

Reducing Collateral Damage in Responses to the Opioid Crisis

On July 13, 2017, the US Department of Justice publicly announced criminal charges against more than 400 health care professionals for medical fraud. Of those, 125 were indicted for crimes related to the illegal distribution of prescription opioids. This sudden burst of prosecutorial activity is the latest in the justice system's swell of energy for "pill mill" takedowns and the enhanced prosecution for the illegal distribution of synthetic opioids. Unfortunately, such legal actions are rarely taken with consideration for how they will affect these networks' most vulnerable actors: the opioid-dependent individuals who have come to rely on these sources.

Consider the Department of Justice's recent actions in light of what we know about the consequences for those with opioid use disorders of the abrupt—or forced—cessation of opioid use or opioid medication provision. Our physical tolerance for opioids, which can be built up over time with regular use, decreases rapidly during periods of abstinence. As a consequence, rates of overdose death are higher among those recently released from prison by at least an order of magnitude.¹ For those who have spent time in specialized treatment facilities, such as rapid detoxification programs with no medication assistance, risk of overdose has been estimated to rise nearly 25-fold in the days immediately following

discharge.² In each of these situations, when regular users have been rapidly disconnected from their regular, steady supply of opioids, opioid tolerance is lost, relapse back into opioid use is common, and the risk of accidental death from opioid overdose is enormously high. Why should we expect the consequences of drug busts and "pill mill" takedowns—when the steady supply of a consistent opioid product is abruptly taken away from patients—to be any different?

To successfully counteract the harmful side effects of these interventions, law enforcement and public health leaders must consider the individuals who consume illicit or diverted opioids and the individuals who serve as person-to-person opioid suppliers (i.e., unscrupulous clinicians, friends and family who share opioids, social contacts who sell opioids within their local communities) in relation to one another—as pairs connected through these relations of exchange and interdependency, whose trajectory and well-being are inextricably linked. Often, members of each group are considered in isolation. Public health and health care professionals aim to shepherd patients through treatment of opioid use disorder in the absence of a functional theory to explain how drug market shifts may generate positive or negative therapeutic effects. Law

enforcement seeks to achieve supply interdiction with little consideration for how consumers will be directly affected by those disruptions in the supply chain.

The importance of these social connections in clinical settings is apparent, especially today as many efforts to improve clinical practices around opioid prescribing encourage the use of tools like doctor-patient treatment agreements, which, by their very nature, assist physicians in mediating medically appropriate consumer-supplier relationships with their patients.³ Beyond the walls of the clinic, our own research has explored how consumer-supplier relationships can modulate the risks of illicit opioids like heroin.⁴ In 2016, we interviewed more than 100 active opioid users about their perceptions of risk and the strategies in which they engage to protect themselves in the midst of a fentanyl-contaminated heroin supply. Although some reported distrust of their dealers, many explained that relying on established dealer relationships helped shield them from harm. We were

told of dealers testing their batch for fentanyl, refusing to sell fentanyl-contaminated product, and even reaching out to customers to warn them about certain lethal batches.

Engaging these insights to reduce overdose and save lives demands a more relational understanding of the opioid crisis. Public officials and service providers should place the dynamics of the consumer-supplier relationship at the center of risk evaluations and intervention designs, taking into account the unique needs of those who receive prescription opioids, those who misuse or divert prescription opioids, and those who consume illicit opioids. There are several, explicit ways that health care providers, public health, and law enforcement can work *together* to minimize the immediate harm of supply changing actions such as those of the Department of Justice. These include the following:

LINKING PATIENTS WITH CARE AFTER A TAKEDOWN

Those receiving opioids from physicians practicing unethically may be living with chronic pain or self-treating an ongoing

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This editorial was accepted December 1, 2017.

doi: 10.2105/AJPH.2017.304270

substance use disorder. Each of these conditions requires proper medical care. Federal action taken against fraudulent prescribers or “pill mill” operations are generally swift and come without notice, abruptly leaving opioid-dependent patients with no pathway to treatment and placing them at risk for more severe opioid use disorder, a more dangerous supply of opioids, and fatal overdose. These risks can be mitigated through activities such as direct patient outreach and targeted referral services. When notified by prosecutors of pending legal action against the Seattle Pain Center network for unethical prescribing, the Washington State Department of Health was successful in reaching patients with opioid prescriptions through their insurance providers.⁵ Preparedness and disaster management are fundamental public health capacities but, as this example demonstrates, public health authorities must be made aware that a takedown is in the works if they are to have ample time to activate and respond.

BETTER COMMUNITY ENGAGEMENT AFTER INTERDICTION

Plans for scaling up outreach and services provision to opioid users can also be designed and put into place before disruptions of the illicit drug supply chain. If some consumer–supplier pairs in the illicit market may protect users from fentanyl exposure and overdose, any disruption to this dyad may result in increased risk for the consumer. These risks could potentially be mitigated by boosting efforts to connect high-risk opioid users with

prevention and treatment services, such as naloxone rescue kits, peer counseling, safe injection materials, and medication for addiction treatment⁶ in the immediate aftermath of drug supply interdictions. Post-interdiction market stress may even present unique opportunities to connect high-risk users with existing treatment, counseling, housing, and other support services.

SUPPLY-SIDE RISK REDUCTION BEYOND THE CLINIC

Similar to current efforts to promote evidence-based prescribing practices, today’s opioid overdose crisis should spur us to design and test novel interventions within the illicit drug market, driven by the existing social and economic ties within that market, to achieve reductions in overdose fatalities. Such interventions might include providing local consumers and suspected low-level suppliers with drug-testing tools or offering anonymous drug-checking services, safe injection locations, and trusted health service facilities. Trusted actors in the illicit market could also be engaged in peer-to-peer naloxone distribution or other harm-reduction activities. Few of these strategies have ever been tested in the United States. Many, though, have been successfully implemented elsewhere—especially drug-checking services—and their potential for positive impact in the United States is high.⁷

CONCLUSIONS

In sum, adopting a relational approach to opioid misuse would

require all of us—public health officials, law enforcement officers, and medical providers, alike—to consider opioid users and suppliers, of whatever variety, in tandem. Therefore, the implementation of these three strategies can only be bred from strong, trusting partnerships across agencies at all levels of government within their respective jurisdictions. Multiple stakeholders—medicine, public health, law enforcement, criminal justice, and more—must work together to forge new collaborations. Without such cooperation, the very individuals who are most at risk may become collateral damage in our efforts to protect them from harm. **AJPH**

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ACKNOWLEDGMENTS

This work was supported by the National Institute on Drug Abuse (awards T32 DA013911 and K24 DA022112) and by the infrastructure and resources provided by the Lifespan/Tufts/Brown Center for AIDS Research, a National Institutes of Health–funded program, grant P30-AI-42853, from the National Institutes of Health, Center for AIDS Research.

Note. The views expressed herein are solely those of the authors and do not necessarily reflect the views of these funding organizations.

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