As an addiction psychiatrist, I have watched with serious concern as the opioid crisis has escalated in the United States over the past several years, and overdose deaths have skyrocketed. The latest numbers from the Centers for Disease Control and Prevention show fatalities spiraling up to about 42,000 in 2016, almost double the casualties in 2010 and more than five times the 1999 figures. The White House Council of Economic Advisers recently estimated that the opioid crisis cost the nation half a trillion dollars in 2015, based on deaths, criminal justice expenses and productivity losses. Meanwhile, foster care systems are overflowing with children whose parents can’t care for them, coroners’ offices are overwhelmed with bodies and ambulance services are straining small-town budgets. American carnage, indeed.
I have also watched a false narrative about this crisis blossom into conventional wisdom: The myth that the epidemic is driven by patients becoming addicted to doctor-prescribed opioids, or painkillers like hydrocodone (e.g., Vicodin) and oxycodone (e.g., Percocet). One oft-quoted physician refers to opioid medication as “heroin pills.” This myth is now a media staple and a plank in nationwide litigation against drugmakers. It has also prompted legislation, introduced last spring by Senators John McCain and Kirsten Gillibrand—the Opioid Addiction Prevention Act, which would impose prescriber limits because, as a news release stated, “Opioid addiction and abuse is commonly happening to those being treated for acute pain, such as a broken bone or wisdom tooth extraction.”

But this narrative misconstrues the facts. The number of prescription opioids in circulation in the United States did increase markedly from the mid-1990s to 2011, and some people became addicted through those prescriptions. But I have studied multiple surveys and reviews of the data, which show that only a minority of people who are prescribed opioids for pain become addicted to them, and those who do become addicted and who die from painkiller overdoses tend to obtain these medications from sources other than their own physicians. Within the past several years, overdose deaths are overwhelmingly attributable not to prescription opioids but to illicit fentanyl and heroin. These “street opioids” have become the engine of the opioid crisis in its current, most lethal form.

If we are to devise sound solutions to this overdose epidemic, we must understand and acknowledge this truth about its nature.

For starters, among people who are prescribed opioids by doctors, the rate of addiction is low. According to a 2016 national survey conducted by the Substance Abuse and Mental Health Services Administration, 87.1 million U.S. adults used a prescription opioid—whether prescribed directly by a physician or obtained illegally—sometime during the previous year. Only 1.6 million of them, or about 2 percent, developed a “pain reliever use disorder,” which includes behaviors ranging from overuse to overt addiction. Among patients with intractable, noncancer pain—for example, neurological disorders or musculoskeletal or inflammatory conditions—a review of international medical research by the Cochrane Library, a highly regarded database of systemic clinical reviews, found that treatment with long-term, high-dose opioids produced addiction rates of less than 1 percent. Another team found that abuse and addiction rates within 18 months after the start of treatment ranged from 0.12 percent to 6.1 percent in a database of half a million patients. A 2016 report in the New England Journal of Medicine concluded that in multiple published studies, rates of “carefully diagnosed” addiction to opioid medication averaged less than 8 percent. In a study several years ago, a research team purposely
excluded chronic-pain patients with prior drug abuse and addiction from their data, and found that only 0.19 percent of the patients developed abuse and addiction to opioids.

Indeed, when patients do become addicted during the course of pain treatment with prescribed opioids, often they simultaneously face other medical problems such as depression, anxiety, other mental health conditions, or current or prior problems with drugs or alcohol. According to SAMHSA’s 2014 National Survey on Drug Use and Health, more than three-fourths of those who misuse pain medication already had used other drugs, including benzodiazepines and inhalants, before they ever misused painkillers. And according to CDC data, at least half of all prescription opioid-related deaths are associated with other drugs, such as benzodiazepines, alcohol and cocaine; combinations that are often deadlier than the component drugs on their own. The physical and mental health issues that drive people to become addicted to drugs in the first place are very much part of America’s opioid crisis and should not be discounted, but it is important to acknowledge the influence of other medical problems and other drugs.

Just because opioids in the medical context don’t produce high rates of addiction doesn’t mean doctors aren’t overprescribing and doing serious harm. The amount of opioids prescribed per person in 2016, though a bit lower than the previous year, was still considered high by the CDC—more than three times the amount of opioids dispensed in 1999. Some doctors routinely give a month’s supply of opioids for short-term discomfort when only a few days’ worth or even none at all is needed. Research suggests that patients given post-operation opioids don’t end up needing to use most of their prescribed dose.
Among people who misused prescription pain relievers in 2013 and 2014, only 22 percent said they received the drugs from their doctor. In turn, millions of unused pills end up being scavenged from medicine chests, sold or given away by patients themselves, accumulated by dealers and then sold to new users for about $1 per milligram. As more prescribed pills are diverted, opportunities arise for nonpatients to obtain them, abuse them, get addicted to them and die. According to SAMHSA, among people who misused prescription pain relievers in 2013 and 2014, about half said that they obtained those pain relievers from a friend or relative, while only 22 percent said they received the drugs from their doctor. The rest either stole or bought pills from someone they knew, bought from a dealer or “doctor-shopped” (i.e., obtained multiple prescriptions from multiple doctors). So diversion is a serious problem, and most people who abuse or become addicted to opioid pain relievers are not the unwitting pain patients to whom they were prescribed.

While reining in excessive opioid prescriptions should help limit diversion and, in theory, suppress abuse and addiction among those who consume the diverted supply, it will not be enough to reduce opioid deaths today. In the first decade of the 2000s, the opioid crisis almost seemed to make sense: The volume of prescribed opioids rose in parallel with both prescription overdose deaths and treatment admissions for addiction to prescription opioids. Furthermore, 75 percent of heroin users applying to treatment programs initiated their opioid addiction with pills, so painkillers were seen as the “gateway” to cheap, abundant heroin after their doctors finally cut them off. (“Ask your doctor how prescription pills can lead to heroin abuse,” blared massive billboards from the Partnership for a Drug-Free New Jersey.) If physicians were more restrained in their prescribing, the logic went, fewer of their patients would become addicted, and the pipeline to painkiller addiction and ultimately to heroin would run dry.

It’s not turning out that way. While the volume of prescriptions has trended down since 2011, total opioid-related deaths have risen. The drivers for the past few years are heroin and, mostly, fentanyl, a synthetic opioid that is 50 times as potent as heroin. Fentanyl has legitimate medical use, but there is also illicit fentanyl, trafficked mostly from China, often
via the Dark Web. Fentanyl and heroin (which itself is usually tainted to some extent with the fentanyl) together were present in more than two-thirds of all opioid-related deaths in 2016, according to CDC data. Painkillers were present in a little more than one-third of opioid-related deaths, but a third of those painkiller deaths also included heroin or fentanyl. While deaths from prescription opioids have basically leveled off, when you look at deaths in which prescription opioids plus heroin and fentanyl were present, then the recorded deaths attributed to prescription opioids continue to climb, too. (An especially pernicious element in the mix is counterfeiters with pill presses who sell illicit fentanyl in pill form deceptively labeled as OxyContin and other opioid pain relievers or benzodiazepines.)

Painkillers were present in a little more than one-third of opioid-related deaths in 2016.

Notably, more current heroin users these days seem to be initiating their opioid trajectory with heroin itself—an estimated 33 percent as of 2015—rather than with opioid painkillers. In the first decade of the 2000s, about 75 to 80 percent of heroin users started using opioids with pills (though not necessarily pain medication prescribed by a doctor for that particular person). It seems that, far more than prescribed opioids, the unpredictability of heroin and the turbocharged lethality of fentanyl have been a prescription for an overdose disaster.

***

Intense efforts to curb prescribing are underway. Pharmacy benefit managers, such as CVS, insurers and health care systems have set limits or reduction goals. State-based prescription drug monitoring programs help doctors and pharmacists identify patients who doctor-shop, ER hop or commit insurance fraud. As of July, 23 states had enacted legislation with some type of limit, guidance or requirement related to opioid prescribing. McCain and Gillibrand’s federal initiative goes even further, to impose a blanket ban on refills of the seven-day allotment for acute pain. And watchdog entities such as the National Committee for Quality Assurance have endorsed a system that compares the number of patients receiving over a certain dose of opioids with the performance rating for a physician.
A climate of precaution is appropriate, but not if it becomes so chilly that doctors fear prescribing. This summer, a 66-year-old retired orthopedic surgeon who practiced in Northern California—I’ll call her Dr. R—contacted me. For more than 30 years, she had been on methadone, a legitimate opioid pain medication, for an excruciating inflammatory bladder condition called interstitial cystitis. With the methadone, she could function as a surgeon. “It gave me a life. I would not be here today without it,” she told me. But one day in July, her doctor said the methadone had to stop. “She seemed to be worried that she was doing something illegal,” Dr. R told me.

Dr. R was fortunate. She found another doctor to prescribe methadone. But her experience of nonconsensual withdrawal of opioids is not isolated. Last year, the nonprofit Pain News Network conducted an online survey among 3,100 chronic pain patients who had found relief with opioids and had discussed this in online forums. While not necessarily a representative sample of all individuals with chronic pain who are on opioids, the survey was informative: 71 percent of respondents said they are no longer prescribed opioid medication by a doctor or are getting a lower dose; 8 out of 10 said their pain and quality of life are worse; and more than 40 percent said they considered suicide as a way to end their pain. The survey was purposely conducted a few months after the CDC released guidelines that many doctors, as well as insurance carriers and state legislatures, have erroneously interpreted as a government mandate to discontinue opioids. In other accounts, patients complain of being interrogated by pharmacists about their doses; sometimes they are even turned away.

The most tragic consequence is suicide. Thomas F. Kline, an internist in Raleigh, North Carolina, has chronicled 23 of them. His count is surely a harbinger of further patient abandonment to come. Meanwhile, so-called pain refugees—chronic pain patients whose doctors have dropped them—search out physicians to treat them, sometimes traveling more than a hundred miles or relocating. And in a recent Medscape survey, half the doctors who were polled expressed fear of violent reactions if patients were refused the prescription.

Knowing all this, what should we do about the opioid crisis? First, we must be realistic about who is getting in trouble with opioid pain medications. Contrary to popular belief, it is rarely the people for whom they are prescribed. Most lives do not come undone, let alone end in overdose, after analgesia for a broken leg or a trip to the dentist. There is a subset of patients who are vulnerable to abusing their medication—those with substance use histories or with mental health problems. Ideally, they should inform physicians of their history, and, in turn, their doctors should elicit such information from them.
Most lives do not come undone, let alone end in overdose, after analgesia for a broken leg or a trip to the dentist.

Still, given that diverted pills, not prescribed medication taken by patients for pain, are the greater culprit, we cannot rely on doctors or pill control policies alone to be able to fix the opioid crisis. What we need is a demand-side policy. Interventions that seek to reduce the desire to use drugs, be they painkillers or illicit opioids, deserve vastly more political will and federal funding than they have received. Two of the most necessary steps, in my view, are making better use of anti-addiction medications and building a better addiction treatment infrastructure.

Methadone and buprenorphine are opioid medications for treating addiction that can be prescribed by doctors as a way to wean patients off opioids or to maintain them stably. These medications have been shown to reduce deaths from all causes, including overdose. A third medication, naltrexone, blocks opioids’ effect on the brain, and prevents a patient who tries heroin again from experiencing any effects. In 2016, however, only 41.2 percent of the nation’s treatment facilities offered at least one form of medication, and 2.7 percent offered all three medications, according to a recent review of a national directory published by SAMHSA. We must move beyond the outmoded thinking and inertia that keep clinics from offering these medications.

Motivated patients also benefit greatly from cognitive behavioral therapy and from the hard work of recovery—healing family rifts, reintegrating into the workforce, creating healthy social connections, finding new modes of fulfillment. This is why treatment centers that offer an array of services, including medical care, family counseling and social services, have a better shot at promoting recovery. That treatment infrastructure must be fortified. The Excellence in Mental Health Act of 2014, a Medicaid-funded project, established more robust health centers in eight states. In 2017, House and Senate bills were introduced to expand the project to 11 more. It’s a promising effort that could be a path to public or private insurance-based community services and an opportunity to set much-needed national practice standards.

These two priorities are among the 56 recommendations put forth last October by President Donald Trump’s Commission on Combating Drug Addiction and the Opioid
Crisis. Indeed, there is no dearth of ideas. In Congress, more than 90 bills aimed at the opioid crisis have been introduced in the 115th session, dozens of hearings have been held and later this month, the House Energy and Commerce Committee will begin holding a week of legislative hearings on measures to fight the opioid crisis. The White House’s 2019 budget seeks $13 billion over two years for the opioid epidemic, and the president recently nominated a “drug czar” to helm the Office of Drug Control Policy, though the candidate has minimal experience in the area.

As we sort through and further pursue these policies, we need to make good use of what we know about the role that prescription opioids plays in the larger crisis: that the dominant narrative about pain treatment being a major pathway to addiction is wrong, and that an agenda heavily weighted toward pill control is not enough.