

CONGRESSIONAL BRIEFING ON SUBSTANCE MISUSE AND PREVENTION

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America's First Opioid Epidemic (1860s-1930s)

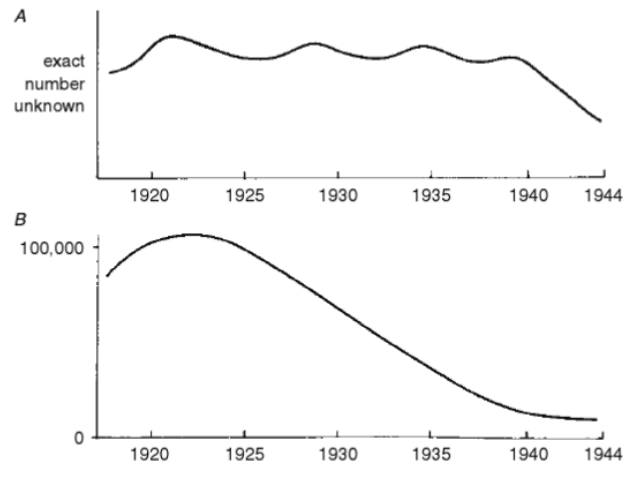


Figure 9 Prevalence of nonmedical addiction between 1917 and 1944. *A*, hypothesized; *B*, according to the Bureau of Narcotics.

Source: D.T. Courtwright, 2001

America's First Opioid Epidemic (1860s-1930s)

Opioid:

- Morphine and opium
- Addiction was overwhelmingly the result of medicinal opioid use

Demographics:

- 1800's: White, native-born, middle and upper income, middle aged women (particularly housewives). Concentrated in South.
 - Male addicts were often physicians and other professionals
 - Chinese migrants (opium smoking)
- By 1920s shift toward young, low-income males addicted to heroin and morphine , nonmedical use
 - Veterans of the Civil War
- **Estimated Prevalence:** Fewer than 0.72 addicts per thousand persons prior to 1842, rising to 5.49 per thousand by the 1890s, with estimated peak near 1921 though fluctuations followed



America's First Opioid Epidemic (1860s-1930s)

Interventions:

- First federal regulation of drugs
- Supply control
 - Shift medical practices
 - The Opium Exclusion Act (1909): Bans the import of opium the purpose of smoking
- Criminalization of Suppliers
 - The Harrison Narcotics Tax Act (1914): Restricts physicians ability to prescribe opioids, and prohibits opioid prescriptions for the purpose of addiction maintenance
 - The Heroin Act (1924): Prohibits the manufacture, importation, and possession of heroin, even for medicinal uses
- World War II disrupts global heroin supply routes

America's Second Opioid Epidemic (1960s – 1980s)

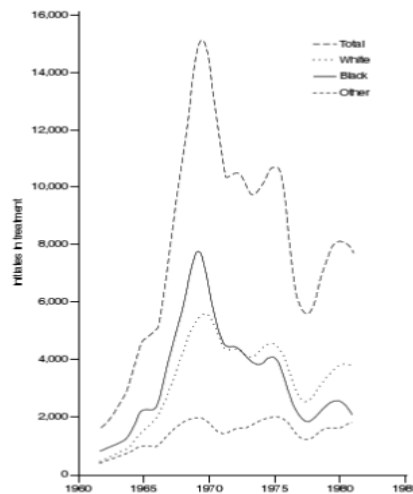


Figure 12 Year of first use for heroin addicts entering treatment, 1977 through 1981. Total for the last two years, 1980 and 1981, are corrected for treatment lag. Note that year of first use is not always the same as the year of addiction, which may take some time to develop, and that regional patterns vary, with coastal cities typically peaking before inland cities. (See DuPont,

Source: D.T. Courtwright, 2001

America's Second Opioid Epidemic (1960s-1980s)

- **Opioid:**
- Heroin, methadone
 - Increasing purity allows heroin to be sniffed or smoked, which broadens its appeal to demographics who would otherwise not inject
- **Demographics:**
- Predominately male, urban, low SES blacks
- Some Whites
 - Young, upper and middle class suburban whites
 - *Vietnam veteran - Vet used and became addicted to heroin in Vietnam, use and addiction quickly declined after returning to the United States
- **Prevalence:** 3.09 addicts per thousand



America's Second Opioid Epidemic (1960s-1980s)

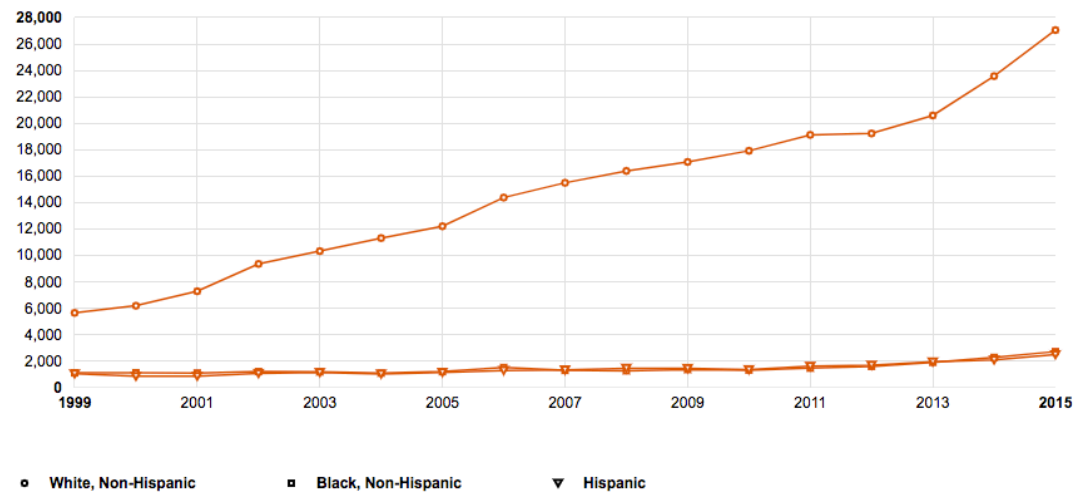
Interventions:

- Government policies focused on *criminal law enforcement*
- Government sponsored addiction treatment
- Public awareness and outrage
- Rise of methadone maintenance/clinics
- Disruption of heroin supply chain during Vietnam and other Cold War conflicts
- Crack-cocaine replaces heroin in urban communities

America's Third Opioid Epidemic

(1999- present)

Opioid Overdose Deaths by Ethnicity



Source: Kaiser Family Foundation



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America's Third Opioid Epidemic

(1995 - Present)

Opioid:

- Predominately prescriptions opioids (Oxycodone, hydrocodone) but also methadone, heroin, and a rising number of synthetic opioids (e.g. fentanyl)

Demographics:

- White
- Majority male
- Young and middle-aged
- Widespread
 - Appalachia, Midwest, New England, and Western states
 - Rural communities
- In 2016, opioid abuse rates are rising dramatically in traditionally underrepresented populations especially synthetic opioids

Prevalence:

- 11.8 million past year opioid misusers aged 12 or older (2016)
 - 11.5 million people (4.3% of the population) past year prescription pain relievers misusers (2016)
 - 948,000 past year heroin users aged 12 or older (2016)
- **175** overdose deaths per day in 2015
 - 42 death per day on prescription opioids



PUBLIC HEALTH RESPONSE = PREVENTION

Recommendations That Address Social and Environmental Risk Factors Contributing to American Opioid Epidemic

Commission Proposal	Next Steps Needed
Implement reimbursement for Recovery Support Services for job training, supportive and recovery housing	Utilize Medicaid to reimburse supportive housing programs that co-locate employment, education, and health services
Develop family-centered treatment and disseminate best practice for family access to screening, treatment, and parental support such as kinship care strategies	Promote and finance two-generation, family-centered treatment and support for children under foster and kinship care
Support College Recovery Programs that include “sober housing” to help students recover from addiction	Involve community leaders in designing preventive systems for younger children to promote healthy behaviors, social skills, community opportunities, and pro-social involvement
Develop best practices for employer education and support to allow employers to hire, retain, and facilitate treatment for employees seeking help for substance use disorders	Broaden public health-based approaches to rebuild workforce capacity among victims of past drug epidemics
Develop model state regulations and legislation to decouple felony convictions and eligibility for business and occupational licenses	Extend the benefits of public health-based interventions to individuals who were burdened by criminal justice rather than public health approaches to the disease of addiction during America’s earlier opioid crisis
Collaborate to develop housing strategies that develop best practices for recovery residences, remove zoning restrictions, and discriminatory provisions that prevent MAT patients from being housed in communities during recovery	Strengthen supports for public housing providers to avoid eviction when residents are amenable to treatment for opioid addiction

Source: Matthew, 2018