



Facing Opioids in the Shadow of the HIV Epidemic

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The United States is in the midst of an opioid crisis. An estimated 2.1 million Americans had an opioid use disorder in 2016. The rate of opioid overdose deaths has increased by 500%

since 1999, and each day an estimated 115 Americans die from opioid overdose.¹ Despite the proven effectiveness of medication-assisted treatment (MAT) for opioid use disorders, the opioid mortality rate has now surpassed that of the AIDS epidemic during its peak in the early 1990s — a time when there was no effective treatment for HIV/AIDS.²

Given that U.S. HIV incidence and AIDS mortality declined dramatically after the advent of antiretroviral therapy in the mid-1990s, it is not surprising that the AIDS response is often celebrated not just as an unqualified success, but also as a blueprint for the response to other emerging threats to population health.³

However, there are vital lessons to be learned from failures in the response to HIV as well as from the successes. Learning these lessons will require a less celebratory accounting of where we stand with the current HIV epidemic than we have seen so far.

Effective treatment for HIV has been available in the United States for more than two decades, and the majority of people living with HIV in this country (86%) have now received that diagnosis. Still, less than two thirds of people living with HIV remain in care (62%), and viral suppression has been achieved in less than half the cases (49%).² The benefits of scientific progress have been unequally distributed, with growing

ethnic and sexuality-related disparities in new infections, dual diagnoses, and overall mortality. If current HIV diagnosis rates persist, one in two black men who have sex with men in the United States will contract HIV during their lifetime.²

This failure of equity should draw our attention to the importance of social factors in shaping who benefits from effective biomedical therapies. Each of the following lessons has the potential to improve the population health impact of MAT for opioid use disorder in the United States.

First, the existence of effective medical treatment does not mean that people who need treatment can and will obtain it. Even as efforts are under way to scale up access to MAT, it is vital not to assume a position of “if we build it, they will come.” Though MAT scale-up is a necessary step for increasing access, engaging the

80% of people with opioid use disorders who currently receive no treatment also requires identifying cultural, social, economic, and structural barriers to access to care.⁴ In areas where MAT is available, studies already reveal age-based, racial, and ethnic disparities in treatment engagement and completion.⁵ If we fail to address the contextual barriers that shape engagement with MAT, biomedical advances may actually exacerbate health disparities by benefiting people who are more socially advantaged rather than the population as a whole.

Second, we need to stop considering only one person at a time and address the structural drivers of the crisis. Since the 1990s, HIV researchers have recognized that the virus's spread is driven by structural factors such as economic inequality, sexual oppression, gender inequality, and racism. A key lesson for the opioid epidemic is that without achieving long-term changes in the structural inequalities that render some populations vulnerable to opioid addiction, we will not be able to slow the epidemic. Structural drivers of the opioid epidemic include eroding economic opportunity, market-driven health care, insufficient regulation of pharmaceutical markets, evolving approaches to pain treatment, and limited access to effective drug treatment. Combating the epidemic will require addressing these drivers.

Third, reducing stigma could improve access and adherence to treatment. Decades of HIV research demonstrate that stigma is an important structural barrier that undermines people's ability to access and engage with treatment, yet the vast majority of anti-

stigma interventions for HIV/AIDS have focused on changing individual attitudes, rather than on community or societal norms. If responses to the opioid crisis took a comprehensive approach to stigma, they could address family, community, and societal norms, extending far beyond targeting individual attitudes. Interventions that could combat drug-related stigma include legislative change to stop the criminalization of substance use disorders; antistigma training workshops for key community actors such as churches, police, and health care providers; and social marketing campaigns that promote tolerance and combat widespread discriminatory attitudes toward people with opioid use disorder. Development of these strategies could be greatly assisted by engaging directly affected communities in policymaking, service provision, and social marketing campaigns.

Fourth, mobilized family and community support networks can help improve health care engagement. Although HIV research shows that social support from family, community, and other social networks can facilitate HIV treatment and adherence, U.S. policymakers and public health practitioners have done little to leverage such resources for improving access. Similarly, there are unrealized opportunities to mobilize family support networks to improve access to MAT. Opioid interventions could include the creation of community groups to support the families of people living with opioid use disorder; coscheduling of health care appointments for patients and family members, including both biologic and *de facto* (chosen) families; and development of pol-

icies that recognize and compensate people for the care work that can be vital in the path to recovery.

Finally, community activism is crucial to making MAT widely available and increasing its uptake. Community activism and the engagement of civil society and stakeholders were crucial to expanding access to antiretroviral therapy. For the opioid epidemic, an analogous "opioid movement" may be required for MAT to become acceptable to — and demanded by — communities throughout the United States. This lesson is particularly pertinent given that methadone clinics have historically faced considerable community resistance in the United States. To promote civic mobilization among communities affected by opioid use, state and city governments could invest more money in existing community organizations, and universities and hospitals could implement community-based participatory interventions that engage community actors as partners in addressing the epidemic.

Taken together, these lessons add up to one powerful reminder: the response to the opioid epidemic must incorporate social as well as biomedical approaches in order to ensure effectiveness. In the United States, our failure to address the structural drivers of the HIV/AIDS epidemic led to the concentration of suffering among the most socially disadvantaged populations. As millions of dollars are appropriated at the state and federal levels for the opioid crisis, we face a choice. Committing those resources exclusively to biomedical solutions is likely to reproduce the sharp disparities that we have seen with HIV. Al-

ternatively, learning from the failures of our response to HIV as well as our successes can help us leverage social and community support to ensure that the opioid response is maximally successfully and benefits all sectors of society.

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The SUPPORT for Patients and Communities Act — What Will It Mean for the Opioid-Overdose Crisis?

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Opioid-overdose deaths have increased every year for the past two decades, driving a drug-overdose epidemic that killed more than 72,000 Americans in 2017.¹ Thanks in large part to sustained efforts by health advocates, medical professionals, and affected people, Congress has acted on several occasions to address this ongoing and largely preventable crisis. In 2016, President Barack Obama signed the Comprehensive Addiction and Recovery Act (CARA) and the 21st Century Cures Act, which contain numerous provisions designed to increase access to evidence-based care and treatment for people with substance use disorders (SUDs). Neither law substantially altered the federal policy landscape, however, and overdose-related deaths have continued to increase.

More than a decade into this crisis, the country still lacks an integrated federal response to reduce the rates of overdose-related death and disability. Although the office of the surgeon general has fought to address the stigma still

associated with addiction and has strongly supported proven public health interventions such as increased access to sterile syringes and the opioid-antagonist naloxone, the office of the attorney general has embraced a “war on drugs” approach focused on arrest and incarceration. Meanwhile, the Office of National Drug Control Policy has been without a director since President Donald Trump was inaugurated, and the Trump administration has threatened crippling cuts to its budget and purview. Republicans in Congress have repeatedly attempted to repeal the Affordable Care Act, a law that significantly reduced the number of people with heroin use disorders who are uninsured.²

Against this backdrop, Trump signed the SUPPORT for Patients and Communities Act in October 2018. Although the 250-page law does little to further a coordinated federal strategy for addressing the epidemic, many of its provisions will be beneficial for people with SUDs and those at risk for SUDs, including provisions

that are designed to improve pain management, support the development of the SUD-treatment workforce, and eliminate kickbacks for referring patients to so-called recovery homes. The law’s most important provisions, however, are those intended to increase access to evidence-based treatment and follow-up care, particularly for pregnant women, children, people in rural areas, and people in recovery from an SUD.

Opioid-agonist therapy with methadone or buprenorphine is the standard for treating opioid use disorder (OUD), but legal restrictions and lack of funding have made these medications inaccessible for many people: only about 20% of Americans with OUD report having received treatment in the previous year.³ The law attempts to address this lack of access to opioid-agonist therapy and other services and supports.

It focuses particular attention on pregnant women and children. Perhaps most notably, it requires that state Children’s Health Insur-