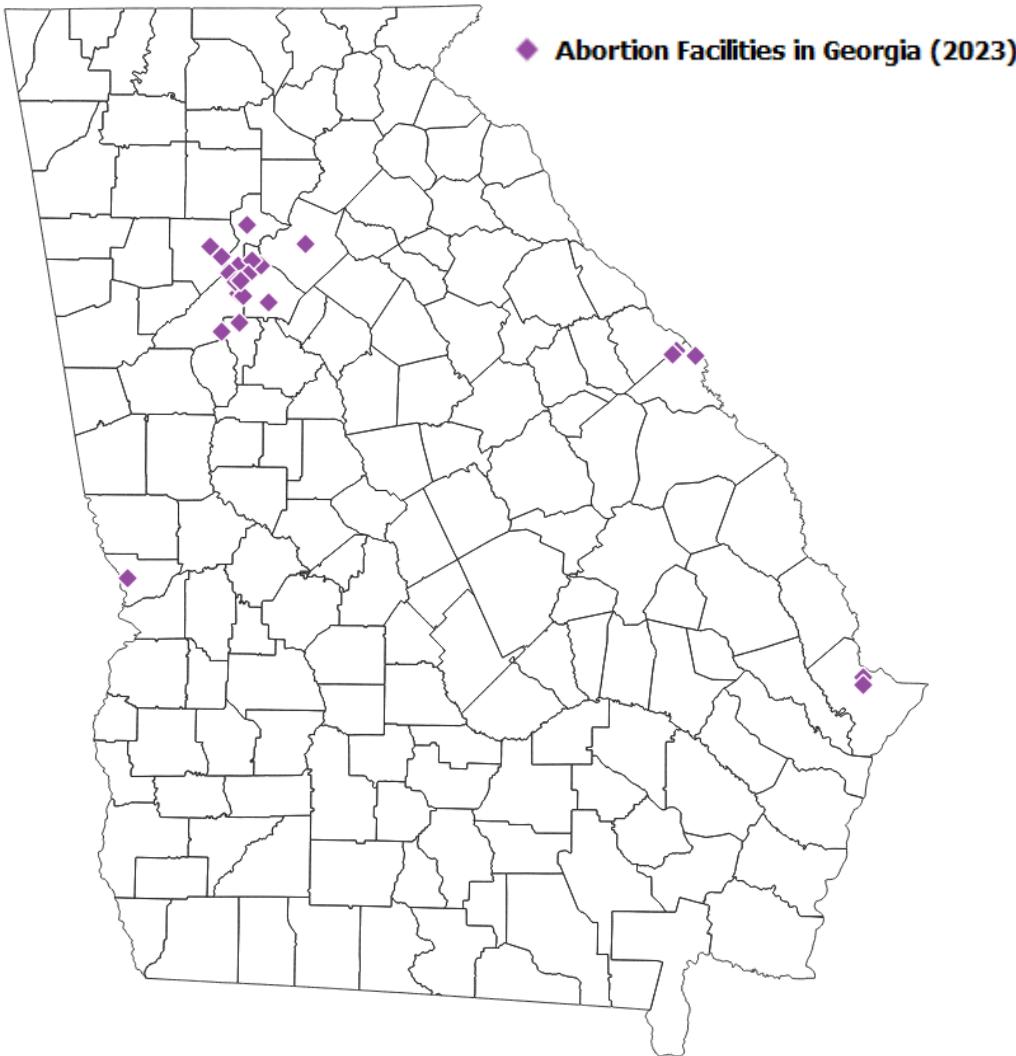
- Opioid exposure is a growing fact pattern in cases of child welfare
 - Key to these cases: What evidence is required to establish abuse and neglect at birth based on prenatal substance exposure?
 - Many courts have found that **evidence of prenatal substance exposure alone**—such as a mother's positive drug screen, a mother's admitted substance use, or a baby's positive drug screen—is enough to support state intervention at the time of birth based on a finding of civil child abuse or neglect.
 - What constitutes evidence of actual harm or imminent risk of harm needed to establish abuse and neglect? The need for intensive medical treatment and severe withdrawal symptoms constitute evidence of harm
 - Can prenatal substance exposure result from a pregnant mother's participation in medically approved substance treatment support abuse and neglect funding? It depends.
- This is antithetical to a proactive public health approach.

Low Accessibility



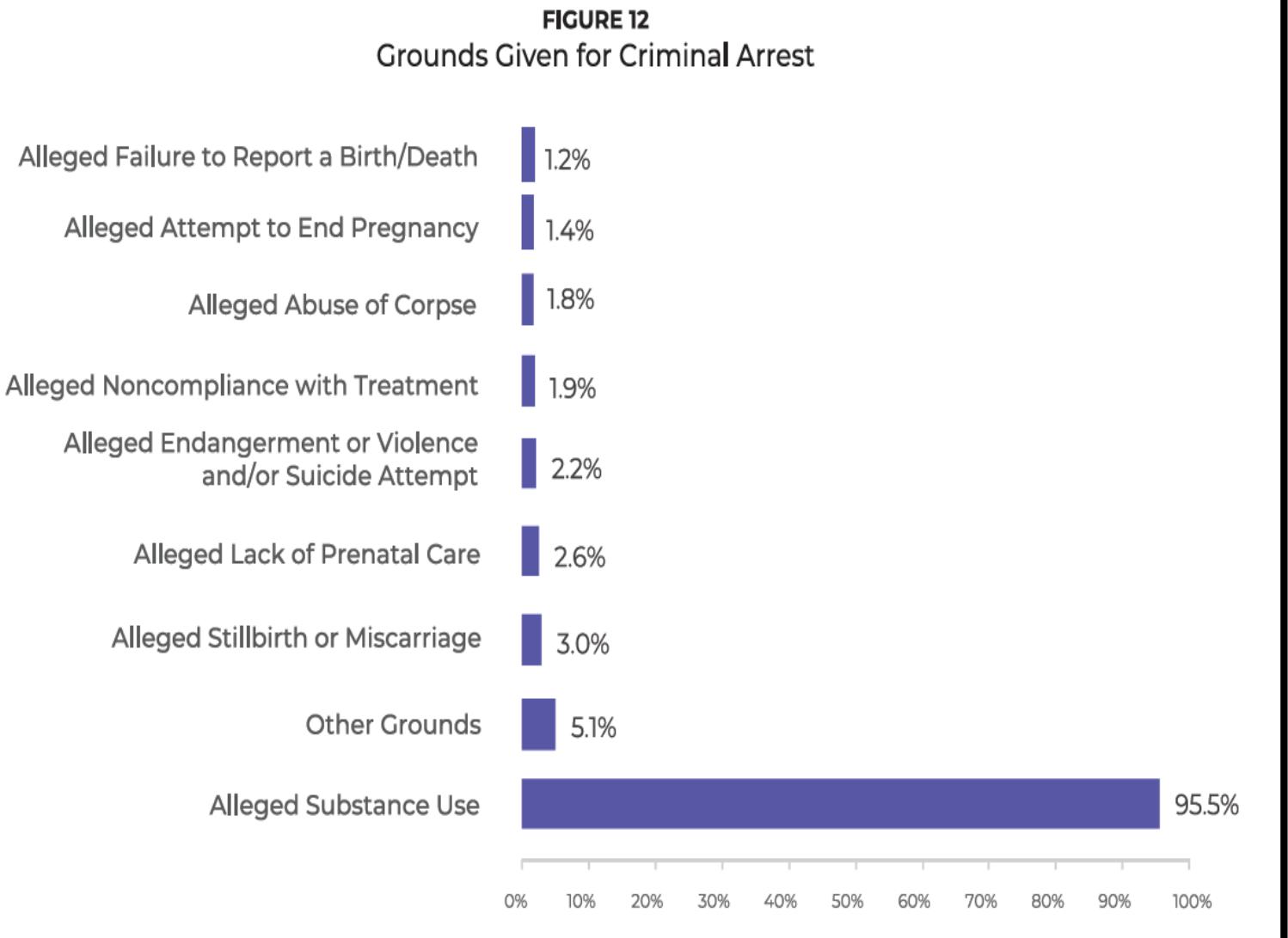
Percent Low Birth Weight

PREGNANCY JUSTICE



THE CRIMINALIZATION OF PREGNANCY

- Pregnancy criminalization as an instance in which someone is either arrested for reasons related to their pregnancy, or where the terms of their bail, sentencing, or probation are heightened because they became pregnant after being charged with an unrelated crime.





DISCUSSION AND IMPLICATIONS

INTERPRET THE FINDINGS AND DISCUSS THEIR IMPLICATIONS





SUMMARY AND IMPLICATIONS: INVESTING IN COMMUNITIES FOR PREVENTION

- Proven public health interventions - including harm reduction - as hopeful innovations to help stem the opioid epidemic
 - Focuses on social, environmental, and health-related disparities in local contexts
 - Scrutinizes regulatory frameworks for inequitable outcomes
- Addressing collateral consequences of drug war policies
- Moving away from criminalization and stigma to focus on recovery to meet basic human needs
 - Further criminalization or incarceration
 - Family Separation
 - Abstinence-only treatment and education
- Forward-leaning approaches will require learning from past practices and using data in innovative ways

SHOW ME THE DATA!
PROVIDE AN UNDERSTANDING OF THE DATA SOURCES AND
METHODOLOGIES USED



Measure	Description	Geographic coverage
<u>Housing & Transportation Index</u>	Housing and transportation affordability	National; Census Block Groups
<u>Historic Redlining Score</u>	Historic redlining in US neighborhoods based on HOLC maps	National; Imputed to Census Tracts
<u>Social Vulnerability Index</u>	Community resilience when confronted by external stresses on human health	All US counties and census tracts since 2000
<u>Medicaid Opioid Rx Rates by Geography</u>	Opioid prescriptions within the Medicaid program	National, state, county and Zip code
<u>Opioid Treatment Providers</u>	Information on Providers who have enrolled in Medicare under the Opioid Treatment Program	National; Addresses
<u>Legislative history/database</u>	Bills that are introduced, passed, failed	National
<u>Global Wildland Urban Interface</u>	The data helps understand the dynamics of housing growth and wildland vegetation patterns	Worldwide
<u>National Risk Index</u>	Identifies communities in the United States that are most at risk from natural hazards.	National; County; Census Tracts

Measure	Description	Geographic coverage
<u>Demographic, Economic, Population and Social data for Georgia</u>	American Community Survey data five-year estimates throughout the state of Georgia	Georgia; County, City, Census Tract, Zip code
Online Analytical Statistical Information System (OASIS)	Mortality/morbidity, maternal and child health, infant mortality, and population characteristics including drug overdoses by type, and ER/Inpatient visits	County
<u>Emergency Medical Services (EMS) data</u>	Fatal and nonfatal overdose, naloxone administration; emergency medical services	National; County
<u>Environmental Justice Index</u>	measures the cumulative impacts of environmental and social stressors on public health using data on environmental hazards, socioeconomic status, and built environment	National; Census Block Groups
<u>Atlanta Police Department</u>	Historic crime data in the city of Atlanta	Atlanta; Addresses
<u>Picture of Subsidized Households</u>	Detailed demographic and geographic information on households receiving housing subsidies, including household composition, income levels, and the location	County, Census Tracts

Measure	Description	Geographic coverage
<u>NEMSIS</u>	Drug Overdose Surveillance Dashboard	National; Counties
<u>Environmental Protection Agency</u>	A ton of data on health and the environment (e.g., farmer's markets, land cover)	National; Census Block Groups
<u>The Neighborhood Atlas</u>	Area Deprivation Index	National; Census Block Groups
<u>Atlanta Regional Commission</u>	Open Data and Mapping Hub	Atlanta Regional
<u>USDA Forest Service</u>	Land cover; forest, climate	National; Census Block Groups
<u>Multi-Resolution Land Characteristics</u>	Multi-Resolution Land Characteristics	National
<u>Naloxone Distribution Maps</u>	Naloxone sites	Georgia

THANK YOU!!

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