The U.S. Opioid Epidemic

Opioid addiction in the United States has reached epidemic proportions, threatening not only public health but economic output and national security.

Backgrounder by Claire Felter
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Introduction

The United States is grappling with one of its worst-ever drug crises. More than six hundred people a week die from opioid-related overdoses, and some experts say the death toll may not peak for years. Meanwhile, millions more Americans suffer from opioid addiction.

The crisis has reached such a scale that, beyond the risks it poses to public health, it is becoming a drag on the economy and a threat to national security. Analysts say the problem started with the overprescription of legal pain medications, like oxycodone, but note that it has intensified in recent years with an influx of cheap heroin and synthetic opioids, like fentanyl, supplied by foreign-based drug cartels.

In recent years, the U.S. government has ramped up efforts to cut both the foreign and domestic supply of opioids, limiting the number of prescriptions in the United States while providing counternarcotics assistance to countries including Mexico and China. Meanwhile, federal and state officials have attempted to reduce demand by focusing less on punishing drug users and more on treating them. Other countries where opioid use has also spiked, such as Canada and Australia, are experimenting with different policies.
What drugs are contributing to the crisis?

Opioids, a class of drugs derived from the opium poppy plant, can be divided into two broad categories: legally manufactured medications and illicit narcotics.

Opioid medications, including oxycodone, hydrocodone, and morphine, are commonly prescribed to treat pain, while methadone is primarily used in addiction treatment centers to reduce patients’ dependence on opioids. Opioids gained popularity among doctors in the 1990s for treating patients who had undergone surgery or cancer treatment, but in the last fifteen years physicians have increasingly prescribed them for chronic conditions, such as back or joint pain, despite concerns about their safety and effectiveness.

"We didn’t develop an opioid epidemic until there was a huge surplus of opioids, which started with pharmaceutical drugs."

— Bridget G. Brennan, New York Special Narcotics Prosecutor

Heroin has for decades been the most commonly used illegal opioid. Over the last several years the heroin supply in the United States has soared, and the drug can now be obtained for a third of the price it was in the early 1990s.

People in the last few years have increasingly turned to synthetic opioids, such as fentanyl, which is especially lethal. Some law enforcement officials have labeled the drug “manufactured death” because it is cheaper and up to fifty times more potent than heroin. Fentanyl-related deaths are largely caused by the drug’s illegal use, though it can also be prescribed as a painkiller. The Centers for Disease Control and Prevention (CDC) notes that heroin and fentanyl are most often used in combination with other drugs, such as cocaine, or alcohol, which increases the risk of overdose.
What is the scale of the epidemic?

Overdose deaths involving opioids have quadrupled since 1999. In 2015, the most recent year for which data is available, opioid overdoses killed more than thirty-three thousand people, or nearly five times the number of U.S. military service members killed in the post-9/11 wars in Iraq and Afghanistan.

U.S. Opioid Overdose Deaths

Many health experts attribute the rising death toll to what they say has been years of overprescribing by physicians. Doctors began prescribing more opioids amid a growing concern that pain was going undertreated, and also because pharmaceutical companies began marketing them more aggressively while claiming they posed little risk. Health-care providers have reported feeling pressure to prescribe opioid medications rather than alternatives, such as physical therapy or acupuncture, because patients request them and other treatments are often more costly or less accessible.

Source: National Institute on Drug Abuse
Opioid-related deaths have grown in lockstep with the volume of opioids prescribed. A spike in the use of illegal opioids in the United States followed the rise in prescriptions, as many users turn to heroin and other illegal drugs once they can no longer obtain enough of their prescribed drug to keep pace with what may be a developing addiction. “We didn’t develop an opioid epidemic until there was a huge surplus of opioids, which started with pharmaceutical drugs distributed legally,” says New York Special Narcotics Prosecutor Bridget G. Brennan.

What are the demographics of the opioid crisis?

The vast majority of those who overdose on opioids are non-Hispanic white Americans, who make up more than 80 percent of the annual total. Non-Hispanic black Americans and Hispanic Americans each account for about 10 percent of cases. Economists Anne
Case and Angus Deaton have argued that the rise in what they call “deaths of despair,” which include drug overdoses, particularly among white Americans without college degrees, are primarily the result of wages stagnating over the last four decades and a decline in available jobs.

U.S. military veterans, many of whom suffer from chronic pain as a result of their service, account for a disproportionately high number of opioid-related deaths. Veterans are twice as likely as the general population to die from an opioid overdose, according to a study commissioned by the National Institutes of Health.

**What have been the socioeconomic consequences?**

The opioid epidemic is having devastating consequences on public health, causing high rates of hepatitis C, HIV, and other diseases, mainly due to shared syringes. Meanwhile, mothers may pass an opioid dependency on to their children if they use while pregnant. Incidences of neonatal abstinence syndrome almost quadrupled from 2000 to 2012. The opioid crisis may also have contributed to an uptick in the number of children in foster care.

Opioids have also begun to take a toll on the economy. Testifying before the U.S. Senate, Federal Reserve chief Janet Yellen linked the opioid epidemic to declining labor-force participation among “prime-age workers.” Princeton University economist Alan Krueger says it could account for 20 percent of the decline in participation among men and 25 percent among women from 1999 to 2015. As one example of this, a boiler manufacturing company in Ohio, the state with the second-largest number of opioid-related deaths, reported that at least a quarter of its job applicants failed drug tests. The firm says the workforce shortage costs it roughly $800,000 in orders a year, which end up going to foreign competitors.

**Where are the heroin and fentanyl coming from?**
The opioid crisis has also become a national security concern. Most of the heroin coming into the United States is cultivated on poppy farms in Mexico, with eight cartels controlling production and operating distribution hubs in major U.S. cities. Mexican cartels, which the U.S. Drug Enforcement Administration (DEA) has called the “greatest criminal drug threat to the United States,” typically smuggle narcotics across the U.S. southwest border in passenger vehicles or tractor trailers. Large quantities of heroin are also produced in South American countries, particularly Colombia, and trafficked to the United States by air and sea. Although most of the world’s heroin comes from Afghanistan, only a small portion of the U.S. supply is produced there.

A soldier stands guard before a poppy field is destroyed during a military operation in Coyuca de Catalan, Mexico. Henry Romero/Reuters
Most fentanyl coming to the United States is produced in China, U.S. officials say, and commonly transited through Mexico. Chinese authorities “have struggled to adequately regulate thousands of chemical and pharmaceutical facilities operating legally and illegally in the country,” says a 2017 report [PDF] issued by a congressionally mandated commission.

**What has the United States done to restrict foreign narcotics?**

Over the past decade, the United States has provided Mexico with nearly $3 billion in counternarcotics aid, including for police and judicial reforms, in a program known as the Merida Initiative. The initiative, which U.S. officials say led to the capture of some top cartel leaders, including Joaquin “El Chapo” Guzman, has continued under the administration of President Donald J. Trump, though funding has declined in recent years. Through a similar partnership with Colombia, the United States has provided almost $10 billion since 2000; it effectively drew to a close following the end to civil conflict there in 2016.

The DEA, the leading U.S. agency involved in counternarcotics, has also coordinated efforts with China, which has designated more than one hundred synthetic drugs as controlled substances. Beijing banned production of four fentanyl variations in 2017, although some analysts fear these moves will only spur clandestine labs to create new alternatives.

Recent U.S. administrations have also increased the number of border patrol agents to approximately twenty thousand. Heroin seizures and trafficking arrests more than doubled [PDF] between 2010 and 2015, mostly near the southwestern border.

In his first weeks in office, President Trump issued executive orders directing the construction of a southern border wall and additional increases to the number of border patrol agents. Some analysts say a wall would do little to curb drug flows, however, as
most illicit drugs are smuggled through ports of entry.

**What are some efforts to restrict domestic supply?**

Federal agencies, state governments, insurance providers, and physicians all influence the supply of opioid medications.

Federal regulators have introduced new limits on opioid prescriptions, reducing the total nationwide by 18 percent from their 2010 peak to 2015, according to the CDC. The agency issued guidelines in March 2016 advising physicians not to prescribe opioids as a first-line therapy. The DEA reduced production quotas for pharmaceutical manufacturers by at least 25 percent that year for opioids categorized as Schedule II drugs, or ones that are currently accepted for medical use but carry high risk of misuse; these include oxycodone, fentanyl, and morphine. The agency has proposed additional cuts for 2018.

U.S. Attorney General Jeff Sessions announced in August 2017 that the Justice Department will hire a dozen attorneys to investigate health-care providers suspected of dispensing prescription opioids for nonmedical use.

Additionally, lawmakers in more than fifteen states have passed or are considering legislation limiting opioid prescriptions since the start of 2016. States including Mississippi, Ohio, and Oklahoma, as well as dozens of cities, are suing pharmaceutical companies, alleging they overstated the benefits of prescription opioids and concealed the risks.

**What is the United States doing to reduce demand?**

Previous federal antidrug campaigns relied on incarceration to deter drug use and trafficking but have been widely criticized for failing to keep people from cycling in and out of prison and for disproportionately targeting African Americans. In recent years, federal and state officials have shifted toward prevention and treatment.
President Barack Obama reduced prison sentences for hundreds of nonviolent drug offenders during his tenure. However, he failed to secure legislation that would have eliminated mandatory minimum sentences for federal drug crimes. His administration also established hundreds of new drug courts, which proponents say are a more effective alternative to incarceration. Drug courts, the first of which was launched in 1989, under the George H.W. Bush administration, provide nonviolent offenders an alternative to the criminal-justice system that involves monitoring and rehabilitation services rather than prison time.

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In 2016, President Obama signed legislation authorizing more than $1 billion in funding, largely in the form of state grants, to expand opioid treatment and prevention programs, as well as make the drug naloxone, which can counteract opioid overdoses in emergencies, more readily available.

Meanwhile, some city and local governments have launched what are known as harm-reduction programs, which focus on limiting virus transmission and overdoses through the promotion of safer drug use. Critics of such programs argue that decriminalization would lead to higher rates of drug use.

In August 2017, President Trump directed administration officials to use “all appropriate emergency and other authorities” to respond to the epidemic, a move that will free up emergency aid for federal and state health officials to increase access to treatment. Meanwhile, a presidential commission has recommended other policies [PDF] to combat the crisis.
Many working on the issue believe the government should direct more resources toward educating the public about risks. “I don’t think we’ve done enough in terms of informing people about the dangers—about the nexus between opioid medication and heroin and illicit drugs,” says Brennan. “If we did the kind of information campaign that was so successful with tobacco, I think we could see terrific results.”

How are other countries dealing with opioid addiction?

The Netherlands. The Netherlands permits the sale and use of small amounts of cannabis to steer users away from so-called hard drugs [PDF], such as cocaine and heroin, and has implemented harm-reduction policies. In the 1990s the country began offering heroin at no cost, and the rate of high-risk or so-called problem use has halved from 2002 to some fourteen thousand in 2012 [PDF], according to the European Monitoring Centre for Drugs and Drug Addiction. Proponents of decriminalization point to the Netherlands for evidence that these policies work, though critics claim they have not curbed organized crime.

Canada. Amid a growing opioid crisis of its own, Canada has authorized the opening of supervised consumption sites and partnered with China to curb fentanyl flows into the country, but the health ministry says “huge gaps” remain in the government’s ability to track and respond to the problem. A government report on opioid-related deaths in 2016—there were some 2,500—was the first attempt at a nationwide tally. Meanwhile, British Colombia and Alberta, two of Canada’s most populous provinces, have declared a public health emergency and crisis, respectively, boosting funding for addiction treatment and increasing access to naloxone.

Australia. Heroin use in Australia declined following an abrupt shortage of the drug in 2000, but the country has seen a sharp increase in the use of prescription opioids, now the cause of more than two-thirds of opioid-related deaths there. In 2012, the health ministry announced it would launch a nationwide electronic system already being used in
Tasmania to monitor opioid prescriptions, but it has not yet been rolled out. The government is expected to ban over-the-counter painkillers containing codeine starting in 2018, noting that the move is a “very broad-brush approach” to the issue.

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Resources

Laurie Garrett urges the Trump administration to target pharmaceutical companies in Foreign Policy.

The Guardian maps the spread of opioid overdose deaths in the United States.

Margaret Talbot looks at opioid use in West Virginia, the state with the most deaths from overdoses, for the New Yorker.