

Countering the Opioid Crisis: Time to Act Podcast — Download the PDF

Episode 4: Addressing the Recent Trends in the Opioid Epidemic

Guests: Rachel Levine, Brad Finegood

Host: Ruth Katz

Narrator: Welcome to *Countering the Opioid Crisis: Time to Act*, from the National Academy of Medicine and the Aspen Institute. This podcast explores the most critical drivers of the opioid epidemic and key strategies to stem the crisis. Host Ruth Katz leads the Aspen Institute's Health Medicine and Society Program and co-chairs the National Academy of Medicine's Action Collaborative on Countering the U.S. Opioid Epidemic. Here's Ruth.

Ruth Katz: In the depths of the COVID-19 pandemic last year, drug-related deaths rose to the highest annual increase seen in 50 years, nearly 30% higher than in 2019, according to the Centers for Disease Control and Prevention. More than 93,000 people have died from overdoses with most of those deaths being opioid related. Overdose rates increased overall last year, but communities of color experienced larger increases in overdose rates than white Americans did. The road to addiction starts with legal prescription medication for many people. And since 2013, the widespread use of synthetic opioids, such as Fentanyl, has added to the deadly trends we see today. And just the past five years overdose deaths from synthetic opioids increased by 42%.

Today, we will learn about what's behind the latest overdose statistics from the CDC and what they mean for the opioid epidemic. To help us understand it all we'll hear from experts at the local and federal level. With us is U.S. Assistant Secretary for Health, Dr. Rachel Levine, who also co-chairs the National Academy of Medicine's Action Collaborative on Countering the U.S. Opioid Epidemic. Also joining is Brad Finegood, strategic advisor in public health in Seattle in King County in Washington. Rachel, Brad, thank you both. We're delighted to have you here.

Rachel: Thank you very much.

Brad: Thank you.

Ruth: For a while, it really seemed that we were making some real progress in combating the opioid epidemic, but the new CDC data point to a very dire, and I think very discouraging picture. I want to ask what these numbers mean. How badly are we doing now? Why the setback? And Rachel, let me start with you. I want to start with the national, the big picture perspective. What's going on here?

Rachel: You are entirely correct. Across America we are seeing increases in substance use, and we have seen a startling rise in drug overdoses since the beginning of the COVID-19 pandemic. There are lots of different reasons for this, but of course, you know, our country has been very challenged, and people have been suffering due to COVID-19. And so I think stressors such as illness, deaths of loved ones, social isolation, economic challenges, et cetera, have really had an impact on people throughout the country. You pointed out the data, but you know, when we get past the statistics those are people, those are individuals, those are someone's loved one that has died from an overdose. And, you know, it doesn't count the thousands and thousands and tens of thousands of people really struggling with the disease of addiction. And this is in addition to other mental health challenges. So, you know, we certainly have our challenges put before us to deal with in the federal government

Ruth: In a previous life, you served the secretary of health in Pennsylvania. And so given that experience now, what are we seeing at the state level, as opposed to the federal level?

Rachel: Well, Pennsylvania and other states are seeing the same trends in terms of increasing use of different substances, not only opioids, but other substances, such as stimulants, methamphetamine, cocaine, and others, significant rise in terms of other mental health issues. It has to do with the pandemic and all of the downstream impacts of the pandemic. And so we have to deal with this at the local, state and federal level.

Ruth: Brad, you're the guy at the local level. You're living this, you're working this, at the local level day in and day out. What's it like for you? Do you think your experience with Seattle and King County is typical of what's happening at other local communities, or is there something special about where you live and work?

Brad: Every single person who dies is somebody's loved one. That's, somebody's child, that's often somebody's sibling, that's somebody's grandchild. And for me, that's real. My brother died of a drug overdose 15 years ago. And so every single person that dies is somebody's loved one., aThat is why this issue is so important, because of the 93,000 people that died last year, those people are connected to folks. What we're seeing at the local level is a really changing dynamic in drug use and drug supply. In October of 2019, a couple of years ago, we got notified of four local teenagers that died of drug overdose.

For us this is huge. Since we started in the past decade, we've never had more than four or five teenagers in a whole year die of drug overdose. And so the more investigation that we did into it, the more that this reaffirmed this trend, that we were seeing a real change in lethality of our drug supply and the way that drugs were coming into our community. So, all of a sudden we started to see this influx of fentanyl coming into our community on the west coast. And that being very different than the east coast, they were coming in the form of these counterfeit pills that were made to look exactly like legitimate pills that you would get from a doctor or pharmacy, hence lowering the threshold of what people would find acceptable. So, not only now overdose impacting people with significant substance use disorders and addictions as Dr. Libyan was talking about, but we started to see a younger group of people starting to use these substances and passing away. This has changed also as that quantity of high lethality drugs coming into our community has expanded. And now we're seeing that go from an experimental novice population to even a drug of choice for people who have been long-term users and that increases the lethality again, tremendously. So as we continue to go through this evolution, it's really continued to impact our community in really, really negative ways.

Ruth: So this is a significant change from what you've seen in the past.

Brad: Absolutely. In 2015, we had only three people in our community, in our whole county, in the greater Seattle King County community, only three people died of a fentanyl overdose just six years ago. This year, we're getting close to 300 people already that have died of fentanyl related overdose.

Rachel: And that's what we're seeing at the federal level as well. We are seeing significant increases in the number of deaths due to these synthetic fentanyl compounds. This is not fentanyl the medication. These are synthetic compounds that are made from different chemicals, that are sent primarily from

China and to Mexico and put together by the cartels in Mexico and then sent into the United States. You remember, fentanyl can be hundreds and hundreds of more times more powerful than something like morphine and can be even a hundred times more powerful than heroin. So these are very, very dangerous compounds, which increase the risk of overdose and death.

Ruth: So in response to these changes that each of you had seen whether federal or state, local level, how would you adjust your own strategies to deal with these enormous changes and these terrible numbers that we're seeing?

Rachel: Well, from the federal level, you know, we are working with four pillars. The first pillar is prevention, and we have many different prevention efforts in schools, prevention efforts in communities, and then prevention efforts with the medical community to prescribe opioid pain medications more carefully and judiciously. In addition, we are emphasizing harm reduction, and at its heart, that means more and more distribution of the lifesaving medicine Naloxone or Narcan. We want to have that in everyone's hands, so that they can save a life as well as our first responders, but really everyone to carry Naloxone. But we have other harm reduction efforts that include syringe service programs and something called fentanyl strips. And then we have to get people into treatment, particularly, evidence-based treatment with medication for opioid use disorders, and then get people into recovery.

Ruth: Brad, have your strategies changed at the local level in response to the new numbers, the new activities that you're seeing, taking place at the local level?

Brad: It's great to hear what Dr. Levine is saying to know that at the local level and at the federal level, we're very in sync with the work that we're doing. It's so important to be able to double down and expand on what we know works and maybe pull back from what we know hasn't been working before, or that's been causing other compounding traumas with folks and especially in communities of color. It makes me think of a quote from Albert Einstein that we can't solve our problems with the same thinking that we use to create them. And so, you know, this war on drugs mentality that we've had for so many years has caused so much trauma to communities of color. I remember working in prisons myself and walking into the room as a white male, and I was the only white male in a room of 10 people of color and noting that, because of the war on drugs, these people were taken out of their communities.

So we have to double down on healing, and healing of the intergenerational trauma that's happened to communities. We need to do this in a very person-centered way, and take this as the public health approach that Dr. Levine was talking about. We need to be able to double down on harm reduction strategies and ways to engage people, whether that's Naloxone, whether that's needle exchange, we need to look at other ways to engage people. For us, as people have continued to migrate towards using pills and counterfeit pills, we have to think about how we engage these people, because these are people that haven't necessarily been in our systems of care. Also, how do we identify where people connect to our systems of care, whether that's healthcare systems, whether that's jail and settings of incarceration and how do we get the right service to the people in a way in which they're willing to accept it? So the traditional treatment system of "come into my residential treatment system" might work for some people, but for some people that might not be what they want. So how do we lower the barriers of access to care where people are willing to walk through that door and receive the help? Because if we alienate them and push them away we might never see them again.

Ruth: How do we do that? How do we lower those barriers and get the people in the door that you want through the door?

Brad:

We go to people, you know, we go to people and we ask them. One of the projects that we've been working on is a project that I'm really proud of. It's a collaborative design project with people who are actively using drugs. We're calling it the Council on Expert Advisers for Drug Use. And those people are actually people who are out there using drugs. And we engage them when we talk to them in a way in which we're equals. And we say, how do we change our system of care to better suit you? You know, for so long in our treatment system, we've said, if you are not conforming to what we need you to do in a very abstinence-based model, then you're not succeeding, but we need to look more internally at ourselves and see how do we adapt our systems of care, whether that's Naloxone distribution, whether that's harm reduction, whether that's drug checking services, there's all sorts of things.

You know, we have a lot of bureaucratic barriers that we have to carry that we put upon ourselves. You know, things like the X waiver, which what's the federal government lowered the standard for which a buprenorphine prescriber can apply. In my opinion, in my humble opinion, at the local level, we need to be able to get rid of that altogether, and we need to make buprenorphine as available as possible, but because we have evidence-based treatments, we just need to get them out as far and wide as possible.

Rachel: We agree with that. I mean, we want to make evidence-based treatment and medication for opioid use disorder as available as possible. That includes methadone. That includes, of course, buprenorphine, which we've been discussing, as well as a medicine called long-acting naltrexone, which is used a little differently. So that is why we have eliminated the training requirements for someone to be able to get their X waiver. The X waiver is a permission from the DEA to prescribe buprenorphine. And it isn't that we don't want people trained. We really want to make that training in medical school, and then people's residency programs, that should be part of being a physician or another provider such as a nurse practitioner or a physician's assistant. We agree with eliminating the X waiver. We actually cannot do that administratively. That has to be an act of Congress. But we agree with eliminating the X waiver, making that training available to medical students and residents. And then of course, have physicians be able to do continuing medical education to be able to prescribe, these very important medications.

Brad: The federal government has been amazing, this administration, about lowering those barriers, not only to X waiver, but lowering the restrictions on mobile methadone and methadone bands. As Dr. Olivia was talking about, a very evidence-based treatment about being able to get to people that have difficulty accessing. So there's a ton of appreciation for the forward progress that's been moving recently

Ruth: Again, perfect segue to what I want to focus on next: strategies, changing strategies at the federal level. As you both know, during COVID, we've seen changes to policies and regulations that had the effect of increasing access to treatments and support services for opioid use disorder, or OUD, such as the availability of telehealth services. And, as you just mentioned, the X waiver, . Which among those - or all of those, or some that we haven't even discussed- which one of those should be made permanent? It was great during COVID, but it's worked so well you all think it should be made a permanent part of our arsenal of dealing with this epidemic. Rachel, at the federal level. **Rachel:** We definitely want to make permanent many of the tele-health measures that have been put in place. So we are looking at, under the secretary's leadership at health and human services, to, take the best

practices of tele-health, including mental health tele-health and substance use disorder tele-health, such as prescribing buprenorphine through tele-health, and make those permanent. So we're working on that. We have eliminated the training requirement for the X waiver, and then we'll see what Congress does, but the X waiver itself. And we really want to incorporate these aspects into primary care. And so we are working through our behavioral health coordinating council, that I'm co-chair of with the assistant secretary for Samsung, Dr. Delphin Britain. And we have a specific work group looking at the intersection of medical issues and behavioral health issues, and making sure that primary care physicians have the training and the backup to be able to, for instance, to prescribe buprenorphine, to see patients suffering from the disease of addiction.

Ruth: Brad is our guy on the ground, are there other things that, in your experience during COVID, are there other things that you'd like to see be made permanent or new things that you would add to the list?

Brad: Let me just say that, you know, what Dr. Levine was saying is just music to our ears at the local level. And just to have that leadership from the top, take this on as a cause is so important. One of the things at the local level that we continue to fight the uphill battle against is stigma and stigma towards people with substance use disorders, not just opiate use disorders, but all substance use disorders. So, also, you know, stimulants and benzodiazepines and other types of, substances, and really, you know, having that leadership come top down for the medical community is so important because we see it in our healthcare system. You know, our people who are out there suffering, often don't feel comfortable accessing our system of care because of trauma that they've experienced before in their healthcare settings.

So systemically this isn't necessarily a policy change, but we need to do more, as Dr. Levine was saying, about instituting stigma reduction strategies and training within our healthcare system, in our schools. I can't tell you how important that is to change the culture, because if we can really start to change the culture of the way that we see people, who have complex behavioral health conditions, who have substance use disorders, we'll be able to go far. One other thing I'll just add to that from a policy perspective is, you know, people who do use stimulants, there's no effective medications. Like we talked about before. There's some that have shown some limited promise in some trials and some studies, but one of the really effective tools that we know is very evidence-based is a treatment called contingency management.

And it's basically like providing incentives for people for the behavior you want. And if I think about it from my perspective, when we were in person, I would always go to the meetings where there was food. I'm very food motivated, right. It's a reward. And so for people who are using substances, if they can be rewarded for, the behavior that we're trying to help them achieve, that would be great. Contingency management, unfortunately, is one of those items that's not funded through the Medicaid system. And so if we can start to look at ways to institute contingency management as an evidence-based practice and be able to figure out how we fund that service for people with stimulant use disorder, I think would go really far, to helping to at least provide a little bit of aid at the local level to how we can address the stimulant use disorder within our community.

Ruth: Brad, besides food, what else works well with this population?

Brad: Yeah, I mean, that's a really good question. I'm sorry. You know, what's really important is to ask people what's valuable to them. For a lot of these people who are suffering with complex substance use disorder and might be unsheltered or something like that, it's basic survival items. Sometimes it's just a

little bit of a cash incentive, a \$5 or \$10 cash incentive, so that they know that like, they can have some basic survival items like food that day, but what's important is that it's not meaningful to me to give to them, but it's meaningful for the people to be able who are receiving the incentive. That it's meaningful for them. Because the evidence shows that that's what changes the behavior is when people receive meaningful rewards for their behavior

Ruth: And to be part of it, to be asked what will make a difference? Let me turn specifically for a moment to ask about both of you about young people. As you know, they're one of the fastest growing groups at risk of developing Opioid Use Disorder. From both of your perspectives, why is this happening, and why is this particular group so vulnerable?

Rachel: Well, I think that young people have suffered significantly from the COVID-19 pandemic, and they have suffered the times physically. And we're seeing that now play out now in certain states as schools open, but also emotionally from the challenges of the pandemic to themselves, and their family. That's leading to increases in a number of different mental health issues, whether that's depression, anxiety, eating disorders, but also as you mentioned, substance use disorder issues. And so we need to have specific programs that target young people. There is a specific group in our behavioral health coordinating council that is addressing that, and SAMHSA the Substance Abuse and Mental Health Services Administration has specific grant programs for schools and other programs that target helping children and particularly adolescents. You know my field in medicine is pediatrics and adolescent medicine.

So I certainly know how vulnerable children and teens can be from a mental health point of view and from a substance use disorder point of view. And so we have to help children and their families. We have to help them from a prevention point of view. They have to make sure that their families have access to harm reduction materials such as Naloxone. We have to get them into treatment that can include, for appropriate teenagers, medication for opioid use disorder. And we have to work with them to get them into recovery.

Brad: I would send a huge amen to everything. Dr. Levine has said. YWe've seen the pandemic have monumental effects on youth. There's an author by the name of Johann Hari, who does a lot of research on substance abuse and recovery. And he says that the opposite of addiction isn't recovery, but the opposite of addiction is connection. Right? And so like, how do we help people connect? I also think that youth have been significantly impacted by the way that substances have come into the community. I've talked a little bit earlier about the presence of fentanyl in counterfeit pills and what that's done is it lowered the initial threshold to intake of opioids for the first time. Previously you would have needed a small care when or use a needle to, use heroin. And there's a huge threshold jump to get to that point with experimental use.

We also know that prevention is that there's very evidence-based prevention mechanisms out there, but that experimentation is somewhat normal for youth, and where they feel comfortable. And if they feel comfortable with pills, then this becomes a really dangerous mixture. The other thing that I'll say, through our research that we've been able to do, as more youth have died, as you mentioned, Ruth, is the impact of social media has been significant. Not only as Dr. Levine was talking about, about the pressures that are put on youth because of what they see through social media, but the connections that they're able to make with other youth who are using or to get drugs through social media. So it's made the world that much closer and that much more easily accessible to much more lethal drug supply, which is a recipe for disaster. So all of these impacts on top of each other, on top of social isolation and depression that has brought with the, with the results of what we've needed to do to cull

the COVID pandemic, have just wreaked havoc on our youth that in a really quiet manner, but is real, but we're really seeing it in the outcomes of overdoses

Ruth: We've been focusing up until now on government responses, whether we're talking about the state, local, federal level. Let me turn to a little bit about the role of the private sector here. Rachel, as I mentioned, in my introduction, you're a co-chair of the National Academy Medicines Collaborative on Countering the U.S. Opioid Epidemic, which is a public-private partnership to address the opioid epidemic across the healthcare spectrum. And Brad, I assume, in fact, I think you mentioned early on, that you've been involved in a similar kind of work. So my question for both of you is how important are these public-private partnerships in helping to reverse the deadly trends that we've been talking about and not just the opioid epidemic, but other forms of addiction as well. What kind of role do they play and how important? Do they make a difference?

Rachel: So I absolutely think they make a difference. I think public-private partnerships are essential for us to make lasting progress on this issue. And I'm so pleased to be working with the National Academy of Medicine. We need to work with the medical community again on all aspects of this. So for example, with prevention, we need to work with the medical community on what I like to call this opioid stewardship, which is the careful and judicious prescription of pain medicines. Pain medicines are necessary for severe acute and chronic pain. If you're in a car accident or you might have cancer pain or something like that, but clearly they've been over-prescribed, they're prescribed to pediatric and adolescent patients as well. So there are a number of programs that we developed in Pennsylvania, but also that are being worked on nationally to continue to work with medical providers to really limit the opioid prescriptions that they write, which limits the exposure to people to opioids, which could lead to the disease of addiction.

And again, we need to work with the medical community in terms of co-prescribing the Naloxone, for example, for patients on opioids and making sure that they emphasize the importance of this lifesaving antidote to an overdose, and then work with the medical community in terms of the medication for opioid use disorder. For example, we've been talking about buprenorphine. So this is working at the at the state, local and federal level with our state and local public health and mental health professional colleagues, as well as working with medical schools, residency programs and medical associations as well.

Brad: The only thing that I would add to that because Dr. Levine is so right that the bringing together the private and the public sector is so important. And especially within the healthcare setting to change the care that people get. We know that locally, approximately 10 to 15% of the people who die of substance related causes of overdose are unsheltered. So that's a significant amount of people. That are unsheltered who suffer from substance use disorder, right? And not all people who are unsheltered have addiction, not all people and, and by and large, most people who have, who have addiction and substance use related issues, aren't homeless, right. There are people who have homes and there are people who have jobs and there are people who go to work. And so, you know, another group that we need to continue to work with is within the private sector is employers and employee assistance programs.

And point to like, what is good care? Point to what is evidence-based treatment? If we have employers who won't allow, we've had a lot of stigma as Dr. Levine could probably tell you throughout time around getting access to evidence-based medications like methadone, buprenorphine, naltrexone, if we have employers who, who won't allow that as part of the workplace, we need to work to do some education around that, because we know that that decreases mortality decreases lethality. I remember when I,

one of my first jobs working in this field was working in a methadone clinic and as a young clinician walking in and, even saying to myself, why are we switching one addiction for another that's far from what we're doing, what we're doing is we're providing evidence-based treatment for people who are suffering that can lower the risk of overdose, that that can help them maintain function in their life.

That can help people parent on a daily basis. That can help people hold and maintain a job. And that's what we need to do is we need to work with a public and private sector to help have these evidence-based treatments be on the uptake. And then also about employing people, because we know that we have huge issues on workforce issues in our community. And so how can we help give jobs to people who have past behavioral health or criminal legal system involvement so that we can help promote them and give them opportunities to succeed in the community?

Ruth: One final question with two parts, again, for each one of you. Part one, what is the one thing we can and should do immediately at the federal, state, and local level to address the opioid epidemic and reverse the numbers that I talked about in my introduction. And part two, what's the one thing we can and should do in terms of long-term to address the broader issue of addiction. Who wants to go first? Rachel?

Rachel: Sure, I'll go first. So, you know, I think that the one thing we need to do is to collaborate. We need to collaborate with local, state, and federal health officials and human service officials to be able to address that. So I wish it was as simple as that, if we do this one thing that we will fix the overdose crisis, but it is not going to be that simple. I think that we have to focus on prevention. We have to focus on harm reduction and reversing overdoses. We have to work on treatment and then getting people into a long-lasting recovery. So it's all of those different things. From a longer point of view, I want to emphasize two concepts that we haven't spent as much time on. One is, and Brad was alluding to this, the social determinants of health, meaning there are many different things that influence health that we don't think of itself.

Rachel: Housing, as he mentioned, is health. The environment is health. Economic opportunity, and a living wage are actually health issues. Availability of transportation, education, nutrition, all of those things are health issues. So we really do need a whole of government approach as we look at this. And the other is health equity. Is that we have to have a strong health equity lens as we look at this, because this has really impacted some communities more than others. As for example, COVID-19 has impacted some communities more than others, particularly disadvantaged communities, communities of color, particularly vulnerable communities that have suffered from the overdose crisis and have suffered from COVID-19 and other health disparities that have been really prevalent for too long. And so we need to take across health and human services, is really one of the top priorities of the secretary, as well as across the administration to look at equity and health equity. And that's what we're going to do,

Ruth: Brad, long-term, short-term solutions from your perspective.

Brad: Yeah, thanks, Ruth. And let me just say again, this conversation is so, I have so much gratitude for being at this conversation, but also for hearing from Dr. Levine to know that the leadership at the top is so supportive of what we at the local level feel that we need to do. I would totally agree in the short-term I believe that we need to reduce stigma as we were talking about before, because as stigma permeates our community towards people with substance use disorder, that creates a lot of othering. It creates a lot of vitriol towards people with substance use disorder and people who are trying to help

people with substance use disorder. We've had stories where we've had people from our service sector who have been verbally accosted by people in the community for trying to help people.

Brad: And so we need really to lower stigma. Also in the short-term, we really need to get an all hands on deck approach, right? This isn't just a small, my little section of government needs to work on this, because we can't do this without all doing this together. I would move what Dr. Levine said, maybe as a long-term goal about reducing disparities into like my short-term realm, because we know so many communities of color have been disproportionately impacted by overdose numbers and the war on drugs in those communities over time. In the long-term the social determinants of health are so important. I wouldn't be true to myself, Ruth, if I didn't say we needed to look at other countries around the world at what has been effective. There are so many different policies about getting other medications, other opioid agonists out there for people who are suffering. We know that overdose is happening with fentanyl at a higher rate also because it's so much more powerful and lethal that we have less time to find somebody and reverse an overdose, even if somebody does have Naloxone on them. So we need to look at tactics and strategies in other countries like supervised consumption where people don't have to be using a loan in isolation. So I would say that those are the two big long-term things for me as we move forward.

Ruth: Terrific. Well, Brad, Rachel, thank you so much for your time and for this incredibly informative conversation, it's been great to have you here.

Rachel: Thank you so much. It was a pleasure.

Brad: Likewise, thank you,

Ruth: Dr. Rachel Levine is U.S. Assistant Secretary for Health. She also co-chairs the National Academy of Medicine's Action Collaborative on Countering the U.S. Opioid Epidemic. Brad Finegood is a Strategic Advisor for Public Health in Seattle and King County in Washington. Be sure to follow us on your favorite podcast app and make it easier for others to find this podcast by giving us a rating and apple podcasts. Thank you for joining us. I'm your host, Ruth Katz. Be well and stay safe.

Narrator: Ruth Katz is Vice President and the Executive Director of the Aspen Institute's Health Medicine and Society Program. She Co-Chairs the National Academy of Medicine's Action Collaborative Countering the U.S. Opioid Epidemic.

The conversations in this podcast build on the ongoing work of the NAM Action Collaborative. The Action Collaborative is committed to developing, curating, and disseminating multi-sector solutions designed to reduce opioid misuse and improve outcomes for all who are impacted by the opioid crisis.

To learn more about the Action Collaborative, please visit nam.edu/opioidcollaborative

Our theme song was composed by Benjamin Learner and Joshua Sherman and recorded at Old Mill Road Recording in East Arlington, Vermont. The Aspen Institute's Pearl Mak created our logo. Our podcast editor and producer is Shanna Lewis. Special thanks to the Aspen Institute and The National Academy of Medicine.