The opioid epidemic is finally a national emergency – eight years too late

August 28 2017, by Erin Winstanley

"It has been many long, hard, agonizing battles for the last few years and you fought like a warrior every step of the way. Addiction, however, won the war. To the person who doesn't understand addiction, she is just another statistic who chose to make a bad decision."

Despite working nearly two decades as an addiction scientist, I cannot read Kelsey Grace Endicott's mother's eulogy without crying. The opioid epidemic has turned those who lost their lives to addiction into statistics, while leaving their families in sorrow.

Overdose deaths in the U.S. have tripled since 2000, with 52,404 deaths in 2015 as the highest ever recorded. While the Centers for Disease Control and Prevention (CDC) has yet to release official statistics for 2016, early estimates put the number of deaths at as many as 65,000.

On August 10, President Trump declared the opioid epidemic a national emergency. Nearly a decade into this epidemic, this national emergency was declared at least eight years too late. Policymakers have missed opportunities to implement strategies scientifically demonstrated to reduce overdose deaths and help people recover.

Declaring a national emergency is important, but it's not clear what steps the administration will take or how much funding will be committed to these strategies. We have proven prevention and treatment services that we need to significantly expand, and we need the money to do this.

The right treatments

Declaring the opioid epidemic a national emergency expands the availability of federal funding; frees up public health workers to address the issue; and makes it possible to remove regulatory barriers to lifesaving medications.

In a speech on May 11, Attorney General Jeff Sessions suggested that tools like "Just Say No" and Drug Abuse Resistance Education (DARE) can help fight the opioid epidemic.

However, addiction science has repeatedly proven that such drug prevention programs are ineffective. Some would argue that we are biologically wired to try new things, so education alone is not sufficient to prevent repeated drug use.

Prevention efforts are part of the solution, but we need more immediate solutions for people already ensnared by addiction. Naloxone, known by the brand name Narcan, is usually the only thing that can prevent death when someone has overdosed on opioids. Science has unequivocally demonstrated that naloxone can reverse an opioid overdose, if administered in time and in an adequate dose.

When patients with opioid use disorders are treated with FDA-approved medications like methadone and buprenorphine, they not only reduce their use of opioids but they are also less likely to overdose. When these drugs are used to treat addiction, they are referred to as medication-assisted treatment. Medication-assisted treatment helps many people, particularly early in recovery, when otherwise their brains seem to focus only on using more drugs. In fact, a National Institute on Drug Abuse study found that only about 7 percent of patients can stop using opioids without buprenorphine.

We need drugs like naloxone and buprenorphine to prevent deaths and help people recover from addiction. In the past few years, state governments have taken significant steps to remove regulatory barriers and expand community access to naloxone.

But policies are infrequently aligned with addiction science. In 2015, only 11 percent of people who needed addiction treatment received it. There are not enough medication-assisted treatment treatment slots available: A recent study estimated that the U.S. was short 1.3 million treatment slots for medication-assisted treatment in 2012. Demand has only increased since then.

There is an entrenched belief that people choose to use drugs and that this choice reflects a moral failing. Even the director of the U.S. Department of Health and Human Resources – which cites medication-assisted treatment as part of its strategy – has been quoted saying: "If we're just substituting one opioid for another, we're not moving the dial much."

Moving too slowly

Early on, everyone believed that the epidemic was fueled by widely available prescription pain relievers. Books like "American Pain" by John Temple described "drug tourists" routinely traveling from states like Kentucky and West Virginia to Florida, where millions of prescription pills were dispensed at "pill mills."

Such overprescribing and doctor-shopping did contribute to the current epidemic. States have been successful at dispensing fewer prescription opioids, but this doesn't help the nearly 2.6 million Americans already addicted, or the 329,000 who report currently using heroin.

And, since 2014, it has become clear that the epidemic is no longer just

about prescription opioids. In addition, heroin is frequently mixed or substituted with powerful synthetic opioids like fentanyl or carfentanil. They require far more of the overdose reversal drug naloxone than is routinely dispensed in communities.

Meanwhile, in poor and rural areas, community resources for public services are being exhausted by the costs of the epidemic.

Areas that have been disproportionately impacted by the epidemic, like West Virginia, have woefully inadequate access to harm-reduction services like syringe exchange programs and specialty addiction treatment. A clinic at our university that dispenses buprenorphine has more than 600 people on its waiting list. We will soon open a second clinic that will help reduce but not eliminate the waiting list.

A bill passed by President Obama, the 21st Century Cures Act, is making approximately US$1 billion in funding available to help states combat the opioid epidemic. But, as Dr. Keith Humphreys at Stanford University has said: This is not enough. We likely need 50 times that, as Ohio spent $1 billion in 2016 on the opioid epidemic.

Fighting back

It can be hard to grasp the devastation of the opioid epidemic. As the President's Commission on Combating Drug Addiction and the Opioid Crisis has described it, in the scale of deaths, it's like the September 11 terrorist attacks happening every three weeks. A national emergency would have been declared 10 years ago if such a disaster occurred every three weeks. And it can be even harder to imagine the emotional turmoil and the depth of sorrow felt by the families who've lost their daughters, sons, brothers, sisters, mothers and fathers.

I think it's fair to say that we all want a simple solution – something that

we can wrap our arms around. Something that can be done in one legislative session. But that has not worked and it will not work, just as declaring a national emergency is not enough.

Addiction scientists know what needs to be done to turn the tide. While we may not understand every aspect of the epidemic and certainly need more research to understand these deaths of despair, we are eager to collaborate with communities to find empirically informed solutions, such as medication-assisted treatment. The President's Commission on Combating Drug Addiction and the Opioid Crisis consists of four politicians and one addiction scientist. It might help to start by asking an expert, rather than politicians, what should be done.

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