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**ACTION, NOT RHETORIC, NEEDED TO REVERSE  
THE OPIOID OVERDOSE EPIDEMIC**

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# Action, Not Rhetoric, Needed to Reverse the Opioid Overdose Epidemic

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## The Rise of the Epidemic

In 2011, the Office of National Drug Control Policy (ONDCP) released a watershed report, *Epidemic: Responding to America's Prescription Drug Abuse Crisis*. The report broke with decades of tradition to shift the agency's rhetorical focus toward a more evidence-based, proactive approach to what had previously been termed the "War on Drugs," and announced the agency's goal of decreasing unintentional opioid overdose deaths in the United States by 15% within five years.<sup>1</sup> Unfortunately, that has not come to pass: the number of Americans lost to overdose increased from 41,340 in 2011, when ONDCP set its goal, to 47,055 in 2014.<sup>2</sup> More Americans now die each year of drug overdose than died of HIV/AIDS during the peak of that terrible epidemic.<sup>3</sup>

The root causes of the opioid crisis include not only over-prescribing of opioid pain relievers (OPR), but also an interplay of economic stress, social isolation, and systemic pressures on the health care system to address patients' complex physical and mental health needs combined with a lack of the appropriate tools and incentives to do so.<sup>4</sup> Many policy solutions, however, focus solely on overprescribing of OPRs and fail to address any of the underlying causes of the epidemic.<sup>5</sup> As a result, while the number of OPR-related

deaths in the U.S. appears to have plateaued, fatal heroin overdoses have more than tripled since 2010.<sup>6</sup> Concurrently, a surge in the availability of illicitly manufactured synthetic opioids appears to be driving a significant increase in overdose deaths.<sup>7</sup>

As evidenced by the ONDCP's report, the rhetoric associated with the opioid epidemic is different in many ways than the response to previous drug-related crises, which overwhelmingly relied on blaming, shaming, and punishing those most impacted.<sup>8</sup> However, many of these changes have remained in the rhetorical realm. Despite widespread acknowledgement that opioid overdose is an epidemic, it has largely failed to produce an epidemic-appropriate public health response.<sup>9</sup> This must change. Dramatically reducing the number of lives unnecessarily lost to overdose requires an evidence-based, equity-focused, well-funded, and coordinated response. We present in this brief article suggestions for improving and refocusing the response to this simmering public health crisis.

## Improving Clinical Decision Making

Most of the increase in opioid prescribing is driven by well-intentioned efforts to reduce the burden of untreated pain. This is a worthy goal: chronic pain affects millions of Americans and often occurs in tandem with other medical and mental health conditions including depression and anxiety.<sup>10</sup> Opioid therapy is indispensable for treatment of severe cancer and HIV/AIDS pain, and is invaluable for palliative care.<sup>11</sup> However, OPR therapy for other conditions is often no more effective than other interventions, and often carries a higher risk of harm.<sup>12</sup> Indeed, the Centers for Disease Control and Prevention now advises against the routine or first-line use of opioid therapy for chronic pain

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and recommends frequent re-evaluation of the benefits and harms of opioid therapy once begun.<sup>13</sup>

Much of the rise in inappropriate OPR prescribing was driven by pharmaceutical marketing campaigns that targeted doctors and professional organizations with sometimes misleading information regarding the effectiveness and dangers of OPRs.<sup>14</sup> Insufficient knowledge of recent guidelines and recommendations, conversely, may have the unintended effect of depriving patients of medically appropriate opioid therapy, a burden which may fall disproportionately

nist naloxone decreases the risk of overdose death, access to these proven treatments remains grossly inadequate.<sup>17</sup> Only approximately 11% of Americans who needed drug or alcohol treatment in 2013 were able to access it, and availability of naloxone continues to be hampered by cost, legal concerns, and other barriers.<sup>18</sup>

To reduce this lack of access, insurers should remove onerous prior authorization requirements for MAT and be required to cover naloxone, including where the medication is intended to be used on a

person other than the insured.<sup>19</sup> Compliance with the Mental Health Parity and Addiction Equity Act, which requires that drug treatment be provided on equal terms to medical and surgical care, should be strictly enforced.

At both federal and state levels, arcane laws and regulations make it considerably more difficult for practitioners to prescribe medications to treat OUD than the medications known to cause it. This absurd situation has no basis in evidence and should be dismantled. At the same time, a wide variety of non-evidence-based “treatment” providers have flourished.<sup>20</sup> These providers, many of which likely increase risk of negative outcomes including fatal overdose, should be tightly regulated. A dramatic increase in funding for the development of non-opioid treatment (and potentially non-addictive opioid treatment) for both chronic and acute pain is desperately needed.

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on racial and ethnic minorities.<sup>15</sup> Unfortunately, most physicians receive little training in evidence-based pain management, and only a handful of states require them to remain abreast of the latest evidence.<sup>16</sup>

To reduce this knowledge gap, state licensing boards should require that all physicians receive training or demonstrate efficacy in evidence-based opioid prescribing, as well as recognizing and appropriately responding to opioid use disorder (OUD). This training should be funded by neutral entities, not pharmaceutical companies. Additionally, states should strongly consider imposing additional oversight on the “self-regulating” medical profession, which in many cases has been slow to respond to the epidemic. Insurers can also help reduce inappropriate prescribing by discouraging the use of methadone for treatment of pain (an outsize driver of OPR overdose), covering non-opioid therapies such as physical therapy to the same extent as opioid therapy, and disincentivizing OPR therapy in situations where best available evidence suggests that those medications are inappropriate.

### **Improving Access to Evidence-Based Treatment**

Although treatment with methadone and buprenorphine, referred to as medication assisted treatment (MAT), dramatically improves outcomes for many people with opioid addiction and the opioid antago-

### **Investing in Comprehensive Public Health Approaches**

Given the extensive investments in infrastructure across the U.S. in interventions like prescription drug monitoring programs (PDMPs), it is important to ensure that these resources explicitly embrace public health goals and applications. Rhode Island, where a Governor’s Task Force on Opioid Addiction and Overdose adopted a four-point plan aiming to reduce overdose deaths by one-third in three years, has emerged as a leader in this area. The Rhode Island Plan is comprehensive in approach but strategic in execution, and uses PDMP data for tracking Plan progress. The *Prevention* initiative tackles co-use of benzodiazepines and opioids by creating provider guidelines on this specific risk. Its *Treatment* initiative rolls out MAT in prisons and jails, in the community, and in hospitals. *Rescue* efforts expand naloxone as the standard of care, by providing sustainable community-based naloxone sources and naloxone at the pharmacy. *Recovery* expands recovery centers and peer recovery

support capacity, especially in the emergency department, post overdose. While it is too early to tell if these efforts will have the intended effect, they exemplify an integrated, coordinated, health-focused agenda to addressing overdose.

### Re-focusing Law Enforcement Response

Although governmental agencies have largely adopted public health rhetoric to describe substance use disorder (SUD), the public officials most likely to interact with people with the disease of addiction are not physicians or public health workers but law enforcement and correctional officers. Of ONDCP's \$25 billion annual budget, less than half is allocated to prevention and treatment; the majority remains slated for interdiction and enforcement.<sup>21</sup> Some federal and state prosecutors have responded to the epidemic by charging individuals who deliver drugs used in fatal overdoses with homicide, and some jurisdictions have increased penalties for drug-related crimes. Aside from their futility, these types of punitive laws and aggressive law enforcement actions have numerous unintended health consequences, including fueling the spread of HIV and discouraging help-seeking during overdose events.<sup>22</sup>

On the other hand, there have been a number of innovative police initiatives across the U.S. that mark a departure from the strictly punitive approach towards one that confronts the opioid crisis as primarily a public health issue. For example, more than 2000 law enforcement agencies nationwide are now trained and equipped to reverse opioid overdose using naloxone, and more than half a dozen jurisdictions operate law enforcement assisted diversion (LEAD) programs that train, permit, and encourage officers to refer people who use illicit drugs to a case manager for referrals to housing, health, and other programs in lieu of arrest.

Although SUD diagnosis and treatment in correctional settings remain scandalously inadequate, initiatives in over 150 jurisdictions permit people in need of addiction treatment to present to a police station and be assisted in navigating to an SUD treatment program. While this is a positive step, it also represents a misalignment of scarce public resources, as the police officers being asked to provide evidence-based, non-judgmental assistance to people who use drugs are often neither trained nor equipped to do so.

### Conclusion

The country confronts a challenge equal to that posed by HIV in the 1980s. Despite good intentions, a change in tone and some positive movement, Americans with the disease of addiction are still often stigmatized, criminalized, and denied access to evidence-based

care. Structural change to address both the causes and effects of the epidemic is urgently needed. In the case of HIV/AIDS, failure to deploy non-judgmental, evidence-based interventions was directly responsible for the preventable deaths of hundreds of thousands of Americans. Improvement, when it came, was championed not by officials but by activists such as ACT UP.<sup>23</sup> We are now faced with the choice of whether to learn from that mistake — or repeat it.

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