Perspectives on the Opioid Overdose Epidemic

By Nicolas Terry

It may be hard to remember, but in October 2017, prior to social distancing, masks, and mass demonstrations, the federal government declared a public health emergency regarding the opioid overdose crisis. That crisis has not disappeared; indeed, in some ways it has worsened. That emergency order has been renewed multiple times, as recently as April 2020. Overall, drug overdose deaths continue to tick up. Although deaths from prescription opioids and heroin are down, deaths from synthetic opioids have surged and account for almost half of all deaths. About 70,000 people die from opioid overdoses every year, and, overall, the epidemic has taken more than half a million lives. During the three months after the COVID-19 national emergency was declared, there have been significant increases in the use of illicit drugs, led by non-prescribed fentanyl (up 31.96 percent) amid reports of opioid overdoses "skyrocketing."

Continued focus from policymakers is difficult in the face of the COVID-19 pandemic, and, arguably, the Trump administration lost interest in opioids after the passage of the SUPPORT Act in 2018. The emergence of COVID-19 and, most recently, the urgent need to respond to vivid reminders of systemic institutionalized racism, have rendered a renewed focus on the opioid overdose crisis ever more doubtful.

Notwithstanding, there are remarkable points of connection underlying these three emergencies. All three are "wicked problems" that do not easily reduce to binary choices. They involve difficult socioeconomic trade-offs and typically overlap with other problems. While any Venn diagram that can be imagined is complicated, concentrating on the intersection points, as illustrated here, is informative.

Both COVID-19 and police violence have disproportionately harmed persons and communities of color. The opioid overdose crisis also has a racial component. The reaction to prior substance use crises, such as crack cocaine, was almost exclusively one of increased criminalization and incarceration, particularly of persons of color. However, for a few years at the peak of the opioid overdose epidemic coincident with increased deaths of whites from prescription opioids, states began prioritizing harm reduction models. Equally, if the U.S. prison population were not disproportionately Black, one can speculate that there would have been an increase in decarceration during COVID-19 in response to the high infection rates associated with congregate living. There is clear evidence that harm reduction strategies, such as syringe services, safe injection facilities, and decriminalization, are effective public health tools of harm reduction. However, stigmatization of drug users as possessing moral defects and being criminals solely because they have a chronic disease mirrors the stereotyping, imposed inferiority, and slave language applied to Black Americans.

All three public health emergencies are the product of broad and well-known, but no less inexcusable, systemic failures. First, the U.S. safety net has been exposed as totally inadequate in the face of pervasive poverty, inadequate and unsafe housing, and the continued decline in quality employment opportunities. Perhaps no safety net could have scaled up as quickly as the pandemic demanded, but at least the structural outline could have been there. The minimal safety net fails almost all; for example, those with serious substance use disorders will find themselves shut out from public housing while the recently decarcerated seldom find employment and are likely to join the ranks of the homeless before their almost inevitable final overdose.

Second, problems with the health care system are intense for many people of color and those with substance use disorders. Access to care is almost nonexistent for the tens of millions of uninsured that have grown exponentially during the pandemic. It is particularly acute in states that have refused to expand Medicaid (many of which are southern states with their own narrative of acute, post-segregation institutional racism). However, access problems are increasing nationwide as many blue- and increasingly white-collar workers cannot afford to use the insurance they and their employer pay for because of cruelly high out-of-pocket costs. Even those with insurance that covers their opioid use disorder might not be able to find a nearby provider or one that is "in-network."

Third, we inhabit a society that has increasingly sacrificed well-functioning government in favor of markets and private entities. This leads not only to the inequities that form much of the bases for substance use and racial injustice, but also perpetuates the dominance of social and economic hierarchical structures that lack incentives to promote social resilience or public health capacity and, in many cases, are antithetical to the solidarity necessary to combat a pandemic or racial injustice, never mind both.

Assuming we survive today's syndemic, one unanswered question is whether our society will emerge as a better place with solidarity tempering traditional American individualism. If that question were to be posed to the involuntary participants in the first of our three public health emergencies, those who have suffered from serious opioid use disorder (or their surviving family members), it is unlikely we would hear a positive response.

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