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Preventing, in Addition to Treating, the Opioid Epidemic

In “Harm Reduction Strategies for the Opioid Crisis,” Tessie Castillo discusses the steps that should be taken nationwide to curb the opioid epidemic. She cites the many harm reduction strategies that have been adopted by North Carolina such as making Naloxone, a drug that reverses overdose, available to the public; educating first responders and people who frequently come in contact with opioid users about the effect of opioids and what to do in a situation of an overdose; and exchanging old syringes for new ones. The next harm reduction strategy, she believes, is implementing facilities where it is legal to take drugs in front of medically trained staff. The main goal of the harm reduction strategies is to lessen the negative effects the opioid epidemic is having on the general public. As these dramatic steps may be lessening the negative effects by reducing the bloodborne diseases and decreasing overdoses, they are not addressing the main issue. Although I do agree with the drastic harm reduction strategies Castillo addresses in her 2018 article to *treat* the opioid epidemic, I would argue there should be more done to *prevent* it.

Although controversial, harm reduction strategies are necessary, as Castillo notes. Some

people believe that these actions are a way of enabling the drug users and giving them more of a reason to continue their use. Despite the merits of these arguments, taking severe measures such as these harm reduction strategies may be helpful. Castillo offers evidence of these

strategies having a positive impact on the effects of the opioid epidemic in the United States. For example, one of the necessary harm reduction strategies Castillo mentions is making Naloxone more available to the public through pharmacies and allowing first responders and people impacted by users to have the drug on hand. After North Carolina implemented this strategy, “community based distribution programs across the state handed out over 60,000 overdose prevention kits containing Naloxone to people at risk for overdose and their loved ones” between August of 2013 and February of 2018, and “people across the state reported using 10,240 of these kits to reverse an overdose” (192). This evidence indicates that people are likely to take advantage of Naloxone if it is made more accessible to the public, which, in turn, can lessen the negative effects of the opioid epidemic as it reduces the number of opioid overdoses.

Another needed harm reduction strategy that Castillo mentions is the “syringe exchange.” This entails allocating public locations where people can hand in their old syringes and get clean ones back while also offered the opportunity for HIV testing and rehabilitation programs (192). Castillo credits studies over the years that have shown that syringe exchanges “significantly reduce the spread of HIV, Hepatitis C, and other blood borne illnesses among injection drug users” and make people who take part in these programs “more likely to seek treatment for drug use than people who do not” (192). With this evidence it is clear that syringe exchanging is lessening the negative effects of the opioid epidemic as it decreases the spread of diseases related to it and even causes more people to seek help. Both exchanging syringes and increasing the Naloxone availability have proven to have a positive impact on the troubling opioid epidemic.

While harm reduction strategies have helped reduce the negative outcomes of the opioid epidemic, it cannot entirely stop the epidemic. More needs to be done to prevent it. Too often, doctors overprescribe opioids, which are the main “gateway” to opioid abuse. While it may sound like an extreme measure, I believe that prescriptions of opioids should be limited. Medical insurances have already noticed the problem and begun to act on it. After 2011, “Medicare would deny coverage for more than seven days of prescriptions equivalent to 90 milligrams or more of morphine daily, except for patients with cancer or in hospice” (Hoffman). While limiting opioids not only prevents the opioid abuse gateway, it forces doctors to also prescribe medication or treatments that are more specific to the patient’s case. Doctors would still be able to prescribe other medications after the limit of opioids is already prescribed. These would include over-the-counter aspirin, ibuprofen, and acetaminophen. Along with medication, doctors could also go another route by referring patients to non-drug therapies such as acupuncture in which very thin needles are inserted at different places in the skin to interrupt pain signals. Moreover, the advances in technology are skyrocketing which can also lead to high-tech methods that could be used as an alternative to opioids. This includes “radio waves” which involves inserting a needle next to the nerve responsible for the pain and burning the nerve using an electric current created by radio waves. This short-circuits the pain signal. Pain relief can last for or up to one year. All of these alternatives give favorable reason to use these methods of pain relief instead of taking opioids. The funding for these alternative methods could come from the previous funding source of the overprescribed opioids.

The opioid epidemic is a very concerning issue as it is increasing blood borne illness rates and taking lives whether it is from diseases or from overdoses. As Castillo observes, harm reduction strategies are working to treat those already addicted. While these strategies have shown improvement in the negative effects of the opioid epidemic, limiting the prescription of opioids will prevent the crisis from continuing or even from starting for some people. Maybe the most dramatic of all of the steps is to stop opioid dependence before it even starts.

Works Cited

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