WEST VIRGINIA UNIVERSITY

Tackle the epidemic, not the opioids

Unless attention turns to what leads to addiction and overdose, treatment will always be out of date, says **Judith Feinberg**.

Of the estimated 70,000 deaths from drug overdose in the United States in 2017 — the most recent year for which finalized figures are available — more than two-thirds were caused by opioids, including prescription pain relievers, fentanyl and its analogues, and heroin. Since 2000, the US Congress has passed several bills to address this opioid epidemic, starting with the DATA 2000 legislation that allows more physicians to prescribe buprenorphine, an opioid derivative used to treat opioid addiction. Other initiatives have focused on expanding treatment options and strategies for pain control, as well as slowing the flow of illicit opioids from overseas. Two years ago next month, US President Donald Trump declared opioid addition a public-health emergency. Last year, federal research funding to control opioid misuse and manage pain reached US$1.1 billion.

All of these efforts have specifically targeted opioids. And that is part of the problem.

Historically, substance misuse has come in waves, with a new drug supplanting the previous one: the 'heroin chic' of the 1990s followed the 'crack babies' of the 1980s. By the time federal programmes target a specific drug, the issue is being attacked where it was, not where it is. Funding should be targeted to substance misuse, not to the *drug du jour*.

The current opioid epidemic is a symptom of the fraying of the socio-economic fabric of the rural United States. The epidemic arose in the 1990s in areas that had experienced economic decline, a brain drain and population loss over decades. Many factors combined to create a monstrous situation in which small towns were flooded with prescription opioids: the preponderance of injury-prone hard labour jobs, requirements that physicians routinely ask patients about pain, aggressive marketing by the pharmaceutical industry, greed and extensive job losses from the collapse of key rural industries such as coal mining.

By the time Congress moved to address the opioid epidemic, the pattern of drug use had started to shift. Once, those using multiple drugs combined opioids with alcohol and other drugs, such as anti-anxiety agents that act on the central nervous system. Where I work in central Appalachia (West Virginia, southern Ohio, eastern Kentucky and northeastern Tennessee), opioids are being rapidly supplanted or exacerbated by cheap, readily available, high-potency methamphetamine. When opioids are used, they are being increasingly combined with stimulants such as cocaine — which, like methamphetamine, is thought to help to counteract the depressant effect of opioids.

Federal grants come tagged for combating opioids and cannot be repurposed to deal with the rising incidence of methamphetamine misuse. The narrow focus on opioids means we cannot keep up with the *drug du jour* cycle: we will just keep playing whack-a-mole.

Similar short-sightedness has kept us from addressing syndemics — epidemics that accompany the use of injection drugs. Although there has been some (but not enough) funding to slow the spread of HIV and hepatitis C among people who inject drugs, little attention has been paid to other potential conditions, such as endocarditis, a life-threatening infection of the heart. Injection-drug users are particularly susceptible, because needles puncturing unclean skin or delivering drugs prepared with unclean paraphernalia introduce bacteria directly into the bloodstream. West Virginia University's flagship hospital in Morgantown now has a dedicated ward for these patients, some of whom require intensive care and heart surgery. In 2018, the hospital admitted 373 people for endocarditis (it was the primary diagnosis for 73 of these), with total costs exceeding $37 million; there were no signs of this trend slowing in the first half of 2019. This pattern is seen throughout the United States, yet the US Centers for Disease Control and Prevention has not made endocarditis a reportable illness, so does not track its incidence.

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Even more neglected are efforts to understand why the rural United States is vulnerable. Why is attention focused on this drug or that drug, when the real question is why is there a raging epidemic of addiction?

In Kermit, West Virginia, a coalfield town with about 400 inhabitants, a local family-run pharmacy received 9 million pain pills in 2 years. The collapse of the coal industry in central Appalachia made the region particularly vulnerable. McDowell County, on West Virginia's southern border, had a population of 100,000 in 1970, when coal was king. It now has 19,000 residents and a boarded-up Walmart store. Donations of used clothing, shoes and hotel-size toiletries sit on tables for the taking at the entrance to the county health department. Local officials tell me that half of the county's children are in foster care. Life expectancy is falling, and the primary causes of death among rural middle-aged white men are overdose, suicide and liver disease. Our interviews with people who inject drugs in southern West Virginia reveal hopelessness, boredom and despair. Opioids ease the pain from years of crawling through mine tunnels and the harshness of everyday life. Perhaps the pertinent question isn't why people turned to opioids, but why didn't even more people take that path?

Without an effort to rebuild the social and economic fabric of rural communities, addiction will persist. That's where the real problem lies, and as yet there are no serious attempts to address it. Our current approach to drug misuse means that we will always be playing catch-up and leaving vulnerable people behind. ■

Judith Feinberg *is a professor of behavioural medicine, psychiatry and infectious diseases at West Virginia University in Morgantown.*
e-mail: judith.feinberg@hsc.wvu.edu