

The following Opioids Advocacy Planks—provided by the AAFS Opioids and Emerging Drugs ad hoc Committee—have been approved by the AAFS Board of Directors:

Opioids Advocacy Planks

1. **Inclusion of ME/C and crime labs in opioid response funding.** Funds that are available to states and local communities for prevention, treatment, harm reduction, and interdiction should also support the medical examiners, coroners, forensic toxicologists, and crime laboratories. All of these resources must be enhanced in a cumulative manner to combat the challenges that opioids present to communities.
2. **Instrumentation grants for drug chemistry, forensic toxicology, and forensic science academia.** The proliferation of novel psychoactive substances (NPS), or “designer drugs,” requires new state-of-the-art analytical instrumentation. This instrumentation is expensive and cannot be purchased on the Coverdell grants, which are too small for this purpose. The opioid crisis has depleted the financial resources of toxicology and drug chemistry laboratories. Additionally, academic forensic science departments need to educate and train their students on modern instrumentation; however, NIJ currently disallows the purchase of these instruments by academic departments on their research grants. Thus, a separate or amended grant program is needed and should include funds for training on new analytical instrumentation. Furthermore, the instruments should be owned by the grantee, not the federal government after purchase.
3. **Forensic Pathology Workforce initiatives (student loan forgiveness, J1 waivers, e.g.).** The opioid crisis has significantly exacerbated the forensic pathology workforce shortage. Legislation should recognize that forensic pathology is direct patient care of a medically underserved population. Legislation could also create a path for student loan forgiveness.
4. **Creation of an Office of Forensic Medicine (OFM) at the CDC.** An OFM would consolidate current programs into an umbrella office directed by a forensic pathologist. Such an office would parallel the existing Center for State, Tribal, Local, and Territorial Support (CSTLTS), but instead of serving public health labs, it would serve the medical examiner and coroner community. The Current NVDRS and SUID/SUDC programs would form the base of this office. Such an office would enable a greater interface with the ME/C community and provide a voice within the CDC. Grant programs could be better tailored to meet the needs of the ME/C community.
5. **Creation of NIDA Centers of Excellence to research metabolism and physical and cognitive effects of NPS.** There is insufficient scientific literature on many of the NPS. Information must be developed on drug metabolism, pharmacokinetics, and their physical and cognitive effects. Also, there is a need to develop expertise in this area, focusing on not only analytical chemistry, but pharmacology as well. Current emergency scheduling orders may not become permanent due to the lack of safety and efficacy data. Furthermore, pharmacological data is needed to prosecute DUIs involving NPS. The DEA contracts for some of this research, but the information is not in the public domain. **NIDA has announced that they will not fund significant programs on NPS due to the profusion of these substances.** NIDA should establish multiple centers to collectively create the infrastructure required to research NPS as they appear, as well as to train the next generation of experts in this area.

6. **Appropriate intelligence gathering and information sharing.** Although the federal government continues to improve its data collection and sharing processes, more work could be done in this area. State and local efforts that support the federal government should be reimbursed. Several State Forensic Epidemiologists exist, but could be expanded to create a network and an interface between the federal and state governments.
7. **Drug Scheduling of analogues.** The current Federal Analogue Act is hampered by its lack of clarity. No set definition exists for when a chemical is “substantially similar” to a Schedule I or II controlled substance. Initially, temporary emergency scheduling of fentanyl analogues was imposed after deaths resulted from acute intoxication with these compounds. Current “core structure” scheduling does not require overdoses before interdiction, but its temporary nature and application to only fentanyl analogues is cause for concern. Legislation is needed to impose permanent chemical class scheduling of the fentanyl analogues as well as the synthetic cannabinoids, cathinones, and other major classes of NPS.
8. **PDMP access to ME/C.** Prescription Drug Monitoring Programs (PDMP) facilitate cause of death determinations when drug overdose is suspected. However, not all forensic pathologists/coroners have access to these vital public health resources. Many PDMP programs are accessed using a DEA Registration Number assigned to prescribing health care providers, barring forensic pathologists who do not prescribe medication from this information.

Last revision: 8/9/19 by AAFS Executive Committee