Health Report

To Bishop Jeffrey N. Leath, General Officers, Connectional Officers, Host Presiding Elder, Reverend C. Robert Finch, Co-Host Presiding Elder, Reverend Linda Thomas Martin, Pastors, Ordained clergy, Episcopal Supervisor Dr. Susan Leath, Lay Delegates, Missionaries and Youth of this 144th Session of the West Tennessee Annual Conference in the Thirteenth Episcopal District of the African Methodist Episcopal Church, I present this health report.

The current opioid crisis is the deadliest drug crisis in American history. Prescription opioid use is higher in the US than in any other country worldwide. Drug overdose has become the leading cause of death in Americans under age 50, exceeding car accidents and guns. In 2016, over 64,000 people died from drug overdoses; up from 53,000 in 2015. In comparison, overdose deaths were 16,000 in 2010 and 4000 in 1999. Public health experts estimate that nationwide, over 500,000 might die over the next 10 years from the opioid epidemic. All races are similarly affected; from 2010-2014, opioid use deaths have increased by 200-300% among Caucasians, African Americans and Native Americans, and 140% among Hispanics.

People are affected by opioids at younger ages as time has passed. In 2000 the most common age for drug deaths was around 40 (those who first became addicted to prescription drugs). Now, in addition to this group, there is another group of younger users addicted to heroin and fentanyl instead of prescription opioids. The youngest members of society are not exempt; toddlers and young children are increasingly being found unconscious or dead after taking an adult’s drugs and infants born to addicted mothers suffer from and require treatment for neonatal abstinence syndrome.

What are opioids? Their names are familiar: morphine, heroin, oxycodone, hydrocodone. They act on the brain’s pain centers, which provide pain relief. They also affect the brain’s reward centers, which make them devastatingly addictive. The respiratory centers are also affected, which can lead to respiratory depression, and ultimately respiratory failure and death.

How did the crisis come about? In the 1980s a few medical journal articles claimed opioids ware not as addictive as originally thought. Then came emphasis on patient satisfaction and pain as the “fifth vital sign”. This was followed by the

manufacture of medications such as OxyContin and their aggressive marketing by drug companies as effective pain relievers with a low abuse/addiction potential. The number of pain clinics also grew and some of these treated patients without actual diagnosed pain. At the same time, heroin became more widely available and its price dropped, so many who were already addicted to prescription opioids turned to heroin.

In 2014 illegally-manufactured fentanyl entered the drug supply. Fentanyl is much more potent than other opioids; as little as 2 milligrams can be lethal. It is so potent that police officers and first responders helping overdose victims can themselves become overdosed by touching or inhaling it. Fentanyl can often be mixed with heroin and cocaine, and also be made into pills which are often indistinguishable from prescription opioids, benzodiazepines and other controlled substances. Some dealers might seek out fentanyl because of its potency although many dealers and users are unaware of its presence.

Insurance companies also play a role, limiting access to less-addictive medications or therapies in favor of opioids, because of cost.

What is being done to combat the epidemic? The federal government has established programs to crack down on overprescribers and also “Take Back” programs which allow the return of unused controlled substances to pharmacies. Drug manufactures are also being required to sponsor educational programs for prescribers.

State and local governments have responded by passing legislation which falls into any of 4 categories: 1) Prescription Drug Monitoring Program (PDMP) enrollment. These programs list recipients of controlled substances and the drugs received, and prescribers must enroll in their state’s program. 2) Prescribers must check the PDMP whenever prescribing controlled substances. 3) Opioid prescribing cap laws, which limit the quantity of medications and duration of treatment. 4) Pill mill laws, which allow for closer monitoring and regulation of pain clinics. Tennessee has enacted laws in all these categories.

Prevention is usually discussed; however, we also need to focus on those who are already addicted. The most effective treatment programs combine less-addictive drugs (e.g. buprenorphine, methadone) with behavioral counseling. Another strategy is using naloxone, which counteracts acute overdoses. Efforts are being made to provide all police officers and first responders with naloxone as well as making it available at pharmacies without a prescription.

Attention also needs to be directed at improving how our medical system manages pain. Studies are focusing on the use of less-addictive or non-narcotic medications and also therapies for pain control.