The opioid crisis and its morbid and mortal consequences have captured the public spotlight, and rightly so. In response, public health professionals have pursued a variety of approaches in analyzing data to highlight aspects of the crisis that may help inform a solution. Two current articles in JAMA Network Open, “The Burden of Opioid-Related Mortality in the United States”1 by Gomes et al and “Patterns of Immediate-Release and Extended-Release Opioid Analgesics Use in the Management of Chronic Pain, 2003-2014”2 by Hwang et al, add to the current discussion and reveal some potential for misdirection from the goal of reversing current trends in opioid use.

Gomes et al1 provide a report on poisoning deaths related to opioids over time from a Centers for Disease Control and Prevention database. They find that the rate of such deaths increased during the 15-year period (2001-2016) of observation. A more than 3-fold increase in opioid-related deaths among individuals aged 15 to 24 years and those aged 25 to 34 years is striking, as is the fact that in 2016, 1 in 10 deaths in the former and 1 in 5 deaths in the latter were related to opioids. It is tragically clear that opioids, and overdose in particular, have played an enormous role in deaths among younger and middle-aged adults. We should also note that many of these deaths involve more than opioids in isolation. Our own query of the Centers for Disease Control and Prevention WONDER Multiple Cause of Death database showed that among opioid-related deaths for 2016 (n = 43,491), alcohol, cocaine, or benzodiazepines were also present in 19,646 deaths (45%).3 Such data help to illustrate our challenge. Opioid poisoning, with and without other substances, identifies a tragedy. The question is whether or how these analyses might point toward solutions.

One seductive target for action is restraint of opioid prescriptions: their dose, duration, and formulation.4 A case can be made that risk will be attenuated by attacking all 3 aspects of prescribing, and policy makers and regulators have taken up this solution with enthusiasm. However, such regulatory efforts have also inaugurated a tide of nonconsensual tapers in otherwise stable patients, for which evidence of benefit is lacking5 and reports of harm are concerning.6

What about avoiding certain higher-risk formulations? Data from Hwang et al7 hint that the return on investment for prescribing extended-release/long-acting (ER/LA) formulations may be low. While ER/LA formulations remain, in correlational data at least, a risk factor for overdose in patients,7 such prescriptions are in decline. Using data resources large enough to reflect national trends, Hwang et al report that long-acting opioids represent a small proportion of opioids prescribed. Even among persons receiving long-term (>90-day) prescriptions, immediate-release formulations outnumber ER/LA formulations by 4 to 1. Physicians were half as likely to add ER/LA prescriptions to long-term regimens in 2014 (1.8%) compared with 2009 (4.0%).

It may be important to note that people receiving such prescriptions tend to be older: in the study by Hwang and colleagues, 72% were aged 45 years or older and 29% were aged 65 years or older. The burden of opioid-related death, however, has been shown to fall disproportionately on younger adults.1 While older adults are not exempt from opioid toxic effects, a focus on ER/LA prescription is not likely to substantially protect young adults.

While neither analysis sought solutions, the stark tragedy of young adults dying compels our attention. The findings from Gomes et al1 alone drive home the point that the time has come to treat substance use problems as mainstream medical issues. One can plausibly hope that restraint in prescribing, particularly to younger adults, will prevent some new cases of addiction. However, the
factors causing young and middle-aged adults to use illicit opioids, alcohol, or cocaine are not fully remediable through the narrow window of prescription control, even if excess prescriptions played a role in today’s predicament.

Effective clinical engagement with people with unhealthy substance use can make important contributions to reverse this deadly epidemic. What constitutes effective clinical engagement, and what informs such an approach? For people with an opioid use disorder, medications present the most effective strategy, even if they are not successful for all. Given randomized clinical trial outcomes and observational analyses examining mortality, medication treatments, particularly those using opioid agonists (eg, buprenorphine and methadone), should be a bedrock on which treatment is built. Models of care that enable physicians working collaboratively with nurses to prescribe medications for opioid use disorder within primary care have been described within community health centers. However, clinical strategies allowing physicians or nurse practitioners to work in teams to engage patients with the use of medications are not being implemented with the necessary urgency. A continuing national failure to ensure the accessibility of such treatment disgraces us in a time of tragedy. At the same time, we must offer other forms of assistance, as some with addiction can effectively achieve recovery with the support of psychological therapies, housing, and help returning to work in addition to medications.

The barriers to achieving progress that would protect lives at risk go beyond money for treatment (although more funds could help, if properly deployed). Money alone cannot fix a system in which health professionals of many disciplines have not been trained systematically in understanding and responding to addiction as a mainstream health concern. In this regard, an enthusiastic recommendation for training in responsible opioid prescribing, as was offered by a presidential commission, underestimates the problem considerably. Our view is that curricular attention to addiction should rapidly expand within medicine, nursing, and allied health professions.

It will be challenging to reverse the trend of opioid overdose deaths given the extent of the epidemic as described by many, including Gomes et al. Training health professionals how to clinically respond to the addiction epidemic and building systems that enable effective care will be much easier in a health system that adopts payment processes that do not construct barriers to patients who need help. Medical efforts to address substance use disorders, and in particular opioid use disorders, should grow within primary care and be allied with the addiction subspecialty care system. Accessible, effective medical care that routinely includes medications should be the standard to which clinical practice is held.

ARTICLE INFORMATION

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