Taking On the Scourge of Opioids

Sally Satel

On March 1, 2017, Maryland governor Larry Hogan declared a state of emergency. Heroin and fentanyl, a powerful synthetic opioid, had killed 1,468 Maryland residents in the first nine months of 2016, up 62% from the same period in 2015. Speaking at a command center of the Maryland Emergency Management Agency near Baltimore, the governor announced additional funding to strengthen law enforcement, prevention, and treatment services. “The reality is that this threat is rapidly escalating,” Hogan said.

And it is escalating across the country. Florida governor Rick Scott followed Hogan’s lead in May, declaring a public-health emergency after requests for help from local officials across the state. Arizona governor Doug Ducey did the same in June. In Ohio, some coroners have run out of space for the bodies of overdose victims and have to use a mobile, refrigerated morgue. In West Virginia, state burial funds have been exhausted burying overdose victims. Opioid orphans are lucky if their grandparents can raise them; if not, they are at the mercy of foster-care systems that are now overflowing with the children of addicted parents.

An estimated 2.5 million Americans abuse or are addicted to opioids—a class of highly addictive drugs that includes Percocet, Vicodin, OxyContin, and heroin. Most experts believe this is an undercount, and all agree that the casualty rate is unprecedented. At peak years in an earlier heroin epidemic, from 1973 to 1975, there were 1.5 fatalities per 100,000 Americans. In 2015, the rate was 10.4 per 100,000. In West Virginia, ground zero of the crisis, it was over 36 per 100,000. In raw numbers, more than 33,000 individuals died in 2015—nearly equal to the number of deaths.
from car crashes and double the number of murders. Meanwhile, the opioid-related fatalities continue to mount, having quadrupled since 1999.

The roots of the crisis can be traced to the early 1990s when physicians began to prescribe opioid painkillers more liberally. In parallel, overdose deaths from painkillers rose until about 2011. Since then, heroin and synthetic opioids have briskly driven opioid-overdose deaths; they now account for over two-thirds of victims. Synthetic opioids, such as fentanyl, are made mainly in China, shipped to Mexico, and trafficked here. Their menace cannot be overstated.

Fentanyl is 50 times as potent as heroin and can kill instantly. People have been found dead with needles dangling from their arms, the syringe barrels still partly full of fentanyl-containing liquid. One fentanyl analog, carfentanil, is a big-game tranquilizer that's a staggering 5,000 times more powerful than heroin. This spring, “Gray Death,” a combination of heroin, fentanyl, carfentanil, and other synthetics, has pushed the bounds of lethal chemistry even further. The death rate from synthetics has increased by more than 72% over the space of a single year, from 2014 to 2015. They have transformed an already terrible problem into a true public-health emergency.

The nation has weathered drug epidemics before, but the current affliction—a new plague for a new century, in the words of Nicholas Eberstadt—is different. Today, the addicted are not inner-city minorities, though big cities are increasingly reporting problems. Instead, they are overwhelmingly white and rural, though middle- and upper-class individuals are also affected. The jarring visual of the crisis is not an urban “gang banger” but an overdosed mom slumped in the front seat of her car in a Walmart parking lot, toddler in the back.

It’s almost impossible to survey this devastating tableau and not wonder why the nation’s response has been so slow in coming. Jonathan Caulkins, a drug-policy expert at Carnegie Mellon, offers two theories. One is geography. The prescription-opioid wave crashed down earliest in fly-over states, particularly small cities and rural areas, such as West Virginia and Kentucky, without nationally important media markets. Earlier opioid (heroin) epidemics raged in urban centers, such as New York, Baltimore, Chicago, and Los Angeles.

The second of Caulkins’s plausible explanations is the absence of violence that roiled inner cities in the early 1970s, when President Richard Nixon called drug abuse “public enemy number one.” Dealers do not
engage in shooting wars or other gang-related activity. As purveyors of heroin established themselves in the U.S., Mexican bosses deliberately avoided inner cities where heroin markets were dominated by violent gangs. Thanks to a “drive-through” business model perfected by traffickers and executed by discreet runners — farm boys from western Mexico looking to make quick money — heroin can be summoned via text message or cell phone and delivered, like pizza, to homes or handed off in car-to-car transactions. Sources of painkillers are low profile as well. Typically pills are obtained (or stolen) from friends or relatives, physicians, or dealers. The “dark web,” too, is a conduit for synthetics.

It’s hard to miss, too, that this time around, the drug crisis is viewed differently. Heroin users today are widely seen as suffering from an illness. And because that illness has a pale complexion, many have asked, “Where was the compassion for black people?” A racial element cannot be denied, but there are other forces at play, namely that Americans are drug-war weary and law enforcement has incarceration fatigue. It also didn’t help that, in the 1970s, officers were only loosely woven into the fabric of the inner-city minority neighborhoods that were hardest hit. Today, in the small towns where so much of the epidemic plays out, the crisis is personal. Police chiefs, officers, and local authorities will likely have at least one relative, friend, or neighbor with an opioid problem.

If there is reason for optimism in the midst of this crisis, it is that national and local politicians and even police are placing emphasis on treatment over punishment. And, without question, the nation needs considerably more funding for treatment; Congress must step up. Yet the much-touted promise of treatment — and particularly of anti-addiction medications — as a panacea has already been proven wrong. Perhaps “we can’t arrest our way out of the problem,” as officials like to say, but nor are we treating our way out of it. This is because many users reject treatment, and, if they accept it, too many drop out. Engaging drug users in treatment has turned out to be one of the biggest challenges of the epidemic — and one that needs serious attention.

The near-term forecast for this American Carnage, as journalist Christopher Caldwell calls it, is grim. What can be done?

**ROOTS OF A CRISIS**

In the early 1990s, campaigns for improved treatment of pain gained ground. Analgesia for pain associated with cancer and terminal illness
was relatively well accepted, but doctors were leery of medicating chronic conditions, such as joint pain, back pain, and neurological conditions, lest patients become addicted. Then in 1995 the American Pain Society recommended that pain be assessed as the “fifth vital sign” along with the standard four (blood pressure, temperature, pulse, and respiratory rate). In 2001 the influential Joint Commission on Accreditation of Healthcare Organizations established standards for pain management. These standards did not mention opioids, per se, but were interpreted by many physicians as encouraging their use.

These developments had a gradual but dramatic effect on the culture of American medicine. Soon, clinicians were giving an entire month’s worth of Percocet or Lortab to patients with only minor injuries or post-surgical pain that required only a few days of opioid analgesia. Compounding the matter, pharmaceutical companies engaged in aggressive marketing to physicians.

The culture of medical practice contributed as well. Faced with draconian time pressures, a doctor who suspected that his patient was taking too many painkillers rarely had time to talk with him about it. Other time-consuming pain treatments, such as physical therapy or behavioral strategies, were, and remain, less likely to be covered by insurers. Abbreviated visits meant shortcuts, like a quick refill that may not have been warranted, while the need for addiction treatment was overlooked. In addition, clinicians were, and still are, held hostage to ubiquitous “patient-satisfaction surveys.” A poor grade mattered because Medicare and Medicaid rely on these assessments to help determine the amount of reimbursement for care. Clearly, too many incentives pushed toward prescribing painkillers, even when it went against a doctor’s better judgment.

The chief risk of liberal prescribing was not so much that the patient would become addicted — though it happens occasionally — but rather that excess medication fed the rivers of pills that were coursing through many neighborhoods. And as more painkillers began circulating, almost all of them prescribed by physicians, more opportunities arose for non-patients to obtain them, abuse them, and die. OxyContin formed a particularly notorious tributary. Available since 1996, this slow-release form of oxycodone was designed to last up to 12 hours (about six to eight hours longer than immediate-release preparations of oxycodone, such as Percocet). A sustained blood level was meant to be a therapeutic
advantage for patients with unremitting pain. To achieve long action, each OxyContin tablet was loaded with a large amount of oxycodone.

Packing a large dose into a single pill presented a major unintended consequence. When it was crushed and snorted or dissolved in water and injected, OxyContin gave a clean, predictable, and enjoyable high. By 2000, reports of abuse of OxyContin began to surface in the Rust Belt—a region rife with injured coal miners who were readily prescribed OxyContin, or, as it came to be called, “hillbilly heroin.” Ohio along with Florida became the “pill mill” capitals of the nation. These mills were advertised as “pain clinics,” but were really cash-only businesses set up to sell painkillers in high volume. The mills employed shady physicians who were licensed to prescribe but knew they weren’t treating authentic patients.

Around 2010 to 2011, law enforcement began cracking down on pill mills. In 2010, OxyContin’s maker, Purdue Pharma, reformulated the pill to make it much harder to crush. In parallel, physicians began to re-examine their prescribing practices and to consider non-opioid options for chronic-pain management. More states created prescription registries so that pharmacists and doctors could detect patients who “doctor shopped” for painkillers and even forged prescriptions. (Today, all states except Missouri have such a registry.) Last year, the American Medical Association recommended that pain be removed as a “fifth vital sign” in professional medical standards.

Controlling the sources of prescription pills was completely rational. Sadly, however, it helped set the stage for a new dimension of the opioid epidemic: heroin and synthetic opioids. Heroin—cheaper and more abundant than painkillers—had flowed into the western U.S. since at least the 1990s, but trafficking east of the Mississippi and into the Rust Belt reportedly began to accelerate around the mid-2000s, a transformative episode in the history of domestic drug problems detailed in Sam Quinones’s superb book *Dreamland*.

The timing was darkly auspicious. As prescription painkillers became harder to get and more expensive, thanks to alterations of the OxyContin tablet, to law-enforcement efforts, and to growing physician enlightenment, a pool of individuals already primed by their experience with prescription opioids moved on to low-cost, relatively pure, and accessible heroin. Indeed, between 2008 and 2010, about three-fourths of people who had used heroin in the past year reported non-medical use
of painkillers—likely obtained outside the health-care system—before initiating heroin use.

The progression from pills to heroin was abetted by the nature of addiction itself. As users became increasingly tolerant to painkillers, they needed larger quantities of opioids or more efficient ways to use them in order to achieve the same effect. Moving from oral consumption to injection allowed this. Once a person is already injecting pills, moving to heroin, despite its stigma, doesn’t seem that big a step. The march to heroin is not inexorable, of course. Yet in economically and socially depleted environments where drug use is normalized, heroin is abundant, and treatment is scarce, widespread addiction seems almost inevitable.

The last five years or so have witnessed a massive influx of powder heroin to major cities such as New York, Detroit, and Chicago. From there, traffickers direct shipments to other urban areas, and these supplies are, in turn, distributed further to rural and suburban areas. It is the powdered form of heroin that is laced with synthetics, such as fentanyl. Most victims of synthetic opioids don’t even know they are taking them. Drug traffickers mix the fentanyl with heroin or press it into pill form that they sell as OxyContin.

Yet, there are reports of addicts now knowingly seeking fentanyl as their tolerance to heroin has grown. Whereas heroin requires poppies, which take time to cultivate, synthetics can be made in a lab, so the supply chain can be downsized. And because the synthetics are so strong, small volumes can be trafficked more efficiently and more profitably. What’s more, laboratories can easily stay one step ahead of the Drug Enforcement Administration by modifying fentanyl into analogs that are more potent, less detectable, or both. Synthetics are also far more deadly: In some regions of the country, roughly two-thirds of deaths from opioids can now be traced to heroin, including heroin that medical examiners either suspect or are certain was laced with fentanyl.

**The Basics**

Terminology is important in discussions about drug use. A 2016 Surgeon General report on addiction, “Facing Addiction in America,” defines “misuse” of a substance as consumption that “causes harm to the user and/or to those around them.” Elsewhere, however, the term has been used to refer to consumption for a purpose not consistent with medical or legal guidelines. Thus, misuse would apply equally to the person
who takes an extra pill now and then from his own prescribed supply of Percocet to reduce stress as well as to the person who buys it from a dealer and gets high several times a week. The term “abuse” refers to a consistent pattern of use causing harm, but “misuse,” with its protean definitions, has unhelpfully taken its place in many discussions of the current crisis. In the Surgeon General report, the clinical term “substance use disorder” refers to functionally significant impairment caused by substance use. Finally, “addiction,” while not considered a clinical term, denotes a severe form of substance-use disorder — in other words, compulsive use of a substance with difficulty stopping despite negative consequences.

Much of the conventional wisdom surrounding the opioid crisis holds that virtually anyone is at risk for opioid abuse or addiction — say, the average dental patient who receives some Vicodin for a root canal. This is inaccurate, but unsurprising. Exaggerating risk is a common strategy in public-health messaging: The idea is to garner attention and funding by democratizing affliction and universalizing vulnerability. But this kind of glossing is misleading at best, counterproductive at worst. To prevent and ameliorate problems, we need to know who is truly at risk to target resources where they are most needed.

In truth, the vast majority of people prescribed medication for pain do not misuse it, even those given high doses. A new study in the Annals of Surgery, for example, found that almost three-fourths of all opioid painkillers prescribed by surgeons for five common outpatient procedures go unused. In 2014, 81 million people received at least one prescription for an opioid pain reliever, according to a study in the American Journal of Preventive Medicine; yet during the same year, the National Survey on Drug Use and Health reported that only 1.9 million people, approximately 2%, met the criteria for prescription pain-reliever abuse or dependence (a technical term denoting addiction). Those who abuse their prescription opioids are patients who have been prescribed them for over six months and tend to suffer from concomitant psychiatric conditions, usually a mood or anxiety disorder, or have had prior problems with alcohol or drugs.

Notably, the majority of people who develop problems with painkillers are not individuals for whom they have been legitimately prescribed — nor are opioids the first drug they have misused. Such non-patients procure their pills from friends or family, often helping
themselves to the amply stocked medicine chests of unsuspecting relatives suffering from cancer or chronic pain. They may scam doctors, forge prescriptions, or doctor shop. The heaviest users are apt to rely on dealers. Some of these individuals make the transition to heroin, but it is a small fraction. (Still, the death toll is striking given the lethality of synthetic opioids.) One study from the Substance Abuse and Mental Health Services Administration found that less than 5% of pill misusers had moved to heroin within five years of first beginning misuse. These painkiller-to-heroin migrators, according to analyses by the Centers for Disease Control and Prevention, also tend to be frequent users of multiple substances, such as benzodiazepines, alcohol, and cocaine. The transition from these other substances to heroin may represent a natural progression for such individuals.

Thus, factors beyond physical pain are most responsible for making individuals vulnerable to problems with opioids. Princeton economists Anne Case and Angus Deaton paint a dreary portrait of the social determinants of addiction in their work on premature demise across the nation. Beginning in the late 1990s, deaths due to alcoholism-related liver disease, suicide, and opioid overdoses began to climb nationwide. These “deaths of despair,” as Case and Deaton call them, strike less-educated whites, both men and women, between the ages of 45 and 54. While the life expectancy of men and women with a college degree continues to grow, it is actually decreasing for their less-educated counterparts. The problems start with poor job opportunities for those without college degrees. Absent employment, people come unmoored. Families unravel, domestic violence escalates, marriages dissolve, parents are alienated from their children, and their children from them.

Opioids are a salve for these communal wounds. Work by Alex Hollingsworth and colleagues found that residents of locales most severely pummeled by the economic downturn were more susceptible to opioids. As county unemployment rates increased by one percentage point, the opioid death rate (per 100,000) rose by almost 4%, and the emergency-room visit rate for opioid overdoses (per 100,000) increased by 7%. It’s no coincidence that many of the states won by Donald Trump—West Virginia, Kentucky, and Ohio, for example—had the highest rates of fatal drug overdoses in 2015.

Of all prime-working-age male labor-force dropouts, nearly half—roughly 7 million men—take pain medication on a daily basis.
“In our mind’s eye,” writes Nicholas Eberstadt in a recent issue of Commentary, “we can now picture many millions of un-working men in the prime of life, out of work and not looking for jobs, sitting in front of screens—stoned.” Medicaid, it turns out, financed many of those stoned hours. Of the entire non-working prime-age white male population in 2013, notes Eberstadt, 57% were reportedly collecting disability benefits from one or more government disability programs. Medicaid enabled them to see a doctor and fill their prescriptions for a fraction of the street value: A single 10-milligram Percocet could go for $5 to $10, the co-pay for an entire bottle.

When it comes to beleaguered communities, one has to wonder how much can be done for people whose reserves of optimism and purposefulness have run so low. The challenge is formidable, to be sure, but breaking the cycle of self-destruction through treatment is a critical first step.

**TREATMENT OPTIONS**

Perhaps surprisingly, the majority of people who become addicted to any drug, including heroin, quit on their own. But for those who cannot stop using by themselves, treatment is critical, and individuals with multiple overdoses and relapses typically need professional help. Experts recommend at least one year of counseling or anti-addiction medication, and often both. General consensus holds that a standard week of “detoxification” is basically useless, if not dangerous—not only is the person extremely likely to resume use, he is at special risk because he will have lost his tolerance and may easily overdose.

Nor is a standard 28-day stay in a residential facility particularly helpful as a sole intervention. In residential settings many patients acquire a false sense of security about their ability to resist drugs. They are, after all, insulated from the stresses and conditioned cues that routinely provoke drug cravings at home and in other familiar environments. This is why residential care must be followed by supervised transition to treatment in an outpatient setting: Users must continue to learn how to cope without drugs in the social and physical milieus they inhabit every day.

Fortunately, medical professionals are armed with a number of good anti-addiction medications to help patients addicted to opioids. The classic treatment is methadone, first introduced as a maintenance therapy in the 1960s. A newer medication approved by the FDA in 2002 for the treatment of opioid addiction is buprenorphine, or “bupe.” It
comes, most popularly, as a strip that dissolves under the tongue. The suggested length of treatment with bupe is a minimum of one or two years. Like methadone, bupe is an opioid. Thus, it can prevent withdrawal, blunt cravings, and produce euphoria. Unlike methadone, however, bupe’s chemical structure makes it much less dangerous if taken in excess, thereby prompting Congress to enact a law, the Drug Addiction Treatment Act of 2000, which allows physicians to prescribe it from their offices. Methadone, by contrast, can only be administered in clinics tightly regulated by the Drug Enforcement Administration and the Substance Abuse and Mental Health Services Administration. (I work in such a clinic.)

In addition to methadone or buprenorphine, which have abuse potential of their own, there is extended-release naltrexone. Administered as a monthly injection, naltrexone is an opioid blocker. A person who is “blocked” normally experiences no effect upon taking an opioid drug. Because naltrexone has no abuse potential (hence no street value), it is favored by the criminal-justice system. Jails and prisons are increasingly offering inmates an injection of naltrexone; one dose is given at five weeks before release and another during the week of release with plans for ongoing treatment as an outpatient. Such protection is warranted given the increased risk for death, particularly from drug-related causes, in the early post-release period. For example, one study of inmates released from the Washington State Department of Corrections found a 10-fold greater risk of overdose death within the first two weeks after discharge compared with non-incarcerated state residents of the same age, sex, and race.

Any amount of time spent in care has some benefit for the individual and for society as well. This is a truism of treatment and alone justifies enrollment, even if attrition rates are high and even if lasting benefits are negligible. While on methadone, for example, patients almost always fare better. Though a sizeable fraction of patients will continue to use drugs and alcohol, engage in crime, and use emergency-room services, they do harmful things to themselves and others at a mercifully lower rate. Retention in treatment is also associated with substantial reductions in death from overdose and other medical causes. In my methadone clinic, for example, many patients hold very decent jobs; they come to the clinic at 6 a.m. to take their dose—or pick up a month’s worth if they have been drug-free for a period of time—and go
off to work. Still, as research has repeatedly shown, even patients who have done well on methadone have even odds of falling back to old patterns within a year of leaving the clinic.

The same general pattern of reduced risk applies to people while they are taking buprenorphine and injectable naltrexone: The longer they stay in treatment, the better they do, and anti-addiction medication reliably prolongs the stay. But once the patient is out of treatment, relapse rates are significant—at least half. Of course, the more stable a person is when he leaves treatment—with a settled place to live, a job, and a healthy social network—the better his odds of staying off drugs. But too few get that far. In a recent article in the *American Journal of Psychiatry*, Kathleen Carroll and Roger Weiss present a comprehensive review of buprenorphine studies to date and find that half of all patients drop out within six months.

The mixed performance of bupe has surprised many health authorities. After all, its relatively benign safety profile allows doctors who pass an eight-hour test to prescribe it from their offices. Easier access has made bupe the most popular anti-addiction medication initiated today—often in such demand, in fact, that many opioid users have difficulty finding a doctor to prescribe it. The dearth of prescribers is partly a problem of spotty Medicaid coverage, to be sure, but an arguably larger impediment is actually physician reluctance to prescribe bupe. No matter how well intentioned, few doctors have the time or training to work with these patients, who can be exceptionally challenging and who often require counseling and monitoring in the form of observed urine toxicology screens.

Though the National Institute on Drug Abuse, the former Surgeon General, and many public officials insist (rather naïvely) that addiction is a “disease like any other,” or a “brain disease” easily treated out of an office with the right medication (that is, bupe), it hasn’t turned out that way. Medication can do only so much when patients’ lives need fixing, and hard-won personal transformations are not readily fostered in rushed primary-care offices, even by the most devoted clinician.

Another problem is the abuse of bupe itself. The medication is now the third most diverted prescription opioid after oxycodone and hydrocodone. Some patients sell part of their monthly supply, and cash-only bupe mills are springing up. Smuggling into jail is easy, too, as the strips are so easily concealed (about half an inch by a quarter-inch and clear,
they can be applied over a child’s drawing or text in a book). Finally, bupe is also extremely potent in people who do not consume opioids regularly. A mere two milligrams are enough to kill. In fact, bupe poisonings of children have increased as unintentional exposure of young children to prescription opioids has been declining since 2009 (after the CDC established an initiative to prevent pediatric exposures in the home).

Drug-abuse treatment is not a straightforward enterprise. Patients are a heterogeneous crowd. Some merely require the stabilizing effect of replacement medication, while others need a full existential make-over; most fall in between. In addition, not every patient wants or needs anti-addiction medication. No matter the form of treatment, one of the biggest challenges, it turns out, is getting individuals to enter treatment and stay in it.

TOOLS OF ENGAGEMENT

When a person overdoses and personnel rush to the scene, they administer naloxone, or Narcan, a short-acting antidote that is generally delivered as a nasal spray. One might think that upon regaining consciousness the victim would pledge to relinquish drugs. All too often, though, the just-revived individual simply walks away. “A lot of times, [the users] get upset with you when you bring them back,” Timmy Hall, a former Baltimore police officer, told PBS NewsHour, “because they feel like you wasted the money they spent. You know, that’s the feeling that they wanted. They wanted that feeling, and you took it away from them.”

The paradox of naloxone is that it saves people who can then overdose again. “We’ve had people who have been ‘Narcanned’ in excess of five to 10 times,” one New Jersey police chief told a reporter. If the patient does agree to be taken by ambulance to the emergency room, there’s a good chance he’ll bolt before a treatment referral is even made. And even if he enters treatment, there is a 40% to 60% chance he will drop out within a few months. Recently, the Wall Street Journal reported on two facilities in New Jersey. At one Ocean County hospital run by RWJ Barnabas Health, 200 patients who were revived with naloxone were offered treatment. Over two years, only two of them agreed to enter detox programs, which precede actual treatment and rehabilitation, and both dropped out within a couple of days. In nearby Camden County, a program offered revived patients $15,000 vouchers for detox and intensive outpatient treatment. Only nine of the nearly 50 patients who were offered the
vouchers starting in October 2015 entered treatment — and four of them quickly dropped out.

No one sets out to become an addict. People just want to get relief in the short term. This is why many addicts are so ambivalent about quitting. Years of use have conditioned them to desire drugs, to crave them powerfully, at the first feeling of distress. Opioids have helped them cope with anxiety, despair, loneliness, emptiness, boredom, and hopelessness. And after years of neglecting themselves, their families, and their futures, a new layer of misery has settled itself upon their bedrock of discontent. Relief, not nodded-out oblivion, is what most users seek. What’s more, addicts are not particularly good at delaying gratification. So when craving hits, they often act.

Thus, forging a bridge between overdose victims and treatment requires new ideas. In Pittsburgh, for example, a group of specially trained emergency medical technicians conduct 90-minute interviews with overdose victims who have been revived so they can connect them to existing social-support programs and do follow-up visits. Chillicothe, Ohio, has instituted a similar program; police visit the home of each person in the county who overdosed during the prior week and try to connect him to treatment.

Maryland now offers the Overdose Survivors Outreach Program where “recovery coaches,” who are specially trained former addicts, are paired with overdose survivors after they arrive in the emergency room. Coaches encourage treatment: perhaps a starter dose of buprenorphine in the emergency room to curb the urge to use within the next day or so. If ongoing treatment is refused, coaches supply naloxone and stay in close touch after the patient goes home, encouraging formal treatment and helping with outstanding court obligations, social services, and job searches. The National Governors Association has endorsed the approach. Evaluations of its impact are underway.

Opioid addicts in Boston can walk into Faster Paths, where they are quickly given access to an addiction urgent-care center at Boston Medical Center. The idea is to engage the person when he feels receptive and move him into treatment. There is access to a primary-care doctor for medical problems, plus follow-up from a licensed drug counselor. Doctors at Zuckerberg San Francisco General offer a similar program with special emphasis on attending to opioid users who are already in the hospital for a medical problem like endocarditis, infections, or Hepatitis C.
Departing from their traditional roles, police officers are becoming “counselors, doctors, and social workers,” as a headline in the *Washington Post* described it. For example, in Gloucester, Massachusetts, drug users can walk into the police station, hand over their heroin, and enter treatment within hours—without arrest or charges. It’s called the “Angel Program.” Many men of the Gloucester fishing fleets who took opioids for their battered bodies are among the participants. A community nonprofit called PAARI—or Police Assisted Addiction and Recovery Initiative—was developed to support the Gloucester addiction initiative and to aid other police departments in implementing similar programs.

**Enhanced Retention**

More intensive contact with patients should help to keep more of them in care, but dropout will still happen. Less time in treatment means less exposure to vital recovery strategies, such as identifying the highly specific circumstances in which they are most vulnerable to craving, and thus to relapse, and developing and practicing strategies for subduing urges to use. This is why leverage to keep patients in treatment is so vital to success. Most of the time, that leverage comes from the addict’s own life, as many if not most patients come to treatment because someone—a spouse, boss, child, or parent—mightily twisted their arms.

But sometimes this is not enough to keep them there. Researchers have discovered several strategies for prolonging treatment. One involves incentives. A vast literature exists, for example, on the use of redeemable vouchers to extend retention and reduce drug use. Such vouchers have monetary value that patients can exchange for food items, movie passes, or other goods or services that are consistent with a drug-free lifestyle. In one incentive model, a research team out of Johns Hopkins offered $10 an hour to addicts to work in a “therapeutic workplace,” but only if they submitted clean urine. Workplace participants provided significantly more opiate-negative urine samples than controls; they also reported more days employed, higher employment income, and less money spent on drugs.

To enhance retention, all treatment programs should put serious effort into combining incentives with quality counseling and anti-addiction medication if necessary. But this will be a challenge, as cash-strapped clinics cannot afford to provide material encouragement to patients, let alone devote precious personnel time to supervising an
incentive program. One domain stands out as having leverage built into its way of doing business: the criminal-justice system. With its emphasis on monitoring and accountability, the criminal-justice system is home to some of the most promising treatment and rehabilitation models. In fact, we should revise the oft-repeated “we can’t arrest our way out of this epidemic,” to say, more accurately, that we can’t incarcerate our way out of it.

Drug courts are a prime example. Many of the nation’s roughly 3,000 drug courts offer offenders dismissal of charges for completion of a 12- to 18-month treatment program. Critically, the courts impose swift, certain, and fair consequences when participants fail drug tests or commit other infractions, such as missing meetings with probation officers or skipping work-training classes. The sanctions can escalate depending on the number of infractions committed, ranging from mild, such as a warning from the judge, to community service and more intensive probation supervision, to flash incarceration (temporary sentences of one to 10 days).

These courts are more effective than conventional corrections options, such as mandatory jail time or traditional probation. According to the National Association of Drug Court Professionals, offenders whose cases are handled by drug courts are about one-half to one-third less likely to return to crime or drug use than those who are monitored under typical probationary conditions. On average, two-thirds of drug-court participants graduate drug-free at 18 months. The relatively recent use of anti-addiction medications is already showing great potential to make such mandated treatment even more effective.

What’s more, if carrot-and-stick approaches are scrupulously applied, and perhaps combined with anti-addiction medication, it is very possible that not every opioid addict will even need rehabilitation. A program called HOPE (Hawaii’s Opportunity Probation with Enforcement) that treats methamphetamine addiction, for which there is no medication, shows how sanctions such as flash incarceration and incentives alone can work, while reserving treatment for the most refractory participants. A randomized study found that after one year participants were 55% less likely to be arrested for a new crime compared with those on traditional probation, and 72% less likely to use drugs. They were also 61% less likely to skip appointments with their supervisory officer, and 53% less likely to have their probation revoked. Programs modeled on Hawaii’s
“swift, certain and fair” approach are having success in Washington state, Alaska, Texas, South Dakota, and other places. Manchester, New Hampshire, and Worcester, Massachusetts, have programs specifically tailored to opioid addicts (including anti-addiction medication) that are in the process of being evaluated.

With many drug users involved in addiction-related crime, such as shoplifting, prescription forgery, and burglary, there comes a point when shielding them from the criminal-justice system is not in society’s best interests—or their own. Criminal-justice authority combined with contingencies can impart order to lives in disarray. The addition of anti-addiction medications—methadone, buprenorphine, or naltrexone—will almost surely make that synergy even stronger.

The most dramatic form of leverage is involuntary civil commitment. Most states have some form of involuntary substance-abuse treatment, though it is rarely used. That may be changing, however. In Kentucky, for example, Casey’s Law allows parents, relatives, or friends to petition the court for treatment of two to 12 months on behalf of an addicted person who “presents a danger or threat of danger to self, family, or others.” New Hampshire is considering a bill that would impose involuntary care on individuals who lack “the capacity to care for [their] own welfare.” The governor of Indiana recently signed a similar bill into law. A proposed Washington state measure would allow a person to be committed if, within a 12-month period, he had three or more arrests connected to substance abuse, had one or more hospitalizations related to drug abuse, or displays three or more visible track marks indicating intravenous heroin use.

**HARM REDUCTION**

The health-care and law-enforcement systems are the traditional portals through which addicts pass. But in the midst of an entrenched crisis, localities are turning to once-inconceivable strategies under the banner of harm reduction, a strategy geared first toward reducing opioid-related death and disease, and second toward reducing drug use—if, and only if, the user wants to. A classic example is needle exchange, first implemented in the U.S. in the late 1980s to halt the spread of HIV among intravenous drug users. Today, as a way to reduce harm, users are also instructed in “smart use” rules, such as buying only from dealers they know and trust; using with a buddy, making sure one’s buddy doesn’t
pass out before injecting oneself; and taking a small amount before the full shot.

Spurred by the rapid rise of fentanyl-related deaths, harm-reduction strategies are gaining momentum. In spring 2016, for example, Boston opened the Supportive Place for Observation and Treatment, or the SPOT, on Albany Street near Boston University’s medical campus. Individuals who have already injected drugs can go to SPOT to ride out the high, be treated by nurses should complications develop, and, ideally, be persuaded to embark on a path to recovery. According to its website, “The SPOT will offer engagement, support, medical monitoring, and serve as an entryway to primary care and treatment on demand for 8-10 individuals at a time who are over-sedated from the use of substances and who would otherwise be outside on a street corner, alleyway, or alone in a public bathroom, at high risk of overdose.”

The idea of “Safe Consumption Sites,” or SCSs, is also gaining traction. As the name implies, people bring their own drugs to inject in hygienic booths in the presence of nurses who can administer oxygen and naloxone if needed. A Vancouver facility called Insite is considered a model for North America. Insite staff members urge patrons to go into treatment, but also distribute clean needles to help prevent the spread of viruses such as HIV and Hepatitis C, and naloxone kits just in case. Data show fewer incidences of public injection in neighborhood venues (such as public bathrooms where someone can overdose undiscovered and die), fewer overdose deaths, and, in some evaluations, greater cost effectiveness due to averted health-care costs.

Early this year, the Ontario government agreed to help fund three supervised sites in Toronto and one in Ottawa. There are no SCSs in the U.S., but in January local officials endorsed the creation of two supervised sites in the Seattle area. A bill introduced in the California Assembly would allow localities to establish SCSs. In San Francisco, Burlington, New York City, Philadelphia, Ithaca, and Baltimore, they are under serious consideration by local health officials.

It is imperative that these initiatives be studied closely and in real time by independent researchers. Safe Consumption Sites are intended for areas already marred by high levels of public drug use. Still, it’s hard to imagine communities greeting them with uniform enthusiasm; grudging tolerance may be the best such facilities can expect. Presumably, programs that are good at ushering clients into treatment
would be more attractive to a skeptical public. Likewise with programs that require clients to pay a nominal fee to use the services or expect them to make an in-kind contribution, such as helping to maintain the facility or tending to the urban environs. This kind of reciprocity, while unfortunately considered by some harm-reduction advocates to be an imposition on the patrons of the sites, would be therapeutic, as people need to feel useful, and to see that others are grateful for their efforts.

Consumption sites enable drug use, critics charge; they represent a form of surrender. Perhaps, as they allege, some clients would have eventually quit had the facility not been there to make it safer to use drugs. Then again, other users might well have overdosed and died but for the existence of those sites; better yet, perhaps staff managed to usher into treatment some users who would not otherwise have enrolled. It’s a fraught tradeoff—keeping some people using who might have stopped, while trying to make the population and the neighborhood safer overall. But when so many users avoid or drop out of treatment, one can see the virtue of such a tradeoff. It is imperative, then, that the costs and benefits of injection sites be elucidated by researchers who are scrupulously independent and conduct their studies prospectively, not after the fact. Up to now, most analyses of such facilities have been conducted by the programs’ own developers, a methodology that undermines the credibility of their findings.

An even more drastic concept is actual distribution of pharmaceutical-grade heroin to individuals who have failed methadone treatment. A number of such clinics exist in some European countries, and one opened a couple of years ago in Vancouver. It is difficult to foresee serious interest developing in this country, and even harder to imagine a campaign for flat-out legalization. After all, we essentially just tried it, starting in the 1990s, with the liberalized prescribing of a legal substance (opioid painkillers) dispensed by legal entities (physicians and pharmacists) and effectively provided on request. The results are tragically familiar.

LOOKING FORWARD

Through the pall, creative energy and good will are bursting forth all over the country, from fishing communities in Massachusetts to coal towns in Kentucky to Seattle’s edgy experiment. Amid anxieties about the implications of health-care reform for treatment coverage and
possible cuts to the Drug Czar’s office, there are some positive signs from the nation’s capital: President Trump has placed the opioid crisis fairly high on his agenda. In February, he told a gathering of police chiefs and sheriffs that “Prisons should not be a substitute for treatment.” And in March, he established the President’s Commission on Combating Drug Addiction and the Opioid Crisis. In April, Secretary of Health and Human Services Tom Price rolled out a five-point agenda and released the first half of the $1 billion appropriated by Congress.

The federal government can provide much-needed additional funding for treatment. This will be imperative if the Medicaid expansion is rolled back, as it has brought coverage to about 1.3 million substance abusers who were too poor for private insurance but not poor enough for Medicaid. But it is at the state and county levels that the real progress will be made. Locales are developing inventive modes of engagement; treatment programs are beginning to test novel kinds of incentives; and justice programs are starting to combine enforced structure with medication. As we have seen, the worst of the crisis is in small communities where everyone knows someone who has been affected by an opioid addiction. It makes sense that the effort to find inspired solutions would be most concentrated there; we should invest in those solutions and learn from them. There won’t be a master blueprint that works everywhere — this is not a problem that will ever lend itself to such a scalable solution, especially in small towns.

At least at this point, if not for the duration of this crisis, we need to allow medical professionals, law-enforcement officials, community organizations, and the loved ones of those affected to attempt different, even radical, solutions and evaluate their effectiveness. Policymakers should support such experimentation, and fund it, but must resist the urge to pretend that better funding alone will end the scourge of opioids.

Indeed, the lingering lesson of the opioid crisis is that nothing ever changes. This time around, the casualties are largely white drug users with little education dying young in communities that are “hemorrhaging jobs and hope,” in the words of J. D. Vance. But this bleak fact is an instance of a larger truth. No matter where people live or how much money they have, those in great pain will seek solace and oblivion through intoxicants, as they have done forever.